Get ready for phase one of sweeping IPPS reform
CMS takes first steps toward cost, severity

On August 1, CMS announced plans for sweeping reform to the IPPS, with some changes effective October 1, and others to be phased in over a three-year period.

CMS administrator Mark McClellan, MD, PhD, says that starting October 1, CMS will use estimated hospital costs instead of charges as a basis for acute-care inpatient reimbursements, with full implementation in fiscal year (FY) 2009. CMS will also begin to use severity of patients’ illnesses to calculate DRG payments, with full implementation planned for FY 2008.

These changes are explained in full in the IPPS final rule, which you can read on the CMS Web site (www.cms.hhs.gov/AcuteInpatientPPS/downloads/cms1488f.pdf).

HIM directors should begin training and educating coding, financial, and case management staff about the changes to severity now, says Gloryanne Bryant, RHIA, RHIT, CCS, corporate director of HIM/coding compliance for Catholic Healthcare West in San Francisco. “A lot of HIM/coding staff have not been exposed to severity-adjusted DRGs, so additional education will be needed to alert coding staff.”

The change in the basis for reimbursement from charges to costs involves much more work and analysis for hospitals’ accounting departments than it does for HIM/coding, says lead instructor Kimberly Anderwood Hoy, JD, CPC, director of Medicare ad compliance at HCPro, Inc., in Marblehead, MA. “HIM staff should focus their efforts, as always, on correct coding and the reimbursement will follow.”

A three-phase approach to cost
Rather than immediately basing inpatient stay payment on costs, FY 2007 payments will be based on one-third costs and two-thirds charges. In FY 2008, two-thirds of payment for inpatient stays will be based on costs and one-third on charges, followed by full implementation of costs in FY 2009. IPPS payment rates will increase by 3.5% overall, or $3.4 billion. Only 2% of hospitals nationwide will see a reduction in payments. CMS attributes this hit in payment not to DRG changes, but to certain wage index changes. No DRG has an FY 2007 payment reduction of more than 5.4%, and some DRGs have significant payment increases.

However, specialty hospitals—particularly those that treat cardiac admissions—will see a decline in payment. Cardiac specialty hospitals, for example, will experience a
projected payment decline of more than 5% between FY 2006 and FY 2009. But the news is less grim than was projected in the IPPS proposed rule.

“It’s good news for hospitals that this will be spread out over three years,” says James S. Kennedy, MD, CCS, senior physician executive with FTI Cambio Health Solutions in Brentwood, TN. “Cardiac hospitals that were going to get creamed in the proposed rule got a break.”

The move to estimated costs instead of charges seeks to eliminate “gaming” under the current charge-based DRG payment system. Also, some hospitals’ list charges exceed their costs of providing these services, and cost-based reimbursement should help with reform.

Steps toward severity of illness

The second part of IPPS reform includes a two-year period for implementing severity of illness as a basis for payment. Effective October 1, the final rule

► adds 20 new groups to the existing DRG system—12 medical, eight surgical (see “FY 2007 new/deleted DRGs” on p. 3)
► eliminates eight DRGs (see “FY 2007 new/deleted DRGs” on p. 3)
► raises the total number of DRGs to 538 from the current 526
► modifies 32 existing DRGs

These changes will allow HIM/coding to better capture the severity of patients’ illnesses, and will promote equitable reimbursement of more severe conditions. “If you’re a coder, you don’t necessarily need to know these new DRGs, but staff should have a refresher on the diagnoses that fall into them [to assure proper DRG assignment],” Hoy said.

Note that this change differs considerably from the one described in the April IPPS proposed rule. CMS had initially proposed to adopt a consolidated severity-adjusted (CSA)-DRG system, possibly as early as 2007. The CSA-DRG system was based on a product developed by 3M Health Information Systems and included 861 DRGs. CMS plans to implement a full severity-adjusted DRG system in 2008 and will spend the next several months seeking the best choice.

Again, staff education must start now. “Unlike current DRGs where you have a principal and a secondary diagnosis, and one secondary diagnosis can qualify you for a DRG, with severity, all the secondary diagnoses account to the weight,” Bryant says. “ Coders need to understand that what normally wouldn’t impact a DRG can impact a severity case.”
New technologies with temporary add-on payments

HIM directors should take note of the new medical services and technologies in the IPPS final rule, Hoy says. These devices are approved for considerable additional reimbursement. Physicians must be trained to document and coders must be trained to code appropriately.

These changes include add-on payments for a back pain treatment technology called X STOP Interspinous Process Decompression System, which is used as an alternative treatment in place of conservative treatments (e.g., physical therapy) and aggressive treatments (e.g., major back surgery). Report X STOP surgical cases using ICD-9-CM code 84.58 (Implantation of interspinous process decompression device).

According to CMS, these cases will generally group to either DRG 499 or DRG 500 (Back and neck procedures except spinal fusion with/without complication/comorbidity, respectively). CMS will pay a maximum additional $4,400 for cases that involve this technology.

CMS also continued two add-on payments for FY 2006 technologies. These include the following:

- Restore® Rechargeable Implantable Neurostimulator for the treatment of chronic pain. Report this device with newly created ICD-9-CM code 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator).

Other IPPS changes

The IPPS final rule also

- increases quality measures to 21
- revises the inpatient outlier formula (threshold set at $24,475)
- includes Emergency Medical Treatment and Active Labor Act (EMTALA) changes to labor and delivery, as well as specialty hospitals

FY 2007 new/deleted DRGs

New DRGs
- DRG 560 (Bacterial and tuberculosis infections of nervous system)
- DRG 561 (Nonbacterial infections of nervous system except viral)
- DRG 562 (Seizure age > 17 with CC)
- DRG 563 (Seizure age > 17 without CC)
- DRG 564 (Headaches age > 17)
- DRG 565 (Respiratory system diagnosis with ventilator support 96+ hours)
- DRG 566 (Respiratory system diagnosis with ventilator support less than 96 hours)
- DRG 567 (Stomach, esophageal, and duodenal procedures age > 17 with CC with major gastrointestinal diagnosis)
- DRG 568 (Stomach, esophageal, and duodenal procedures age > 17 with CC without major gastrointestinal diagnosis)
- DRG 569 (Major small and large bowel procedures with CC with major gastrointestinal diagnosis)
- DRG 570 (Major small and large bowel procedures with CC without major gastrointestinal diagnosis)
- DRG 571 (Major esophageal disorders)
- DRG 572 (Major gastrointestinal disorders and peritoneal infections)
- DRG 573 (Major bladder procedures)
- DRG 574 (Major hematologic/immunologic diagnosis except sickle cell crisis and coagulation disorders)
- DRG 575 (Septicemia with mechanical ventilation 96+ hours age > 17)
- DRG 576 (Septicemia without mechanical ventilation 96+ hours age > 17)
- DRG 578 (Infectious and parasitic diseases with OR procedure)
- DRG 579 (Postoperative or posttraumatic infection with OR procedure)
- DRG 583 (Carotid artery stent procedure)

Deleted DRGs
- DRG 20, DRG 24, DRG 25, DRG 148, DRG 154, DRG 415, DRG 416, and DRG 475
Editor’s note: This is the second part of a two-part series. This month’s story examines a sample Program for Evaluating Payment Patterns Electronic Report (PEPPER) report. Last month’s article described how PEPPER can improve undercoding.

PEPPER is a free and often untapped goldmine of information, says Kimberly Hrehor, MHA, RHIA, CHE, project director for the hospital payment monitoring program quality improvement organization support center at TMF Health Quality Institute in Austin, TX.

“We feel that the data are a very important part of helping hospitals look at where they might be able to conduct auditing and monitoring, with the whole goal of improving systems and processes to prevent payment errors,” Hrehor says.

And preventing payment errors—particularly underpayments/undercoding—is one way that you can use the reports, says Glenn Krauss, RHIA, CCS, CCS-P, CPUR, an independent consultant in Maryville, TN.

The report on p. 5 shows how one Wisconsin facility’s data (for quarter one, fiscal year 2006) regarding DRG 416 compare with the state median. If your facility falls in the 75th–90th percentiles, this could mean that either your data truly do fall above the median or upcoding is taking place, says Krauss. “People become very concerned. Yes, it is a reason to be concerned. Go back to your records and have a physician involved in the process substantiate that the documentation and diagnosis is supported by the clinical information,” he says.

If your facility falls in the 10th percentile, you could be leaving money on the table, Krauss says. Ideally, a facility’s percentages will fall into the median. “But even if you’re in the median, you still want to look at your records to make sure that you’re not missing anything,” he adds. “It doesn’t mean that you’re doing a good job to capture severity.”

As noted last month, a Wisconsin hospital for which Krauss had consulted used PEPPER data to determine that its percentage of patients in DRG 416 (septicemia, age > 17) was 42.4% of its total patients in

- DRG 416
- DRG 320 (kidney and urinary tract infections, age > 17, with a complication or comorbidity)
- DRG 321 (kidney or urinary tract infections, age > 17, without a complication or comorbidity)

However, the state median for this patient population is 48% (p.5). Having concrete data from the report helped to justify improvement efforts regarding physician documentation, Krauss says. “We looked at our last 50 records [for this DRG] and what we found was a lot of urosepsis. Doctors think that this term is synonymous with sepsis of a urinary source.”

<table>
<thead>
<tr>
<th>BCCS Subscriber Services Coupon</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start my subscription to BCCS immediately.</strong></td>
</tr>
<tr>
<td><strong>Options:</strong></td>
</tr>
<tr>
<td>Print</td>
</tr>
<tr>
<td>Electronic</td>
</tr>
<tr>
<td>Print &amp; Electronic</td>
</tr>
</tbody>
</table>

**Order online at www.hcmarketplace.com. Be sure to enter source code N0001 at checkout!**

**Sales tax (see tax information below)***

**Grand total**

*Tax Information
Please include applicable sales tax. Electronic subscriptions are exempt. States that tax products and shipping and handling: CA, CT, FL, GA, IL, IN, KY, MA, MD, MI, NC, NJ, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI. State that taxes products only: AZ. Please include $27.00 for shipping to AK, HI, or PR.

**Your source code: N0001**

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
</tr>
<tr>
<td>Organization</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Phone</td>
</tr>
<tr>
<td>Fax</td>
</tr>
</tbody>
</table>

**E-mail address**
(Required for electronic subscriptions)

- Payment enclosed.
- Please bill me.
- Please bill my organization using PO #
- Charge my: AmEx MasterCard VISA

**Signature**
(Required for authorization)

<table>
<thead>
<tr>
<th>Card # Expires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your credit card bill will reflect a charge to HCPro, the publisher of BCCS.</td>
</tr>
</tbody>
</table>

Mail to: HCPro, P.O. Box 1168, Marblehead, MA 01945 Tel: 800/650-6787 Fax: 800/639-8511 E-mail: customerservice@hcpro.com Web: www.hcmarketplace.com

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, contact the Copyright Clearance Center at www.copyright.com or 978/750-8400.

© 2006 HCPro, Inc.
## Sample short-term care PEPPER report

### Short-term care Program for Evaluating Payment Patterns Electronic Report (PEPPER)

**DRG 416, percentage of DRGs 416, 320, 321 discharges**

<table>
<thead>
<tr>
<th>Time periods</th>
<th>Target area discharge count</th>
<th>Denominator count (all DRG 416, 320, 321 discharges)</th>
<th>Percent (target area count / denominator)</th>
<th>Target area average length of stay (ALOS)</th>
<th>Denominator ALOS</th>
<th>Target average Medicare payment</th>
<th>Target sum Medicare payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 FY 2003</td>
<td>13</td>
<td>27</td>
<td>48.1%</td>
<td>7.1</td>
<td>6.1</td>
<td>$7,210.54</td>
<td>$93,736.98</td>
</tr>
<tr>
<td>Q2 FY 2003</td>
<td>3</td>
<td>18</td>
<td>16.7%</td>
<td>8.3</td>
<td>4.6</td>
<td>$7,946.52</td>
<td>$23,839.56</td>
</tr>
<tr>
<td>Q3 FY 2003</td>
<td>13</td>
<td>19</td>
<td>68.4%</td>
<td>8.0</td>
<td>6.8</td>
<td>$9,054.57</td>
<td>$117,709.42</td>
</tr>
<tr>
<td>Q4 FY 2003</td>
<td>15</td>
<td>37</td>
<td>40.5%</td>
<td>7.7</td>
<td>5.4</td>
<td>$8,034.67</td>
<td>$120,520.06</td>
</tr>
<tr>
<td>Q1 FY 2004</td>
<td>9</td>
<td>23</td>
<td>39.1%</td>
<td>6.4</td>
<td>5.2</td>
<td>$8,233.84</td>
<td>$74,104.53</td>
</tr>
<tr>
<td>Q2 FY 2004</td>
<td>12</td>
<td>25</td>
<td>48.0%</td>
<td>6.0</td>
<td>5.3</td>
<td>$7,721.78</td>
<td>$92,661.36</td>
</tr>
<tr>
<td>Q3 FY 2004</td>
<td>8</td>
<td>20</td>
<td>40.0%</td>
<td>9.8</td>
<td>6.5</td>
<td>$8,031.49</td>
<td>$64,251.92</td>
</tr>
<tr>
<td>Q4 FY 2004</td>
<td>7</td>
<td>24</td>
<td>29.2%</td>
<td>5.9</td>
<td>5.2</td>
<td>$8,094.85</td>
<td>$56,663.93</td>
</tr>
<tr>
<td>Q1 FY 2005</td>
<td>8</td>
<td>32</td>
<td>25.0%</td>
<td>5.0</td>
<td>5.1</td>
<td>$7,929.82</td>
<td>$63,438.56</td>
</tr>
<tr>
<td>Q2 FY 2005</td>
<td>7</td>
<td>32</td>
<td>21.9%</td>
<td>5.9</td>
<td>5.2</td>
<td>$8,049.98</td>
<td>$56,349.85</td>
</tr>
<tr>
<td>Q3 FY 2005</td>
<td>7</td>
<td>26</td>
<td>26.9%</td>
<td>5.4</td>
<td>4.7</td>
<td>$7,950.22</td>
<td>$55,651.51</td>
</tr>
<tr>
<td>Q4 FY 2005</td>
<td>11</td>
<td>28</td>
<td>39.3%</td>
<td>7.5</td>
<td>5.7</td>
<td>$8,234.48</td>
<td>$90,579.23</td>
</tr>
<tr>
<td>Q1 FY 2006</td>
<td>14</td>
<td>33</td>
<td>42.4%</td>
<td>6.8</td>
<td>5.4</td>
<td>$9,154.65</td>
<td>$128,165.10</td>
</tr>
</tbody>
</table>

¹ Target discharges = total DRG 416 discharges in the time period

### Statewide comparative data for target proportion:

<table>
<thead>
<tr>
<th>Time periods</th>
<th>90th percentile</th>
<th>75th percentile</th>
<th>Median</th>
<th>10th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 FY 2003</td>
<td>6.9%</td>
<td>57.1%</td>
<td>42.7%</td>
<td>22.2%</td>
</tr>
<tr>
<td>Q2 FY 2003</td>
<td>66.7%</td>
<td>56.3%</td>
<td>40.0%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Q3 FY 2003</td>
<td>71.4%</td>
<td>57.9%</td>
<td>43.8%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Q4 FY 2003</td>
<td>68.4%</td>
<td>51.5%</td>
<td>40.3%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Q1 FY 2004</td>
<td>71.4%</td>
<td>57.1%</td>
<td>46.7%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Q2 FY 2004</td>
<td>67.7%</td>
<td>60.0%</td>
<td>46.1%</td>
<td>23.1%</td>
</tr>
<tr>
<td>Q3 FY 2004</td>
<td>75.0%</td>
<td>58.1%</td>
<td>46.2%</td>
<td>20.8%</td>
</tr>
<tr>
<td>Q4 FY 2004</td>
<td>67.9%</td>
<td>58.3%</td>
<td>46.4%</td>
<td>23.8%</td>
</tr>
<tr>
<td>Q1 FY 2005</td>
<td>75.0%</td>
<td>65.4%</td>
<td>51.2%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Q2 FY 2005</td>
<td>72.2%</td>
<td>62.1%</td>
<td>51.8%</td>
<td>23.8%</td>
</tr>
<tr>
<td>Q3 FY 2005</td>
<td>74.4%</td>
<td>65.2%</td>
<td>50.7%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Q4 FY 2005</td>
<td>71.4%</td>
<td>58.3%</td>
<td>50.0%</td>
<td>30.4%</td>
</tr>
<tr>
<td>Q1 FY 2006</td>
<td>76.5%</td>
<td>62.5%</td>
<td>48.0%</td>
<td>28.6%</td>
</tr>
</tbody>
</table>

Statewide comparative data were calculated using percentages from prospective payment system hospitals.

Medicare fiscal year (FY) = October 1–September 30

### Summary

**Change from quarter one (Q1) FY 2003 to Q1 FY 2006**

<table>
<thead>
<tr>
<th>From Q1 FY 2003</th>
<th>To Q1 FY 2006</th>
<th>Percentage point change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital proportion</td>
<td>48.1%</td>
<td>42.4%</td>
</tr>
<tr>
<td>State median</td>
<td>42.7%</td>
<td>48.0%</td>
</tr>
</tbody>
</table>

Source: Glenn Krauss, independent consultant, Maryville, TN. Reprinted with permission.

---

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, contact the Copyright Clearance Center at [www.copyright.com](http://www.copyright.com) or 978/750-8400.

© 2006 HCPro, Inc.
Increase coding staff’s productivity with an incentive plan

Before implementing any financially based incentive plan, obtain approval from your organization’s administration and human resources (HR) department. To gain their support, the HIM manager must demonstrate that the plan will result in cost savings by reducing contracted staff or the use of overtime; improving unbilled days or days in accounts receivable; or reducing turnover of coding staff.

Use caution, however, if you plan to create an incentive plan for one group of employees and not for others. Improving the morale of only one group will cause others to feel left out, which may cause you and your organization grief that will outweigh the benefits that you hope to derive. If an incentive plan is approved, the individual managing it will need to work with payroll to establish a procedure and a payment code for the incentive payments.

Following are the four common components of an incentive plan:

- **Premise**
- **Eligibility**
- **Standards or performance expectations**
- **Reward**

**The premise**

This is a statement that describes what the plan will achieve or ensure. It establishes the global parameters for the plan. In this example, the incentive payment is individual-based, but it requires teamwork for individual coders to achieve the goal.

**Eligibility**

In this section of the plan, management defines who may be eligible for incentive compensation. This section may also address the matter of disqualifiers.

**Performance standards**

In this part of the plan, management defines the standards. These can include an average completion time per type of record (e.g., inpatient, ambulatory surgery, emergency department, outpatient diagnostics, etc.) and a per pay period expectation of total completed records. This section may also address disqualifiers.

**The reward**

Once you finalize the other components of the plan, you as the manager—in cooperation with HR—must determine the incentive plan.

HR may have a policy that states that the amount may not exceed a percentage of the current employee’s hourly wage or of the team’s average hourly rate. HR may require that the payment be equal to the payment in place in other departments.

If you are developing the plan to offset contracted assistance, you can tie the payment to the cost of contracted staff.

---

**Sample minimum performance standards chart**

<table>
<thead>
<tr>
<th>Record type</th>
<th>Performance standard</th>
<th>Per pay period expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>14 minutes</td>
<td>343 records</td>
</tr>
<tr>
<td>Ambulatory surgery</td>
<td>7 minutes</td>
<td>686 records</td>
</tr>
<tr>
<td>Emergency department records</td>
<td>4 minutes</td>
<td>1,200 visits</td>
</tr>
<tr>
<td>Outpatient diagnostics</td>
<td>1.5 minutes</td>
<td>3,200 cases</td>
</tr>
</tbody>
</table>

*Source: Rose T. Dunn, RHIA, CPA, FACHE, COO of First Class Solutions, Inc., St. Louis.*
Regardless of the method that you use, the amount that you select should result in cost savings for the organization, as well as additional compensation for the employees involved.

**Exclusions**

Exclusions may also be a part of the plan’s reward section. You shouldn’t reward an employee for inaccurate or incomplete coding. Common exclusions can include:

- records that are coded but not dropped yet because a query is open
- inaccurately coded or abstracted records
- records that are reworked due to coding edits
- coding errors found by the lead coder, the auditor, or third-party payers

For an example of an incentive plan, see “Example of a financially based coding incentive plan” below.

**Editor’s note:** This story was excerpted from the new HCPro book *Coder Productivity: Tapping your Team’s Talents to Improve Quality and Reduce Accounts Receivable,* by Rose Dunn, RHIA, CPA, FACHE. It demonstrates a strategy for HIM managers to improve the productivity of coding staff by creating a money-based incentive plan. To order a copy, visit www.hcmarketplace.com/prod-4059.html.

---

**Example of a financially based coding incentive plan**

**Coding Incentive Plan, St. Elsewhere Medical Center**

**HIM Department**

**Premise:** This incentive plan shall reward individual productivity in excess of the established performance standards at a quality level of 96% or higher when there are no records left uncoded for more than six days following discharge and the unbilled amount is equal to or less than $3 million.

**Eligibility:** All coders who have been employed one or more years with the surgery center are eligible to participate in the plan if they have achieved the minimum productivity standards for two consecutive pay periods. Employees who have been counseled within the past three months or who fail to sustain production at the expected minimum standards for two or more pay periods will be excluded from participation in the Plan for 90 days from date of counseling or for an additional two consecutive pay periods, respectively.

**Performance standards:** To receive incentive payments, an individual must meet the quality requirement of 96% or higher and must exceed the performance standards in the chart (see “Sample minimum performance standards chart” on p. 6) each pay period. Additionally, the department's performance must meet or exceed the criteria defined in the premise above.

For any employee who codes multiple record types, his or her actual production by type will be multiplied by the performance standard noted below and summed. If the total minutes exceed 4,800 for the pay period, this employee will be then eligible to receive incentive payments if the department's performance criteria also are achieved.

**Example:** Carolyn Coder is competent in both inpatient coding and ambulatory surgery coding. During the pay period, she coded 15 inpatient records and 400 ambulatory surgery records. Her total coding minutes are as follows: $5,250 = (175 \times 14 \text{ minutes}) + (400 \times 7 \text{ minutes}). Therefore, she is eligible for incentive pay.

Quality will be monitored by random coding audits conducted by the lead coder, third-party payer audits, and our external coding audit.

**Incentive payment:** When an eligible coder who has records accurately coded in excess of the minimum performance standards outlined above and when the department complies with the criteria defined in the premise, he or she will receive an additional payment of $0.21 per minute.

Using the example described above, Carolyn Coder is eligible for incentive pay of $94.50 (5,250 minutes – 4,800 required minutes = 450 minutes x $0.21/minute).

**Effective date:** This Plan is effective July 1 and may be modified from time to time or terminated by management.
ICD-9-CM: Sequence and code your way to accurate claims

Editor’s note: This is the third part of a three-part series. This month’s article covers anemia, neoplasms, and overweight/obese conditions.

Coding conditions and symptoms such as anemia, neoplasms, poisonings, and adverse affects using ICD-9-CM requires attention to detail and thorough documentation, says Deborah Grider, CPC, CPC-H, CPC-P, CCS-P, EMS, president of Medical Professionals, Inc., in Indianapolis. Be sure to keep official ICD-9-CM guidelines in mind when sequencing these diseases and their manifestations.

Anemia in chronic diseases

Patients with conditions such as chronic kidney disease (CKD) can suffer anemia as a result during dialysis. If you encounter this type of record and must code it, identify the type of anemia using the 285.x series of codes (revised December 1, 2005). These include:

- 285.2, anemia in chronic illness
- 285.21, anemia in CKD
- 285.22, anemia in neoplastic disease
- 285.29, anemia of other chronic illness

If the physician’s primary treatment is for anemia (e.g., a chemotherapy patient suffering from anemia), sequence anemia as the primary diagnosis and the malignancy as the secondary diagnosis.

When an encounter is for management of an anemia associated with chemotherapy, immunotherapy, or radiotherapy, and the physician only treats the anemia, sequence the anemia as the primary diagnosis, followed by the appropriate neoplasm code, and then the E code (E933.1, Antineoplastic and immunosuppressive drugs).

If an encounter is for management of dehydration due to a malignancy or the therapy, and the physician only rehydrates the patient, sequence dehydration first, followed by the malignancy diagnosis.

Report it even if your fiscal intermediary (FI) does not pay for it, says Grider. “Many carriers won’t pay for this—they bundle the IV therapy into the chemo treatment and consider it incidental, but that’s a carrier issue, not a coding issue.”

Don’t make the mistake of coding anemia as the primary reason for the encounter for a dialysis patient undergoing treatment. Report it as a secondary diagnosis. “Code the cause of the anemia [e.g., CKD] in the first position, and the anemia second,” Grider says. Only sequence the 285.x series first when the reason for the encounter is the anemia treatment.

Coding example: A patient suffers from anemia in neoplastic disease due to primary carcinoma of the liver. List 285.22 first, followed by carcinoma of the liver primary site (155.2) as the secondary diagnosis.

Overweight/obese conditions

Code 278.0 (overweight and obesity) was recently revised to include fifth digits of specificity, and now also requires the use of a body mass index (BMI) V code, if known.

It’s important to report this code because physicians performing procedures on morbidly obese patients often need more time and resources to complete the procedure (e.g., cholecystectomies). Also, reporting this code along with a proper BMI V code can help a claim meet national and local coverage determinations for medical necessity requirements for bariatric surgery. For example, a Medicare patient qualifies for bariatric surgery coverage if his or her BMI is 35 or over (morbid obesity). Report the V code as a secondary diagnosis.

“Even though Medicare only looks at the first-listed diagnosis [on electronic claims], I can almost guarantee you that they will not pay the claim for bariatric surgery unless they see the BMI and the documentation,” Grider says.

Coding example: Mr. Smith, a morbidly obese 50-year-old male with a BMI of 36.5 and obstructive sleep apnea, reports for treatment. He is diagnosed with sleep apnea. Code the encounter as follows:

- 780.51 (sleep apnea)
Neoplasms

Neoplasms are abnormal formations of tissue and can be benign or malignant. Some malignant neoplasms can be in situ localized, meaning that they do not invade surrounding tissues.

When coding neoplasms, code the cancer’s origin as the primary site, and report the areas to which the cancer spreads as the secondary site. Use the index with the physician’s description of the neoplasm as the starting point (e.g., Disease, Bowen’s—see Neoplasm, skin in situ). Find it in the neoplasm table, verify it in the tabular list, and code it by anatomical site. Sometimes the pathology report does not define the type of neoplasm, and the patient must return for additional tests. If that’s the case, “Do not code a neoplasm as malignant without a definitive pathology report,” Grider says.

Look carefully at the physician’s documentation when coding neoplasms, because certain anatomic terms can determine code assignments, such as

- **connective tissue**—If the physician’s description does not include blood vessel, bursa, fascia, ligament, muscle, peripheral nerves, sympathetic and parasympathetic nerves and ganglia, synovia, tendon, use skin as the anatomic site

- **bone**—Consider carcinomas and adenocarcinomas of any type as metastatic from another site unless identified as intraosseous or odontogenic

Neoplasm coding tips

- Do not code neoplasms as active cancers after they have been eradicated through treatment. If the patient is no longer being treated for the neoplasm, code it as a “history of” using category V10, Personal history of malignant neoplasm.

“A lot of medical societies recommend that you code these as active cancers for five years—some are even saying for seven years,” Grider says. But according to the official ICD-9-CM guidelines, when the patient is no longer being treated, or is simply being managed under evaluation and management guidelines, do not code it as an active cancer. “Many oncologists are still coding these as active diseases, but that’s something that [HIM professionals] have to work on diligently.”

If the patient receives ongoing drug therapy, and the malignancy is primary, code it as primary. For example, if a breast cancer patient takes Tamoxifen as part of ongoing therapy, and she does not have an existing neoplasm and has been cancer-free for three years, then code the malignancy as primary. If no personal history exists, but the patient has a family history of cancer, use the appropriate family history code.

Neoplasm sequencing tips

Keep the following in mind when sequencing neoplasms:

1. If a patient is admitted to a hospital only for chemotherapy/immunotherapy/radiation therapy, code the treatment as primary using the V58 series. If a patient is having two types of treatment, the sequencing of codes does not matter. “[The treatments are] equal in complexity,” Grider says. Code the malignancy as secondary.

2. If the patient is admitted to the hospital for treatment of the malignancy, and, once admitted, the physician decides to administer chemotherapy, code the chemotherapy as secondary.

3. List the malignancy toward which the chemotherapy/other treatment is directed as the first-listed diagnosis. For example, if a breast cancer patient’s disease spreads to the gastrointestinal (GI) system and reports for treatment of the GI system, code that as the first-listed diagnosis/secondary site and the breast cancer as the primary site/secondary diagnosis. “It can get...”

> continued on p. 10
confusing, but always code where the [neoplasm] started, and also what you’re treating,” Grider says.

4. If a patient is admitted, undergoes treatment, and experiences complications (e.g., nausea, vomiting, or dehydration) code the treatment as the principal diagnosis using V58.0, V58.11, or V58.12, and report the complication as secondary.

5. If the reason for the admission is to determine the extent of the malignancy, list the primary malignancy or metastatic site as the principal or first-listed diagnosis—even if the physician provides chemotherapy on the same day.

Note: Grider says some payers do not accept V codes in the mistaken belief that they represent preventive services. “That is not correct, there are many V codes that identify problems,” she says. Take proper steps to appeal these claims. Talk to your FI’s medical directors, medical societies, and state medical association and ask them to provide education.

Demand ischemia is coming: Be on the lookout

by Robert S. Gold, MD

One of the most common problems that coders face is inadequate documentation to justify admissions for chest pain. Some hospitals have in place great outpatient systems to help with this problem. For example, they may require that patients who pass through initial emergency department (ED) screens go to observation status for the next step. Once physicians rule out myocardial infarction (MI) or presume that the chest pain does not represent acute coronary syndrome (ACS), the patient goes home. If physicians discover a reason for admission, the patient is admitted as an inpatient.

Other hospitals admit patients as inpatients whenever ED physicians can’t immediately determine the cause of the chest pain or they determine that it is insignificant. But this presents a problem. Physicians don’t document conditions of “demand ischemia” in such a way that you can avoid assigning DRG 143 (chest pain). The result is that you can be left with an inordinately high number of cases with this diagnosis.

In a recent issue of Briefings on Coding Compliance Strategies, I introduced the concept of demand MI. Many of the above situations of chest pain in which the workup shows that the patient did not have a grossly abnormal stress test, that the patient underwent cardiac catheterization and there were no findings of significant coronary obstruction, or that the patient had three normal troponins, might represent cases of demand ischemia as well.

Definition of demand ischemia

Recent American College of Cardiology (ACC) literature provides insight to the definition of demand ischemia of the heart. The heart is a muscle. It works all the time, every day. It pumps blood to the brain, the kidneys, the lungs, and to itself through the coronary arteries. The coronary arteries take off from the base of the aorta behind two of the leaflets of the aortic valve. The third leaflet—the noncoronary aortic leaflet—has an indentation called the sinus of Valsalva.

Blood flows into the coronary arteries during the diastolic phase of the heart cycle. During the systolic phase, the aortic valve leaflets are forced upward into the root of the aorta and they close off the ostia (i.e., the openings) of the coronaries. When the left ventricle relaxes in diastole, the aortic valve leaflets close, and then blood can then flow into the coronaries.
As long as there is enough open tubing in the coronaries, enough oxygen, enough blood, and the patient is in stable condition, then everything is fine. With increased metabolic demand (as can happen with exercise, more rapid work of the heart, or infection), the coronaries may not be able to supply enough blood.

**Supply and demand**

As demand for anything increases, and supply is limited or diminished, it hurts the consumer. As long as a sufficient supply of blood and oxygen is available to the heart, the patient is okay. But, with certain conditions, supply is limited, and that causes pain.

For example, in routine coronary atherosclerosis of mild or moderate degree, limited supply of oxygenated blood may be the reason why a patient, with stress or exercise, feels chest pain (i.e., angina). And because the chest pain is due to stress or exercise in the face of unchanging coronary artery disease (CAD), it’s a supply issue, and that’s stable angina. Let’s look at another condition that leads to supply problems. When the heart muscle becomes massive in size, but the availability of blood to perfuse the muscle is limited due to the normal number of coronaries, patients may experience chest pain in the face of stress or exercise. If these patients have hypertrophic cardiomyopathy and experience chest pain after stress or exercise, but the pain goes away when they stop, and they can repeat the same amount of exercise before chest pain returns, that’s a supply problem, and that’s stable angina.

Aortic stenosis, another chronic stable condition, can cause two supply problems: not enough blood getting to the root of the aorta and increasing left ventricular size. If patients with significant aortic stenosis get chest pain with exercise or stress, that is also a supply problem, and that’s also stable angina.

These are all supply issues and represent stable angina. These three conditions are primary diseases of the heart. When there are sudden changes in the heart, the coronaries, the oxygen supply, or the body’s need for oxygenated blood, the heart is called upon to meet these demands, and sometimes it just can’t do it.

**Tachyarrhythmia as a demand issue**

If a patient with mild CAD, moderate CAD, or no CAD at all is faced with the onset of rapid ventricular rate—as can happen with ventricular tachycardia or atrial fibrillation with rapid ventricular response—the sudden demand for oxygenated blood to the myocardium increases immediately. If a patient has such a rapid heart rate, there is no diastolic interval (i.e., there is not enough time to fill the left ventricle with each stroke). The result is inadequate delivery of oxygenated blood to the heart in time of need and chest pain. Chest pain due to a demand issue is unstable angina. If the inadequate flow of blood goes on long enough, or if the rate is rapid enough, a patient can develop considerable hypoxia to the myocardium and develop a demand MI—that’s what kills a patient with ventricular tachycardia.

**Blood loss as a demand issue**

If a patient with mild, moderate, or no CAD at all is faced with sudden loss of blood (i.e., being in an auto accident with external or internal blood loss), the sudden demand for oxygenated blood increases. The hypovolemia requires the heart to beat faster to supply oxygenated blood to the body, only there isn’t enough blood, and the heart itself wants more—causing possible chest pain. There is suddenly increased demand by the heart, and a sudden change causing this demand, making this a problem of demand. Cardiac chest pain caused by demand issues is unstable angina.

If the hypoxic state persists, gets worse, and hemorrhagic shock ensues, then the part of the heart most distant from the coronaries—the endocardial layer—

> continued on p. 12
may lose cells, resulting in a leak in troponin and a subendocardial MI (NSTEMI) and a demand MI.

Sepsis as a demand issue

If a patient with mild, moderate, or no CAD at all gets a serious infection, becomes septic, and suffers systemic inflammatory response due to the infection (with the sudden call for oxygenated blood by the whole body) the patient’s circulation to the heart is impaired. The patient may experience chest pain on a demand basis, and this also represents unstable angina. If the circulation is so impaired that it results in significant anoxia that causes subendocardial cells to die and there is a release of troponin, the patient has a demand MI.

The ACC’s outlook

The continuum of unstable angina and NSTEMI has been a focus of the American Heart Association (AHA) and the ACC. The lead author of practice guidelines regarding this continuum is Eugene Braunwald, MD, FACC. See the original and subsequent references at http://circ.ahajournals.org/cgi/content/full/102/10/1193.

Dr. Braunwald has published a table of considerations for unstable angina that has been evaluated and tested for years and is valuable today.

Braunwald classification of unstable angina

Severity

- Class I: New onset, severe or accelerated angina
- Class II: Angina at rest, subacute
- Class III: Angina at rest, acute

Clinical circumstances

- Class A: Secondary unstable angina—an identified extrinsic cause (e.g., anemia, infection, fever, thyrotoxicosis, or atrial fibrillation with rapid ventricular response)

- Class B: Primary unstable angina
- Class C: Postinfarction unstable angina (within two weeks of documented infarction)

Braunwald and others have agreed that the first step that a physician should take in consideration of unstable angina is to rule out a secondary cause (i.e., demand cause). If it is a demand cause of unstable angina or NSTEMI, then the patient’s treatment is different than someone with true ACS, unstable angina, or NSTEMI. These are demand ischemia causes.

Unless there’s an additional reason to consider that ACS has occurred at the same time as the external problem, the patient does not need catheterization, aspirin, beta blockers, or any treatment for ACS, because it doesn’t exist. Other ACC and AHA guidelines discuss the workup and treatment guidelines for acute MI due to ruptured coronary plaque. These patients with demand ischemia—unless there’s some compelling reason to think otherwise—don’t have rupture of a coronary plaque. Basically, physicians don’t treat these unstable anginas other than treating the disease that caused the increased demand.

If physicians treat the thyrotoxicosis, the chest pain goes away. If they transfuse two units of packed cells to the acute bleeder, the chest pain goes away. If they start antibiotics and stop the tachyarrhythmia, the chest pain goes away. They don’t have to catheterize the demand unstable angina patient or the NSTEMI patient because there’s nothing acutely wrong with the coronaries.

Coding conclusion: In all of these cases, assign the principal diagnosis to the cause of the unstable angina or NSTEMI. Physicians should call a case unstable angina or NSTEMI due to the cause of the increased demand when that’s what it is. Never assign demand NSTEMI to DRG 121 or 122, because physicians don’t treat it the same as a real MI.
Dear Briefings on Coding Compliance Strategies subscriber,

As you open this month's issue, you will undoubtedly notice that Briefings on Coding Compliance Strategies is sporting a new look. We hope you’ll agree that it is a very positive change.

Not only does the new design allow for easier reading and absorption of information, it also allows us to include more content in the same 12 pages, along with our monthly Coding Q&A insert.

But we want to hear from you. We’re committed to making sure that Briefings on Coding Compliance Strategies continues to deliver the inpatient coding guidelines and updates, compliance tools, documentation improvement strategies, and timely news that you need. Your suggestions and feedback are extremely valuable. Please feel free to drop us a line at any time.

In the meantime, enjoy Briefings on Coding Compliance Strategies' brand-new look!

Sincerely,

Brian D. Murphy
Senior Managing Editor
HCPro, Inc.
bmurphy@hcpro.com
781/639-1872, Ext. 3216
I’ve heard from certain sources that when I use ICD-9-CM, I should code the reason for the exam first. But I always code the findings, unless the exam is negative. For example, when I code a radiology exam, if a patient reports to the hospital because of an arm injury, and the x-ray reveals a broken ulna, then I could code the broken ulna before the injury. Is that incorrect?

It is appropriate to code the findings as the principal diagnosis. However, if the physician does not find an acute disease, then he or she would code the reason for the examination. For further information please review Coding Clinic, first quarter 2000, pp. 4–6.

Conscious sedation is being used often for computed tomography (CT) scans and magnetic resonance imaging (MRI) in our hospital. Can we capture the sedation charge if the patient is an inpatient? Also, physicians send the patient to the recovery room following the procedure. I’m an an inpatient coder, and billing staff have asked me to add an ICD-9-CM procedure code for this treatment. I don’t think that we can code for this, and I wanted your opinion.

If a patient is having a CT scan and an MRI and needs conscious sedation, you would bill the sedation through the chargemaster. You can code the CT scans and MRIs to capture why the patient receives the conscious sedation. For coding completeness, our facility codes all MRIs/magnetic resonance angiographies as well as CTs/CT angiographies.

Sandy Sillman, RHIT, PAHM, DRG coordinator for Henry Ford Health System in Detroit, answered the previous two questions.

If home care services will be started five days after discharge (because that is when the home care has staff availability), do we code the discharge as 01 or 06, because home care services will not happen within 72 hours?

When a hospital reports discharge status 06 (discharge to home health agency [HHA]), CMS will be looking for an HHA charge within the three-day window. If a charge is not generated by the HHA during this time period, discharge disposition 06 has been billed in error. If you know that HHA services will not begin for five days postdischarge, assign discharge disposition 01 (home).

What is the definition of a state-designated assisted living facility? I am unable to locate a description. Also, for home health, how would you treat patients who are discharged to home health but don’t meet the assessment? For example, home health performs its home assessment and determines that the patient does not qualify for home health services.

To answer the first part of your question, state-designated assisted living facilities are organizations that are licensed by the state as assisted living facilities. Following is a definition of assisted living.

> continued on p. 2
posted by the Department of Health and Human Services:

Assisted living facilities offer a housing alternative for older adults who may need help with dressing, bathing, eating, and toileting, but do not require the intensive medical and nursing care provided in nursing homes. Assisted living facilities may be part of a retirement community, nursing home, or senior housing complex, or they may stand alone. Licensing requirements for assisted living facilities vary by state and can be known by as many as 26 different names, including residential care, board and care, congregate care, and personal care.

To answer the second part of your question, the proper discharge disposition is 01, because the patient did not meet criteria for home care services. Consider using a standardized form to help verify the initiation or the denial of service so you can assign the correct discharge disposition code.

If an emergency department (ED) patient or inpatient is discharged to jail, a halfway house, the sheriff’s custody, or court, should we code all of these circumstances using discharge disposition 01? We think that if the patient is going to one of these facilities, then it is not his or her home, and it would mislead people to believe that the patient did go to his or her home. Could you please explain this for us? Is there possibly another code that we could use, such as 05?

According to the National Uniform Billing Committee’s (NUBC) frequently asked questions eight and nine, patients discharged to court/law enforcement, and those discharged/transferred to residential care should be assigned discharge disposition code 01 (home or self-care).

The portion of the description indicating discharge to “self-care” is the part that many coders forget. This code indicates that the patient does not require any continuing skilled medical treatment postdischarge and that he or she will be “residing” somewhere other than a facility that provides skilled medical care.

If an ED patient who has received partial or complete treatment leaves the facility before being formerly discharged or receiving discharge instructions, should we assign discharge disposition code 07 or 01?

Patients who leave the ED prior to completion of treatment have “discontinued” their care. The NUBC states the following:

The full definition of 07 is “Left against medical advice or discontinued care;” therefore, that is the appropriate code to use when the patient discontinues care.

In the event that the patient completes treatment and leaves prior to formal discharge and issuing of discharge instructions, assign discharge disposition code 01 (home or self-care). In this scenario, the treatment has been completed, but the hospital discharge process has not. A patient’s discharge disposition is not dependent upon completion of a hospital process, only upon the completion of treatment.

Sandy Nicholson, MA, RHIA, CCS-P, CEO of HCR Solutions, LLC, in Locust Grove, GA, answered the previous four questions.
### Infections and parasitic diseases

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>052.2</td>
<td>Postvaricella myelitis</td>
</tr>
<tr>
<td>053.14</td>
<td>Herpes zoster myelitis</td>
</tr>
<tr>
<td>054.74</td>
<td>Herpes simplex myelitis</td>
</tr>
</tbody>
</table>

### Neoplasms

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>238.71</td>
<td>Essential thrombocytopeny</td>
</tr>
<tr>
<td>238.72</td>
<td>Low-grade myelodysplastic syndrome lesions</td>
</tr>
<tr>
<td>238.73</td>
<td>High-grade myelodysplastic syndrome lesions</td>
</tr>
<tr>
<td>238.74</td>
<td>Myelodysplastic syndrome with 5q deletion</td>
</tr>
<tr>
<td>238.75</td>
<td>Myelodysplastic syndrome, unspecified</td>
</tr>
<tr>
<td>238.76</td>
<td>Myelofibrosis with myeloid metaplasia</td>
</tr>
<tr>
<td>238.79</td>
<td>Other lymphatic and hematopoietic tissues</td>
</tr>
</tbody>
</table>

### Endocrine, nutritional, and metabolic, immunity

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>277.30</td>
<td>Amyloidosis, unspecified</td>
</tr>
<tr>
<td>277.31</td>
<td>Familial Mediterranean fever</td>
</tr>
<tr>
<td>277.39</td>
<td>Other amyloidosis</td>
</tr>
</tbody>
</table>

### Blood and blood-forming organs

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>284.01</td>
<td>Constitutional red blood cell aplasia</td>
</tr>
<tr>
<td>284.09</td>
<td>Other constitutional aplastic anemia</td>
</tr>
<tr>
<td>284.1</td>
<td>Pancytopenia</td>
</tr>
<tr>
<td>284.2</td>
<td>Myelophthis</td>
</tr>
<tr>
<td>288.00</td>
<td>Neutropenia, unspecified</td>
</tr>
<tr>
<td>288.01</td>
<td>Congenital neutropenia</td>
</tr>
<tr>
<td>288.02</td>
<td>Cyclic neutropenia</td>
</tr>
<tr>
<td>288.03</td>
<td>Drug-induced neutropenia</td>
</tr>
<tr>
<td>288.04</td>
<td>Neutropenia due to infection</td>
</tr>
<tr>
<td>288.09</td>
<td>Other neutropenia</td>
</tr>
<tr>
<td>288.4</td>
<td>Hemophagocytic syndromes</td>
</tr>
<tr>
<td>288.50</td>
<td>Leukocytopenia, unspecified</td>
</tr>
<tr>
<td>288.51</td>
<td>Lymphocytopenia</td>
</tr>
<tr>
<td>288.59</td>
<td>Other decreased white blood cell count</td>
</tr>
<tr>
<td>288.60</td>
<td>Leukocyteos, unspecified</td>
</tr>
<tr>
<td>288.61</td>
<td>Lymphocytosis (symptomatic)</td>
</tr>
<tr>
<td>288.62</td>
<td>Leukemoid reaction</td>
</tr>
<tr>
<td>288.63</td>
<td>Monocytosis (symptomatic)</td>
</tr>
<tr>
<td>288.64</td>
<td>Plasmacytosis</td>
</tr>
<tr>
<td>288.65</td>
<td>Basophilia</td>
</tr>
<tr>
<td>288.69</td>
<td>Other elevated white blood cell count</td>
</tr>
<tr>
<td>289.53</td>
<td>Neutropenic splenomegaly</td>
</tr>
<tr>
<td>289.83</td>
<td>Myelofibrosis</td>
</tr>
</tbody>
</table>

### Nervous system and sense organs

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>323.01</td>
<td>Encephalitis and encephalomyelitis in viral diseases classified elsewhere</td>
</tr>
<tr>
<td>323.02</td>
<td>Myelitis in viral diseases classified elsewhere</td>
</tr>
<tr>
<td>323.41</td>
<td>Other encephalitis and encephalomyelitis due to infection classified elsewhere</td>
</tr>
<tr>
<td>323.42</td>
<td>Other myelitis due to infection classified elsewhere</td>
</tr>
<tr>
<td>323.51</td>
<td>Encephalitis and encephalomyelitis following immunization procedures</td>
</tr>
</tbody>
</table>

### Circulatory system

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>429.83</td>
<td>Takotsubo syndrome</td>
</tr>
<tr>
<td>478.19</td>
<td>Nasal mucositis (ulcerative)</td>
</tr>
<tr>
<td>478.19</td>
<td>Other diseases of nasal cavity and sinuses</td>
</tr>
</tbody>
</table>

### Respiratory system

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>518.7</td>
<td>Transfusion related acute lung injury (TRALI)</td>
</tr>
<tr>
<td>519.11</td>
<td>Acute bronchopasm</td>
</tr>
<tr>
<td>519.19</td>
<td>Other diseases of trachea and bronchus</td>
</tr>
</tbody>
</table>

### Digestive system

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>521.81</td>
<td>Cracked tooth</td>
</tr>
<tr>
<td>521.89</td>
<td>Other specified diseases of hard tissues of teeth</td>
</tr>
</tbody>
</table>

### Genitourinary system

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>608.20</td>
<td>Torsion of testis, unspecified</td>
</tr>
<tr>
<td>608.21</td>
<td>Extravaginal torsion of spermatic cord</td>
</tr>
<tr>
<td>608.22</td>
<td>Intravaginal torsion of spermatic cord</td>
</tr>
<tr>
<td>608.23</td>
<td>Torsion of appendix testis</td>
</tr>
<tr>
<td>608.24</td>
<td>Torsion of appendix epididymis</td>
</tr>
<tr>
<td>616.81</td>
<td>Mucositis (ulcerative) of cervix, vagina, and vulva</td>
</tr>
<tr>
<td>616.89</td>
<td>Other inflammatory disease of cervix, vagina, and vulva</td>
</tr>
<tr>
<td>618.84</td>
<td>Cervical stump prolapse</td>
</tr>
<tr>
<td>629.29</td>
<td>Other female genital mutilation status</td>
</tr>
<tr>
<td>629.81</td>
<td>Habitual abortor without current pregnancy</td>
</tr>
<tr>
<td>629.89</td>
<td>Other specified disorders of female genital organs</td>
</tr>
</tbody>
</table>

### Complications of pregnancy, childbirth, and puerperium

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>649.00</td>
<td>Tobacco use disorder complicating pregnancy, childbirth, or the</td>
</tr>
</tbody>
</table>

---

**Editor’s note:** CMS published the final coding changes scheduled for October 1 and the implementation of ICD-9-CM codes in the June 23 Transmittal 990. The following are new diagnosis and V codes only. Be sure to review the rule for deletions, revisions, new procedure codes, and subterms.
Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum complication

649.01 Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition

649.02 Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with mention of antepartum complication

649.03 Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication

649.04 Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication

649.10 Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable

649.11 Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition

649.12 Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication

649.13 Obesity complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication

649.14 Obesity complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication

649.20 Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication

649.21 Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition

649.22 Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with mention of antepartum complication

649.23 Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication

649.24 Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication

649.30 Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable

649.31 Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition

649.32 Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of antepartum complication

649.33 Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication

649.34 Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication

649.40 Epilepsy complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication

649.41 Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition

649.42 Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered with mention of antepartum complication

649.43 Epilepsy complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication

649.44 Epilepsy complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication

649.50 Spotting complicating pregnancy, unspecified as to episode of care or not applicable

649.51 Spotting complicating pregnancy, delivered, with or without mention of antepartum condition

649.53 Spotting complicating pregnancy, antepartum condition or complication

649.60 Uterine size date discrepancy, unspecified as to episode of care or not applicable

649.61 Uterine size date discrepancy, delivered, with or without mention of antepartum condition

649.62 Uterine size date discrepancy, delivered, with mention of antepartum complication

649.63 Uterine size date discrepancy, antepartum condition or complication

649.64 Uterine size date discrepancy, postpartum condition or complication

Musculoskeletal system and connective tissue

729.71 Nontraumatic compartment syndrome of upper extremity

729.72 Nontraumatic compartment syndrome of lower extremity

729.73 Nontraumatic compartment syndrome of abdomen

729.79 Nontraumatic compartment syndrome of other sites

731.3 Major osseous defects

Conditions in the perinatal period

768.7 Hyponatremia

770.87 Respiratory arrest of newborn

770.88 Hypothermia of newborn

775.81 Other acidosis of newborn

775.89 Other neonatal encephalopathy and metabolic disturbances

779.85 Cardiac arrest of newborn

Symptoms, signs, and ill-defined conditions

780.32 Complex febrile convulsions

780.96 Generalized pain

780.97 Altered mental status

784.91 Postnasal drip

784.99 Other symptoms involving head and neck

788.64 Urinary hesitancy

788.65 Straining on urination

793.91 Image test inconclusive due to excess body fat

793.99 Other nonspecific abnormal findings on radiologic and other examinations of body structure

795.06 Papancocoiolai smear of cervix with cytologic evidence of malignancy

795.81 Elevated carcinoembryonic antigen [CEA]

795.82 Elevated cancer antigen 125 [CA 125]

795.89 Other abnormal tumor markers

Injury and poisoning

958.90 Compartment syndrome, unspecified

958.91 Traumatic compartment syndrome of upper extremity

958.92 Traumatic compartment syndrome of lower extremity

958.93 Traumatic compartment syndrome of abdomen

958.99 Traumatic compartment syndrome of other sites

995.20 Unspecified adverse effect of unspecified drug, medicinal and biological substance

995.21 Arthus phenomenon

995.22 Unspecified adverse effect of anesthesia

995.23 Unspecified adverse effect of insulin

995.27 Other drug allergy

995.29 Unspecified adverse effect of other drug, medicinal and biological substance

New V codes

V18.51 Family history, colonic polyps

V18.59 Family history, other digestive disorders

V26.34 Testing of male for genetic carrier status

V26.35 Encounter for testing of male partner of habitual aborter

V26.39 Other genetic testing of male

V43.86 Bariatric surgery status

V58.30 Encounter for change or removal of nonsurgical wound dressing

V58.31 Encounter for change or removal of surgical wound dressing

V58.32 Encounter for removal of sutures

V72.11 Encounter for hearing examination following failed hearing screening

V72.19 Other examination of ears and hearing

V82.71 Screening for genetic disease carrier status

V82.79 Other genetic screening

V85.51 Body Mass Index, pediatric, less than 5th percentile to less than 95th percentile for age

V85.52 Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age

V85.53 Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age

V85.54 Body Mass Index, pediatric, greater than or equal to 95th percentile for age

V86.0 Estrogen receptor positive status [ER+]

V86.1 Estrogen receptor negative status [ER-]