Talk about ICD-10: Focus on five tricky diagnoses

From a CDI standpoint, ICD-10-CM/PCS implementation seems to be going relatively well. In fact, in a recent poll on the ACDIS website, 53% of respondents say they are not experiencing any real problems, while 27% say they are only experiencing a couple of minor issues.

As CDI programs move deeper into the post-implementation world, staff are identifying those changes that are having the greatest effect on DRG assignments, and those they are struggling with. Here are a few documentation issues that stand out.

**Atrial fibrillation (AFib)**

There is little guidance for documenting and coding AFib as a principal diagnosis when it is a new onset. The ICD-10-CM definitions are not specific for a patient who has not had AFib previously. In addition, some CDI specialists question whether or not they should query for every AFib diagnosis that is unspecified. (Read a related article regarding unspecified diagnoses on p. 21.)

It’s been an ongoing issue, says Robert S. Gold, MD, CEO of DCBA, Inc., in Atlanta, who notes that CMS’ ICD-10-CM/PCS Coordination and Maintenance Committee does have the matter on its radar screen. New onset or initial episode of AFib could have a code soon, and it could read “AFib, initial episode” and then “chronic AFib” with its three models:

- Paroxysmal
- Persistent
- Long-standing/Permanent

Hopefully CMS will also include a digit for association with mitral valve disease or not as these are treated differently, says Gold.

For now, CDI specialists should stay tuned and watch for updates. If they review a case with a new onset or initial episode of AFib, they should work to clearly identify it as new onset, says Laurie L. Prescott, MSN, RN, CCDS, CDIP, CDI education director at HCPro in Danvers, Massachusetts. Although we do not have a code for this in ICD-10-CM, CDI should query to specify it as not a chronic issue. The physician, she says, should discuss possible etiologies and document the patient’s symptoms or complications as well as response to treatment to support the need for inpatient care.

**Peripherally inserted central catheter (PICC)**

There’s been a handful of concerns around documenting and coding PICCs, including:

- What procedure code to use if the catheter tip ends up in the cavoatrial junction (CAJ), the joint between the superior vena cava and the atrium
- What procedure code to use if both fluoroscopy and ultrasound are performed, as the code set only allows for one or the other

Sharon Salinas, CCS, HIM manager at Barlow Respiratory Hospital in Los Angeles, says her facility has been using the code for superior vena cava (SVC). If the catheter tip ends up at the junction, it is not actually in the atrium, which she says justifies this code selection.

Prescott agrees with Salinas and says the CAJ describes the point at which the superior vena cava meets the superior wall of the right atrium. This meeting point, she says, is located at the inferior end of the superior vena cava; if the catheter travels below that point it would enter the heart.

“This is a perfect example of how coders and [CDI specialists] can work together,” says Prescott. “CDI specialists with a clinical background likely will offer more experience related to anatomy questions, especially those related to procedure codes.”

As for the fluoroscopy and ultrasound, the concern is whether or not coding both will make it appear as if two PICC lines were placed. Some say there isn’t an option to choose both, while others say you should be able to code radiologic guidance. Since the insertion would only be coded once, it should be possible to code both.
“A guidance code would be used twice, one for each type used,” Salinas says.

Prescott suggests this question be posed to Coding Clinic. “The choice will not impact the MS-DRG so likely should not be a huge CDI issue,” she adds.

**Gastrointestinal bleed (GI bleed)**

The existing codes for hemorrhagic shock lead to two routes: traumatic or post-procedural. The question CDI specialists face is whether or not the shock secondary to GI bleed should be documented, or if this case should be documented as hypovolemic or other shock.

Back in ICD-9, there was no specific code for hemorrhagic shock, though many groupers offered that description as an option that mapped to the all-purpose code 785.59 (shock without trauma), says Judy Riley, RHIT, CCS, AHIMA-approved ICD-10 trainer and CDI/coding manager at LRGHealthcare in Laconia, New Hampshire.

However, in ICD-10, there is the more specific option of coding R57.1 (hypovolemic shock), if it is documented, or R57.8 (other shock) when associated with hemorrhage.

“R57.8 would be my choice if the hypovolemia were not documented,” says Riley, “but I would query for that documentation to get to the more specific [code].”

If the physician only stated as “shock” or “shock due to GI bleed,” Prescott would “query for the type of shock and likely offer as a choice hypovolemic shock.”

**Debridement**

Many of the debridement documentation issues from ICD-9 have continued into ICD-10-PCS, such as whether the debridement is excisional or non-excisional.

You can’t presume that “sharp” equals “excisional,” says Judy Sturgeon, CCS, CCDS, clinical coding/reimbursement compliance manager at Harris Health System in Houston.

The coder has to know how deep the debridement went, and it’s critical to know of what tissue, not “to what tissue,” Sturgeon says. “In the old days, ‘excisional debridement to the bone’ was coded as ‘of the bone,’ but [that is no longer true in ICD-10].” (Read the related article regarding the latest edition of Coding Clinic on p. 28.)

In addition, CDI specialists should look for additional procedures performed, or additional objectives of the procedure, says Sturgeon. In ICD-10, the objective of the procedure can change the code to something else.

CDI teams should also structure educational efforts to target aspects of debride ments that physicians struggle with, to ensure the physician identifies the debridement as excisional and describes a cutting away of tissue.

Teach your physicians to state “down to and including,” says Prescott. “For example, ‘an excisional debridement, using a number 10 blade, was performed with removal of necrotic tissue down to and including the bone.’”

**Sepsis**

The transition to ICD-10-CM/PCS has introduced some new sepsis-related documentation concerns, including the fact that “systemic inflammatory response syndrome (SIRS) due to pneumonia” does not automatically translate to “sepsis” in ICD-10-CM.

CDI specialists should query for the diagnosis of sepsis if there is clinical support for the condition in the chart, or risk missing the ability to code the SIRS component entirely, says Sturgeon.

When the patient might have sepsis, or the documentation states “sepsis” and cultures come back negative, query to find out if the sepsis was ruled out or resolved, says Sturgeon.

“We must be alert to the fact that sepsis and SIRS can no longer be coded together,” Prescott says. “If either terms are used, or the provider documents ‘SIRS due to an infection,’ a query will be required.”

Other sepsis-related concerns haven’t changed, Prescott says.

“We must still capture the presence of severe sepsis and septic shock as appropriate, and we must make sure the status of present on admission is well documented,” she says. “Lastly, as this diagnosis is a high focus for auditors, so documentation should clearly support the presence of sepsis as supported by the appropriate clinical indicators and treatment plan.”