Coronary artery disease (CAD) develops when the arteries that supply the blood to the heart muscles become hardened and narrowed due to a buildup of cholesterol and other materials, such as plaque, on their inner wall. It’s also called atherosclerosis.

CAD is the most common type of heart disease and occurs in a wide range of patients. This chronic condition is the leading cause of death in the United States for both men and women. Usually, but not always, the complications associated with CAD are what lead to death, rather than the chronic condition itself, says Cheryl Ericson, MS, RN, CCDS, CDIP, associate director of education for the Association of Clinical Documentation Improvement (CDI) Specialists in Danvers, Massachusetts.

Atherosclerosis can reduce blood flow, and as a result it can decrease oxygen to the heart muscles. If the heart muscles don’t get enough oxygen for long enough, infarction can result, leading to tissue necrosis or death, Ericson says. If it’s only a brief lack of oxygen, the patient might develop chest pain, more specifically angina, which is a specific type of chest pain associated with CAD. Prolonged oxygen deprivation can lead to tissue death, which is an acute myocardial infarction (AMI). In addition, CAD weakens the heart muscles, thereby contributing to heart failure and different arrhythmias.

The thing that’s tricky from a CDI perspective is that CAD is not something that typically needs to be treated in the inpatient setting, Ericson says. Physicians can usually monitor and treat patients very well in the outpatient setting. As such, CDI specialists need to look for the acute reason for the admission, that is, the new symptom associated with the chronic CAD, which is often the cause of the inpatient admission.

ICD-9-CM codes for coronary atherosclerosis appear in the 414 series of codes. The codes include choices that describe the affected vessel(s):
- Unspecified type of vessel (414.00)
- Native vessel (414.01)
- Autologous biological vein bypass graft (414.02)
- Nonautologous biological bypass graft (414.03)
• Artery bypass graft (414.04)
• Unspecified type of bypass graft (414.05)
• Native coronary artery of transplanted heart (414.06)
• Bypass graft (artery) (vein) of transplanted heart (414.07)

Coding Clinic provided guidance on how to select
the correct fifth digit to identify a native artery or a by-
pass graft in ICD-9-CM, says Shannon E. McCall,
RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CCDS,
director of HIM and coding for HCPro, a division of
BLR, in Danvers.

“If the physician just used the term ‘CAD’ and we
know the patient had a CABG [coronary artery bypass
graft] procedure in the past without further identifica-
tion in the documentation, it defaulted to an unspeci-
fied vessel,” McCall says.

Coding CAD in ICD-10-CM

In ICD-10-CM, the default isn’t necessarily the
same, McCall says. In ICD-10-CM, the default is to a
native vessel (I25.10) because even if a patient had
a bypass, he or she still has atherosclerosis of the native
vessel.

Coders will find the code for atherosclerotic heart
disease of native coronary artery in subcategory I25.1.

Another difference between coding for athero-
sclerosis in ICD-9-CM and ICD-10-CM is the addition
of combination codes in ICD-10-CM, McCall says. When
it comes to CAD or arteriosclerosis, coders often
have to use two categories of codes to fully describe
a patient with CAD and also angina (e.g., 411.1) in
ICD-9-CM.

If the patient does have angina in the setting of
CAD, coders will choose a combination code in ICD-
10-CM that identifies CAD and the presence of angina
pectoris as well as its type, if specified.

If the patient does not have angina pectoris, coders
will report I25.10 (atherosclerotic heart disease of na-
tive coronary artery without angina pectoris).

For patients with angina pectoris, subcategory

Coders will find the code for atherosclerotic heart
disease of native coronary artery in subcategory I25.1.
I25.11- includes the following additional choices that further clarify the patient’s condition:

- I25.110, atherosclerotic heart disease of native coronary artery with unstable angina pectoris
- I25.111, atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
- I25.118, atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
- I25.119, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris

“We can assume a causal relationship between the coronary artery disease and angina, even if the provider puts them as two separate line items in a problem list,” McCall says, which is important from an inpatient standpoint.

Sequencing is a significant problem with coding currently in ICD-9-CM because unstable angina typically brings the patient into the hospital. The underlying cause, most commonly CAD would be assigned as the principal diagnosis McCall says.

“Right now we’re using a Coding Clinic that says if the person has a history of coronary artery disease and they have angina, you can sequence the CAD first,” Ericson says.

Sequencing CAD first groups to a different MS-DRG than sequencing angina first; however, both of these MS-DRGs are very susceptible to denial for medical necessity.

“With these combination codes, the sequencing is a non-issue because it is a single code,” Ericson says.

In patients with atherosclerotic heart disease of a native coronary artery, ICD-10-CM instructs coders to use an additional code, if applicable, to identify:

- Coronary atherosclerosis due to lipid rich plaque (I25.83)
- Coronary atherosclerosis due to calcified coronary lesion (I25.84)

Several of the codes in I25.11- also feature Excludes1 notes. In ICD-10-CM, an Excludes1 note is a pure excludes note and means the two conditions are mutually exclusive. A patient cannot have both conditions at the same time.

Notes under subcategory I25.11- exclude unstable angina or angina pectoris without atherosclerotic heart disease (I20.0-).

ICD-10-CM still includes codes for patients who have undergone a CABG and have CAD. Those codes will identify whether the CAD affects a graft or a transplanted heart.

The physician must document the type of graft, whether it is venous or arterial. That information may or may not be in the physician’s documentation currently, McCall says.

“From a documentation standpoint, it may be helpful to ensure the physician identifies somewhere in the record that the patient had a CABG in the past,” she says. “If they have had vessels bypassed, whether it involved using the saphenous vein or if it was a radial artery or if it was some other type of grafting, then it may be helpful to know if the CAD is affecting that graft.”

The physician also needs to document the type of angina, if present. As with the other native vessels, ICD-10-CM includes combination codes for:

<table>
<thead>
<tr>
<th>Codes that act as their own CC</th>
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<tbody>
<tr>
<td>In ICD-10-CM, certain codes act as both the principal diagnosis and their own CC. When coders report any of the following codes, they will also get credit for a CC:</td>
</tr>
<tr>
<td>- I25.110, atherosclerotic heart disease of native coronary artery with unstable angina pectoris</td>
</tr>
<tr>
<td>- I25.700, atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris</td>
</tr>
<tr>
<td>- I25.710, atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris</td>
</tr>
<tr>
<td>- I25.720, atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris</td>
</tr>
<tr>
<td>- I25.730, atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris</td>
</tr>
<tr>
<td>- I25.750, atherosclerosis of native coronary artery of transplanted heart with unstable angina</td>
</tr>
<tr>
<td>- I25.760, atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina</td>
</tr>
<tr>
<td>- I25.790, atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris</td>
</tr>
</tbody>
</table>
• Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris (I25.70-)
• Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris (I25.71-)
• Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris (I25.72-)

The combinations specify the same choices for types of angina as the native vessel codes.

**CDI and CAD**

CDI specialists need to remember their role really isn’t to memorize the codes, Ericson says. The coders are still going to be the ones doing code assignment. “What you want to do is make sure there is precise documentation so the most accurate code can be assigned,” Ericson says. That means CDI specialists must determine a query threshold.

“What I mean by that is, if the information is not going to have a significant impact on the claim, is it the role of CDI to query for additional specificity of the affected vessel?”

As such, organizations need to determine who will query in these types of situations because it really becomes a coding accuracy issue rather than a claims submission issue,” she says. “Unfortunately, it isn’t possible to query for every unspecified code, so CDIs often have to limit their query efforts based on the department’s mission.”

The type of angina is very important. “One of the things we want to work on as CDI specialists is oftentimes the physician uses the term ‘chest pain,’” Ericson says. Even cardiologists sometimes use it.

“Chest pain is too vague because it doesn’t necessarily reflect a cardiac issue in terms of coding, so we need them to tell us if it’s angina rather than chest pain,” she says. “So we’re going to have to try and get them away from using that language. We really want to know if there is a cardiac issue and if so, what type of angina is present in this patient with coronary artery disease.”

If the provider continues to use the term “chest pain,” then CDI specialists should clarify whether the patient’s chest pain is ischemic or non-ischemic.

“The reason why we would want to do that is because if it’s ischemic chest pain, that is one of the ICD-10-CM inclusion terms for angina,” Ericson says. “That’s going to allow us to then take advantage of that relationship between coronary artery disease and angina that we have in ICD-10 that we didn’t have in ICD-9.”

She continues, “The physician has to always be very clear in saying what is causing the chest pain. If it’s cardiac, that’s an important finding. They should tell you it’s a cardiac type of chest pain.”

CDI specialists and coders want to make sure to look for any kind of clinical indicators of angina, Ericson says. Consider these questions:

- Did the physician order nitroglycerin?
- Did the physician order aspirin?
- Did the physician order oxygen?
- What else did the physician order for the patient?

“If you want that precise coding, you’re going to look at whether or not there’s a history of CABG,” Ericson says. “If the patient has a history of CABG, we can’t assume that the coronary artery disease is of the native vessel. Then you can even look for a history of a transplant, because then we definitely can’t assume it’s of the native vessel. It could be of the transplanted vessel.”

CDI specialists will need to determine what level of detail makes the most sense for their organization, Ericson says.

“It’s really a coding precision issue, and so we don’t want to antagonize our physicians by querying too much on things that aren’t going to have a huge impact in regards to what we’re billing on our claims,” she adds.

**MS-DRGs and CAD**

If a patient has CAD and unstable angina, the combination code acts as both a principal diagnosis and a CC. (See p. 3 for a list of applicable codes.)

Coders and CDI specialists may think that’s great because they have a CC, Ericson says. However, when coders and CDI specialists look at the MS-DRGs associated with these codes, they see that they need an
Querying for chest pain

Cheryl Ericson, MS, RN, CCDS, CDIP, associate director of education for the Association of Clinical Documentation Improvement Specialists in Danvers, Massachusetts, explains how she queries a physician about chest pain and also provides a sample query.

"Whenever we see chest pain, if you can’t get your physicians used to saying angina rather than chest pain, start asking them is it ischemic, non-ischemic.

“You have a patient with a history of coronary artery disease (CAD) who admitted with chest pain. I always like to say when and where I get my information. The more quotes you can use, the better, because then it’s showing the individuality of the patient and that record.

“Next I am going to ask the physician to clarify, and I always like to tell the physician when and how to clarify. For this particular example, I would use a multiple choice if the physician is able to mark on the query form itself, in which case the query would be kept as part of the health record. That’s why I said ‘please clarify below.’

“If the physician is writing in the progress notes, I might say, ‘Please respond in the progress notes in the next 24 hours.’ I always like to tell them how to respond and what’s the time frame of doing it. What I want to know is can the chest pain be further clarified.

“Remember, whenever we have a multiple choice or if you’re using a yes/no, which has recently been expanded beyond present on admission, you always have to include ‘unable to determine’ or something similar as well as ‘other’ for the physician to write in freehand.

“Because I said that this one query example would be part of the record because they would be marking on it, that’s why there’s a physician signature, date, and time. If the physician was writing in the progress notes, then you wouldn’t need to have a physician signature, date, or time, but we’d have to have it authenticated if it became part of the health record.”

Chest pain sample query

Ms. Smith has a history of CAD and was admitted with chest pain per the history and physical (where/when). Please clarify below (how/when) if the chest pain can be further clarified as:

- Ischemic
- Non-ischemic
- Unable to determine
- Other _____________

MD signature: __________________________
Date/time: ____________

MCC in order to maximize this DRG.

“The CC will be counted,” Ericson says. “But in terms of MS-DRG reimbursement, it’s not going affect the overall payment amount.”

The CC will more likely have an impact for facilities paid under APR-DRGs because the CC from the unstable angina is going to have value. That value just isn’t reflected under the MS-DRG classification system, Ericson says.

Codes for atherosclerosis without an MCC group to MS-DRG 302, while those with an MCC group to MS-DRG 303.

“One thing that I did want to point out is that you very well may see cases where we have DRGs that are falling under the MS-DRG 311, which is for angina pectoris,” McCall says. With the implementation of ICD-10-CM, when facilities start looking at MS-DRG 311, they may see a decrease in the number of cases that go into that DRG unless CAD is not present in those cases.

MS-DRG 311 is lower-paying than MS-DRG 302 or 303. ICD-10-CM won’t cause large shifts in MS-DRG grouping, but it may cause a shift away from MS-DRG 311.

“If you’re coding records in ICD-10 and you notice that you’re in a different DRG and you see something that doesn’t look right, you may want to take another look at it,” McCall says. “But absolutely, whether or not it’s of a native vessel or if it’s of a bypass graft, it’s still going to fall under MS-DRG 302 or 303.”
Keep in mind that MS-DRGs 302 and 303 are among the medical necessity denials, Ericson says. The geometric mean length of stay for patients with atherosclerosis without an MCC is two midnights. That may cause a problem with CMS’ 2-midnight rule, which instructs physicians to admit patients whose stay in the hospital is expected to cross two midnights.

A patient with CAD and angina wouldn’t necessarily qualify to be in the inpatient setting. Once that patient has a myocardial infarction, that’s when he or she will need inpatient care. “But if the patient just suffering from angina, then that’s something that can usually be treated successfully in the outpatient setting,” Ericson says.

Queries can help reflect accurate SOI, ROM

Coding tells a patient’s story, based on the narrative the physician provides in his or her documentation. Accurately painting a picture of the patient’s severity of illness (SOI) and risk of mortality (ROM) is essential for good patient care, and it is becoming increasingly important for quality measures and payment.

MS-DRGs group similar clinical conditions (diagnoses) and the procedures furnished by the hospital during the stay. The patient’s principal diagnosis and up to 24 secondary diagnoses that may include comorbidities or complications will determine the MS-DRG assignment.

The MS-DRG system includes three levels of severity:
- With MCC, which reflects the highest level of severity
- With CC, which is the second highest level of severity
- Without CC/MCC, which does not significantly affect SOI and resource use

For example, a patient is admitted with acute renal failure secondary to dehydration and treated appropriately with IV fluids. The rehydration corrected the acute renal failure, and the patient did not require dialysis. Coders would sequence ICD-9-CM code 584.9 (acute kidney failure, unspecified) as the principal diagnosis with code 276.51 (dehydration) as a secondary diagnosis.

This case groups to MS-DRG 675 (other kidney and urinary tract procedures without CC/MCC). This MS-DRG has a relative weight of 1.3558, a geometric mean length of stay (GMLOS) of 1.8 days and an arithmetic mean length of stay (AMLOS) of 6.5 days.

Let’s say the physician also documents that the patient is diabetic (ICD-9-CM code 250.00) and has a stage III decubitus ulcer of the heel (707.07, 707.23) that is present on admission (POA). The stage III ulcer is an MCC (as long as the ulcer is POA), so the case now groups to MS-DRG 673 (other kidney and urinary tract procedures with MCC). The relative weight increases to 3.0591, the GMLOS increases to 6.4 days, and the AMLOS becomes 9.8 days.

APR-DRGs

Most coders and CDI specialists are familiar with how MS-DRGs work. CMS implemented them back in 2007.

3M developed all patient refined DRGs (APR-DRGs) in 1990 to address both SOI and ROM over all patient populations. The APR-DRG system is composed of a clinical model and four SOI and ROM subclasses for each base APR-DRG. These subclasses are broken down into four levels:
- 1: Minor
- 2: Moderate
- 3: Major
- 4: Extreme

Hospitals use APR-DRGs for internal quality improvement, and many states use them for public reporting.

APR-DRGs are weighted according to CMS guidelines, and they are updated accordingly each year, says Sara Baine, MSN-Ed, CCDS, a CDI consultant for MedPartners HIM in St. Louis. There are expected mortality percentages based on the state data APR-DRGs, and it’s a standard methodology that’s used by most rating agencies, Baine adds.
Documenting SOI, ROM

In some cases a patient can look healthy on paper but in actuality has a high SOI and ROM.

Consider this case: An 86-year-old female was found unresponsive at home. Her past medical history includes:
• Diabetes mellitus Type 2
• Hypertension
• Hyperlipidemia
• Coronary artery disease

The physician documents the following information:
• Blood pressure 76/50
• Respiratory rate 8
• Heart rate 105
• Temperature 104 degrees
• Saturation on non-rebreather 87%
• Chest x-ray negative
• Complete blood cell count: White blood cell count 42,000
• Basic metabolic profile: BUN 62, creatinine 3.4
• Urinalysis: turbid urine, 4+ leuk esterase, greater than 50 WBCs, 4+ bacteria

The patient was given 3 liters of fluid in the ED, as well as Levophed® drip IV and Vancomycin® IV. She was intubated and placed on a ventilator.

Based on this documentation, the coder reported ICD-9-CM code 458.9 (hypotension) as the principal diagnosis, with the following secondary diagnoses:
• 599.0, urinary tract infection
• 790.7, bacteremia
• 250.00, diabetes mellitus
• 780.2, syncope and collapse
• 593.0, disorder of kidney and ureter
• 401.9, essential hypertension
• 809.7, altered mental status

The coder also reported ICD-9-CM Volume 3 procedure codes 96.71 (ventilator for less than 96 hours) and 96.04 (intubation).

“The mortality review appears to contradict the case as it’s documented by a clinician,” Peppers says. If the physicians do not document properly, they will not accurately represent the patient’s SOI and ROM. “Physicians have to be sure that they document all of the treatments and add a diagnosis to it.”

What should the physician have documented and what should the coder or CDI specialist have queried for to better represent how sick this patient was?

The patient came into the ED, was intubated, and received multiple medications. “You used a lot of resources on this patient,” Peppers says. According to the SOI and ROM, this patient should have been walking and talking, and the facility should not have used many resources to treat her.

To accurately reflect the patient’s condition, her SOI and ROM should both be 4, Peppers says. If the physician treats a condition, he or she should get credit for it. “It’s a big disservice to your hospital and to your facility if you let a patient go through without showing that severity of illness and risk of mortality as what it should be to show all the resources that you used on that patient,” she notes.

Most of the time with SOI and ROM, coders and CDI specialists are looking for a potential diagnosis that’s not documented in the record, Baine says. The physician has alluded to a diagnosis with clinical indicators. “You’ve got to grab that information out and correlate it into a competent, clinical non-leading query,” she adds.

Querying for SOI, ROM

Coders and CDI specialists can use a three-step approach to query for SOI and ROM, Baine says.

The first step is to review the clinical indicators. “You’re determining what indicators are significant for a complex diagnosis,” Baine says. Don’t pull in clinical indicators that are related to something else. “You can’t lump two diagnoses into one query. It would be great if we could do that because physicians get very angry if you have to place three or four queries.” In addition, some facilities limit the number of queries a CDI specialist or coder can send at one time.

Step two is to look at the treatment. What kind of treatment is applicable for the diagnosis? “Don’t put treatments in the query that are not essential to the diagnosis you’re looking for,” Baine says. Doing so
could steer the physician in a different direction and be considered leading.

Step three is to determine the appropriate diagnoses for each query. The majority of queries for SOI and ROM will be potential diagnoses, Baine says. “You can’t introduce new evidence, but if you can give sufficient information about what the clinical indicators are, the treatment plan that was offered, and diagnoses, if you’re able to do that within your query guidelines for your facility, then you should be able to get the information you need from the physician.”

In many cases, CDI specialists will need to speak to the physician face to face because the physician may not understand what the CDI specialist is looking for. The CDI specialist may need to give extra background information from the chart as well. “You can’t just give the one you were looking for and say, ‘This is what I need,’ ” Baine says. “You need to give the physician a listing of appropriate diagnoses.”

Applying the query process

How would coders and CDI specialists follow this three-step process for the ED patient who died on day 3 of her stay? Coders and CDI specialists could send four separate queries for this case.

The first query involves the principal diagnosis.
Step 1, clinical indicators: 84-year-old patient with:
• Urinary tract infection
• Temperature 104 degrees
• Unresponsive
• Blood pressure 76/50
• Heart rate 105
• Saturation 87% on non-rebreather
• White blood cell 42,000

Step 2, treatment:
• 3 liters IV fluid
• Levophed drip
• Intubated/ventilator
• Vancomycin IV

Step 3, potential diagnoses:
Based on the information provided, please document if you are treating any of the following:
• Septic shock
• Shock unrelated to trauma
• Unable to determine
• Other (please specify)

The second query focuses on the respiratory problems.
Step 1, clinical indicators:
• Patient’s respiration at 8 breaths per minute and oxygen saturation at 87% on non-rebreather. In addition, the patient is unresponsive.

Step 2, treatment:
• Non-rebreather progressed to intubation/ventilator management. Patient had assist control vent with rate of 12, oxygen level to 90%.

Step 3, potential diagnoses:
Based on the information provided, please document if you are treating any of the following:
• Acute respiratory failure
• Acute respiratory insufficiency
• Other diagnosis (please specify)
• Unable to determine

Some facilities may have templates for coders and CDI specialists to use when choosing diagnoses. “Make sure that you audit that and delete any diagnosis that is not pertinent or that doesn’t match your indicators and treatment,” Peppers says.

The third query opportunity involves the patient’s unconsciousness.
Step 1, clinical indicators:
• Unresponsive to painful stimuli
• Pupils 4 mm and nonreactive

Step 2, treatments:
• Neuro checks q1h

Step 3, potential diagnoses:
Based on the above information, please document if you are treating any of the following:
• Coma
• Obtunded
• Other diagnosis (please specify)
• Unable to determine

Coma and obtunded are the only pieces of information
applicative for these clinical indicators and treatment, Baine says. “You want to give the physician sufficient information to make a valid choice so it’s not a leading query.”

The fourth potential query involves renal function.

Step 1, clinical indicators:
- 86 y/o pt with chronic renal insufficiency
- BUN 62, creatinine 3.4
- Documented baseline creatinine of 1.0
- Unresponsive
- Blood pressure 76/50

Step 2, treatments:
- 3 liters IV fluid
- Levophed drip

Step 3, potential diagnoses:
Based on the information provided, please document if you are treating any of the following:
- Acute renal failure with acute tubular necrosis
- Acute renal failure without acute tubular necrosis
- Other diagnosis
- Unable to determine

“We’re looking for acute renal failure with acute tubular necrosis, and one of the reasons that we were going for the tubular necrosis is because of the blood pressure being low, 76/50, and renal failure with your 3.4 creatinine and with a baseline of 1,” Peppers says.

Based on the clinical indicators and treatment, the patient’s actual principal diagnosis should have been 038.9 (septicemia), Peppers says. But coders and CDI specialists need to query for that information because it is not obvious from the documentation.

In addition, coders or CDI specialists should query for potential secondary diagnoses. These should be:
- 785.52, septic shock
- 584.5, acute kidney failure with lesion of tubular necrosis
- 518.81, acute respiratory failure
- 780.01, coma
- 599.0, urinary tract infection
- 995.92, severe sepsis
- 250.00, diabetes mellitus Type 2

The procedures remain the same. This coding reflects a patient with an SOI and ROM of 4, which shows she was very sick.

**Coding Clinic continues to focus on ICD-10-PCS**

*by Sharme Brodie, RN, CCDS*

Many coders and CDI specialists memorized previous Official Guidelines for Coding and Reporting, Coding Clinic for ICD-9-CM and do not have to give them a lot of forethought before applying correctly to their day-to-day reviews. Although many of the Official Guidelines for Coding and Reporting remain the same in ICD-10, none of Coding Clinic’s previous advice can be applied to the new code set. Without years of new Coding Clinic advice under their belts, it may take some time before the staff exhibits the same ease when applying ICD-10-CM/PCS codes to the documentation provided.

CDI and coders alike will probably have the most difficulty using the new ICD-10-PCS codes. No one can say with certainty how smoothly the transition from ICD-9-CM to ICD-10-CM/PCS will be, and because ICD-10-PCS is a completely new system (which has not been used by any other country) there will be growing pains.

CDI staff need to learn what information the coding staff needs to correctly code a chart. Coding Clinic for ICD-10-CM/PCS, Third Quarter 2014 p. 3, provided an example of this in the discussion of correctly coding a modified Blalock-Taussig shunt procedure. When coding bypass procedures there will be two general guidelines. The first applies to general bypasses; the fourth character represents the body part bypassed “from” and the seventh character will represent the body part bypassed “to.” The second applies to coding coronary artery bypass procedures where the meaning of these characters will be different; the fourth character represents the number of arteries involved in the procedure and the seventh character will represent the area bypassed “to.”

A fair amount of advice in this Coding Clinic pertains
to two principal documentation dilemmas. The first regards coding and documentation for a condition that is a manifestation secondary to a disease process. The second concerns when a step in a procedure is inherent to that procedure and therefore would not be coded separately. These represent dilemmas because there are times when the opposite can be true—a condition can be coded separately because although it is a manifestation it is not considered integral to the disease process or a step in the procedure in not inherent.

Coding Clinic essentially tells us that each individual case needs to be decided based on the documentation provided. If the CDI specialist or coders isn’t sure if the condition, or step, is integral or not, the physician should be queried to clarify the situation before coding the chart. Charts involving interventions or procedures should be vetted by the CDI staff so the coders don’t have to worry about querying. A CDI specialist with some surgical experience may be able to help in this regard, particularly if they understand the steps performed during a given surgical procedure.

Provider documentation

Coding Clinic reiterated that code assignment may be based on documentation from other physicians, such as consultants, residents, anesthesiologists, etc. as long as the information does not conflict with the attending physician’s documentation. In the case of a conflict, the attending physician’s documentation supersedes all others.

Documentation in the medical record by any physician that is directly involved in the care and treatment of a patient can be used for code assignment. Whether a resident’s documentation needs to be co-signed by the attending physician is a questionsituation best addressed by the hospital’s internal policies, medical staff bylaws, and/or other applicable local/state/federal regulations.

The Official Guidelines for Coding and Reporting define a provider as “the individual legally accountable for establishing a diagnosis.” If a provider is considered legally accountable for establishing a diagnosis within the regulations governing the provider and the facility, then his or her documentation can be used for code assignment and to report a new diagnosis. This would include nurse practitioners and physician assistants’ documentation in the health record.

Inpatient documentation is not limited to the face sheet, discharge summary, progress notes, history and physical, or other reports designed to capture diagnostic information. Coders should review the chart in its entirety prior to code assignment; codes should not be assigned. Code assignment should not be based solely on one area of the documentation.

Nonphysician documentation

In previous issues of Coding Clinic for ICD-10-CM/PCS, Coding Clinic stated that a procedure provided and documented by a nonphysician can be coded. This documentation may be the only evidence that the procedure was performed.

Examples of such procedures include infusions carried out by nursing staff, mechanical ventilation provided by a respiratory therapist, or a drug ordered by a physician and administered by a nurse.

There must be documentation to substantiate the procedure code (again, note that this advice only applies to procedure coding, not diagnosis coding). This guidance reinforces the best practice of that CDI specialists examining the complete medical record, including ancillary staff notes, for documentation of any procedures provided by nonphysician personnel.

Coding Clinic also states that if a physician does not document external cause information, coders may use nonphysician documentation. If the nonphysician’s and the physician’s documentation conflict, the physician’s documentation takes precedence.

Signs and abbreviations

As previously advised and reiterated by Coding Clinic, coders cannot assign a diagnosis based on up and down arrows. These Up and down arrows can have different meanings to different people, and could simply mean a change from previous results. Only a provider can diagnose a patient’s condition, so if the provider is using arrows in his or her documentation, query for clarification and ask for appropriate documentation to be provided in the medical record.

Per the Official Guidelines for Coding and Reporting Section III.B, abnormal findings (i.e., labs, x-rays, pathologic and other diagnostic results) are not to be coded and reported unless the provider indicates their
Son of impossible, improbably, and unlikely
Determine when to code a condition

by Robert S. Gold, MD

I wrote an article in 2008 for Briefings on Coding Compliance Strategies about whether to always code a documented condition.

At that time, my direction was related to the improper understanding of the ICD-9-CM Official Guidelines for Coding and Reporting and the advice in Coding Clinic. The idea for the article came from audits where I had found that coding professionals were inappropriately assigning codes from parts of the medical record where the doctors, early in the workup of a complex patient, were describing differential diagnoses in their evaluation of the patient; these professionals were assigning codes for every one of these diagnoses. I recalled the exact verbiage of the guidelines and advice as follows:

From the ICD-9-CM Official Guidelines for Coding and Reporting:

Two or more comparative or contrasting conditions
In those rare instances when two or more contrasting or comparative diagnoses are documented as “either/or” (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

A symptom(s) followed by contrasting/comparative diagnoses
When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.

From Coding Clinic May/June 1984, we get further into the issues:

If the diagnosis at the time of discharge is stated as suspected, questionable, likely, ?, or probable, code the condition as if it existed or was established. A diagnosis at the time of discharge prefaced by the term rule out is to be translated as “suspected.” A diagnosis stated as “Suspected ________________, but not confirmed” needs further consideration to determine whether it refers to a “suspected condition” at the time of discharge or a “suspected condition” at the time of admission but not established during the episode of hospitalization.

Some people out there will tell you to assign certain codes because “the coding guidelines say you can do it,” and they refer to the ones above. But read the citation a little more carefully:

Uncertain diagnosis
If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to
be ruled out”, or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

This means that the physician concluded the patient had a condition, after workup at the time of discharge even though he or she couldn’t prove it. Despite absence of proof, if the physician’s clinical judgment is that a patient indeed had, after workup, a particular condition, you code that condition as if it exists.

If the physician doesn’t tell you that the condition undoubtedly was or was not present, you cannot make that judgment. If you are left with no conclusion, you often feel that you have to go after one rather than to assign a code for a symptom with no apparent cause.

What prompts me to dwell further on this concept is a trend I’m seeing, following “education” in clinical documentation improvement (CDI), in which physicians are advised to write “possible,” “probable,” “questioned,” or “likely” in front of everything. I especially have seen this in children’s hospitals, probably because CDI in children’s hospitals is so new. Many CDI specialists are trying to learn by themselves, or they are bringing consultants in who try to apply Medicare concepts to kids.

Why do they do it? Because with both APR-DRGs and MS-DRGs, a decreased number of diagnoses are still considered CCs or have a large impact on severity of illness or risk of mortality. With hospital reimbursement depending more heavily than ever on the identification of a proper principal diagnosis and a CC or MCC, coders find themselves under additional stress to get something with a higher DRG relative weight. And sometimes one specific coding guideline gets in the way of truth and honesty.

How physicians work

Docs don’t usually work that way. Docs are used to, unless they are trained improperly, evaluating what’s in front of them and coming up with a diagnosis. It may take a minute, it may take a few hours, it may take several days and lots of tests and consultations—but they like to get the answer.

Docs are detectives. If they haven’t been trained in a program that tells residents, “Don’t ever come up with a diagnosis—what if you’re wrong?” then they pride themselves on getting it right. You don’t see a surgeon operate on a belly for “possible appendicitis.” The operation is for “acute appendicitis.” Sometimes the doc is wrong, and then you’ll see, “The appendix appeared normal but huge lymph nodes were found in the cecal mesentery. Final diagnosis: Mesenteric adenitis.”

Can some diagnoses be elusive? Sure. The origin of a GI bleed may not be found, but the diagnosis of GI bleed is still there. The gastroenterologist may very well have an idea of what’s going on after doing upper or lower GI scopes and maybe a bleeding scan of what he or she thought, after study, was the origin of the bleed. This is okay; this isn’t playing games with the system.

In contrast, if you see physicians or nurse practitioners or physician’s assistants documenting “covering for possible gram negative or gram positive or anaerobic organisms” and expect a coder to assign codes for all of these, that’s just plain wrong. That is playing games, and it’s inviting Recovery Auditor invasions and denials of payments. You can’t do this. You shouldn’t do this.

If a 45-year-old man appears with painless jaundice (cancer of the head of the pancreas until proven otherwise) and CT scan shows a huge mass in the area of the head of the pancreas (cancer of the head of the pancreas, undoubtedly) and large para-aortic lymph nodes and holes in the liver (widely metastatic, incurable cancer of the head of the pancreas) and positive lung scan (poor guy!), what diagnostic testing will be done? What treatment will be done? Maybe palliative chemotherapy. But most likely, no surgery will be offered. Why make the patient suffer through an operative procedure for no gain? This is a “possible,” “probable,” and “VERY LIKELY” cancer of the head of the pancreas with metastases to the nodes, liver, and lung.

This is what the intent of the rule is. It is NOT to give a patient three diagnoses, none of which exist. The issue centers on honesty and the time of discharge.
Q If a patient is admitted with malnutrition and the physician documented the patient to be malnourished from mild to severe, would the CDI team use DRG 641 (severe malnutrition) as a working DRG, or should we query the physician to clarify the severity or type of malnutrition?

A DRG 641 would require use of ICD-9-CM code 261 (nutritional marasmus), which is a high-risk diagnosis vulnerable to denial. The same is true for ICD-9-CM code 260 (kwashiorkor). These conditions describe a very specific type of severe malnutrition that is typically found in third-world countries and doesn’t normally exist in the U.S.

Even if it wasn’t a vulnerable diagnosis, the difference between mild and severe malnutrition constitutes the difference between a CC and an MCC designation. So first look to see what clinical indicators and treatment support were documented in the record. In my opinion, the treatment is often what separates mild malnutrition from severe malnutrition. If the clinical indicators and treatment support severe protein calorie malnutrition (ICD-9-CM code 262), I would query the provider to clarify his or her documentation.

Cheryl Ericson, MS, RN, CCDS, CDI-P, AHIMA-approved ICD-10-CM/PCS trainer, associate director of education for ACDIS and CDI education director for HCPro in Danvers, Massachusetts, answered this question.

Q Is a query titled “Sepsis query” considered leading even if it is an open-ended question?

A We must remember that we cannot be leading in our query practice; we cannot point out which answer we anticipate. We also do not want to indicate anywhere on the query form an expected payment or reimbursement based on the answer provided.

For example, you cannot refer to a relative weight in multiple-choice answers, or state which answer is a CC/MCC. Labeling a query with a title can also be interpreted as leading. In your example, “Sepsis query” may indicate the answer you wish to receive is “sepsis.” I have seen queries for functional quadriplegia labeled as such, and this is leading in nature. Another famous query title that gives away the answer is “Acute blood loss anemia.” So use caution in titles of queries.

Because of our software programs, queries are often categorized by subject so that when we are looking for the template for acute respiratory failure, we can easily find it in the template dictionary. Although it is fine for the query to be labeled that way in the system, the version seen by the provider should not be titled. You can understand how a query for respiratory function clarification may be seen as leading when both the query title and one of its multiple-choice answers say “Acute respiratory failure.” You may not intend to lead, but the provider will have a very good idea of the answer you are banking on.

Laurie Prescott, MSN, RN, CCDS, a CDI education specialist for HCPro, answered this question.

Q We are having a debate about when and how to code cerebral edema. A patient comes in with a closed traumatic fracture of the skull and cerebral
edema without loss of consciousness. How should we code this case in ICD-9-CM and ICD-10-CM?

A Cerebral edema is a very serious condition. It can cause death if it’s not treated. In ICD-9-CM, cerebral edema is captured with code 348.5. It’s always an MCC. Code 348.5 includes traumatic, vasogenic, and cytotoxic cerebral edema.

In ICD-10-CM, if it is traumatic cerebral edema, you’re going to capture that with an S06.- code, just like it is an intracranial injury. You’re going to use the fourth digit to tell whether you’ve got a loss of consciousness, and the seventh digit is going to capture the episode of care.

This includes diffused and focal cerebral edema. Know that it’s an MCC only on the initial encounter.

Let’s say your patient comes back in with some subsequent routine care, or maybe he’s got a malunion of that skull fracture. He’s got a little bit of cerebral edema going on. Know that you lost your MCC on that subsequent care because that seventh-character extension is going to change.

So in order to look up cerebral edema in ICD-10-CM, you’ll go to edema under brain, and it gives you the subterm traumatic. It directs you to see “injury, intracranial, cerebral edema.” Here in the index, you’ve got intracranial injury and cerebral edema, along with traumatic. But it doesn’t matter if it’s diffused or focal. It’s still captured with S06.1-. But we do now have a code for traumatic cerebral edema. It’s not like it was with ICD-9-CM.

If you look in your Tabular List, you have an instructional note that instructs you to code also the skull fracture. You’ll see a similar note under the skull fracture to code also any associated intracranial injuries.

This is an opportunity to query, possibly. You may have to ask the physician, “Is this from the injury, or is this possibly from a surgery that the patient had to relieve a hemorrhage or to relieve some type of injury of the brain?”

Sometimes instead of just assuming it’s traumatic, you may have to ask that question. If it’s not traumatic, remember you keep your MCC if it’s not the initial encounter.

Kim Carr, RHIT, CCS, CDIP, CCDS, AHIMA-approved ICD-10-CM/PCS trainer, AHIMA ICD-10 ambassador and clinical documentation director for HRS in Baltimore, answered this question.

Which ICD-10-CM seventh character would be used for a patient who has a meniscectomy for a meniscal tear if he failed conservative treatment? He was already treated for the condition, but this is the first time he is presenting for surgery.

A This is a good question, and one that my colleagues and I have struggled with and discussed at length. Right now, we have been assigning the seventh character of A since initial treatments include surgical treatment, and it’s the first time the patient is receiving surgical treatment. But this is one of those areas that we’re really hoping that the Coding Clinic workgroup will tackle, and we are going to write in to them because it’s something that we’ve had difficulty with.

There has been the question of whether the seventh character should be subsequent since the patient really has presented for treatment and has been seen by a physician, but because the coding guidelines specifically state that surgical treatment is considered initial, that’s how we’re currently putting it. We just don’t know whether doing so is completely accurate, so we’re waiting for more guidance.

Kristi Stanton, RHIT, CCS, CPC, CIRCC, AHIMA-approved ICD-10-CM/PCS trainer, AHIMA ICD-10 ambassador and senior consultant with the Haugen Consulting Group in Denver, answered this question.