Advanced Procedure and Diagnosis Sequencing in ICD-10

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Live webcast presented on:
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Presented By:

Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CCDS, is the director of HIM and coding for HCPro, Inc. She serves as the director of the Certified Coder Boot Camp® programs. She developed the Certified Coder Boot Camp-Inpatient version and the HCPro ICD-10 Basics Boot Camp. McCall and her team of regulatory specialists collaborated to develop the Certified Coder Boot Camp-ICD-10-CM/PCS versions. She also works with hospitals, medical practices, and other healthcare providers on a wide range of coding-related issues, with a particular focus on coding reviews and audits. She served as an ACDIS advisory board member from 2007 through the end of 2010.

Presented By:

Jennifer E. Avery, CCS, CPC-H, CPC, CPC-I, is a senior regulatory specialist with HCPro, Inc., and serves as an instructor for the Certified Coder Boot Camp®, the Certified Coder Boot Camp®–Online Version, the Certified Coder Boot Camp®–Inpatient Version HCPro’s ICD-10 Basics Boot Camp®, and the Certified Coder Boot Camp-ICD-10-CM/PCS versions. Avery played a vital role in the development of HCPro’s ICD-10-CM/PCS related educational courses. Avery works with hospitals, medical practices, and other healthcare providers on a wide range of coding-related issues with a particular focus on coding education. She has extensive experience with coding for both physician and hospital services.
Learning Objectives

- At the completion of this educational activity, the learner or participant, will be able to:
  - Identify instances in which principal diagnoses also serve as CCs/MCCs in ICD-10
  - Explain which documentation may be taken from ancillary reports
  - Describe general ICD-10-PCS guidelines and ways in which CDI may be involved in review of procedures
  - Describe specific challenges in ICD-10-PCS code assignment

Diagnosis Coding – Definitions

- **Principal diagnosis** – Per the UHDDS, “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care”
- **Additional/other or “secondary” diagnosis** – Coexisting conditions that affect patient care requiring:
  - Clinical evaluation
  - Therapeutic treatment
  - Diagnostic procedures
  - Extended LOS
  - Increased nursing care and/or monitoring
CCs in ICD-9-CM

- Identification of coexisting CC/MCC conditions in ICD-9-CM are found solely in the additional diagnoses for a patient admission
- In the MS-DRG system you only need one condition designated as a CC/MCC to group to the “with CC or with MCC” MS-DRG
- CC example:
  - Principal diagnosis – 250.71 (Type 1 DM with peripheral circulatory disorders)
  - Additional diagnosis – 785.4 (gangrene)  CC condition
    - MS-DRG 300 – peripheral vascular disorders with CC

CCs in ICD-10-CM

- In ICD-10-CM there are some conditions that when assigned as the principal diagnosis will also serve as the CC/MCC for appropriate MS-DRG assignment
- Principal as own CC example:
  - Principal diagnosis – E10.52 (Type 1 DM with diabetic peripheral angiopathy with gangrene)
    - MS-DRG 300 – peripheral vascular disorders with CC
    - Still will be assigned to the same MS-DRG
MCCs in ICD-9-CM

• MCC example:
  – Principal diagnosis – 570 (acute hepatic failure)
  – Additional diagnosis – 572.2 (hepatic coma)

MCC condition
• MS-DRG 441 – disorders of liver, except malignancy, cirrhosis, alcoholic hepatitis with MCC

MCCs in ICD-10-CM

• Principal as own MCC example:
  – Principal diagnosis – K72.01 (acute and subacute hepatic failure with coma)
    • MS-DRG 441 – disorders of liver, except malignancy, cirrhosis, alcoholic hepatitis with MCC
    • Still will be assigned to the same MS-DRG
Principal Diagnoses That Are Their Own CC (Examples)

- Sickle cell crisis with complications (e.g., acute chest syndrome)
- CAD (native, bypass, etc.) with USA
- Atherosclerosis of bypass in extremities with ulceration and/or gangrene
- UC and Crohn’s disease with complications (e.g., abscess, obstruction)
- Aftercare for transplants (heart, lung, kidney, bone marrow, liver, combos)
- Diverticulitis w/ or w/o bleed
- Choledocholithiasis with (acute or chronic) cholangitis w/ or w/o obstruction
- Rheumatoid myopathy w/RA
- SLE with endocarditis or pericarditis
- Chronic obstructive pyelonephritis
- Gestational proteinuria (all trimesters)

Principal Diagnoses That Are Their Own MCC

- Certain bacterial and viral sepsis codes (e.g., anthrax, listerial, candida)
- Various whooping cough with pneumonia
- Cytomegaloviral diseases (e.g., pneumonitis, pancreatitis)
- Invasive pulmonary aspergillosis
- Ascariasis pneumonia
- PE with acute cor pulmonale
- Hepatic failures and liver diseases with coma
- All anatomic locations of Stage 3 and 4 pressure ulcers
- Severe sepsis with septic shock
- Traumatic cerebral edema
AHA’s Coding Clinic

• The AHA will not translate all previous coding advice provided in the ICD-9 Coding Clinics (1984–present)
• “Every effort was made to carry over the ICD-9-CM guidelines and concepts into ICD-10-CM, unless there was a specific change in ICD-10-CM that precluded the incorporation of the same concept into ICD-10-CM” <AHA, Coding Clinic, 4Q 2012>

CHF and Pleural Effusions

• Pleural effusion is commonly seen with congestive heart failure with or without pulmonary edema. Ordinarily the pleural effusion is minimal and is not specifically addressed other than by more aggressive treatment of the underlying congestive heart failure. In this situation it should not be reported unless the coder is directed to do so by the physician. <AHA, Coding Clinic, 3Q 1991>
**CHF and Pleural Effusions**

- Separate code assignment generally would necessitate performance of therapeutic thoracentesis or chest tube drainage to report the additional code (511.9 – CC condition) <AHA, Coding Clinic, 3Q 1991>
  - MS-DRG 293 – heart failure and shock with CC – ~$5600
  - MS-DRG 292 – heart failure and shock without CC – ~$3800

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**CHF and Pleural Effusions**

- Heart failure in ICD-10-CM (category I50.-)
  - Additional digits identify type of HF (congestive, systolic, diastolic)
- Pleural effusions in ICD-10-CM (code J90 or category 91)
  - J90 – pleural effusion, unspecified
  - J91.0 – malignant pleural effusion
  - J91.8 – pleural effusion in other conditions classified elsewhere
CHF and Pleural Effusions

• J91.8 – pleural effusion in other conditions classified elsewhere
  – There is an Excludes2 note for category J91.
    • Pleural effusion in heart failure (I50.-)
    • Pleural effusion in SLE (M32.13)
  – “Excludes2 notes mean ‘not included here.’ When an Excludes2 note appears, it is acceptable to use both the code and the excluded code together, when appropriate.” <ICD-10-CM Official Guidelines>
  – To date there is no updated Coding Clinic guidance on this issue.

Specificity From Ancillary Reports

• Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance <ICD-10-CM Official Guidelines>
  – Same as in ICD-9-CM Official Guidelines
  – Exception in ICD-9-CM
    • “If a physician has documented the general location of a fracture and a radiology report provides a more specific location the coder may code the more specific location based on the radiology report” <AHA, Coding Clinic, 1Q 2004>
Specificity From Ancillary Reports

• Some categories include specific anatomic locations such as:
  – CVAs (hemorrhagic and ischemic)
    • Example – I63.231 – cerebral infarction of unspecified occlusion or stenosis of right carotid artery
  – AMIs
    • Example – I21.02 – ST elevation involving LAD
  – Should we be able to assign the more specific code based off an ancillary/diagnostic report?

• Source of documentation will be key
  – Location of specific vessels for CVAs are traditionally identified on radiology reports such as CTs
    • Usually performed and documented by a non-treating physician—radiologist
    • Must be identified as significant by a treating physician (e.g., neurologist) before code assigned
  – Specific location of occluded vessels resulting in AMI identified on cardiac catheterizations
    • Usually performed and documented by a treating physician—cardiologist therefore supports code assignment
Specificity From Ancillary Reports

- There are times when the provider may not be able to identify and pinpoint exactly which vessel is the culprit
  - Option to capture detail of specificity without making the provider “guess”
  - If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” “still to be ruled out,” or other similar terms indicating uncertainty, code the condition as if it existed or was established.

Anemia Related to Neoplasms

- ICD-9-CM – 285.22 – Anemia in neoplastic disease
  - Sequenced as the principal dx if reason for the admission
  - Additional code(s) for site of neoplasm
- ICD-10-CM – D63.0 – Anemia in neoplastic disease
  - Principal dx: Site of the neoplasm (various codes)
  - Additional code – D63.0 – Anemia in neoplastic disease (non-CC condition)
  - MS-DRG can vary depending on site of neoplasm
Anemia Related to Neoplasms

- ICD-9-CM – 285.3 – Antineoplastic chemotherapy-induced anemia
- ICD-10-CM – D64.81 – Antineoplastic chemotherapy-induced anemia
  - Anemia code is principal dx
  - Additional code(s) for neoplasm
  - T45.1x5 [add 7th character] – Adverse effect of antineoplastic and immunosuppressive drugs
  - Both I-9 and I-10 diagnoses group to MS-DRG 811–812 (w/MCC or w/o MCC) ~$4500–$7000

Polling Question

- Which of the following ICD-10-CM combination codes will NOT be considered its own CC/MCC when utilized as the principal diagnosis in ICD-10?
  - I25.110 (Atherosclerotic heart disease of a native coronary artery with unstable angina pectoris)
  - K57.20 (Diverticulitis of large intestine with perforation and/or abscess without bleeding)
  - L89.144 (Pressure ulcer of left lower back, stage 3)
  - E10.11 (Type 1 diabetes mellitus with ketoacidosis with coma)
ICD-10-PCS Multiple Procedures Guidelines

- During the same operative episode, multiple procedures are coded if:
  - The same root operation is performed on different body parts as defined by distinct values of the body part character <PCS Multiple Procedures B3.2>

Multiple Procedures Guidelines

- Example: Open total abdominal hysterectomy (cervix and uterus)

0 – Medical and surgical
U – Female reproductive system
T – Resection (cutting out or off, without replacement, all of a body part)

<table>
<thead>
<tr>
<th>9 Uterus</th>
<th>0 Open</th>
<th>Z No Device</th>
<th>Z No Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Cervix</td>
<td>0 Open</td>
<td>Z No Device</td>
<td>Z No Qualifier</td>
</tr>
</tbody>
</table>
Impact of ICD-10-PCS Multiple Procedures Guidelines

- Multiple procedures in ICD-10-PCS where ICD-9-CM Volume 3 has a combination procedure code:
  - Example: Open total abdominal hysterectomy (removal of cervix and uterus)
    - ICD-9-CM: 68.49, other and unspecified TAH
    - ICD-10-CM: 0UT90ZZ, resection, uterus
      0UTC0ZZ, resection, cervix
    - Note: Both ICD-9 and ICD-10 require separate code(s) for reporting of synchronous removal of tubes/ovaries (if applicable)

Challenges in ICD-10-PCS Code Assignment

- Sequencing guidance has not been established
  - Will the rules about principal procedure be identified soon?
    - Principal procedure can impact the MS-DRG
    - Currently, the principal procedure is one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If two procedures appear to meet this definition, then the one most related to the principal diagnosis should be selected as the principal procedure. <AHA, Coding Clinic, 2Q 2011>
**Impact on Reimbursement**

- Effects on selecting one procedure versus another
  - Example: Open total abdominal hysterectomy (cervix and uterus) for non-malignancy (i.e., endometriosis) with no CC/MCC conditions
  - ICD-9-CM
    - MS-DRG 743 (RW .9653 ~$5400)
  - ICD-10-CM:
    - Principal procedure: 0UT90ZZ
      - MS-DRG 743 (RW .9653 ~$5400)
    - Principal procedure: 0UTC0ZZ
      - MS-DRG 747 (RW .8818 ~$4900)

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**Surgical Hierarchies**

- The importance of a “surgical hierarchy”
  - MDC 13, surgical DRGs
    - Pelvic evisceration, radical hysterectomy and radical vulvectomy 734–735
    - Uterine and adnexal procedures for malignancy 736–741
    - Uterine and adnexal procedures for non-malignancy 742–743
    - D&C, conization, laparoscopy and tubal interruption 744–745
    - Vagina, cervix and vulva procedures 746–747
    - Female reproductive system reconstructive procedures
      - Other female reproductive system O.R. procedures 749–750
ICD-10-PCS General Guidelines

• Components of a procedure specified in the root operation definition and explanation are not coded separately. Procedural steps necessary to reach the operative site and close the operative are also not coded separately. <PCS Root Operations Guidelines B3.1b>
  • Example: Surgeon performs an anastomosis of the descending colon to the rectum after a sigmoid colon resection
    – The anastomosis would not be coded separately

Potential Scenario for “Overcoding” a Procedure

• “Overcoding” a procedure
  – Example: Open reduction with insertion of an intramedullary nail for a right femoral shaft fracture
  • Correct ICD-10-PCS code: 0QS806Z – repositioning of the right femoral shaft, with internal fixation device, intramedullary
    – It is inappropriate to assign an additional code 0QH806Z – insertion of an intramedullary internal fixation device into the right femoral shaft separately
    – The “device” is already captured in the code of 0QS806Z
Challenges in ICD-10-PCS Code Assignment

• Some procedures may appear to “fit” more than one root operation definition
  – It is the coder’s responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between documentation and the defined PCS term is clear. <PCS Coding Guidelines A11>
    – Example: Physician documents partial resection of duodenum; coder can correlate to root operation “Excision”

• Not all procedural terms are easy to correlate
  – Example: Embolization of a vessel
    • If the objective of the procedure is to completely close a vessel, the root operation is Occlusion
    • If the objective of the procedure is to narrow the lumen of a vessel, the root operation is Restriction
    • However, if you look up Embolization in the ICD-10-PCS Alphabetic Index, it only cross-references to see Occlusion
GEM Mapping Issues

Caution: GEMs may not help when there is more than one option for a procedure

ICD-9-CM Volume 3
- 39.76 – endovascular embolization/occlusion of vessel(s) of head/neck using bioactive coils

ICD-10-PCS
- 03L- (Occlusion)
- 03V- (Restriction)

What’s the Objective of the Procedure?

- Example: Angioplasty
  - ICD-10-PCS Alphabetic Index:
    - see Dilation
      - Expanding an orifice/lumen of a tubular body part
    - see Repair
      - Restoring, to the extent possible, a body part to its normal anatomic structure/function
    - see Replacement
      - Putting in or on biological or synthetic material that physically takes the place/function of all or a portion of a body part
    - see Supplement
      - Putting in or on biological or synthetic material that physically reinforces/augments the function of a portion of a body part
GEM Mapping Issues

ICD-9-CM Volume 3

• 39.50 – angioplasty of other non-coronary vessel(s)

ICD-10-PCS

• 027-, 037-, 047-, 057-, 067- (Dilation)
• 02C-, 03C-, 04C-, 05C-, 06C- (Extirpation)

Extirpation: Taking or cutting out solid matter from a body part (i.e., atherectomy)

What’s the Objective of the Procedure?

• Example: Angioplasty
  – ICD-10-PCS Alphabetic Index:
    • see Dilation
      – Percutaneous transluminal angioplasty (PTA) of right renal artery: 04793ZZ (ICD-9-CM – 39.50, 00.40)
    • see Repair
      – Percutaneous repair (suture) of lacerated right renal artery: 04Q93ZZ (ICD-9-CM – 39.31)
    • see Replacement
      – Percutaneous endoscopic partial resection of right renal artery with nonautologous tissue graft: 04R94KZ (ICD-9-CM – 38.46)
    • see Supplement
      – Percutaneous repair of right renal artery with synthetic graft 04U93JZ (ICD-9-CM – 39.57)
Polling Question

- When coding for reduction of fractures with insertion of internal fixation device(s) you should:
  - Have a code for the reduction of the fracture and a code for the insertion of the device
  - Code for the insertion of the device only (the fracture reduction is included)
  - Code for the reduction of the fracture with a sixth character identifying the type of device inserted

Steps to Take Now to Ensure a Smooth Transition

- PCS definitions
  - CDI and coding staff should work closely to look at a sampling of their top procedures to:
    - Ensure the objective of the procedure is clear based on current documentation
    - Ensure that all information is documented to help select a complete seven-character code
    - Seek guidance from *AHA Coding Clinic for ICD-10* as needed
Challenges in ICD-10-PCS Code Assignment

- Example: Insertion of a central or peripherally inserted central catheter
  - ICD-9-CM Volume 3
    - Catheter vs. totally implanted device? For renal dialysis? With guidance?
  - ICD-10-PCS
    - Body system?
      - 05H: Upper veins
      - 06H: Lower veins
      - 0JH: Subcutaneous tissue and fascia
    - Approach?
      - Open, percutaneous, percutaneous endoscopic?
    - Device?
      - Totally implanted VAD or insertion of central catheter (only)?
      - Intraluminal device or infusion device?

ICD-9-CM Volume 3

- 38.93 – venous catheterization, not elsewhere classified
- 38.95 – venous catheterization for renal dialysis
- 38.97 – central venous catheter placement w/guidance
- 86.07 – insertion of totally implantable vascular access device (VAD)

ICD-10-PCS

- 05H-, insertion, upper veins
- 06H-, insertion, lower veins
- 0JH-, insertion, subcutaneous tissue and fascia
Challenges in ICD-10-PCS Code Assignment

• Insertion of vascular access device (Port-A-Cath®) into chest for chemotherapy
  – ICD-10-PCS Alphabetic Index:
    • Vascular access device
      – Insertion of device in
        • Chest 0JH6-
    • Generally, the central venous access device is placed by puncturing the skin
      – 0JH63-
    • A Port-A-Cath® consists of a reservoir (the portal) and a tube (the catheter); the portal is implanted under the skin in the upper chest
      – Example: 0JH63WZ

Polling Question

• An embolization should always be coded to the root operation occlusion.
  – True
  – False
Questions & Answers

How to submit a question:

1. Go to the Q & A box located on your screen.
2. Type in your question.
3. Click the Icon to send.

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THANK YOU!

For more information about CDI Week and its associated activities and resources, please visit:

http://www.hcpro.com/acdis/cdi_week.cfm

This concludes today’s program.