ICD-10 Troubleshooting: Inpatient
Tips from Coders to Coders

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About the Presenter

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Stacy joined RMC in 2006, and is currently Regional Coding Manager for RMC. In this role Stacy performs coding quality reviews for RMC Clients, as well as internal staff reviews. Stacy has over 20 years’ experience in the Health Information Management field and has held various positions of Coder, Coding Compliance Coordinator and HIM Director. Stacy is multi-talented with inpatient and outpatient skills and a wonderful educator and trainer. Stacy has been a vital part of development and implementation RMC’s ICD-10 training program and participates in ongoing teaching of staff and clients. Stacy enjoys conducting audits, researching coding issues, and providing education to coders. Stacy has recently completed her Associates Degree in HIT and passed her RHIT exam. Her certification is currently pending AHIMA’s receipt of her official transcript. Stacy is also an AHIMA approved ICD-10-CM/PCS Train the Trainer with experience in coding and auditing of ICD-10-CM and PCS. Additionally, Stacy is active in AHIMA, TxHIMA and HAHIMA.
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So... How are YOU doing??

Photo Credit: Connie Calvert
ICD 10 Post Implementation

ICD-10 – Does the Fun Ever Stop?

- Dual coding
- Questions coming in
- Didn’t know what we didn’t know
- Now finding the gaps
- Differences, similarities, challenges
- Where do we go for answers??
  - Guidelines
  - Coding Clinic
  - ICD 10 Handbook
  - Peers/Colleagues

**Be prepared for revisions – changes to advice**
AHA Coding Clinic

- In 2012, Coding Clinic began answering ICD-10-CMS/PCS questions
- 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. However, some of the guidelines in ICD-9-CM included information that may have been clinical in nature and therefore not appropriate for coding guidelines.

AHA Coding Clinic

- However, there are no plans to translate all previous issues of Coding Clinic for ICD-9-CM into ICD-10-CM/PCS since many of the questions published arose out of the need to provide clarification on the use of ICD-9-CM and would not be readily applicable to ICD-10-CM/PCS
  - Care should be exercised as ICD-10-CM has new combination codes as well as instructional notes that may or may not be consistent with ICD-9-CM.
Guidelines and Conventions

Excludes 1

Please see the "Interim advice on excludes 1 note on conditions unrelated" (next slide) posted to the NCHS website with the ICD-10-CM guideline documents. Apparently Excludes1 does not ALWAYS mean the 2 conditions cannot be reported together.....they cannot be reported together when they are RELATED. But if unrelated, per this document, they can still both be reported.

Ref: Coding Clinic, Fourth Quarter 2015: Page 40
DRG Shift

DRG 795 Normal Newborn

- In ICD-9-CM, when a newborn is monitored for signs following maternal chorioamnionitis, the diagnosis code assigned is V29.0
  - Per ICD-9 Guidelines, codes from Category V29 are used to identify those instances where further evaluation or care is given to a newborn because of a potential problem without diagnosis. This category is to be used when newborns are suspected to be at risk for an abnormal condition resulting from exposure from the mom or birth process without signs or symptoms which requires study but after examination and observation, it is determined that there is no need for further treatment or medical care.

DRG 794 Neonate with other significant problems

- In ICD-10-CM, when a newborn is monitored for signs following maternal chorioamnionitis, the diagnosis code assigned is P02.7
  - Per ICD-10 Guidelines, codes from Category P00-P004 are used for newborns who are suspected of having an abnormal condition resulting from exposure from the mom or birth process but without signs or symptoms, and which after exam and observation, is found not to exist. These codes may be used even if treatment is begun for a suspected condition that is ruled out.

DRG Shift

All DRGs without CC

- In ICD-9 when the physician documents “bacteriuria, asymptomatic bacteriuria without urinary tract infection” diagnosis code 791.9 is assigned
  - This is not a CC

All DRGs with CC

- In ICD-10 when the physician documents “bacteriuria, asymptomatic bacteriuria” diagnosis code N39.0 is assigned.
  - This is a CC
CC/MCC Changes

- MDD no longer a CC
- Malignant HTN no longer MCC
- Schatzki’s ring not MCC
  - Now defaults to “Acquired” – opposite of I-9
  - “Congenital” is still an MCC
- New CCs: Persistent A Fib, Mild malnutrition, nicotine withdrawal

ICD-10-CM
Pneumonia with Hemoptysis

ICD-9
- AHA ICD-9 Coding Clinic, Third Quarter 2011, page 12 states symptoms codes are not assigned when they are implicit in the diagnosis or when the symptom is included in the code for the condition.
- The term “hemorrhagic” is shown in the Alphabetic Index as a nonessential modifier for pneumonia. “Hemorrhagic” as a nonessential modifier or supplementary term indicates that any bleeding should not be coded separately.
- Hemoptysis is not coded in ICD-9

ICD-10
- AHA Coding Clinic, 4th Quarter 2013 page 118 states hemoptysis (code R04.2) can be assigned as an additional code when the condition occurs with pneumonia. Although code R04.2 is a Chapter 18 code, codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with the diagnosis.
- Hemorrhagic is no longer an essential modifier for pneumonia in the ICD-10-CM index to diseases.
- Hemoptysis is a “cc” and will affect reimbursement

Diabetes with Associated Conditions

Per the Official Coding Guidelines for ICD-10-CM, the term "with" means "associated with" or "due to,“ when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.

ICD-10-CM assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system. These assumed cause-and-effect relationships may differ between ICD-9-CM and ICD-10-CM.
- Do not code as a Diabetic complication if documentation clearly states that a condition other than diabetes is the cause.

Reference: Coding Clinic 1Q 2016, Page 11
Diabetes with Associated Conditions

Diabetes, type 2 E11.9
with
- amyotrophy E11.44
- arthropathy NEC E11.618
- autonomic (poly) neuropathy E11.43
- cataract E11.36
- Charcot's joints E11.610
- chronic kidney disease E11.22
- circulatory complication NEC E11.59
- complication E11.8
  • specified NEC E11.69
- dermatitis E11.620
- foot ulcer E11.621
- gangrene E11.52
- gastroparesis E11.43

Diabetes with Associated Conditions

- glomerulonephrosis, intracapillary E11.21
- glomerulosclerosis, intercapillary E11.21
- hyperglycemia E11.65
- hyperosmolarity E11.00
  • with coma E11.01
- hypoglycemia E11.649
  • with coma E11.641
- ketoacidosis (Coding Clinic for ICD-9-CM 1Q 2013) E13.10
  • with coma (Coding Clinic for ICD-9-CM 1Q 2013) E13.11
- kidney complications NEC E11.29
- Kimmelsteil-Wilson disease E11.21
- mononeuropathy E11.41
- myasthenia E11.44
- necrobiosis lipoidica E11.620
- nephropathy E11.21
- neuralgia E11.42
Diabetes with Associated Conditions

- neurologic complication NEC E11.49
- neuropathic arthropathy E11.610
- neuropathy E11.40
- ophthalmic complication NEC E11.39
- oral complication NEC E11.638
- periodontal disease E11.630
- peripheral angiopathy E11.51
  - with gangrene E11.52
- polyneuropathy E11.42
- renal complication NEC E11.29
- renal tubular degeneration E11.29

Diabetes with Associated Conditions

- retinopathy E11.319
  - with macular edema E11.311
  - nonproliferative E11.329
    - with macular edema E11.321
    - mild E11.329
    - with macular edema E11.321
    - moderate E11.339
    - with macular edema E11.331
    - severe E11.349
    - with macular edema E11.341
  - proliferative E11.359
    - with macular edema E11.351
- skin complication NEC E11.628
- skin ulcer NEC E11.622
Diabetes with Osteomyelitis

ICD-9
• Per AHA Coding Clinic, First Quarter 2004, page 14-15 “ICD-9-CM assumes a relationship between diabetes and osteomyelitis when both conditions are present, unless the physician has indicated in the medical record that the acute osteomyelitis is totally unrelated to the diabetes.”

ICD-10
• Per AHA Coding Clinic, Fourth Quarter 2013, page 114, ICD-10-CM does not presume a linkage between diabetes and osteomyelitis. The provider will need to document a linkage or relationship between the two conditions before it can be coded as such.

Dehydration with Hypo/Hypernatremia

ICD-9
• When viewing the Alphabetic Index, “dehydration” indexes to 276.51.
• There are indentations with the subentry terms “with hypernatremia 276.0” and “with hyponatremia 276.1.
• Only 1 code is assigned.

ICD-10
• According to AHA Coding Clinic, First Quarter 2014, page 7 two codes are required to fully capture dehydration with hypernatremia (E86.0 and E87.0) and dehydration with hyponatremia (E86.0 and E87.1).
• Coders should follow the index, which leads to coding both the dehydration and hypernatremia/hyponatremia separately.
SIRS Due to Pneumonia Without Sepsis

ICD-9
• Per AHA Coding Clinic, Fourth Quarter 2003, page 79-81 if the terms sepsis, severe sepsis, or SIRS are used with an underlying infection other than septicemia, such as pneumonia, cellulitis or a non-specified urinary tract infection, code 038.9 should be assigned first, then code 995.91, followed by the code for the initial infection. This is because the use of the terms sepsis or SIRS indicates that the patient's infection has advanced to the point of a systemic infection so the systemic infection should be sequenced before the localized infection.

ICD-10
• According to AHA Coding Clinic, Third Quarter 2014, page 4 if the provider lists “SIRS secondary to pneumonia” in his diagnostic statement assign only code J18.9 (Pneumonia, unspecified organism).
• When sepsis is not present, no other code is required. The ICD-10-CM does not provide a separate code or index entry for SIRS due to an infectious process.
• If the health record documentation appears to meet the criteria for sepsis, the provider should be queried for clarification. Encoders are tools that may assist coders; however the codes must be validated and supported by the health record documentation.

C-Section with Vacuum Delivery

ICD-9
• According to AHA Coding Clinic, Second Quarter 2006, page 5 assign two codes for cesarean delivery with vacuum assistance.
• Vacuum extraction is not routinely associated in a C-section and should be reported when done.

ICD-10
• According to AHA Coding Clinic, Fourth Quarter 2014, page 43, vacuum assistance used with cesarean delivery is not separately coded.
• Code only the C-section
Decompensated Heart Failure

- The general definition of decompensated can be applied when assigning ICD-10-CM codes as well.
- The appropriate diagnosis code for documentation of “chronic systolic heart failure, currently decompensated" would be code I50.23 (Acute on chronic systolic heart failure, for decompensated systolic heart failure).
- See Coding Clinics, Second Quarter 2013, page 33 and Third Quarter 2008, page 12

CC 2Q 2013

Question:
Coding Clinic, Third Quarter 2008, p. 12, states “decompensated indicates that there has been a flare-up (acute phase) of a chronic condition.”
Should this general definition of decompensated be applied when assigning ICD-10-CM codes as well? For example, what is the appropriate ICD-10-CM code assignment for a diagnosis of chronic systolic heart failure, currently decompensated?
**CC 2Q 2013**

**Answer:**
Assign code I50.23, Acute on chronic systolic heart failure, for decompensated systolic heart failure.
As previously stated, “decompensated” indicates that there has been a flare-up (acute phase) of a chronic condition.

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**Stroke with Neurological Deficits**

- Per AHA Coding Clinic, First Quarter 2014 page 23, the advice from Coding Clinic, First Quarter 2010 page 5 is still valid.
- Hemiplegia is not inherent to an acute cerebrovascular accident (CVA). Therefore, it should be coded even if the hemiplegia resolves, with or without treatment. The hemiplegia affects the care that the patient receives. Report any neurological deficits caused by a CVA even when they have been resolved at the time of discharge from the hospital.
Unilateral Weakness due to Previous CVA

According to Coding Clinic 1st quarter 2015, page 25, “When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia.”
Vascular Access Devices

Vascular access device is a rather generic term to describe sterile catheter systems used to access a vascular structure either an artery or a vein. Selection of the body part value for insertion of a vascular access device is based on the end placement of the device rather than the point of entry.

- PICC
- CVC with guidance
- CVC without guidance
- Totally Implantable Central VAD

For examples Ref: Coding Clinic, Fourth Quarter 2015: Page 26

Lysis of Adhesions

- Coders should not code adhesions and lysis thereof, based solely on mention of adhesions or lysis in an operative report. As is customary with other surgeries, it is irrelevant whether the adhesions or lysis of adhesions are included in the title of the operation. Determination as to whether the adhesions and the lysis are significant enough to code and report must be made by the surgeon.
Lysis of Adhesions

- Continue to look for the clinical significance of the adhesions. Documentation of clinical significance by the surgeon may include, but is not limited to, the following language: numerous adhesions requiring a long time to lyse, extensive adhesions involving tedious lysis, extensive lysis, etc.
- If uncertainty exists regarding clinical significance, then query the provider.
- See Coding Clinic First Quarter 2014 page 3 and Fourth Quarter 1990 page 18-19 for additional details.

Colectomy with End to End Anastomosis

- Per AHA Coding Clinic, Fourth Quarter 2014, page 42, When a right colectomy is performed with side-to-side functional end-to-end anastomosis, do not assign a code for the side-to-side functional end-to-end anastomosis. ICD-10-PCS Official Guidelines for Coding and Reporting, Section B3.1b, clarifies that procedural steps necessary to close the operative site, including anastomosis of a tubular body part, are not coded separately.
- This guideline would apply regardless of whether the procedure is an end-to-end or a side-to-side anastomosis.
Multiple Procedures

B3.2

During the same operative episode, multiple procedures are coded if:

a. The same root operation is performed on different body parts as defined by distinct values of the body part character.
   Example: Diagnostic excision of liver and pancreas are coded separately.

b. The same root operation is repeated in multiple body parts, and those body parts are separate and distinct body parts classified to a single ICD-10-PCS body part value.
   Example: Excision of the sartorius muscle and excision of the gracilis muscle are both included in the upper leg muscle body part value, and multiple procedures are coded.

c. Multiple root operations with distinct objectives are performed on the same body part.
   Example: Destruction of sigmoid lesion and bypass of sigmoid colon are coded separately.

d. The intended root operation is attempted using one approach, but is converted to a different approach.
   Example: Laparoscopic cholecystectomy converted to an open cholecystectomy is coded as percutaneous endoscopic inspection and open resection.
Total Hysterectomy

**ICD-9**
- For a total (open) hysterectomy, only 1 code is assigned.

**ICD-10**
- For a total (open) hysterectomy, 2 codes are assigned in ICD-10 (resection of uterus and resection of cervix).
- A total hysterectomy includes the removal of the uterus and cervix. Therefore, code both the resection of uterus and cervix. This is supported by the ICD-10-PCS Official Guidelines for Coding and Reporting, which state, “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.”
  - Coding Clinic, Third Quarter 2013, page 28

ICD-10-PCS: Root Operation-Control

- The root term “control” specifically addresses postoperative bleeding.
- Examples of control procedures include postoperative ligation of bleeding arteries and drainage of postoperative hemorrhage.
- Control of other types of bleeding (i.e. intraoperative bleeding, are not coded using the Control root operation. See Coding Clinic, Third Quarter 2013, page 22
- Only three code tables are available for Control procedures: 0W3, 0X3, and 0Y3
ICD-10-PCS: Root Operation-Control

- If an attempt to stop post procedural bleeding is initially unsuccessful and to stop the bleeding requires performing any of the definitive root operations Bypass, Detachment, Excision, Extraction, Reposition, Replacement, or Resection, then that root operation is coded instead of Control.
  - Ex: Resection of spleen to stop post procedural bleeding is coded to resection instead of control
  - *ICD-10 Guidelines-Section B3.7

Coding Example of When Not to Code Control

- History and Physical: patient presented with peritoneal hematoma.
- Operative Report documents hematoma of peritoneum was evacuated and drainage tube was placed.
  - This was not a post procedural hematoma
  - The objective of the procedure was to evacuate the clot
  - When following the Alphabetic Index, “evacuation, hematoma” states to see Exirpation.
  - Exirpation is defined as taking or cutting out solid matter (blood clot)
**Coding Example of When to Code Control**

**Pre-Operative Diagnosis:** Post-tonsillectomy bleeding  
**Post-Operative Diagnosis:** Post-tonsillectomy bleeding  
**Operative Procedure:** Operative Control of postoperative bleeding  
**Findings:** Patient with an arterial bleeder from right tonsillar fossa.  
**Description of procedure:** The patient was taken to the operating room and general anesthesia was administered. A Crowe-Davis mouth gag was placed, and clots were suctioned from the pharynx. An arterial bleeder was noted and was controlled with suction artery. The stomach was then suctioned and about 200-300 mL of blood was noted. The patient was awakened and extubated and transported to the recovery room in stable condition.

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**RMC Internal Answer:**  
ICD-10-PCS code: 0W33XZZ (Control Bleeding in Oral Cavity and Throat, External Approach)  
  - The root operation control is coded because the bleeder is the result of a previous procedure. When cautery is used to stop post-op bleeding, control is the appropriate root operation. The tonsillar area is coded to the body part value 3. The approach is X (external).
Future Plans

• CMS has agreed to look at the issue of non procedural bleeding being coded to “control”
• After ICD-10 implementation, the “control” definition could possibly change in the future.

* AHA Webinar 2015 PCS, part 1

Contrast

• ICD-10-PCS requires coders to identify the type of contrast used for contrast based procedures.
• Current options include:
  – 0, high osmolar
  – 1, Low osmolar
  – Y, Other contrast
  – Z, none
• Contrast details can be found in medication administration records (MAR), Operative Report, and cardiac catheterization reports.
## Contrast Key

<table>
<thead>
<tr>
<th>Contrast Name</th>
<th>Osmolality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diatrizoate, Cysto-Conray II, Metrizoate, Ioxithalamte</td>
<td>High</td>
</tr>
<tr>
<td>Isovue, Omnipaque, Optiray, Oxilan, Ultravist, Xenetix, Iomeprol, Hexabrix, Iopentol</td>
<td>Low</td>
</tr>
<tr>
<td>Visapaque, Isovist</td>
<td>Other (Iso-osmolar)</td>
</tr>
</tbody>
</table>

**Spinal Case Study**

Pre-Op Diagnosis: Cervical stenosis and cervical myelopathy  
Post-Op Diagnosis: Same.  

Procedures:  
1. Anterior cervical discectomy at C3-C4, C4-C5, and C5-C6.  
2. Anterior cervical cage at C3-C4, C4-C5, and C5-C6.  
3. Anterior cervical fusion at C3-C4, C4-C5, and C5-C6.  
4. Anterior cervical hardware at C3-C4, C4-C5, and C5-C6.  
5. Microdissection with operative microscope.

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**Spinal Case Study (Continued)**

Findings: Intraoperative findings were consistent with cervical stenosis and kyphosis.  

Brief History: The patient is a xx year old female who presents with significant signs and symptoms of severe cervical stenosis. She has failed conservative management. She now has progressive myelopathy and significant symptoms. She fully understands the risks, benefits and alternatives of surgical intervention and would like to proceed.
Spinal Case Study (Continued)

Description of Procedure:
The patient was brought to the operating theater, where general endotracheal anesthesia was induced. Once anesthesia was induced, we then prepped and draped the left side of the neck in a standard sterile fashion. We then did a left-sided approach. The left sided approach was performed. We then opened the prevertebral fascia, and got on the anterior cervical spine. We then did a discectomy of C3 and C4.

Spinal Case Study (Continued)

Description of Procedure (Continued):
The endplates were completely curetted off and cleaned. We then removed the posterior longitudinal ligament. We then drilled off the uncovertebral joints, as well as the neural foramina were then opened. We then decompressed the central canal. Bone was then collected and placed into a cage. An anterior cervical fusion was then done at C3-C4. The cage was then inserted in the interspace. Good fixation was obtained.
Spinal Case Study (Continued)

Description of Procedure (Continued):
We then went to the C4-C5 level where the discectomy was done at C4 and C5. The endplates were completely curetted off and cleaned. We went all the way back to the PLL. The PLL was removed, as well as the posterior bridging osteophytes. Bone was then collected and placed into a cage. An anterior cervical fusion was then done at C4-C5. We then went to the C5-C6 level, where the endplates of C5 and C6 were completely curetted off and cleaned. Once this was done, we then went ahead and did a discectomy at C5 and C6.

Spinal Case Study (Continued)

Description of Procedure (Continued):
The endplates were completely cleaned off. The posterior longitudinal ligament was removed. We then collected local bone, which was then placed into another Medtronic cage. An anterior cervical fusion was done at C5-C6. The cage was placed using fluoroscopic guidance and placed in the appropriate position. We then corrected the kyphosis and anterolisthesis by putting on an anterior cervical plate and did some in situ correction of the anterolisthesis by placing anterior instrumentation from C3-C6. We then placed 2 bones screws into C5 and carefully pulled the vertebral body of C4 and C5 anteriorly.
Spinal Case Study (Continued)

Description of Procedure (Continued):
We then compressed across the whole construct, and got good lordosis. We also placed 2 screws into C3, 2 into C4, 2 into C5, and 2 into C6. Good fixation was obtained. AP and lateral x-rays confirmed excellent position of the construct.

Spinal Case Study: Answers

ICD-10-CM
- M48.02 (Spinal stenosis, cervical region)
- G95.9 (Disease of spinal cord, unspecified)
- M40.202 (Unspecified kyphosis, cervical region)

ICD-10-PCS
- 0RG20A0 (Fusion 2-6 Cervical Joint with Interbody Fusion Device, Anterior Approach Anterior Column, Open)
- 0RB30ZZ (Excision of Cervical Vertebral Disc, Open Approach)
  - Only 1 code assigned for disectomy even though it is multiple levels
    (same root operation on the same body part site)
**PTCA/Stent Case Study**

**Procedure:** Primary PTCA and stent placement  
**Indications:** Acute myocardial infarction

**Procedure Description:** Following left heart catheterization, a 6-French JR4 guiding catheter with side holes provided adequate support. The mid-right coronary artery occlusion was crossed with little difficulty using a 0.014 BMW wire. Next the lesion was dilated using a 2 x 20 Maverick balloon. Next a 3 x 23 Vision stent was deployed in the mid right coronary artery. A second 3.0 x 12 Vision stent was deployed proximal to the first stent with an intentional degree of overlap. Following successful primary PTCA and stent of the right coronary artery, there was a 0 percent residual stenosis with excellent antegrade flow. Perclose was utilized for vascular access site closure.

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**PTCA/Stent Case Study: Answers**

**ICD-10-CM:** I21.3 (ST elevation myocardial infarction of unspecified site)  
**ICD-10-PCS:** 02703DZ (Dilation of Coronary Artery, One Site with Intraluminal Device, Percutaneous Approach)  
- Vision is a bare metal stent  
- 2 stents but only one distinct site (mid right coronary artery)  
- Coronary arteries are classified by number of distinct sites treated, rather than number of coronary arteries or anatomic name of coronary artery.

*Multiple stents used to treat a single coronary artery lesion are identified with the device value intraluminal device or drug-eluting intraluminal device. When multiple stents classified to the same device value are used to treat a single coronary artery lesion, that information is not currently captured in the ICD-10-PCS code.*
Traumatic Brain Injury Case Study

Chief Complaint: Car Crash

A xx year old female driver was involved in a car crash on I-Superfast. Patient collided with a SUV. Patient was talking on cellular phone with mother prior to accident. Patient brought to ER in a coma where she is diagnosed with TBI with loss of consciousness of one hour. Glasgow coma scale was 5 on arrival in ED.

Procedure: The patient underwent endotracheal intubation and subsequently placed on mechanical ventilation

Discharge Diagnosis: Traumatic brain injury. Patient was transferred to trauma center for further care.
Traumatic Brain Injury Case Study: Answers

ICD-10-CM
S06.9X3A (Unspecified intracranial injury with LOC of 1-5 hours 59 min, initial)
R40.243 (Glasgow coma scale score 3-8)
V43.51XA (Car driver injured in collision with sport utility vehicle in traffic accident, initial encounter)
Y93.C2 (Activity, hand held interactive electronic device)
Y92.411 (Interstate highway as the place of occurrence of the external cause)

ICD-10-PCS
0BH17EZ (Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening)
5A1935Z (Respiratory Ventilation, Less than 24 Consecutive Hours)
Anemia Case Study: Question

I have a patient admitted for chronic blood loss anemia due to a bleeding mass from esophageal cancer. Nothing can be done for the cancer. Admitted due to the anemia for transfusions. The guideline from the handbook below says D63.0 would be secondary to the anemia. In my case I coded D50.0 for chronic blood loss anemia. So would the guideline still apply?

Coding Guideline

Admission for Complications Associated with a Malignant Neoplasm

Patients with malignant neoplasms often develop complications due to either the malignancy itself or the therapy that they have received. When admission is primarily for treatment of the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm.

The exception to this guideline is anemia. When the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis, followed by code D63.0, Anemia in neoplastic disease. When the admission/encounter is for management of an anemia associated with an adverse effect of the administration of chemotherapy or immunotherapy, and the only treatment is for the anemia, the anemia code is sequenced first, followed by the appropriate codes for the neoplasm and the adverse effect (T45.1x5-). For example:
Anemia Case Study: Answer

Anemia exists because of the malignancy, therefore the cancer would be the principal diagnosis followed by the D50.0 and the D63.0 as secondary diagnoses. As per OCG.

Anuloplasty of the Mitral Valve Case Study: Question

Kindly, I ask you to help me with the below issue:

Patient had an open annuloplasty of the mitral valve with a synthetic substitute without a leaflet excision and also 2 Gore patches sutured in other 2 different parts of the mitral valve (without any excision). When coding in 3M you will get the same code – 02UG0JZ for the annuloplasty as well as for the repair of heart valve with a synthetic patch. Wanting to reflect both parts of the procedure am I allowed to use code 02UG0JZ for annuloplasty and code 02QG0ZZ for the other repair of the valve? Code 02QG0ZZ will not influence the DRG.
**Annuloplasty of the Mitral Valve Case Study: Answer**

Both areas of mitral valve have a patch therefore they both go to supplement. Repair would not be appropriate. See index of PCS Code book for definition of repair as root operation.

Per the ICD 10 PCS coding handbook: The root operation “Repair” represents a broad range of procedures for restoring, to the extent possible, a body part to its normal anatomical structure and function. This root operation is only used when the procedure performed does not meet the definition of one of the other root operations. Examples of “Repair” include herniorrhaphy and suturing of laceration.

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**Blood Evacuated from Hemorrhoid Case Study: Question**

This patient vaginally delivered and blood from hemorrhoid was evacuated after perineal laceration repair. Since they evacuated the blood, drainage seems appropriate, but what would the body part? Please advise.

1 cm x 1 cm hemorrhoid, appeared to be thrombosed, s/t appearance and patient concern that it was very uncomfortable prior to & delivery,

I & E performed after betadine swab for evacuation of small amount of blood, no clot evacuated.
Blood Evacuated from Hemorrhoid Case Study: Answer

069Y3ZZ drainage of lower vein, percutaneous. “Lower vein” as the body part since a hemorrhoid is a swollen vein/a vascular structure in the anus. DRG remains unchanged, 775 vaginal delivery.

Tumor of Cecum Case Study: Question

This patient admitted with previously biopsied low grade tumor of cecum and underwent a resection. Path showed well-differentiated neuroendocrine CA with LN met. I submitted a query and the attending documented “Well differentiated neuroendocrine (Carcinoid) tumor of cecum.” Per Alpha index, we have to choose between benign and malignant carcinoid tumor. From previous facilities I’ve worked at, they recommended to assign the malignant unless they specifically document benign tumor. I asked him to add the met site but he didn’t do that either. Would you please share your thoughts?
Query:
Dear Dr. XXX,
Carcinoid tumor of cecum is documented in the discharge summary. Path report includes the final diagnosis of well-differentiated neuroendocrine carcinoma with lymph node metastasis, pT3 N1.
As low grade tumor and well-differentiated neuroendocrine carcinoma are classified to different diagnosis codes, we'd appreciate if you could clarify and document the final diagnosis after study (with metastatic site, if applicable) to the discharge summary as addendum.

(PROVIDER REPLY:) The final diagnosis has been amended to "Well differentiated neuroendocrine (carcinoid) tumor of the cecum" which accurately reflects the pathologic diagnosis.
Tumor of Cecum Case Study: Answer

Typically benign tumors do not metastasize. The pathology report indicates that there was lymph node metastasis, thereby a malignant tumor, however the pathological findings have not been confirmed by the attending physician. It would be inappropriate to assume malignant until the provider has clarified. **It is important to query with terms that are easily indexable in the ICD10 code book. Trainers suggest requery to the provider with terms such as "benign" or "malignant" for a clear response from the attending physician.

Query:
(Part 1) Dear provider, Please document in summary addendum if the carcinoid tumor is 1. Benign, 2. Malignant, 3. Other, 4. Undetermined
(Part 2) Please document in summary addendum if you agree with the diagnosis of lymph node metastasis, as coders are unable to code from the pathology report.
**Tumor of Cecum Case Study: Provider Update**

Provider replied to query with "malignant carcinoid tumor"

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**Adult ADD Case Study: Question**

How do you code adult ADD? 3M rejects code F98.8 for age incompatibility in an adult, is there an alternative?
**Adult ADD Case Study: Answer**

**RMC Internal Answer:**
RMC will be sending to ICD 10 Ombudsman and Coding Clinic for official guidance.
Trainers recommend coding R41.840- Attention and concentration deficit until official guidance from above resources.

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**Update From Ombudsman**

Thank you for expressing concern with the ICD-10 Medicare Code Editor (MCE) Age Conflict- Pediatric Diagnosis code edit for ICD-10-CM code F98.8 (Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence). We are addressing this issue as part of our annual MCE updates for the FY 2017 inpatient PPS proposed rule. This proposed rule will be published in April/May 2016. Please contact your local MAC to make them aware of any claims that have been denied or rejected in error. If you need help determining contact information for the MAC serving your jurisdiction, please refer to the following link: https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-Provider-Contact-Table.pdf.
**Alcohol Intoxication and Dependence**  
**Case Study: Question**  
Is it appropriate to code both codes for alcohol dependence with withdrawal and alcohol dependence with intoxication when both are present? I’ve been coding the more serious withdrawal code since I get Compliance Edits.

Review documentation to determine if a more specific diagnosis code other than F10.239 (Alcohol dependence with withdrawal, unspecified) should be coded (3M edit).

Review documentation to determine if a more specific diagnosis code other than F10.229 (Alcohol dependence with intoxication, unspecified) should be coded. (3M edit)

Excludes 1 Edits: ICD10 CM tabular Category (F1023): F10.239 should never be used at the same time as F10.220

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**Alcohol Intoxication and Dependence**  
**Case Study: Answer**  
It is not possible to be intoxicated and be in withdrawal at the same time so you would not code both together. However if intoxication was present on admission and several days later the PT developed withdrawal, then documentation would support coding both conditions. And due to interim advice on excludes 1 note, you may code override the edit.
Lysis of Adhesions Case Study: Question

I was wondering how to code lysis of adhesions of the heart. I came up with 02NN0ZZ. (this is pericardium, not sure if I am using the correct Body Part) The surgeon says “extremely dense substernal adhesions were divided with the scissors and electrocautery. Adhesions were unusually severe all over the heart. They were divided.”

Lysis of Adhesions Case Study: Answer

RMC Internal Trainers recommend a query to decipher which part of the heart is being freed (i.e.. Right or left atrium, right or left ventricle, pericardium or other internal structure)
What and How

Think about what your coding and how you’re coding.

• Apply guideline for secondary dx
  ➢ clinical evaluation; or
  ➢ therapeutic treatment; or
  ➢ diagnostic procedures; or
  ➢ extended length of hospital stay; or
  ➢ increased nursing care and/or monitoring.

Tips

• Review coding AND documentation quality
• Feedback to CDI/Providers AND Coders
• Educate! Discuss! Educate!
• Resource for staff questions
Resources

AHA Coding Clinic
ICD 10 CM and PCS Coding Handbook 2016
ICD-10-PCS: An Applied Approach, 2015, Kuehn, Lynn
Ref 1:  http://www.healthcareitnews.com/sites/default/files/companion_images/icd10_2.png
Ref 2:  http://www.memes.com/meme/717099
Ref 4:  http://legacy.owensboro.kctcs.edu/gcaplan/anat/images/Image256.gif
Ref 5:  http://englishwithatwist.com/wp-content/uploads/2013/05/Blog-communication-cartoon.jpg
Ref 6:  https://www.pinterest.com/pin/4402973101041910386/
Thank you!!!!!!
Email: stacy@rmcinc.org

I-10 OVERLOAD
Is there a code for that?

Ref 6