Agenda

- Summary of highlights from AHA's *Coding Clinic for ICD-10-CM and PCS* First Quarter, 2017

- Outpatient Diagnostic Coding

- Screening Colonoscopy

Outpatient Diagnostic Coding

Outpatient Diagnostic Coding

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Outpatient Diagnostic Services

- IMPORTANT!! This advice applies to hospital outpatient <u>AND</u> free-standing facilities

- Coding from a pathologist's findings

  - A pathologist is a physician and if a diagnosis is made then it supports code assignment.

Outpatient Diagnostic Services

- Example

- A patient undergoes outpatient surgery to remove a "skin lesion on scalp"

- The pathologist documents basal cell carcinoma

    - The pathologist confirms Assign C44.41

        - Exception: If the Pathologist, does not confirm a definitive diagnosis then the indication for the submitted specimen would be coded → "skin lesion" – Assign L98.9

Outpatient Diagnostic Services

- Example:

  - Patient presents for outpatient surgery to remove a left breast mass. Both the preoperative and postoperative diagnosis are listed as left breast mass.

  - The pathologist documents "fibroadenoma"

- The outpatient facility would assign D24.2 – benign neoplasm of the left breast

Outpatient Diagnostic Services

- Radiologist findings and appropriate coding

  - Radiologists are physicians too! If the report indicates a confirmed diagnosis, it should be coded.

  - Code to the highest degree of certainty

  - Incidental findings should not be coded

Outpatient Diagnostic Services

- Radiologist findings Example:

- Patient presents with complaints of flank pain. The physician orders abdominal x-rays with a diagnosis of questionable kidney stone.

  - X-ray reveals "bilateral nephrolithiasis with staghorn calculi"

- Correct code assignment for the facility– N20.0 – Calculus of the kidney

Outpatient Diagnostic Services

- Radiologist and Incidental Findings

  - Incidental Findings should not be reported.

    - Example:

      - Patient presents for chest x-rays due to fever and non-productive cough. A/P chest x-ray shows Hiatal hernia. Given that the hernia is an incidental finding – it should not be reported

Outpatient Diagnostic Services

- Coding from laboratory findings interpreted by a pathologist (or other provider)

  - Example:

    - A urine specimen for cytology is submitted from a referring physician to the laboratory for "hematuria"

    - The laboratory findings were interpreted by the pathologist and documents "bladder cancer"

Outpatient Diagnostic Services

Coding from laboratory findings interpreted by a pathologist (or other provider)

- The laboratory findings were interpreted by the pathologist and documents "bladder cancer"

Referring Physician	Laboratory
Assign R31.9 (hematuria) if coded prior to laboratory results	Assign Code C67.9 (bladder cancer)
Assign code C67.9 (Bladder cancer) if results are available	

Outpatient Diagnostic Services

- Coding from laboratory findings NOT interpreted by a pathologist (or other provider)

  - Example:

    - A urine specimen is submitted for urinalysis for "urinary frequency"

    - The laboratory findings identify positive for bacteria (e.g., E-coli) and increased WBCs

Outpatient Diagnostic Services

- The laboratory findings identify positive for bacteria (e.g., E-coli) and increased WBCs

  - Laboratory – Assign codes for "urinary frequency" – R35.0

    - When laboratory tests are not interpreted by a physician only the signs/symptoms may be reported.

    - It would be <u>inappropriate</u> to assign a diagnosis code for a UTI (N39.0) and a code to identify the infectious organism.

Screening, Surveillance and F/U Colonoscopy

Type of Colonoscopy	Code(s)
Screening w/ a New Finding	Assign screening colonoscopy code Z12.11 and the new finding as an additional code (e.g. polyp)
Therapeutic w/definitive treatment	Assign diagnosis code for condition (e.g., polyp)
Surveillance following definitive treatment	Assign screening colonoscopy code (Z12.11) and personal history of colon polyps (Z86.010)
Follow-up after definitive treatment	Assign code for F/U exam after completed treatment for other conditions (Z09) and personal hx of colon polyps (Z86.010)

Screening, Surveillance and F/U Colonoscopy

- Screening Example:

  - A 59 year old female presented for a screening colonoscopy. During the procedure a polyp was found and removed by snare technique. Pathology confirmed villous adenoma.

    - Appropriate Coding:

      - Z12.11 – screening for malignant neoplasm of the colon

      - D12.6 – Benign neoplasm of the colon

Screening, Surveillance and F/U Colonoscopy

- Surveillance Example:

  - A 59 year old male with a history of colon polyps, removed 7 years ago presents for a surveillance colonoscopy. The colonoscopy shows no evidence of abnormality and is completely normal. The provider recommends the patient return for a surveillance colonoscopy in 10 years.

    - Appropriate Coding:

      - Z12.11 – screening for malignant neoplasm of the colon

Screening, Surveillance and F/U Colonoscopy

- Follow-up Example:

  - A 65 year old male, status post polypectomy. Due to the polyp's suspicious nature and potential malignancy, the patient has returned for a follow up colonoscopy. The colonoscopy was normal with no evidence of polyp recurrence. Appropriate Coding:

  - Appropriate Coding

    - Z09 – Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

    - Z86.010 – Personal history of colonic polyps

Screening, Surveillance and F/U Colonoscopy

- Follow-up Example:

  - Appropriate Coding

    - Z09 – Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

    - Z86.010 – Personal history of colonic polyps

Hyperplastic and Adenomatous Polyps

What diagnosis code should be reported for a history of a hyperplastic polyps of the colon or rectum?

- ICD-10-CM code – Z87.19

  - Personal history of other diseases of the digestive system

- A hyperplastic polyp is not a benign neoplasm therefore reporting Z86.010 would be inappropriate.

Hyperplastic and Adenomatous Polyps

- What diagnosis code is assigned for colon polyp, unspecified?

  - The default code is K63.5

    - Hyperplastic polyp

 - Adenomatous/neoplastic polyps are assigned to category D12 based on anatomic location.

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Hepatic Flexure

- ICD-10-CM classifies the hepatic flexure as the "transverse colon"

- ICD-10-PCS classifies the hepatic flexure as the "ascending colon".
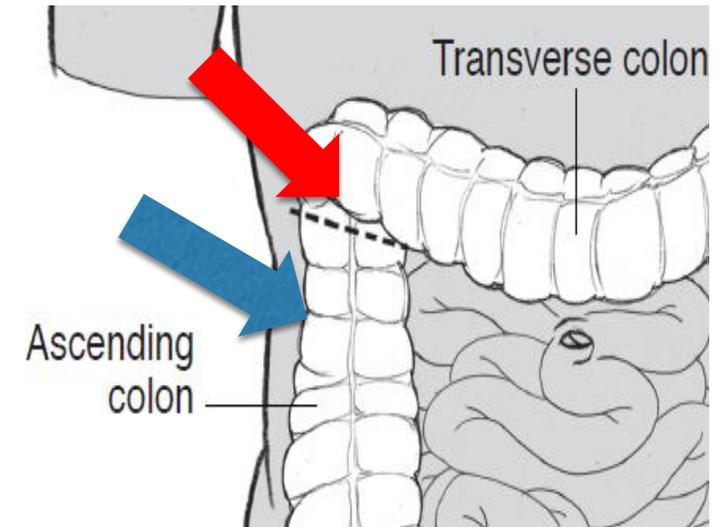
Hepatic Flexure

- Neither classification has a specific entry/body part value for the hepatic flexure which connects the ascending and transverse colon.

  - There is no requirement that both classifications must match.

    - Contact payer/vendor if there are claim edits.
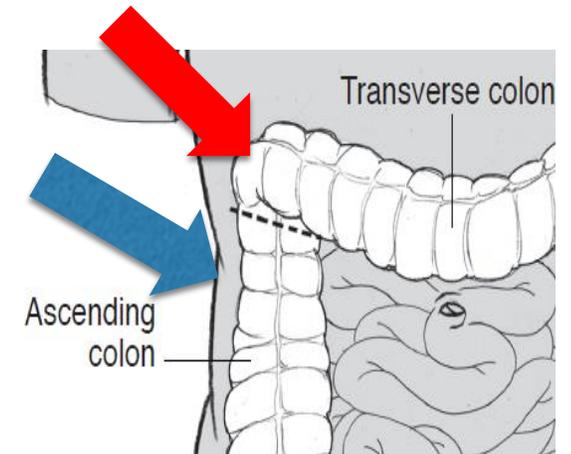
Personal History of Rectal Polyps

- Documentation states, "personal history of rectal polyps"

  - ICD-10-CM does not specifically classify rectal polyps with no mention neoplastic characteristics

  - Code Assignment: Z87.19 – Personal history of other diseases of the digestive system

    - Given that the provider does not indicate benign neoplasm it can not be coded as personal history of benign neoplasm – Z86.01

Postoperative Ileus

- Documentation states "postoperative ileus"

  - Query provider to determine if the condition is considered a postoperative complication (obstruction?)

    - Postoperative complication – assign code K91.89 (other postprocedural complications and disorders of the digestive system) and K56.7 (Ileus, unspecified) to identify the specific complication.

    - NOT a postoperative complication -- assign only K56.7

    - K91.3 (postprocedural intestinal obstruction) should ONLY be assigned for an postoperative obstructive ileus

Chronic Hepatitis C and Hepatic Encephalopathy

- Assign code for chronic viral hepatitis C code – B18.2 and chronic hepatic failure without coma code – K72.10

  - Sequencing will depend on the circumstances of the admission

  - Hepatic encephalopathy is NOT synonymous with hepatic coma

    - K72.11 (chronic hepatic failure with coma) is an MCC

Manual Reduction of Hernia

- Manual reduction of a hernia is NOT separately reported

Cyclical Vomiting Syndrome

- The condition is characterized by recurrent, prolonged attacks of severe nausea, vomiting, prostration with no apparent cause. In some there is severe abdominal pain. Vomiting occurs at frequent intervals for hours or days (1-4 most commonly).

- Encountered often in patients with family history of migraines.

- Can be triggered by colds, infection, intense excitement, emotional stress, menstruation

Cyclical Vomiting Syndrome

- Assign codes K31.89 (Other diseases of the stomach and duodenum) and a code from category R11.- for nausea/vomiting

Symptoms and Definitive diagnoses

- What is the principal diagnosis when a patient is admitted for gross hematuria related to prostate CA?

Symptoms, signs, and ill-defined conditions listed in Chapter 18 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

Symptoms and Definitive diagnoses

- What is the principal diagnosis when a patient is admitted for gross hematuria related to prostate CA?

  - Principal diagnosis – C61 (Prostate CA)

  - Secondary/additional diagnosis – R31.0 (Gross hematuria)

    - Supersedes advice from I-9 Coding Clinic Q2, 2010

    - Hematuria was not a symptom code in ICD-9-CM

COPD with Pneumonia

- ICD-10-CM code J44.0 (COPD with acute lower respiratory infection)

  - Inclusive of bronchitis and pneumonia (but not influenza)

  - Per the instructional notes, J44.0 is assigned as the principal diagnosis and an additional code is assigned for the acute lower respiratory infection. *< AHA, Coding Clinic Q3, 2016>*

COPD with Pneumonia

- ICD-10-CM code J44.0 (COPD with acute lower respiratory infection)

  - EXCEPTIONS: Aspiration pneumonia (J69.0)Ventilator associated pneumonia (J95.851)

    - Neither condition is classified as a "respiratory infection"

    - Sequencing will be dependent on the circumstances of the admission.

- What about J11.0 (Influenza with pneumonia)??

COPD with Asthma

- COPD with asthma, unspecified?

  - Assign only code J44.9 (COPD, unspecified)

COPD with Asthma

- COPD with asthma, unspecified?

  - Instructional note: "Use additional code for <u>type</u> of asthma, if applicable"

  - Do not assign ICD-10-CM code J45.909 (Unspecified asthma, uncomplicated) as a separate code.

- If a specific type of asthma is documented, (mild intermittent, mild/moderate/severe persistent) an additional code should be assigned from category J45.-

COPD with Asthma – Exacerbation

- COPD exacerbation with a [specified type] of asthma

  - Assign only code J44.1 (COPD, exacerbation)

COPD with Asthma – Exacerbation

- COPD exacerbation with a [specified type] of asthma

  - Query the provider if it is unclear whether the asthma was exacerbated as well.

    - COPD does not automatically make the asthma exacerbated

    - Caution! Specific question states "unspecified" but think they meant "uncomplicated" b/c the J45.- 5th character of a 0 or 1 differentiates uncomplicated vs exacerbated for asthma.

Respiratory distress vs. Acute Respiratory Distress Syndrome

- Respiratory distress (adult or child) should be assigned to the default ICD-10-CM code R06.00 (dyspnea, unspecified)

- Acute Respiratory distress syndrome (adult or child) should be assigned to J80

  - States there was a change to the Alphabetic index for 10/1/2016??

Distress
   acute respiratory R06.00
      syndrome (adult) (child) J80

Distress
   respiratory (adult) (child) R06.00

Difficulty Breastfeeding

- ICD-10-CM code P92.5 – Neonatal difficulty in feeding at breast can be assigned for patients < 28 days (outside the perinatal period) if the condition developed in the perinatal period.

Should a condition originate in the perinatal period, and continue throughout the life of the patient, the perinatal code should continue to be used regardless of the patient's age.

<Official Guidelines>

Respiratory Support for Newborns

- Do not assign a PCS code for brief Positive Pressure Ventilation or brief non-invasive ventilation for resuscitation following delivery

  - This service is considered inherent to the delivery

Respiratory Support for Newborns

- Non-invasive ventilation (NIV) is NOT considered mechanical ventilation since it is without endotracheal intubation/tracheostomy.

    - NIV is administered via face/nasal mask, nasal pillow, oral mouthpiece or oronasal mask

    - If performed for ongoing support, assign a code from PCS table 5A0- depending on # of hours, type (continuous or intermittent positive/negative airway pressure)

Catheter with Unknown Tip Site

- Body part character selection for catheters is based on the final tip position of the catheter.

  - Umbilical artery catheterizations where the tip position is <u>unknown</u> should be assigned to the body part character "Y" for a lower artery.

Catheter with Unknown Tip Site

- Central lines via the femoral vein catheterizations rarely require x-ray confirmation and should be assigned to the body part character "Y" for lower vein.

- If final tip position is confirmed the specific location should be selected for the body part.

  - Example – Umbilical vein catheterization confirmed in the inferior vena cava – 06H033T

    - Insertion, device, inferior vena cava, percutaneous, via umbilical vein

Assigning Body Mass Index

- Assign code Z68.1 (BMI of less than 19)

  - CC condition

  - Z68.20 – starts at BMI of 20.0-20.9, adult

  - Beware! Payers may disagree if the only CC condition

    - What about 19.3 or 19.8??

Uncontrolled Diabetes Mellitus

- Uncontrolled DM can either mean with hyperglycemia (too high) or hypoglycemia (too low)- New index entry added for 2017

- Couldn't we argue that poorly controlled, inadequately controlled and even out of control also could mean either??

- Currently, all default to diabetes, by type, with hyperglycemia only

Diabetes, diabetic (mellitus) (sugar)
  uncontrolled
    meaning
      hyperglycemia – see Diabetes, by type, with hyperglycemia
      hypoglycemia – see Diabetes, by type, with hypoglycemia

Toxic encephalopathy – Adverse effect

- Instructional note at G92 (Toxic encephalopathy) states to "Code first (T51-T65) to identify toxic agent"

  - What if it is an adverse effect of a drug properly administered?

  - Documentation states " Toxic encephalopathy due to ciprofloxacin"

Toxic encephalopathy – Adverse Effect

- Documentation states " Toxic encephalopathy due to ciprofloxacin"

  - Assign G92 as the principal diagnosis

  - Assign an additional code for the adverse effect of the specific drug (e.g. ciprofloxacin- T36.8X5-)

  - Final character either A, D, or S

- The Code First note is merely to identify IF the encephalopathy is due to a toxic agent that the T51-T65 would be assigned first to ensure MS-DRG assignment into MDC 21: Injuries, Poisonings and Toxic Effects of Drugs

- Principal diagnosis G92 is assigned to MDC 1: Diseases and Disorders of the Nervous System (unless a newborn)

Toxic encephalopathy – Therapeutic Drug Toxicity

- Instructional note at G92 (Toxic encephalopathy) states to "Code first (T51-T65) to identify toxic agent"

  - What if it is a poisoning/toxicity of a therapeutic drug?

When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T50). The code for the drug should

Toxic encephalopathy – Therapeutic Drug Toxicity

- Documentation states " Toxic encephalopathy due to lithium toxicity due to suicidal intent"

  - Assign poisoning code as the principal diagnosis for the specific drug (e.g. lithium-T43.592-)

  - Final character either A, D, or S

  - Assign G92 as an additional code

  When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate code from categories T36-T50.

- Although T43 is outside the range in the Code First note, it is still assigned to the MDC 21: Injuries, Poisonings and Toxic Effects of Drugs

Alzheimer's Disease without Dementia

- The Alphabetic Index defaults to assigning codes G30.9 [F02.80] but what if there is no supporting documentation for dementia?

  - Dementia is an inherent part of Alzheimer's disease, therefore is assigned regardless of provider documentation.

  - F02.80 (and F02.81 with behavioral disturbance) are manifestation codes indicated with brackets in the Alphabetic index.
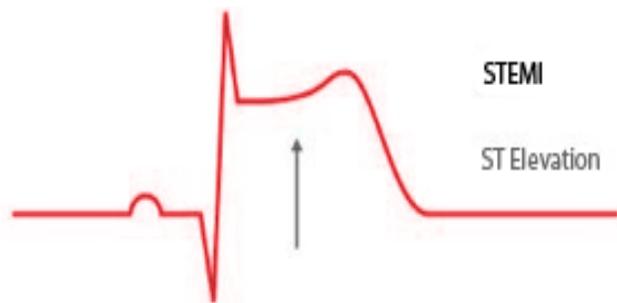
Disease, diseased -
  - Alzheimer's G30.9 *[F02.80]*
  - - with behavioral disturbance G30.9 *[F02.81]*

Demand Ischemia

- Type 2 myocardial infarction (T2MI) is assigned to ICD-10-CM code I21.4 (Non-STEMI)

  - A type 2 MI is marked by non-ST elevation and occurs secondary to other cardiac stress from other causes without atherosclerotic rupture but with myocardial necrosis.

Stage A heart Failure

- Stage A heart failure is defined by the American College of Cardiology and the American Heart Associations as at risk to develop the condition but does not have it yet.

  - Assign code Z81.89 (Other specified personal risk factors, NEC)

  - Do NOT assign codes from category I50.- (heart failure)

CHF with Dysfunction

- Decompensated CHF with <u>associated</u> diastolic or systolic dysfunction may be assigned a code for acute on chronic (I50.23 – systolic, I50.33 – diastolic, or I50.43 – combined)- MCC

- Decompensated" heart failure

  - "Decompensated" indicates that there has been a flare-up (acute phase) of a chronic condition <AHA, *Coding Clinic*, 2Q 2013>

  - If the provider does not document the linkage between CHF and dysfunction assign I50.9

    - *Side note: Suggest query if possible!*

Hypertensive Heart Disease with Failure

- Can CHF be assumed when documented in conjunction with hypertension?

  - Yes, although the code series is not in the inclusion codes it is in the "Use Additional Code" note under I11.0 (Hypertensive heart disease with heart failure)

  - In the absence of a provider identifying a specific cause, the classification assumes a relationship between hypertension and heart involvement.

Weakness of One Limb Status/post CVA

- Assign a code from category I69.33- for monoplegia, upper limb or I69.34- monoplegia, lower limb

  - Unilateral [and singular limb] weakness clearly associated with a stroke is considered to be classified as hemiparesis/hemiplegia [or monoplegia].

  - Applies same logic as AHA *Coding Clinic* Q1, 2015

External Heart Assist Devices

- Insertion of an external heart assist device with <u>removal</u> at conclusion of procedure

  - Only assign Assistance PCS code

    - 5A0221D

    - Extracorporeal assistance, cardiac, continuous, output, impeller pump

      - The duration is ALWAYS continuous

- Insertion of an external heart assist device <u>left in</u> for a few hours postoperatively

  - Assign codes for:

    - Insertion (02HA3RZ)

    - Assistance (5A0221D)

    - Removal (02PA3RZ)

External Heart Assist devices

- If a bilateral external heart assist device is placed (right and left ventricles) during a PCI and one side is removed but the other is left in place for several days

  - Insertion (02HA3RS) – Qualifier identifies "biventricular"

  - Assistance (5A0221D)

  - Removal (02PA3RZ) – Qualifier is "no qualifier" to identify unilateral

    - The body part character is not specific to the right and left ventricles – "A- Heart"

External Heart Assist devices

- Removal of an external heart assist device (Impella®) and replacement with a total artificial heart (Syncardia®)

  - Removal of external heart assist – 02PA0RZ

    - Note approach is "open" for removal

  - Replacement, left ventricle, open, synthetic substitute – 02RL0JZ

  - Replacement, right ventricle, open synthetic substitute – 02RK0JZ

  - https://www.youtube.com/watch?v=o9T3GGTh_FQ .
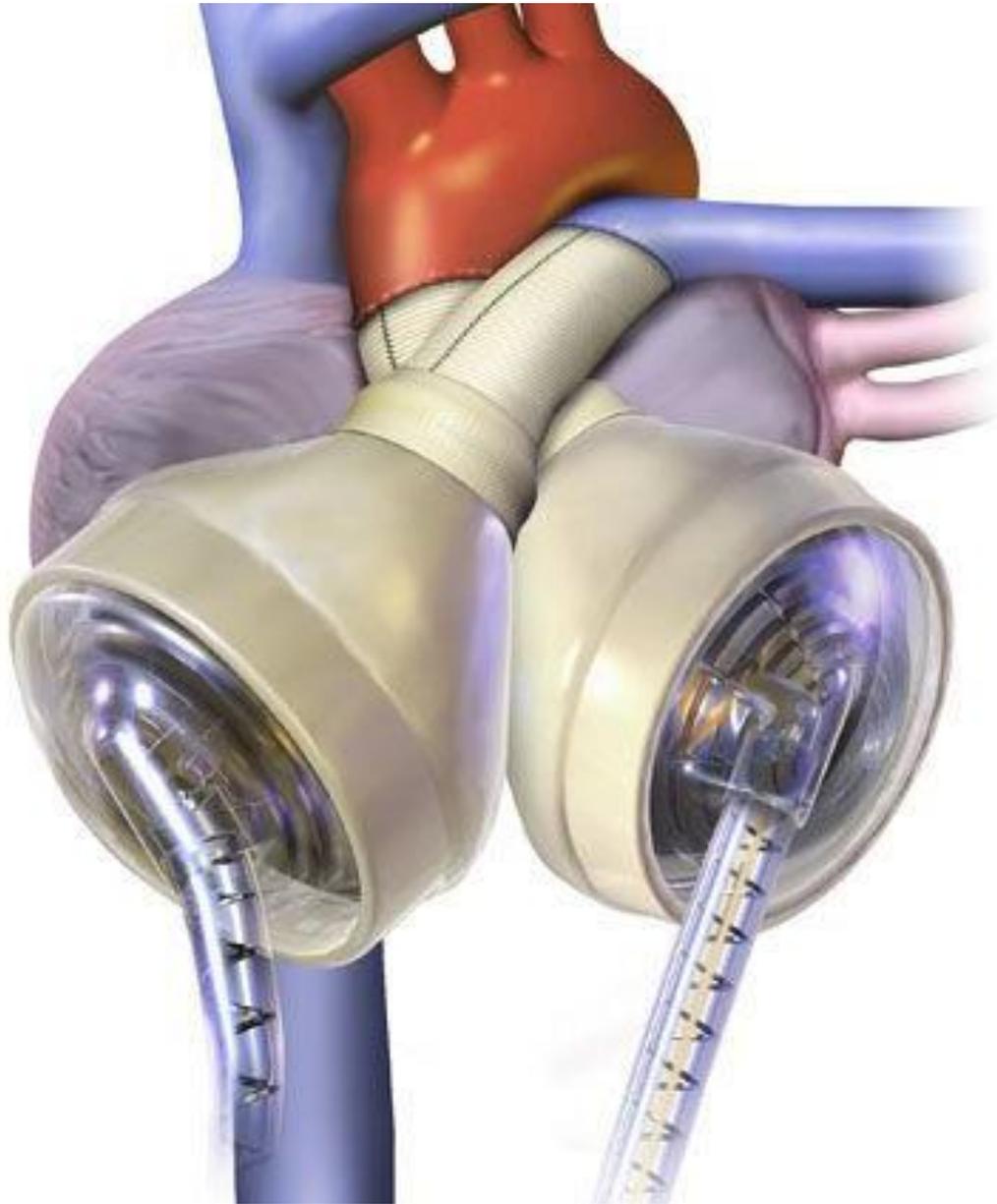
A total artificial heart replaces the native heart's failed ventricles.

https://www.youtube.com/watch?v=qNWM1_KF6tk

Mini-Thoracotomy

- Is a mini-thoracotomy an open or percutaneous approach?

    - OPEN

    - Even though it is minimally invasive it is still considered an open approach.
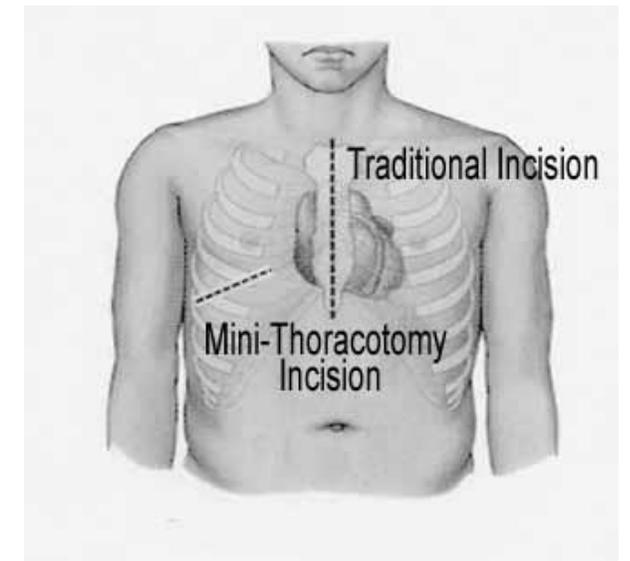
Pressure Ulcers: Hospital vs. Home Health Reporting

- Hospital:

  - Evolving Pressure Ulcer in the Inpatient Setting requires two codes to be reported in the inpatient setting:

    - One for the site and stage upon admission and a second code for the same ulcer site at the highest stage during the inpatient stay.

# Pressure Ulcers: Hospital vs. Home Health Reporting

- Home Health:

  - Evolving pressure ulcers in the home health setting are coded based on the current stage

  - The evolving pressure ulcer guideline is intended for the inpatient setting to allow accurate reporting of the present on admission indicator

Palliative care

- Palliative care (comfort care) ICD-10-CM code Z51.5 can be assigned a principal diagnosis, first-listed or additional diagnosis

  - "Code also, condition the condition requiring care"

    - Not usually a reason for inpatient admission

Chopart Amputation of the Foot

- A patient undergoes Chopart amputation of the right foot. The midfoot is disarticulated at the talonavicular and the calcaneocuboid joints. The toes and the dorsum of the foot is removed. What is the correct ICD-10-PCS code?
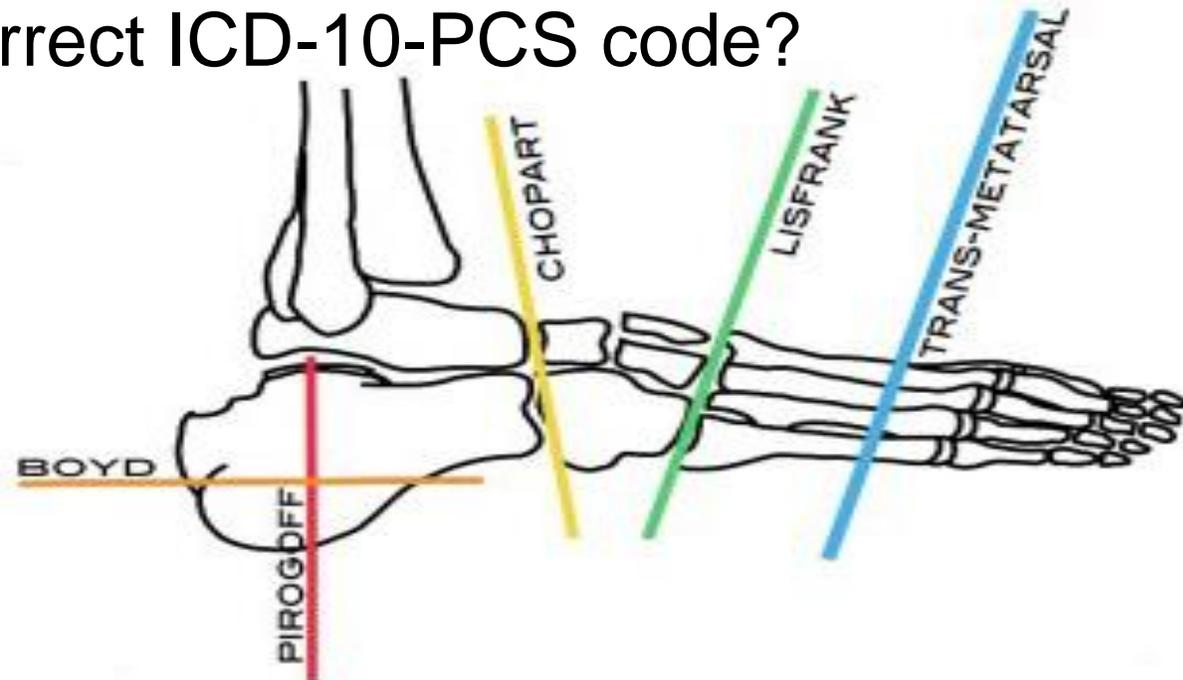
Chopart Amputation of the Foot

- Complete Foot Amputation

  - Resection between the junction of the tarsals and metatarsals

  - Resection between the tarsal bones

    - Correct Code Assignment – 0Y6M0Z0

      - Detachment at the right foot, complete, open approach
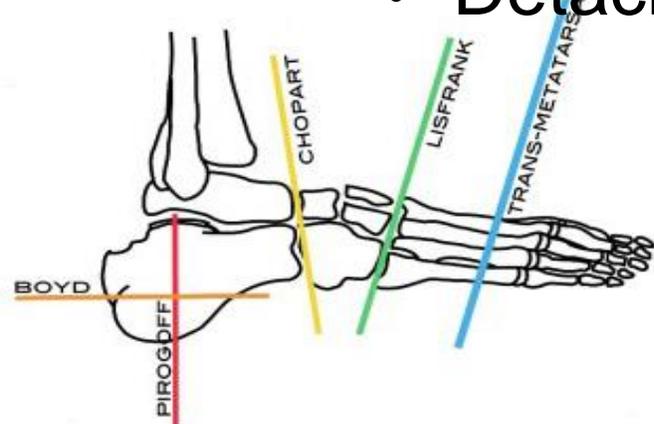
Mitral Valve Repair with Chordae Tendinae Transfer

- Chordae tendinae transfer with resection of mitral valve leaflets is not separately reported as the transfer is inherent to the quadrangle resection of the leaflets and is not separately coded

- http://www.renalandurologynews.com/anesthesiology/mitral-valve-replacement/article/580655/
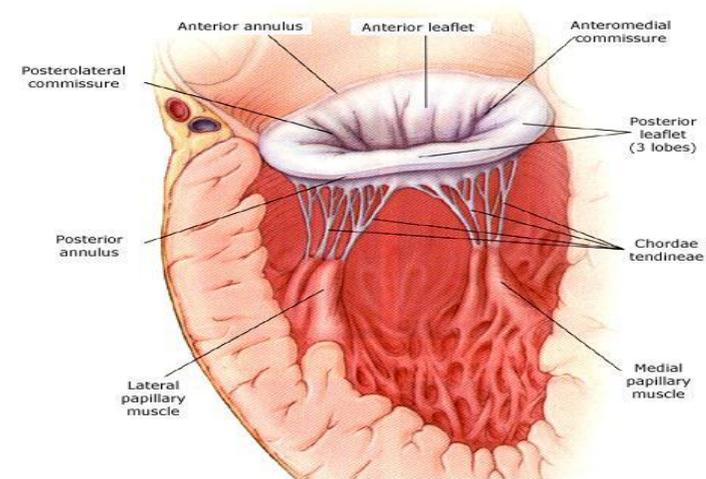
Dry Aspiration – What to Code?

- Physician performs an aspiration of the right knee to rule out infection. The needle is successfully inserted; however, no fluid was found upon aspiration. How should the procedure be coded?

- When successful the root operation would be drainage, however the procedure does not meet the definition.

- The root operation inspection is used when drainage is attempted but not completed.

- Correct Code:0SJC3ZZ – Inspection of right knee joint, percutaneous approach

Failed Diagnostic Punctures

- Which PCS code is assigned for a lumbar puncture that is not successful in obtaining CSF for sampling?

  - Assign PCS code 00JU3ZZ (Inspection, spinal canal, percutaneous, ND, NQ)

  - Drainage would not be appropriate because not fluid was obtained.

Questions?