

Addressing and clarifying 2017 Guideline recommendations

WHITE PAPER

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The AHA's *Coding Clinic for ICD-10-CM/PCS* had both its third and fourth quarter 2016 editions published at the same time this fall. The combined publication is very long—the longest I have ever reviewed—so let's start by looking at some of the changes to the *ICD-10-CM Official Guidelines for Coding and Reporting*.

Trouble with 'with'

As many of you have probably heard, Section A.15 of the new *Guidelines* states that any time the word "with" appears, either in the Alphabetic Index or in an instructional note *not* in the Tabular List, the classification presumes a causal relationship and the conditions *will be linked* even in the absence of provider documentation. *Coding Clinic* reiterates this fact.

For CDI specialists, this may seem like a good thing, but it also means we need to do our homework and make sure all these assumed relationships are truly related. We may find we need more queries to verify these cases with the providers. So be careful and go over each case to make sure it is an accurate representation of what is going on with your patients.

Providers' prerogative

Coding Clinic (p. 119) stresses the new *Guidelines* found in Section A.19, which state that assignment of a diagnosis code must be based on the provider's diagnostic statement that the condition exists, not on clinical criteria used by the provider to establish the diagnosis. That's not to say the clinical criteria don't matter, but that coders and CDI specialists cannot decide when a condition exists based on whether we feel certain criteria are appropriate for a condition.

According to *Coding Clinic* (p. 8), coders have questioned whether ICD-10-CM codes for sepsis may be assigned based on the new clinical criteria that were released in February 2016, The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3).

This *Coding Clinic* states "coders should never assign a code for sepsis based on clinical definition or criteria or clinical signs alone."

FEATURES

- Supportive documentation .2
- Tipping the scales..... 3
- Reminders..... 3
- Additional changes 4
- PCS concerns..... 5
- Sepsis 7
- COPD 7
- POA 8



As with any condition, code assignment should be based strictly on physician documentation (regardless of the clinical criteria the physician used to arrive at the diagnosis). *Coding Clinic* points readers to the 2017 *Official Guidelines for Coding and Reporting* when assigning codes for sepsis, severe sepsis, and septic shock, and states that coders must use the most current version of the ICD-10-CM classification along with the *Guidelines*, and not clinical criteria.

Physicians can use whatever criteria they wish to diagnose the patient, but remember, those criteria do not change how the condition will be coded.

Supportive documentation

For some conditions, coders can use documentation from a clinician that is not the patient's provider, as explained in Section B.14 of the new *Guidelines* and further supported by this edition of *Coding Clinic* (p. 120). Examples include the stages of pressure ulcers and of non-pressure chronic ulcers, body mass index, Glasgow Coma Scale, and National Institutes of Health Stroke Scale (NIHSS). However, the general rule remains that although some information can come from a non-provider, the diagnosis associated with the information must still be documented by the provider.

How we code pressure ulcer stages changed under the new *Guidelines* in sections 12.a.5 and 12.a.6, so this edition of *Coding Clinic* (p. 124) offers additional insight. It states that when a patient is admitted with an ulcer at a certain stage, and that ulcer progresses to a higher level during the encounter, we are to assign two codes now, one for the stage at the time of admission and one for the higher stage at the time of discharge. If an ulcer is present on admission (POA) but is healed during the course of the encounter, coders should only assign one code: that of the site and stage of the ulcer at the time of admission.

Additionally, in April 2016, the National Pressure Ulcer Advisory Panel announced a change in terminology from "pressure ulcer" to "pressure injury" and updated the stages of pressure injury. In *Coding Clinic* (p. 38), coders question whether they can use the same definitions for pressure "ulcers" as "injuries" since there is no index entry for pressure injury.

Coding Clinic answers yes, calling the change one of terminology rather than one of definition.

Tipping the scales

The new *Guidelines* Section 18.e suggests that the Glasgow Coma Scale codes (R40.2-) can be used in a broader scope. *Coding Clinic* (p. 127) directs coders to not only use this scale in conjunction with traumatic brain injury codes, cardiovascular disease, or sequelae of cerebrovascular disease, but also to assess the status of the central nervous system for other nontraumatic conditions, such as monitoring a patient's neurological status and the severity of stroke.

We also have the NIHSS codes (R29.7-); these can also be used in conjunction with acute stroke codes to identify the patient's neurological status and severity of stroke. We are told at a minimum to report the initial score documented, and that we may capture multiple scores. These stroke codes (coma and stroke scale) should follow the acute stroke diagnosis codes. More advice can be found under *Guidelines* Section I.B.14. for information concerning the medical record documentation that may be used for these code assignments.

Reminders

We received many reminders and alerts in this *Coding Clinic*. One entry (p. 23) points to the ICD-10-CM *Official Guidelines for Coding and Reporting* and reminds us that “although there is a presumed relationship between HTN and CKD, the CKD should not be coded as hypertensive if the physician has specifically documented a different cause.”

One of the scenarios presented in this *Coding Clinic* (p. 24) offers a helpful hint that a laceration implies cutting, whereas a bullet wound would be assigned as a puncture.

Coding Clinic (p. 25) also reminds us that per the *Official Guidelines for Coding and Reporting* Section III.B, abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded separately unless the provider indicates their significance. We want to make sure we are reviewing the complete medical record and not making assumptions—the documentation needs to accurately represent what is going on for the patient during the episode of care.

CDI specialists need to make sure documentation and codes reported are consistent with the attending physician's interpretation, according to *Coding Clinic* (p. 26), as the physician is clinically responsible for managing the case and gathering

all of the findings from the consultants and other providers involved in the care of the patient. The plan of care is based on the attending physician's evaluation, interpretation, and collation of all the findings (i.e., pathology, radiology, and laboratory results). This advice is consistent with that previously published in *Coding Clinic for ICD-9-CM*, and is still applicable for the ICD-10-CM code set.

Additional changes

A number of codes and code titles have been changed. Many codes have been added, revised, deleted, and updated. Take some time and go through these changes when possible. It's impossible to cover them all in this white paper, but below are some of the more common ones you're likely to see.

Laterality: Assign a "bilateral code" for the first encounter, as if the condition exists on both sides. For a second encounter where one side has been previously treated and the condition no longer exists, assign the appropriate unilateral code.

Zika: The code for Zika virus infection, as stated previously in *Coding Clinic*, is only assigned in confirmed cases (not possible, suspected, likely, or any similar terminology) based on provider documentation. No testing is required.

Hypertension: We have a new category that describes hypertensive crisis, *Coding Clinic* (p. 27) reminds us. These codes differentiate hypertensive urgency (I16.0), hypertensive emergency (I16.1), and hypertensive crisis, unspecified (I16.9). The ICD-10-CM *Official Guidelines for Coding and Reporting* tell us to assign code I16 for hypertensive crisis when documented as hypertensive urgency, emergency, or unspecified crisis with a code for any identified hypertensive disease. The sequencing will depend on the circumstances of the admission. When we have hypertension documented as accelerated or malignant but not as crisis, urgency, or emergency, the code assigned will be I10 essential (primary) hypertension. The good news is we will get a CC back when hypertension is documented as crisis or urgency.

Cerebral infarct: Because a cerebral infarct can sometimes be the result of a bilateral arterial lesion, a bilateral code was added, according to *Coding Clinic* (p. 28). There are also 48 new codes in category I69, sequelae of cerebrovascular diseases, to differentiate cognitive sequelae similar to the motor, speech, and language deficits. These new codes describe cognitive deficits following cerebrovascular disease.

Mediastinitis: Two codes have been added to J98.5, where all types of mediastinitis were previously coded: J98.51, mediastinitis, and J98.59, other diseases of mediastinum, not elsewhere classified. These new codes will help capture greater

specificity regarding the severity of the condition and differentiate it from disorders of the mediastinum, according to *Coding Clinic* (p. 29).

Gastrointestinal section (K52-): This section received a huge makeover, starting with eight new codes to describe different types of enteritis and colitis. Irritable bowel syndrome has new codes that describe the alteration in stool consistency. A new code was added to identify constipation caused by drugs (K59.03) and chronic idiopathic constipation (K59.04). The diagnosis of megacolon also has some additions: K59.31, toxic megacolon, and K59.39, other megacolon. Look to *Coding Clinic* p. 30 for more information on this.

Acute pancreatitis: Nine codes were added to K85, acute pancreatitis, that describe idiopathic, biliary, alcohol-induced, drug-induced, and other pancreatitis. ICD-10-CM codes also include the severity of the acute pancreatitis: without necrosis or infection, with uninfected necrosis, and with infected necrosis. With this in mind, we always want to know the type and severity for appropriate code assignment, according to *Coding Clinic* (p. 30).

PCS concerns

In almost every class I teach, attendees want to talk about a few specific topics. The first of these is that not everything in the ICD-10-CM/PCS code set makes medical sense, and the latest edition of *Coding Clinic* includes a number of these items. Let's start with some clarifications related to PCS.

One concern relates to root operations used for an ileostomy takedown. *Coding Clinic* says to code ileostomy closure (or takedown) using the root operation "Excision," which confuses many of us because the Alphabetic Index entry under "Takedown, Stoma" leads to "Repair."

Yet, this edition of *Coding Clinic* states coders and CDI specialists should know that various types of procedures, with different root operations, exist for stoma takedown, and that coders should not assign ICD-10-PCS procedure codes based on where the Alphabetic Index directs them without further reviewing the documentation to determine what procedures the physician actually performed.

This is why it is extremely important for CDI specialists to review the complete medical record, including the body of the postoperative note, to make sure the coding staff can determine exactly what the provider performed—we can't just go by the pre-procedure and post-procedure titles. *Coding Clinic* also reminds

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us that all the procedural steps necessary to reach the operative site and close the operative site, including anastomosis of a tubular body part, are part of the procedure and are not coded separately.

Those just learning how to use ICD-10-PCS sometimes think they've identified the correct table for the intervention or procedure performed, but run into an issue and find the appropriate value under a different character. As an instructor, I encourage students to take a second look to reevaluate each choice.

Sometimes, however, close enough is the best possible option. *Coding Clinic* (pp. 20–21) describes a patient with a large pressure ulcer of the right lower leg who presented for debridement. The physician used a VersaJet to debride the area down to healthy muscle tissue, removing necrotic muscle tissue. There is no index entry for muscle extraction or a table for extraction in the muscle section of ICD-10-PCS. Therefore, we would use the body part value describing the right lower leg, subcutaneous tissue and fascia, which doesn't have the specificity you might expect in ICD-10-PCS.

The best advice I have for a CDI specialist is to become very familiar with the tables used for the interventions and/or procedures your facility commonly performs, so you are aware of the values offered in the tables and know the information the coding staff will need to accurately build a code.

In the area of cardiology, the *Official Guidelines for Coding and Reporting* include some modifications. Places where the term “artery sites” was previously used have now been changed to “artery” throughout the *Guidelines*. For more information on this, see p. 134 of this edition of *Coding Clinic*.

New *Guidelines* at section B3.7 clarify the definition of the root operation of “Control,” which has changed to include “stopping, or attempting to stop, post-procedural or other acute bleeding.”

CDI specialists often tell me that even though they aren't saving lives at the bedside, they feel they perform a very important function for their facility's patients as well as the facility itself. What we do not only ensures the facility is paid appropriately, but also provides our patients with an accurate medical record, which helps providers make good decisions about their future care. The information in the medical record also helps determine what we can improve on in the future.

The 7th character extension not only helps us track the patient's care through various stages of recovery, but also lets us keep an eye on the resources used and outcomes achieved, which could reduce the cost of medical care in the future.

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Addressing and clarifying 2017 Guideline recommendations

As an example, because there are clinical differences in joint replacement surgery related to a traumatic fracture versus elective joint replacement, someone who has an unexpected surgical procedure could require more intensive rehabilitation than someone who comes in for an elective surgical procedure, according to *Coding Clinic* (p. 17). As a CDI specialist, making sure the documentation is there to apply an accurate 7th character extension will help determine what works, what doesn't, and where we need to make improvements.

Sepsis

Another concern my Boot Camp students often share is the belief that some areas of the ICD-10-CM/PCS code set aren't actually more specific than ICD-9-CM. In fact, many conditions do not have their own code in ICD-10-CM; instead, they are coded to what *Coding Clinic* describes as “the best available option.” An example of this is sepsis caused by a virus, fungus, or parasite.

Although sepsis is usually caused by a bacterial infection, it can be caused by a virus, fungus, or parasite; if it is, it should be coded to A41.89, other specified sepsis. ICD-10-CM does not provide a specific code for viral sepsis, so A41.89 would be the best available option.

However, just as we would with sepsis caused by bacteria, identifying the type of virus and any organ dysfunction related to the sepsis is still extremely important. We want to make sure the documentation accurately represents what is going on with the patient during the episode of care under review.

COPD

One of the more difficult areas in this *Coding Clinic* (p. 15) is the new advice regarding the sequencing of chronic obstructive pulmonary disease (COPD) and pneumonia. Based on the instructional note “use an additional code to identify infection” found at J44, when COPD is present with a lower respiratory infection such as pneumonia, the pneumonia is sequenced second. (ACDIS members can access a detailed discussion of this guidance by members of the Advisory Board, which took place during the quarterly conference call on November 17.) Pneumonia and bronchitis are considered lower respiratory infections, but influenza is considered an upper *and* lower respiratory infection, so the sequencing will not follow the same rule.

POA

To wrap up this *Coding Clinic*, let's talk about POA status (p. 132).

We are reminded to visit the Centers for Disease Control and Prevention's website for the list of diagnoses that do not require a POA indicator. If we have a chronic condition that develops into an acute exacerbation, and a single code identifies both conditions, we would use the combination code and assign an "N" as the POA indicator.

If we have both acute and chronic conditions, we would assign the appropriate POA indicator depending on when the condition occurred.

With combination codes, if all diagnoses represented by the combination code were POA, then the indicator would be "Y"; if not all conditions represented by the combination code were POA, then we would use "N" for not present at the time of admission.

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