Watch for these ICD-10 coding and documentation traps

by Robert S. Gold, MD

Thankfully, some of the documentation and coding issues I have been screaming about over the past 10 years have been heard with the transition to ICD-10. Some are resolved, some are on the way to being resolved, and some persist in causing me consternation. And, of course, a couple of new concerns have arisen. What follows is a look at some ongoing areas of concern for CDI specialists regarding proper code assignment in ICD-10.

Pneumonias—or not

“Hypostatic pneumonia” represents one of these problem areas. I have written about it previously in other publications. The code for this condition was developed to describe an expired patient found lying in one position for weeks or months, often severely malnourished and with no protein stores to hold fluid in the bloodstream. Frequently these patients’ lungs have turned to the consistency of liver (called hepatization of the lungs) due to settling of fluid in the dependent portions of the lungs.

In ICD-9, the code for this condition was found under pulmonary edema, or congestion of the lungs, as the lungs became severely congested with blood and debris. This led coders to group the diagnosis along with pulmonary edema and respiratory failure. Some consultants taught this as the right code to assign when there was documentation of “pulmonary congestion.”

This condition is no longer found in pulmonary edema and respiratory failure in ICD-10. (That’s a good thing, in my opinion.) Unfortunately, however, it is now found in with the pneumonias—and hepatization of the lungs is definitely not pneumonia, despite some clinical references to lobar pneumonia and red and gray hepatization of the lungs.

In ICD-9, the code for this condition was found under hypostatic pneumonia. This is real hepatization of the lung in a terminal patient. It represents what the initial intent of the code because, back then, we didn’t have x-rays. Now we do, and we can find the condition. But it’s not pneumonia. (To read more about the clinical indications, visit http://tinyurl.com/krz4m7y.)

Yes, there are references to the fact that hepatization of the lung, with the red and gray varieties, is seen in pneumococcal lobar pneumonia. But that’s pneumococcal pneumonia, and it has a name and a code. The term is also seen in veterinary literature describing the findings that may supervene in large animals like cows or elephants who cannot get up and who, after time, experience settling of fluid in the dependent portions of their lungs.

Don’t fall for hypostatic pneumonia as a diagnostic entity. If it’s truly pneumococcal pneumonia, code it as pneumococcal pneumonia.

And that’s another issue. In ICD-9, “lobar pneumonia” was assigned 481, pneumococcal pneumonia. Yes, strep or pneumococcal pneumonia frequently presents with a lobar distribution—a whiteout on x-ray of an entire lobe of the lung. But other organisms can lead to a whiteout of a lobe on x-ray, so without culture proof, it is unwise to presume that it was pneumococcal. You should clarify this issue with the physician.

In ICD-10, the Cooperating Parties wisely detached that inappropriate link, and now lobar pneumonia will be assigned J18.1 to depict its x-ray appearance as being pneumonia in a lobar pattern caused by an unspecified organism. But the very next code in the series is J18.2, hypostatic pneumonia, unspecified organism—and it’s still not pneumonia.

Cardiomyopathy

Okay, next let’s take a look at cardiomyopathy, another subject that has disturbed me when it comes to advice on how to assign the various ICD-9 codes in the 425 series. All of the listed conditions are causes of diseases of the heart muscle or codes that are assigned for cardiomyopathy of other specified diseases with 425.8—and I think that’s a good thing. Even though advice on when to assign 425.4...
has been horribly wrong, at least the code set did what it was supposed to do—allow the physician to define the case of the patient’s sick heart, regardless of whether there was heart failure.

With ICD-10, unfortunately we go back to the dark ages. Now we have two codes that describe what the heart looks like and provide no indication as to the cause of the patient’s sick heart muscle—and that’s just plain wrong.

In ICD-9, we had 425.4 and 425.9, which addressed that the physician, in fact, didn’t know which primary or secondary cardiomyopathy a patient had. The rest of the codes were all specific causes or were tied to specific causes.

Now, with I42.0 dilated cardiomyopathy, we seem to be happy that the patient has a dilated heart from whatever the cause, and there’s no need to question the physician as to what the cause was because we have a code that looks like it’s a specific disease—but it isn’t specific. Conditions that can lead to dilated hearts include the following:

» Ischemic heart disease (now I25.5)
» Peripartum cardiomyopathy (now O90.3)
» Cardiomyopathy due to coxsackie viral myocarditis, that happens in children (now B33.24)
» Toxicity from chemotherapeutic drugs (now included in I42.7)
» Alcoholic cardiomyopathy (now I42.6)
» Cocaine use (also I42.7 as a toxin)
» Takotsubo syndrome, stress cardiomyopathy (now I51.81)

With so many possible choices, so long as we get I42.0, you might ask: Who cares? Well, the data cares. The patient cares. Work with your physicians to get these conditions clarified.

Treatment of heart failure or treatment of the patient at risk of progressing to heart failure depends on controlling the “cardiomyopathy.” If we have no idea what the cause is, the patient and the data both suffer.

Dilated cardiomyopathy is a finding with a zillion possible causes. Yes, the physician may never find the specific cause. It can exist without identifiable cause. But don’t ever be satisfied with I42.0 unless the physician truly just doesn’t know.

Further, we now have a code I42.5 for other restrictive cardiomyopathy. Just as with I42.0, all it says is that the heart muscle doesn’t relax well in diastole and often doesn’t do such a hot job in systole. It says nothing about the cause, and again, there are specific causes of restrictive heart disease. It’s a finding on an echo. It’s not a cause of disease. Assigning the code does not help the world’s database of causes of heart disease or heart failure. It may be valuable to know about this dysfunction, but it’s a dysfunction.

Restrictive dysfunction of the heart can be associated with amyloid cardiomyopathy (E85.- plus I43 cardiomyopathy in disease classified elsewhere), known as the worst cause of diastolic heart failure because of the infiltration of the heart muscle with amyloid proteins called prions. Sarcoidosis can do the same (D86.85), as well as scleroderma (M34.-), hemochromatosis (E83.- plus I42.8), pericarditis of lupus or radiation therapy, and even hearts after transplant.

Yes, there can be, after study, no specific cause found, but this “restrictive cardiomyopathy” should be identified by cause or by, as a default, “I don’t know.” And if the physician doesn’t know, that’s okay, but don’t be satisfied with I42.5 unless the cardiologist specifically can say “I don’t know—
yet—or may never know.”

We have this I43 code to use for cardiomyopathies in diseases classified elsewhere. Maybe this could be subdivided to “dilated cardiomyopathy in diseases classified elsewhere” and “restrictive cardiomyopathy in diseases classified elsewhere,” and then do the same with I42.9 to reflect “I42.91 dilated cardiomyopathy, I don’t know what the cause is” and “I42.2 restrictive cardiomyopathy, I don’t know what the cause is.” That would permit the description of these significant issues of dilation and restriction but outside of the specific causes of heart disease.

**Respiratory**

The next issue I have with ICD-10 is the fact that the respiratory failure series, 518.8x, has almost—but not entirely—been fixed. Where 518.82 was misdefined and misused, we are close to getting it resolved. No longer do we have an equivalent of 518.82 in ICD-10.

Acute and chronic hypoxic and hypercapnic respiratory failure exist in the J96 group. J80 is now defined as ARDS—acute respiratory distress syndrome in adults and children. “Respiratory insufficiency” points to R06.89, other abnormalities of breathing, where it belongs. “Respiratory distress” now points to R06.00, dyspnea, where it belongs.

There are still inappropriate pointers of “acute respiratory distress” to the ARDS code, however, and almost no case of acute respiratory distress is actually indicative of ARDS. ARDS is ARDS, so don’t ever consider the J80 code for ARDS when the patient is not identified as having ARDS—one of the worst causes of acute respiratory failure that exists. Virtually all of these patients are ventilated or they die. Period.

Having lost ARDS in the respiratory failure category, we now have an inane series of codes in the J95 series, intra- and postoperative complications of the respiratory system, not elsewhere classified. Here we see J95.1, acute postoperative pulmonary insufficiency following thoracic surgery, an MCC; J95.2, acute postoperative pulmonary insufficiency following nonthoracic surgery, an MCC; and J95.3, chronic pulmonary insufficiency following surgery.

There is no identifiable, measurable, definable condition in medicine called respiratory insufficiency. All it means in any medical journal published since the 1850s is that the lungs aren’t doing all they should to oxygenate or to clear carbon dioxide. To have codes for this is unfathomable. And to create a severity status of MCC when you can’t measure it is equally inappropriate.

All patients recovering from anesthesia after a procedure have some element of “pulmonary insufficiency.” They haven’t woken enough to thoroughly do the job, so they’re often left on oxygen for a while.

All patients after chest surgery or upper abdominal surgery have pain when they breathe, so they splint their breathing and they need oxygen. Patients after long procedures, or who have heart failure or COPD or other conditions that have an effect on their abilities to do well without the insult of an operative procedure, will need prolonged respirator support while they reverse from anesthesia, and that’s just what they get.

Some people are sensitive to the sedatives or the analgesics used in these procedures and may need additional support after surgery with oxygen or incentive spirometry.

None of these cases are worthy of being assigned a complication code, nor one that has the financial impact of a major complication, because they do not represent a major complication.

This whole series of codes is ludicrous. Even the physician who led the discussions creating them confessed in private that there is no such thing as chronic postoperative respiratory insufficiency, or chronic postoperative respiratory failure, for that matter.

If the patient, indeed, does have acute respiratory failure as a complication of a surgical procedure, a coder should assign J85.821, acute postprocedural respiratory failure. And it deserves to be designated as a major complication.

As a CDI specialist, ask the physician to name the cause of it, like tension pneumothorax or hemothorax or having removed too much lung tissue or cutting both phrenic nerves. But postprocedural pulmonary insufficiency? Don’t go there.

**EDITOR’S NOTE**

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