IT’S COMPLICATED

ICD-10 offers opportunities for complication codes

In ICD-9-CM, almost all of the complication codes are in one chapter—the 900 series. Specifically, categories 996 through 999 capture complications of medical and surgical care that are not classified elsewhere in ICD-9-CM. Note that the term “complication” as used in ICD-9-CM does not imply that a problem has been caused by improper or inadequate care.

Coders first refer to the main term for the condition and look for a subterm indicating a postoperative or other iatrogenic condition. If they can’t find an entry under the main term for the condition, they look under the term “complications” and then look for an appropriate subterm, such as one of the following:

- Nature of complication, such as foreign body, accidental puncture, or hemorrhage
- Type of procedure, such as colostomy, dialysis, or shunt
- Anatomical site or body system affected, such as respiratory system
- General terms, such as mechanical, infection, or graft

To be considered a complication, the condition in question must be more than a routinely expected condition or occurrence. However, just because something is referred to as “expected” doesn’t prevent it from also being a complication, depending on the type of procedure.

Complications in ICD-10-CM

In ICD-10-CM, complication codes are structured very differently. Instead of grouping the codes in one chapter, ICD-10-CM places complication codes near the end of each body system–specific chapter, 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, Massachusetts.

Within the last few categories of the chapter, coders will find a category that indicates intraoperative and post-procedural complications.

“When it comes to those complication codes, they’re going to be about complications that affect that particular body system,” McCall says. Some will be
combination codes, such as I97.710 (intraoperative cardiac arrest during cardiac surgery).

Many of these complication codes will identify the specific type of surgery, McCall says. “It basically will tell you whether you’re operating on the same body system the complication occurred or if you’re operating on a different body system.”

This is a significant improvement over ICD-9-CM for research statistics and mortality data, as complications that occur within a different body system are likely to have more significance because they are less likely to be expected, says Cheryl Ericson, MS, RN, CCDS, CDIP, CDI education director for HCPro.

Code I97.710, for example, indicates the patient suffered cardiac arrest while the surgeon was operating on the heart. If the patient suffered cardiac arrest during a different type of surgery, coders would report I97.711. Anything other than a cardiac surgery will fall under the code I97.711 for cardiac arrest during other surgery, McCall says.

Some of the complication codes are not stand-alone codes, McCall cautions. For example, say a patient suffers an intraoperative cerebrovascular infarction during another surgery, meaning the physician wasn’t operating on the nervous system. Coders would report I97.811 (intraoperative cerebrovascular infarction due to cerebral artery occlusion during other surgery) to show that the patient suffered a stroke during the procedure, as well as an additional code to identify the specific infarction site. For example, if the infarction occurred because of an occlusion in a cerebral artery, coders would report I63.50, which is an MCC, as well.

“Remember that when it comes to any of these codes, you need to pay close attention to the instructional notes,” McCall says. “Some of them are not stand-alone combination codes, but rather may necessitate multiple codes.”

**Quality and documentation**

CMS wants to pay for quality of care and is using coded data, which it refers to as administrative data, as a surrogate for this purpose, says Cheryl Ericson.

“That’s one of the things that’s going to make our role as CDI specialists and coders increasingly difficult,” Ericson says. “We already know there’s a lot of frustration in properly assigning complication codes in ICD-9.”

The good news is ICD-10-CM includes more complication codes. The bad news is the industry still doesn’t have a consensus of when and how to use these codes appropriately.

“There’s a lot of differences regarding when people feel comfortable using a complication code versus when they don’t,” Ericson says.

Remember, coding conventions included in the Tabular List and Alphabetic Index supersede coding guidelines. After that, refer to AHA’s Coding Clinic for ICD-10-CM/PCS for additional advice to clarify the Official Guidelines for Coding and Reporting and the coding conventions.

CDI specialists need to recognize when there is the possibility of a relationship between the care provided and the unexpected outcome and to remember that a complication does not imply the physician did something wrong, Ericson says.

Physicians are sometimes reluctant to document an unexpected outcome as a complication, says Trey La Charité, MD, physician advisor for the University of Tennessee Medical Center at Knoxville’s clinical documentation integrity program, coding, and RAC response. CDI specialists can explain to the surgical staff that complication rates are averages, and that one isolated complication will not ruin a physician’s reputation or destroy his or her perfect report card.

“After all, some baseline surgical complication rate is expected—a surgeon who has never had a complication has not performed enough surgery,” he says.

Additionally, complication rates are risk-adjusted. A sicker patient with additional documented comorbidities has an increased likelihood of a complication occurring, La Charité says.

When an unexpected outcome does occur, “if the code set doesn’t already take us to a complication code, we would have to query the provider to find out if there is a cause-and-effect relationship,” says Ericson. “Did this surgical intervention cause the ensuing condition, or did the condition cause this
outcome regardless of the medical intervention?”

Coders and CDI specialists need to pay careful attention to present on admission (POA) status, Ericson adds. One CMS quality initiative specifically focuses on identifying preventable hospital-acquired conditions (HAC). A HAC is a condition that occurs during the admission as opposed to being POA, which is why that POA status is so important.

“With” and “due to”

Coders and CDI specialists often get confused by the terminology “with” versus “due to.” The term “with” can link two ideas, but it does not demonstrate a cause-and-effect relationship, says Ericson. “This is when you need the physician to say ‘due to,’ to show causality, which is how it is specified within the code set. They could also use phrasing like ‘from’ or ‘secondary to.’ ”

For example, say the provider documents “the infection was due to the urinary catheter” instead of “the patient has a urinary tract infection (UTI) with an indwelling catheter.” In the latter case, “that doesn’t tell the coder that the indwelling catheter caused the UTI,” Ericson says.

The best practice would be to look at the totality of the health record. If the possibility of an undocumented relationship exists that could affect the coding of the record, then query the provider for clarification, Ericson says.

“It’s your responsibility to query,” she adds. “The physician has the freedom to disagree, but if you see a high prevalence of disagreement amongst certain physicians, then that’s something you might want to escalate to your compliance department. We want to make sure the coding accurately reflects the events of the health record rather than worrying about whether it’s going to hit a quality metric or not.”

Editor’s note: This article was originally published in our sister journal Briefings on Coding Compliance Strategies.

Tips to resolve tricky anemia documentation troubles

Anemia is a tricky condition from a diagnostic standpoint because as many as one-third of patients in the U.S. could have some type of anemia, says Cesar M. Limjoco, MD, vice president of clinical services for DCBA, Inc., in Indianapolis.

If a patient with acute bleeding loses enough blood to become anemic, the diagnosis of acute blood loss anemia is appropriate, says Richard D. Pinson, MD, FACP, CCS, of HCQ Consulting in Chattanooga, Tennessee. This definition also encompasses patients who have preexisting anemia and become more anemic due to bleeding.

If the physician just documents “anemia,” he or she is not capturing the patient’s severity of illness, Limjoco says. Coders will report ICD-9-CM code 285.9 when the physician does not specify the type of anemia. Physicians can be much more specific when documenting anemia, Limjoco says. For example, the physician can document acute blood loss anemia (285.1), chronic anemia secondary to chronic kidney disease stage IV or V (285.21), chronic blood loss anemia (280.0), or iron deficiency anemia (280.9).

Physicians don’t document acute blood loss anemia well, says Timothy N. Brundage, MD, CCDS, medical director of Brundage Medical Group in Redington Beach, Florida. Acute blood loss anemia can be linked to a hemorrhagic process, such as any procedure or surgery, fracture, or GI bleed.

“This should be documented separately from its cause,” Brundage says. If a patient experiences post-procedural bleeding, the physician should document whether it is expected—for example, in an elderly patient who fractures her hip, the anemia could be an expected occurrence depending on fracture type, Brundage says.

Even if the amount of blood lost following surgery is expected and routinely associated with the procedure, acute blood loss anemia is still present if anemia occurs, Pinson says.

Editor’s note: This article originally appeared in JustCoding.com.