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Does Coding Really Matter?

Objectives

- Why ICD-10 Coding Matters
- Coding Accurately for Clean Claim Submission
- Most Recent Updates and Clarifications from the Coding Clinic
- Common Coding Mistakes
- Correct Coding of Coding Scenarios

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Overview of ICD-10 Coding

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History of ICD-10 Coding

- **ICD-10** (International Statistical Classification of Diseases and Related Health Problems) was created by the **World Health Organization (WHO)** in 1989 to replace ICD-9.
- Work on ICD-10 began in 1990, became endorsed by the Forty-Third World Health Assembly in 1990, and was first used by member states in 1994.
- WHO manages and publishes the base version of the ICD, but several member states have modified it to better suit their needs. ICD-10 will be replaced by ICD-11 in the future.

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Benefits of ICD-10-CM

- Improved ability to measure health care services, including quality and safety data.
- Augmented sensitivity when refining grouping and reimbursement methodologies.
- Expanded ability to conduct public health surveillance.
- Decreased need to include supporting documentation with claims.
- Strengthened ability to distinguish advances in medicine and medical technology.
- Enhanced detail on socioeconomic, family relationships, ambulatory care conditions, problems related to lifestyle and the results of screening tests.
- Increased use of administrative data to evaluate medical processes and outcomes, to conduct bio-surveillance and to support value-based purchasing initiatives.

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Coding Clinic

- The advice provided in the **Coding Clinic** is the result of a formal cooperative effort between the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), and the Centers for Medicare and Medicaid Services (CMS).

- In addition to these organizations, the Editorial Advisory Board consists of an expert panel of physicians representing the American Medical Association, the American College of Surgeons, the American Academy of Pediatrics, and the American College of Physicians, as well as coding professionals and representing healthcare facilities.

- **Coding Clinic** brings the latest official coding information to coding professionals. CMS affirmation of the **Coding Clinic** as the official source of coding information is noted in the Federal Register, Vol. 74, No. 165, Thursday, August 27, 2009.

- The Official Guidelines for Coding and Reporting are a set of rules that have been developed to accompany and complement the official conventions and instructions provided by the ICD-10-CM and ICD-10-PCS. The **Coding Clinic** is to be used as an official resource when the classification and the guidelines do not provide direction.

- **Coding updates are two times a year** (April & October of each year).

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Home Health (PDGM) Coding

Patient-Driven Grouping Model

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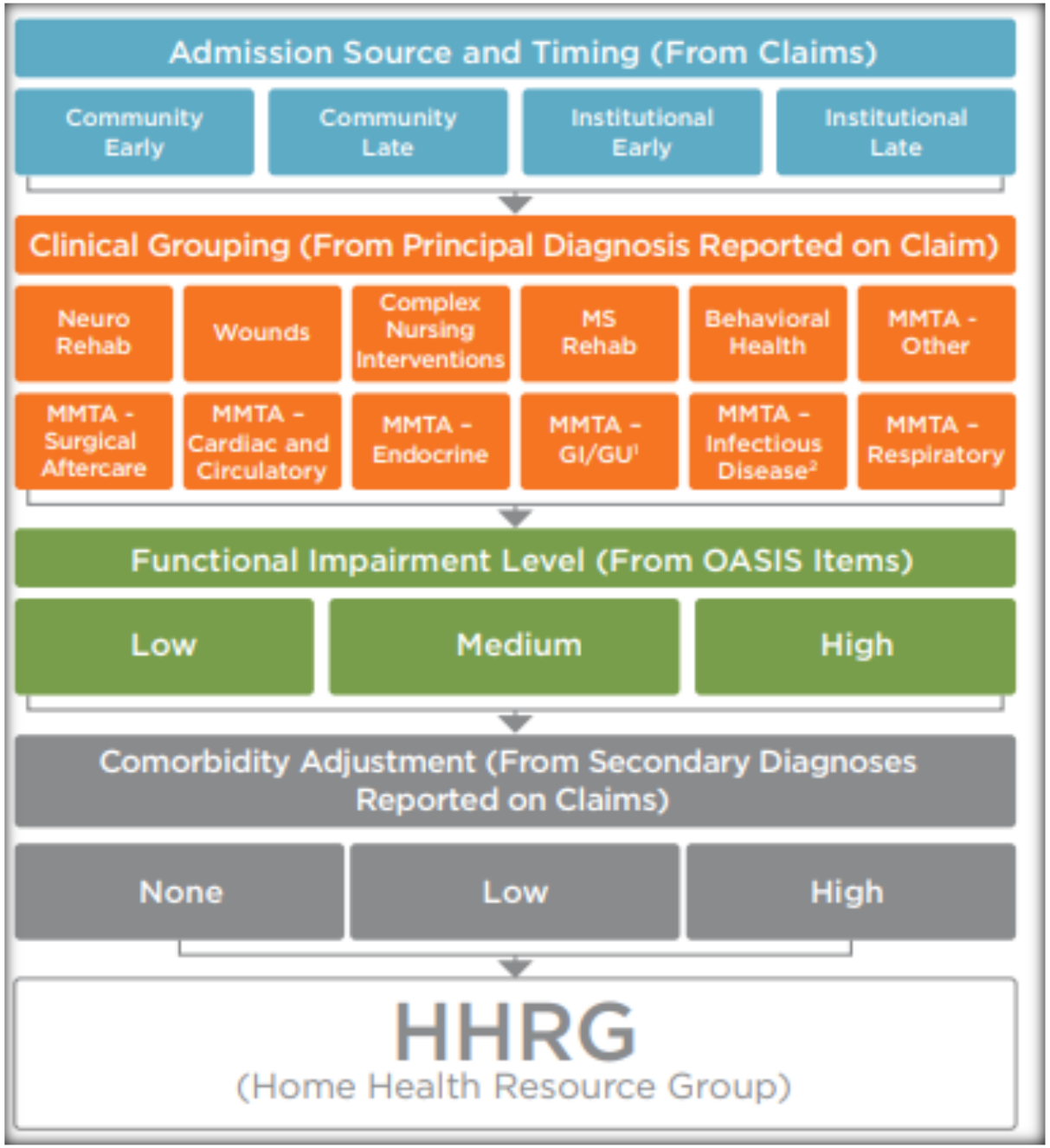
PDGM Structure



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Primary Diagnosis Determines Clinical Grouping

TABLE 1: PDGM CLINICAL GROUPS

CLINICAL GROUP	PRIMARY REASON FOR HOME HEALTH ENCOUNTER IS TO PROVIDE:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/ Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers burns and other lesions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and sub-stance abuse conditions
Medication Management, Teaching and Assessment (MMTA) • MMTA –Surgical Aftercare • MMTA – Cardiac/Circulatory • MMTA – Endocrine • MMTA – GI/GU • MMTA – Infectious Disease/Neoplasms/ Blood-forming Diseases • MMTA –Respiratory • MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment.

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Comorbidity Adjustment Determined by Secondary Codes

Comorbidity Adjustment

The PDGM includes a comorbidity adjustment category based on the presence of secondary diagnoses. Depending on a patient's secondary diagnoses, a 30-day period may receive no comorbidity adjustment, a low comorbidity adjustment, or a high comorbidity adjustment. Home health 30-day periods of care can receive a comorbidity adjustment under the following circumstances:

- **Low comorbidity adjustment:** There is a reported secondary diagnosis that is associated with higher resource use, or;
- **High comorbidity adjustment:** There are two or more secondary diagnoses that are associated with higher resource use when both are reported together compared to if they were reported separately. That is, the two diagnoses may interact with one another, resulting in higher resource use.

A 30-day period can have a low comorbidity adjustment or a high comorbidity adjustment, but not both. If a 30-day home health period of care does not have reported comorbidities that fall into one of the adjustments described above, there would be no comorbidity adjustment applied.

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Primary Diagnosis in PDGM

- Must match the primary reason for home health from the face-to-face encounter by the provider.
- Approximately 4,000 codes are not allowed as a primary diagnosis.
- Can't code diagnosis listed as "probable," "suspected," "questionable," "rule-out," or "working" without verification by the provider.

Common Diagnoses NOT Allowed as a Primary Under PDGM:

- Unspecified codes are not allowed (needs locations, side, type, etc.)
- Muscle weakness
- Abnormal gait (R code)
- Unspecified codes for RA, OA
- All V, W, X, and Y codes
- Post-COVID condition (must code condition first)
- Majority of "Z" codes. (Allowed under PDGM: Z43.0 – Z43.8, Z45.2, Z46.6, Z47.1, Z47.31 – 47.89, Z48.00 – Z48.89, Z51.11 – Z51.5, Z99.0 – Z99.11

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Unspecified Codes

- The majority just need a location added to make it an acceptable PDGM diagnosis.

Examples:

Spondylosis… instead, document spondylosis with location (lumbar, lumbosacral, thoracic, etc.)

Arthritis… instead, document type and location (Osteoarthritis of bilateral knees, RA with or without rheumatoid factor/location/any system involvement)

Assessment and Plan

1. Muscular weakness – ICD9: 728.87, ICD10: M62.81 (primary diagnosis)
    - CONSULT TO NEUROLOGY – Neurocare.
    - Refer to Home Physical Therapy.
    - Prognosis guarded if conditions continue to deteriorate.
    - We discussed possibly shifting focus to hospice care from palliative if neurology has nothing to offer.
2. Kidney replaced by transplant – ICD9: V42.0, ICD10: Z94.0
    - PREDNISONE 5MG TABLET
3. Gait abnormality – ICD9: 781.2, ICD10: R26.9
    - CONSULT TO NEUROLOGY
    - Refer to Home Physical Therapy
4. Hereditary and idiopathic peripheral neuropathy – ICD9: 356.9, ICD10: G60.9
    - CONSULT TO NEUROLOGY
5. Contusion of right hip, subsequent encounter – ICD9: V58.89, 924.01, ICD10: S70.01XD

Warm compress as needed.

6. Bilateral lower extremity edema – ICD9: 782.3, ICD10: R60.0

Use compression stockings. Diuretics not indicated due to low BP.

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What Can Be Used Instead...

Muscle Weakness/Falls/Abnormal

- Muscle wasting and atrophy – with location (Medicare's suggestion as an option to use instead of muscle weakness)
- Sarcopenia
- Arthritis (type) with location affected (knees, hips, generalized, etc.)
- Rhabdomyolysis
- Infection (UTI, Lyme disease, Epstein-Barr virus, Polio, HIV, Syphilis, Toxoplasmosis, Meningitis, etc.)
- Related injury
- Disease process (Parkinson's, CVA residual, COPD, CHF, MS, ALS, fibromyalgia, anemia, hypothyroidism, kidney disease, myasthenia gravis, Guillain-Barre syndrome, spinal cord injuries, cerebral palsy, etc.)
- Hereditary/Idiopathic neuropathy/DM with nerve damage
- Benign paroxysmal vertigo (add specific side)
- Electrolyte disorders or imbalances (for example – periodic paralysis G72.3)
- Drug-related – Drug-induced myopathy

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What Can Be Used Instead...

- Spondylosis, spondylolisthesis, spinal stenosis, collapsed vertebra, DDD, (must include location)
- Lumbago with sciatica (left or right), chronic pain
- Radiculopathy (with location)
- Sciatica (left or right), chronic pain syndrome
- Discitis (with location), muscle or ligament strain of spine
- Cervicalgia, pinched nerve/injury of nerve

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Hospice Coding

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Hospice Primary Diagnosis

The principal (or first) diagnosis code for hospice should be the condition most contributory to the terminal prognosis of six months or fewer, as identified by the hospice physician and any non-hospice attending physician the patient identifies on the NOE form.

Manifestation/Etiology

- If the Medicare Director lists a manifestation diagnosis as the terminal illness on the CTI, coders must follow coding guidelines and report the appropriate etiology code as the first/listed (principal) diagnosis.
- Manifestation codes – require both the disease and the etiology. The etiology will have “code first” listed in the coding manual.
- Codes that have “in disease classified elsewhere” and “due to underlying condition”

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Several Diagnosis Codes Are Not Allowed as a Primary

- V, W, X, Y or Z codes
- Debility
- Failure to thrive
- Dementia codes classified as unspecified
- Fractures
- Any diagnosis codes that cannot be used as the principal diagnosis according to the ICD-10-CM coding guidelines.

Other Things to Remember When Assigning the Principal Hospice Diagnosis:

- When the information provided in the patient's medical records differs from what is documented on the CTI form or nursing admission assessment form, query the physician for clarification.
- No circumstance allows the principal diagnosis code assignment to violate ICD-10-CM official coding guidelines.
- Always include an explanation in the chart when coding guidelines are not followed for the principal terminal diagnosis assignment due to payer requirements.

Sequencing

Coders should be aware of each diagnosis and its relevance to the terminal diagnosis. The sequencing of diagnoses that are related to the terminal prognosis should be coded before those that are unrelated.

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Points to Remember

- Don’t list symptoms in place of a known condition/disease.
- Hospices must report all unresolved secondary diagnoses both related and unrelated to the terminal diagnosis.
- V, W, X, Y, and Z codes may be assigned as secondary diagnoses.
- You may assign debility, failure to thrive, and/or dementia codes classified as unspecified as secondary codes.
- Diagnoses obtained from the nursing assessment, medication profile, or care plan that are not substantiated in the medical records uploaded to the chart, cannot be used in the diagnosis list until they are documented as confirmed with the hospice physician.
- Never list a diagnosis that is resolved (no longer exists). If the historical value of the resolved diagnosis impacts the patient’s terminal prognosis impacts the patient’s terminal prognosis consider assigning the appropriate Z code for the history of the resolved diagnosis, if one exists.
- The word “with” or “in” means “associated with” or “due to” when it appears in a code title, the Alphabetic
- All diagnoses must be stated or confirmed by the physician or qualified provider.
- Never assign diagnoses if stated by a provider with nebulous terms, such as “likely,” “suspected,” or “consistent with”
- Keep in mind that diagnoses cannot be assigned from lab reports or imaging without a physician’s interpretation of those results confirming the diagnosis.
- Many parts of the medical record can provide insight into code assignment or provide reasons for needed provider queries. Some forms of documentation that can support information related to code assignment include the history and physical (H&P), discharge summaries, operative reports, labs, and imaging with interpretation and progress notes.

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CVA's

- Use codes classifiable to I69.0 – I69.3 to report conditions occurring any time after the onset of an acute stroke when neurologic deficits persist.
- Don't assign a code from I69.9 – Sequela of unspecified cerebrovascular disease.
- Most of the Sequela of CVA are combination codes but some require an additional code.
- The coding of acute CVAs is restricted to acute settings (curative measures) only except in certain circumstances.

Types of Dementia That May Be Coded as Primary in Hospice

- Alzheimer's (followed by dementia)
- Parkinson's (followed by dementia)
- Senile degeneration of the brain
- CVA I69.318 (followed by vascular dementia)
- Unspecified Cerebrovascular disease I69.918 (followed by vascular dementia)
- Occlusion/stenosis & others (I65– I67 codes) (followed by vascular dementia)

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Common Coding Mistakes

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Coding Mistakes

- Coding straight from the index. (Read the notes in the Tabular list to be sure your selection is correct).
- Sequencing codes inappropriately. (Example – Coding the underlying disease BEFORE the manifestations; the injury before the E code).
- Omission of specificity and laterality in codes (“Code to the highest level of specificity supported by the medical record documentation.”)
- Assigning too few codes (not coding all patient diagnoses).
- Assigning too many codes (coding resolved conditions).
- Using an old coding manual that doesn’t have the most updated guidance and using outdated codes. (Using an old code version of the code after updates).
- Coding diagnoses not verified by a provider.
- Coding diagnosis is listed as “probable,” “suspected,” “questionable,” “rule-out,” or ”working” without verification by the provider.
- Coding the wrong type of wound (open wound instead of ulcer, etc.).
- Not using all digits and numbers required for the proper code.
- Using an unacceptable principal diagnosis.
- Upcoding.
- Using the 7th character of ”A,” “D,” “S” inappropriately.

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Sequencing

Not following instructions for sequencing codes is incorrect coding and non-compliant with HIPAA standards. When coding, check the code and compliance edits, as well as sequencing, before completing the coding. Instructional notes “Code first,” “use additional code,” and “in diseases classified elsewhere” advise proper sequencing of conditions (ICD-10-CM Guidelines).

“Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis.”

Patient with MSSA pneumonia

Incorrect –

J18.9 – Pneumonia, unspecified organism

Correct –

J15.211 – Pneumonia due to methicillin-susceptible

staphylococcus aureus

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Hypertension, Chronic Kidney Disease, and Heart Disease

Hypertension, chronic kidney disease (CKD), and heart disease are some of the most miscoded conditions in ICD-10-CM.

- "The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term 'with' in the Alphabetic Index." What does this mean? **If a patient presents with hypertension, chronic diastolic heart failure, and stage 3 CKD, as coders, we can presume that the heart disease and kidney disease are due to hypertension,** and code: I13.0 *Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease*, I50.32 *Chronic diastolic (congestive) heart failure, and* N18.30 *Chronic kidney disease, stage 3 unspecified.*
- **The exception to this rule is when the provider specifically documents another cause for one of those conditions.** For example, the same patient presents with hypertension, chronic diastolic heart failure, and stage 3 CKD. However, stage 3 CKD is documented as "due to type 2 diabetes." Since the provider documented a known cause of stage 3 CKD (type 2 diabetes), you would not presume a relationship between hypertension and CKD. This changes the final code selection, leading you to cod I11.0. *Hypertensive heart disease with heart failure*, I50.32, E11.22 *Type 2 diabetes mellitus with diabetic chronic kidney disease*, and N18.30.

In addition to I11.0 and I13.0, hypertension combination codes include (not an all-inclusive list):

- **I11.9** - Hypertensive heart disease without heart failure
- **I12.0** – (HHC) Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end-stage renal disease.
- **I12.9** – Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease.

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Coding Scenario

Error Example

Patient with acute on chronic systolic CHF, HTN, CKD 4, Anemia

- Essential Hypertension I10
- Acute on chronic systolic heart failure I50.23
- Chronic kidney disease, stage 4 N18.4
- Anemia unspecified D64.9

Correct Coding

Patient with acute on chronic systolic CHF, HTN, CKD 4, Anemia

- Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease I13.0
- Acute on chronic systolic heart failure I50.23
- Chronic kidney disease, stage 4 N18.4
- Anemia in chronic kidney disease D63.1

Error Example

Provider documentation states the patient has atrial fibrillation, hypercholesterolemia, hyperlipidemia, and paroxysmal a-fib.

- Unspecified Atrial fibrillation I48.91
- Pure Hypercholesteremia, unspecified E78.00
- Paroxysmal atrial fibrillation I48.0
- Hyperlipidemia, unspecified E78.5

Correct Coding

Provider documentation states the patient has atrial fibrillation, hypercholesterolemia, hyperlipidemia, and paroxysmal a-fib.

- Pure Hypercholesteremia, unspecified E78.00
- Paroxysmal atrial fibrillation I48.0

**(sequencing based on focus of care)

Coding Scenario

Error Example

Patient has sepsis secondary to a urinary tract infection due to a urinary catheter

- Sepsis, unspecified organism A41.9
- Infection and inflammatory reaction due to indwelling urethral catheter (urinary catheter) T83.511A
- Urinary tract infection, unspecified (UTI) N39.0

Correct Coding

Patient has sepsis secondary to a urinary tract infection due to a urinary catheter.

- Infection and inflammatory reaction due to indwelling urethral catheter (urinary catheter) T83.511A
- Sepsis, unspecified organism A41.9
- Urinary tract infection, unspecified (UTI) N39.0

The code for the infection due to the device has a tabular instruction to "**Use additional code to identify the infection.**" This tells us to code the infection due to the device first, followed by the code for the infection.

CVA

- Common mistakes seen include coding **history of cerebral infarction** (stroke) versus **cerebral infarction with residual deficits** and **coding the stroke as current when it is not.**
- Patients with a *history* of stroke may present with residual deficits (don't use the Z86.73 – this means no residuals). Out of the hospital setting, this is what we would expect to see coded. Review the documentation carefully to capture these conditions accurately.
- For example: A provider's documentation states a patient has a history of stroke. In the physical exam, the provider indicates the **patient has right hemiplegia due to a previous stroke.** In this case, it would be **inappropriate to code Z86.73.** Instead, you would code I69.351 *Hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side* to capture the current sequela of the stroke.

Examples of sequela of cerebral infarction codes include (not an all-inclusive list):

- **I69.334** (HCC) Monoplegia of upper limb following cerebral infarction affecting left non-dominant side
- **I69.341** (HCC) monoplegia of lower limb following cerebral infarction affecting right dominant side
- **I69.351** (HCC) Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
- **I69.354** (HCC) Hemiplegia and hemiparesis following cerebral infarction affecting left no—dominant side

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Heart Attack (Myocardial infarction)

- Acute myocardial infarction (AMI) is often miscoded. According to the *ICD-10-CM Official Guidelines for Coding and Reporting*, codes from category I21, **Acute myocardial infarction, may continue to be reported for encounters occurring while the myocardial infarction is equal to, or less than, four weeks old,** and the diagnosis meets the definition for reporting additional diagnoses.
- It's important to review provider documentation to determine when the myocardial infarction occurred. Typically, documentation of the hospitalization for the AMI can provide a timeline for reference when coding.
- Coding **I25.2 Old myocardial infarction** would be **inappropriate** if provider documentation indicates the patient was diagnosed within the four-week period. After the four-week period, if the patient is continuing to need care or treatment, it is inappropriate to continue to code the AMI as current. **It is also incorrect to code for the AMI as resolved or old if the patient is continuing to require care.** Code Z48.812 *Encounter for surgical aftercare following surgery on the circulatory system* would be the appropriate coding for a patient continuing to be treated for a myocardial infarction beyond the first 28 days.

Examples of MI codes: In addition to I25.2 myocardial infarction codes include (not an all-inclusive list):

- **I21.01** (HCC) St elevation (STEMI) myocardial infarction involving left main coronary artery
- **I21.11** (HCC) St elevation (STEMI) myocardial infarction involving right coronary artery
- **I21.3** (HCC) ST elevation (STEMI) myocardial infarction of unspecified site
- **I21.4** (HCC) Non-ST elevation (NSTEMI) myocardial infarction
- **I21.A1** (HCC) Myocardial infarction type 2

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Acute/Chronic Deep Vein Thrombosis vs. History of Deep Vein Thrombosis

When coding for deep vein thrombosis (DVT) review provider documentation carefully to ensure it supports coding acute or chronic DVT. **Don't assume the patient has a current acute or chronic DVT just because they are on anticoagulants or have an embolism protection device, such as an inferior vena cava filter, in place.** If the DVT has resolved report Z86.718 *Personal history of other venous thrombosis and embolism.* A diagnosis for current DVT should only be reported when the condition is active and present.

DVT Codes include (not an all-inclusive list):

- **I82.401** (HCC) Acute embolism and thrombosis of unspecified deep veins of right lower extremity
- **I82.432** (HCC) Acute embolism and thrombosis of left popliteal vein
- **I82.521** (HCC) Chronic embolism and thrombosis of right iliac vein
- **I82.542** (HCC) Chronic embolism and thrombosis of left tibial vein

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Diabetes with Complications

- Another area of coding that is often miscoded is **complications of diabetes.** When it comes to ICD-10-CM codes for diabetes, "With." According to the ICD-10-CM coding conventions, the word "**with**" or "**in**" should be interpreted to mean **"associated with" or "due to"** when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.
- There are many combination codes to consider when coding for diabetes complications. For example, in the Alphabetic Index under "diabetes with," there are many conditions that are considered "due to" diabetes when both conditions are present and provider documentation does not indicate a specific cause (for example, E11.43 *Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy).* When **both type 2 diabetes and gastroparesis** are documented in the record, a diabetes complication code is required. Many times, these conditions are overlooked and coded separately.
- **There is one exception** to the "with" rule per *AHA Coding Clinic* 2018 Vol. 5, which states: "The **'with' guideline does not apply to 'not elsewhere classified (NEC)'** index entries that cover broad categories of conditions. Specific conditions must be linked by the terms 'with,' 'due to,' or 'associated with.'" The guidance further specifies that for **diabetic conditions that would be coded as NEC codes, coding professionals are not to assume a causal relationship,** and the provider must be clear in stating the relationship.

Diabetes combination codes include (not an all-inclusive list):

- **E10.31** (HCC) Type 1 diabetes mellitus with unspecified diabetic retinopathy
- **E10.**40 (HCC) Type 1 diabetes mellitus with diabetic neuropathy, unspecified
- **E11.22** (HCC) Type 2 diabetes mellitus with diabetic chronic kidney disease
- **E11.311** (HCC) Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
- **E11.621** (HCC) Type 2 diabetes mellitus with foot ulcer

As you can see, it's important to review the complete record and understand the ICD-10-CM guidelines to accurately code conditions that are present in each patient. Sometimes the small details may alter the coding significantly. Reviewing coding guidelines annually and communicating with providers about clear documentation is vital.

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Wounds

- Provider documentation that contains conflicting statements such as wound location, laterality, or etiology.
- Clinical documentation that does not support wound code assignment
- Wound records that are not consistently found in the same place in the medical record.
- Skilled services and resources provided are not consistent with the severity of the wound.
- Wound documentation does not support delays in healing and the need for continued treatment.
- Documentation does not include the patient's response to treatment, outcomes, and treatment changes.

Sequela of Cerebral Injury Mistakes

- Linking residuals to the CVA when the provider hasn't linked them.
- Coding residuals from a Transient Ischemic Attack (TIA), (there are no codes for TIA residuals).
- Coding active CVA instead of a residual.
- Not coding specifics of residual when indicates are listed by different verbiage (H&P states left-sided weakness).

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Complications

- Provider must document the relationship between the condition and the care or procedure.
- Documentation not clearly related to the cause-and-effect relationship between two conditions, the provider will need to be queried.
- Making assumptions that two conditions are related. This connection can only be confirmed by the provider.

Neoplasms Coding Challenges

- Provider does not include specifics and details needed for accurate code assessment.
- No documentation of the primary site when metastasis is present. Laterality is needed also for accurate code assignment.
- Unspecified neoplasm laterality will not be a valid primary diagnosis.
- Documentation is not clear as to whether the malignancy is resolved, in remission, or relapsed.
- Making assumptions based on long-term maintenance treatments that neoplasms or malignancies are either active or resolved.
- The terms “mass” and “tumor” are not interchangeable and lead to different code categories, query the provider for further details related to the etiology of a mass or tumor.

Mental Disorder Challenges

- Underlying etiology is needed when coding vascular dementia.
- No clarification for conflicting documentation of the type of dementia.
- Inconsistency with the type of dementia throughout the documentation.
- Don't forget the 'with' convention and when comorbid conditions can be connected to the mental disorder by the ICD-10-CM classification.
- Not making a query to confirm the presence of an unlisted mental/behavioral disorder when there are indications in the record (med list, documentation of symptoms, etc.).

Neuro Disorder Challenges

- No provider specification of "chronic pain syndrome"
- Using terms like "chronic pain" and "generalized pain" is not sufficient for assigning codes for central pain syndrome or chronic pain syndrome.
- No query when there is no cause or source listed for pain and there is documentation that specifies chronic pain.
- Not understanding that Parkinson's disease and parkinsonism are not interchangeable terms.
- No query for conflicting documentation from the provider regarding the type of disorder the patient has.

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Social Determinants of Health (SDOH) Coding Mistakes

- No code assignment of SDOH.
- Literacy level, occupational risk factor exposure, housing, and economic circumstances, and problems related to the social environment are not included in patient assessment.
- Making a mistake that SDOH needs to be provider confirmed, these can be assigned based on clinician documentation.

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Coding Updates
Effective April 1, 2024

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The ICD-10-CM April 1, 2024, update addresses typographical errors. There are no new diagnosis codes being implemented.
https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024

ICD-10-CM Table of DRUGS and CHEMICALS 2024 Addenda April Update

No changes for FY2024 April Update

ICD-10-CM EXTERNAL CAUSE of INJURIES INDEX 2024 Addenda April Update

No changes for FY2024 April Update

ICD-10-CM TABLE of NEOPLASMS 2024 Addenda April Update

No changes for FY2024 April Update

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ICD-10-CM INDEX to DISEASES and INJURIES
2024 Addenda April Update

No Change **B**

No Change **Bronchiolitis (acute) (infective) (subacute)** J21.9
Revise from - chronic (fibrosing) (obliterative) J44.89
Revise to - chronic (fibrosing) J44.89

No Change **C**

No Change **Calculus, calculi, calculous**
No Change - biliary - see also Calculus, gallbladder
Add - - with bile duct involvement - see also Calculus, bile duct
No Change - kidney (impacted) (multiple) (pelvis) (recurrent) (staghorn) N20.0
No Change - - with calculus, ureter N20.2
Add - - - with hydronephrosis N13.2
Add - - - - with infection N13.6
No Change - - congenital Q63.8
Add - - - with hydronephrosis N13.2
Add - - - - with infection N13.6
No Change - ureter (impacted) (recurrent) N20.1
Add - - with hydronephrosis N13.2
Add - - - with infection N13.6

No Change **D**

No Change **Depression (acute) (mental)** F32.A
Revise from - central nervous system R09.2
Revise to - central nervous system G98.8
No Change **Disease, diseased** - see also Syndrome
No Change - sickle-cell D57.1
No Change - - with
Delete - - - priaprism D57.09
Add - - - priapism D57.09
No Change - - Hb-C D57.20
No Change - - - with
Delete - - - - priaprism D57.218
Add - - - - priapism D57.218

No Change **F**

No Change **Feeling (of)**
Revise from - foreign body in throat R09.89
Revise to - foreign body in throat R09.A2

No Change **M**

Add **Mpox** B04

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ICD-10-CM TABULAR LIST of DISEASES and INJURIES

2024 Addenda April Update

No Change **Chapter 1**

No Change **Certain infectious and parasitic diseases (A00-B99)**

No Change **Viral infections characterized by skin and mucous membrane lesions (B00-B09)**

No Change **B04 Monkeypox**
Add Mpox

No Change **Chapter 4**

No Change **Endocrine, nutritional and metabolic diseases (E00-E89)**

No Change **Postprocedural endocrine and metabolic complications and disorders, not elsewhere classified (E89)**

No Change **E89 Postprocedural endocrine and metabolic complications and disorders, not elsewhere classified**

No Change **E89.1 Postprocedural hypoinsulinemia**

Add **Code first**, if applicable, diabetes mellitus (postpancreatectomy) (postprocedural) (E13.-)

Delete **Use Additional** diabetes mellitus (postpancreatectomy) (postprocedural) (E13.-)

No Change **Chapter 6**

No Change **Diseases of the nervous system (G00-G99)**

No Change **Extrapyramidal and movement disorders (G20-G26)**

No Change **G20 Parkinson's disease**

No Change **G20.C Parkinsonism, unspecified**

No Change **Excludes1:**
Revise from secondary parkinsonism (G21-)
Revise to secondary parkinsonism (G21.-)

No Change **Chapter 9**

No Change **Diseases of the circulatory system (I00-I99)**

No Change **Other forms of heart disease (I30-I5A)**

No Change **I49 Other cardiac arrhythmias**

Delete **Excludes1:** neonatal dysrhythmia (P29.1-)
Delete sinoatrial bradycardia (R00.1)
Delete sinus bradycardia (R00.1)
Delete vagal bradycardia (R00.1)

Add **Excludes2:** neonatal dysrhythmia (P29.1-)
Add sinoatrial bradycardia (R00.1)
Add sinus bradycardia (R00.1)
Add vagal bradycardia (R00.1)

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No Change **Chapter 10**

No Change **Diseases of the respiratory system (J00-J99)**

No Change **Influenza and pneumonia (J09-J18)**

No Change **J12 Viral pneumonia, not elsewhere classified**

Delete **Excludes1:** aspiration pneumonia due to anesthesia during labor and delivery (O74.0)
Delete aspiration pneumonia due to anesthesia during pregnancy (O29)
Delete aspiration pneumonia due to anesthesia during puerperium (O89.0)
Delete aspiration pneumonia due to solids and liquids (J69.-)
Delete aspiration pneumonia NOS (J69.0)
Delete congenital pneumonia (P23.0)
Delete congenital rubella pneumonitis (P35.0)
Delete interstitial pneumonia NOS (J84.9)
Delete lipid pneumonia (J69.1)
Delete neonatal aspiration pneumonia (P24.-)

Add **Excludes2:** aspiration pneumonia due to anesthesia during labor and delivery (O74.0)
Add aspiration pneumonia due to anesthesia during pregnancy (O29)
Add aspiration pneumonia due to anesthesia during puerperium (O89.0)
Add aspiration pneumonia due to solids and liquids (J69.-)
Add aspiration pneumonia NOS (J69.0)
Add congenital pneumonia (P23.0)
Add congenital rubella pneumonitis (P35.0)
Add interstitial pneumonia NOS (J84.9)
Add lipid pneumonia (J69.1)
Add neonatal aspiration pneumonia (P24.-)

No Change **J18 Pneumonia, unspecified organism**

No Change **J18.0 Bronchopneumonia, unspecified organism**

No Change **Excludes2:**
Revise from chronic bronchiolitis (J44.9)
Revise to chronic bronchiolitis (J44.89)
Add other specified chronic obstructive pulmonary disease (J44.89)

No Change **Chronic lower respiratory diseases (J40-J4A)**

No Change **J45 Asthma**

No Change **Excludes2:**
Revise from asthma with chronic obstructive pulmonary disease (J44.9)
Revise to asthma with chronic obstructive pulmonary disease (J44.89)
Revise from chronic asthmatic (obstructive) bronchitis (J44.9)
Revise to chronic asthmatic (obstructive) bronchitis (J44.89)
Revise from chronic obstructive asthma (J44.9)
Revise to chronic obstructive asthma (J44.89)
Add other specified chronic obstructive pulmonary disease (J44.89)

No Change **Chapter 11**

No Change **Diseases of the digestive system (K00-K95)**

No Change **Diseases of peritoneum and retroperitoneum (K65-K68)**

No Change **K66 Other disorders of peritoneum**

No Change **K66.0 Peritoneal adhesions (postprocedural) (postinfection)**

Delete **Excludes1:** female pelvic adhesions [bands] (N73.6)

Add **Excludes2:** female pelvic adhesions [bands] (N73.6)
Add female pelvic postprocedural adhesions (N99.4)

No Change **Chapter 15**

No Change **Pregnancy, childbirth and the puerperium (O00-O9A)**

No Change **Complications predominantly related to the puerperium (O85-O92)**

No Change **O85 Puerperal sepsis**

Delete **Excludes1:** genital tract infection following delivery (O86.1-)
Delete urinary tract infection following delivery (O86.2-)

Add **Excludes2:** genital tract infection following delivery (O86.1-)
Add urinary tract infection following delivery (O86.2-)

No Change **Chapter 16**

No Change **Certain conditions originating in the perinatal period (P00-P96)**

No Change **Respiratory and cardiovascular disorders specific to the perinatal period (P19-P29)**

No Change **P28 Other respiratory conditions originating in the perinatal period**

No Change **P28.5 Respiratory failure of newborn**

No Change **Excludes2:**
Revise from respiratory distress of newborn (P22.0-)
Revise to respiratory distress of newborn (P22.0)

No Change **Chapter 17**

No Change **Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)**

No Change **Other congenital malformations (Q80-Q89)**

No Change **Q87 Other specified congenital malformation syndromes affecting multiple systems**

No Change **Q87.8 Other specified congenital malformation syndromes, not elsewhere classified**

No Change **Q87.85 MED13L syndrome**

No Change **Code also**
Revise from congenital malformations of cardiac septa (Q21-)
Revise to congenital malformations of cardiac septa (Q21.-)

No Change **Chapter 18**

No Change **Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)**

No Change **General symptoms and signs (R50-R69)**

No Change **R68 Other general symptoms and signs**

No Change **R68.2 Dry mouth, unspecified**

Delete **Excludes1:** salivary gland hyposecretion (K11.7)

Add **Excludes2:** salivary gland hyposecretion (K11.7)

No Change **Chapter 21**

No Change **Factors influencing health status and contact with health services (Z00-Z99)**

No Change **Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)**

No Change **Z59 Problems related to housing and economic circumstances**

No Change **Z59.1 Inadequate housing**

Delete **Excludes1:** problems related to the natural and physical environment (Z77.1-)

Add **Excludes2:** problems related to the natural and physical environment (Z77.1-)

Coding Updates for October 2024

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- The new updates to the ICD-10-CM code system for fiscal year 2024 include 395 new billable codes in areas such as external causes of morbidity, social determinants of health (SDOH), and osteoporosis.
- 25 Deletions and 13 Revisions

123 code updates in *Chapter 20 – External Causes of Morbidity (V00-Y99)* capture details around accidents and injuries.

W44.B3xA	Plastic toy and toy part entering into or through a natural orifice, initial encounter
W44.H0xA	Other sharp object unspecified, entering into or through a natural orifice, initial encounter
W44.F0xA	Objects of natural or organic material unspecified, entering into or through a natural orifice, initial encounter
W44.F3xA	Food entering into or through a natural orifice, initial encounter

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SDoH ICD-10 codes

Several social determinants of health (SdoH) codes were added including 8 of the 30 new codes in *Chapter 21 - Factors Influencing Health Status and Contact with Health Services (Z00-Z99)*, which capture details related to child upbringing.

Z62.23	Child in custody of non-parental relative
Z62.24	Child in custody of non-relative guardian
Z62.823	Parent-step child conflict
Z62.83	Non-parental relative or guardian-child conflict
Z62.831	Non-parental relative-child conflict
Z62.832	Non-relative guardian-child conflict
Z62.833	Group home staff-child conflict
Z62.892	Runaway [from current living environment]

Osteoporosis ICD-10 codes

Chapter 13 - Diseases of the Musculoskeletal System and Connective Tissue (M00-M99) contains 42 new codes to help further define osteoporosis with pathological fracture. Some examples:

M80.8B2P	Other osteoporosis with current pathological fracture, left pelvis, subsequent encounter for fracture with malunion
M80.8B9D	Other osteoporosis with current pathological fracture, unspecified pelvis, subsequent encounter for fracture with routine healing
M80.0B1K	Age-related osteoporosis with current pathological fracture, right pelvis, subsequent encounter for fracture with nonunion
M80.0B2G	Age-related osteoporosis with current pathological fracture, left pelvis, subsequent encounter for fracture with delayed healing

Diseases of the eye and adnexa ICD-10 codes

Out of the 45 new codes in Chapter 7 - Diseases of the Eye and Adnexa (H00-H59), 29 of them break down orbital muscle entrapment, and identify which part of the muscle is affected. Muscle and soft tissue entrapment happens when a fractured bone displaced by the fracturing force moves back towards its normal non-displaced position, trapping tissue into the fracture site. This condition happens more often in children. A sample:

H50.621	**Inferior oblique muscle entrapment, right eye**
H50.649	**Lateral rectus muscle entrapment, unspecified eye**
H50.662	**Superior oblique muscle entrapment, left eye**
H50.651	**Medial rectus muscle entrapment, right eye**

Streamline updating ICD-10-CM codes across the organization

As always, October 1 will be here before we know it. Even as the turbulence in the medical coding world stabilizes, updating clinical terminologies across all systems and departments within a health system or health plan is an enormous task. It's estimated that it takes one full-time engineer at least 10 hours to update one dataset with over 25 reference tables and/or value sets!

A data governance solution backed by expert clinical terminologists, can help your organization quickly leverage updated, quality data and ensure you have plenty of time for an accurate, governed system configuration before CMS deadlines.

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Most Recent Updates and Clarifications from the Coding Clinic

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Coding Clinic

- *Coding Clinic for ICD-10-CM and ICD-10-PCS* is the **quarterly newsletter published by the American Hospital Association's Central Office on ICD-10-CM and ICD-10-PCS.** The advice provided in the Coding Clinic is the result of a formal cooperative effort between the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), and the Centers for Medicare and Medicaid Services (CMS). In addition to these organizations, the Editorial Advisory Board consists of an expert panel of physicians representing the American Medical Association, the American College of Surgeons, the American Academy of Pediatrics, and the American College of Physicians, as well as coding professions representing healthcare facilities.
- Published since 1984, **Coding Clinic brings the latest official coding information to coding professionals,** auditors, third-party payers, government agencies, and consultants who are interested in and dedicated to improving the accuracy and uniformity of medical coding.

AHA Central Office

- The AHA Central Office serves as the official coding clearinghouse on the proper use of the ICD-10-CM, ICD-10-PCS, and HCPCS Level II classification systems. Our office provides coding advice regarding the proper application of these systems using the Alphabetic Index, Tabular List, Official Coding Guidelines, and AHA Coding Clinic advice.
- Coding advice is provided based upon specific medical record documentation submitted for each coding request. Please note, our office cannot provide clinical information and any request asking for clinical interpretation will be returned unanswered.

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Coding Clinic Q & A's

Question

A 55-year-old obese patient presented due to bilateral venous stasis disease, lymphedema, and lipodermatosclerosis associated with venous stasis ulcer of the right lateral calf. When referencing lipodermatosclerosis in the Alphabetic Index, an instructional note to see "varix, leg, with, inflammation" leads to a code that describes varicose veins. However, the patient does not have varicose veins. What is the appropriate code assignment for lipodermatosclerosis without documented varicose veins?

Answer

Assign code M79.3, Panniculitis, unspecified, for lipodermatosclerosis. In addition, assign codes L97.219, non-pressure chronic ulcer of right calf with unspecified severity, I87.2, venous insufficiency (chronic) (peripheral), and I89.0, lymphedema, not elsewhere classified, to capture venous stasis disease with right venous stasis calf ulcer and lymphedema. Lipodermatosclerosis, also referred to as sclerosing panniculitis or hypodermitis sclerodrmaformis, is a form of panniculitis, in which the skin of the lower legs becomes discolored, tight, and painful. It would not be appropriate to report codes for varicose veins when there is no provider documentation supporting the condition.

Question

A 65-year-old patient presented for follow-up, as well as management of chronic conditions, and complained of joint pain due to rheumatoid arthritis. The provider documented rheumatoid arthritis with inflammatory polyarthropathy in the assessment, with a steroid injection provided as treatment. How should rheumatoid arthritis with inflammatory polyarthropathy be reported?

Answer

Assign code M06.4, inflammatory polyarthropathy, for inflammatory polyarthropathy in a patient with rheumatoid arthritis. ICD-10-CM classifies inflammatory polyarthropathy as a specified type of rheumatoid arthritis under category M06, other rheumatoid arthritis; therefore, the more specified code (M06.4) is reported in lieu of code M06.9, rheumatoid arthritis, unspecified. Code M06.9 is assigned when rheumatoid arthritis is documented without further specification.

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Coding Clinic Q & A's

Question

A patient who recently had lumbar decompression surgery was readmitted with progressive worsening of low back pain radiating down both legs. The patient was diagnosed with dynamic **18 First Quarter 2024 Coding Clinic**

Instability, lumbar spondylolisthesis, and cauda equina syndrome prompted further surgery. During this admission, the patient underwent an L4-S1 transforaminal lumbar interbody fusion (TLIF) with posterior instrumentation. Following the TLIF procedure, the patient continued to experience bilateral paresthesias with impaired sensation, and the provider documented postlaminectomy syndrome. A query was submitted to determine the cause of the spondylolisthesis. The provider's response to the query stated, "The sp0ondylolisthesis occurred in the postoperative period after a decompression/laminectomy surgery secondary to multiple factors, including the decompression surgery which weakened the posterior tension band, patient's weight and obesity causing extra stress." Is postlaminectomy lumbar spondylolisthesis reported as a postoperative complication or as a postlaminectomy syndrome?

Answer

Assign codes M96.89, other intraoperative and postprocedural complications and disorders of the musculoskeletal system, M43.16, spondylolisthesis, lumbar region, G83.4, cauda equina syndrome.

As previously published in *Coding Clinic* First Quarter 2022, pages 51-52, and stated in the *Official Guidelines for Coding and Reporting*, section 1.B.16, "it is not necessary for the provider to explicitly document the term "complication." The cause-and-effect relationship documented between the surgery and the condition is sufficient.

Code M96.1, postlaminectomy syndrome, not elsewhere classified, is not assigned when the condition is further specified by the provider as lumbar spondylolisthesis.

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Coding Clinic Q & A's

Question

A patient who is status post a recent coronary artery bypass graft (CABG) procedure was admitted with progressive purulent drainage from the surgical wound. The provider documented "sepsis due to staphylococcus pyogenes deep operative wound infection, status post CABG." In this case, would code T81.40XA, infection following a procedure, unspecified, initial encounter, be assigned with code T81.44XA, sepsis following a procedure, initial encounter? Code T81.40XA does not provide any additional information regarding the depth of the surgical site infection.

Answer

Based on the documentation of deep wound infection, assign codes T81.42XA, infection following a procedure deep incisional surgical site, initial encounter, T81.44XA, sepsis following a procedure, initial encounter, and A41.1, sepsis due to other specified staphylococcus, for the sepsis due to the staphylococcus pyogenes infected operative wound status post-CABG.

In this case, the provider specifically documented a postsurgical wound infection (surgical site infection). The *ICD-10-CM Official Guidelines for Coding and Reporting*, section I.C.1.d.5.b., for sepsis due to a postprocedural infection, states, "For sepsis following a postprocedural wound (surgical site) infection, a code from T81.41 to T81.43, infection following a procedure, [or] T81.49, infection following a procedure, other surgical sites… that identifies the site of the infection should be sequenced first if known. Assign an additional code for sepsis following a procedure (T81.44)…use an additional code to identify the infectious agent."

Question

The patient recently underwent a small and large bowel resection, as well as an excision of an enterocutaneous fistula. He presented to the Emergency Department and a computed tomography (CT) showed a postoperative intra-abdominal abscess, which was drained percutaneously. The provider's discharge diagnosis was "Postoperative intra-abdominal abscess." In the Tabular list, "Intra-abdominal abscess following a procedure" is an inclusion term in subcategory T81.43, infection following a procedure, organ, and space surgical site. There is also an instructional note to, "Use additional code to identify infection." Is it appropriate to assign both codes T81.43XA, infection following a procedure, organ and space surgical site, initial encounter, and K65.1, Peritoneal abscess, for this case?

Answer

Yes. Answer codes T81.43XA and K65.1 for the postprocedural intra-abdominal abscess. Both codes are needed to fully capture this diagnosis. The instructional note, "use additional code to identify infection" supports the assignment of code K65.1.

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Coding Clinic Q & A's

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Question

A 54-year-old patient with multilevel lumbar spinal stenosis and neurogenic claudication presented for surgical treatment. During lumbar decompression and facetectomy at L5-L5, a dural tear was identified and repaired with two sutures. Valsalva maneuver was performed twice and there appeared to be no signs of cerebrospinal fluid leakage. Postoperative plans included keeping the patient flat overnight. The provider documented that the intraoperative durotomy was due to dural adhesions and epidural scarring. Would it be appropriate to report an intraoperative dural teat in this case? **Coding Clinic First Quarter 2024 21**

Answer

Assign code G97.41, accidental puncture or laceration of dura during a procedure, for the intraoperative dural tear. A dural tear is clinically significant and should always be reported when documented by the provider. Code G97.41 includes incidental (inadvertent) durotomy.

Question

A 70-year-old patient with lumbar disc herniation with severe cauda equina compression, multilevel stenosis, and disc degeneration presented for surgical treatment. During bone removal in the area of severe stenosis, a small dural opening was found secondary to bone removal. The dural opening was closed with a suture as well as with fibrin glue. The provider was queried regarding the dural tear and clarified that the laceration was inherent to thinning dura and the degree of stenosis and erosion through the dura. Should the intraoperative dural tear be reported for this case?

Answer

Assign code G97.41, accidental puncture or laceration of dura during a procedure, for the intraoperative dural tear that required repair. Although the provider clarified that the dural tear was inherent to the thi8nning dura and degree of stenosis and erosion, a dural tear is clinically significant and shoul always be reported when documented by the provider.

Question

A 17-year-old patient with a history of thoracic adolescent idiopathic scoliosis (AIS) has developed adding-on phenomenon following a previous T2-T12 posterior spinal fusion. The patient has developed progression of the lumbar curvature ove rthe past year and now presents for a posterior spinal fusion of T2-L3 for correction of the adding-on phenomenon. What is the correct ICD-10-CM code assignment for "adding-on phenomenon" that occurred following previous spinal fusion for scoliosis correction?

Answer

Assign code M96.89, other intraoperative and postprocedural complications and disorders of the musculoskeletal system, from the adding-on phenomenon that occurred following a previous posterior spinal fusion, and code M41.125, adolescent idiopathic scoliosis, thoracolumbar region, to further specify the disorder as directed by the instructional note at code M96.89. Also, assign code Z98.1, arthrodesis status since the patient is status post prior spinal fusion.

Coding Clinic Q & A's

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Question

A patient presents to the Emergency Department with shortness of breath due to an exacerbation of asthma. The patient did not take his PRN medication, albuterol, because he lost his inhaler. *Coding Clinic* First Quarter 2021, pages 12-13, clarified that PRN medications **24 First Quarter 2024 Coding Clinic** are not classified as long-term drug therapy. Is it appropriate to assign a code for underdosing when a PRN medication, such as albuterol is not taken?

Answer

It is not appropriate to assign a code for underdosing when a PRN medication is not taken. Assign code Z91.198, patient's noncompliance with other medical treatment and regimen for other reasons. Albuterol may help with the symptoms of asthma; however, it is not a maintenance medication, and the asthma exacerbation was not caused by the patient not taking albuterol.

Question

A patient who is status post chemoradiation for Hodgkin's disease presents with esophageal and gastric outlet obstruction, due to the progression of metastatic leiomyosarcoma to the liver, causing external compression of the gastrointestinal tract. The provider was queried regarding documentation of transaminitis, hyperbilirubinemia, and elevated liver function tests, and clarified, "Acute liver injury due to metastatic liver disease and chemotherapy." There is no documentation of traumatic injury to the liver. However, acute liver injury is classified into subcategory S36/11, injury of liver/ What is the correct code assignment for non-traumatic acute liver injury due to metastatic liver disease and chemotherapy?

Answer

Assign Codes K71.8 toxic liver disease with other disorders of the liver, C78.7 secondary malignant neoplasm of the liver and intrahepatic bile duct, and T45/1Z5A adverse effect of antineoplastic and immunosuppressive drugs, initial encounter, for non-traumatic acute liver injury, due to metastatic liver disease and chemotherapy. ICD-10-CM does not specifically classify non-traumatic acute liver injury; therefore, reference code K71/8 in the Alphabetic Index as follows:

Disease
Liver
Drug-Induced – see Disease, liver, toxic
Toxic K71.9

- Code K71.8 is assigned since the cause of the acute liver injury is known. *Coding Clinic* Second Quarter 2015, p. 17 clarifies that when acute liver injury is documented, cod **26 First Quarter 2024 Coding Clinic**
- The exact nature of the liver problem, if known. If the etiology of the liver injury is not clearly documented, query the provider for clarification.
- *ICD-10-CM Official Guidelines for Coding and Reporting*, Section I.C.19.e.5.a., states, "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 have a 5th or 6th character "5" (for example T36.0X5-).

Coding Clinic Q & A's

Question

A 67-year-old patient went into cardiac arrest at home. The patient was resuscitated by emergency medical services (EMS) and was awake and oriented upon arrival at the emergency department (ED). In the ED, the patient was placed on a cardiac monitor and pulse oximetry. An EKG was performed and confirmed a complete heart block. The patient was subsequently admitted to undergo an emergency pacemaker placement in the cardiac catheterization laboratory. Is it appropriate to assign a code from category I46, Cardiac arrest, or should code Z86.74, Personal history of sudden cardiac arrest, be assigned when a patient has a cardiac arrest outside of the hospital and is resuscitated prior to admission?

Answer

Assign code I46.2, Cardiac arrest due to underlying cardiac condition, since the patient is receiving continued care for the cardiac arrest. This condition meets the definition of a reportable additional diagnosis in requiring clinical evaluation, therapeutic treatment, and diagnostic procedures. This advice is applicable regardless of where the cardiac arrest occurred and/or whether or not the patient is resuscitated.

It is not appropriate to assign code Z86.74, Personal history of sudden cardiac arrest, when the condition is current, and the patient is receiving treatment. This is consistent with the *Official Coding Guidelines*, Section I.C.21.c.4, which states "Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence and therefore may require continued monitoring." Please note that the underlying cause of the cardiac arrest is coded first.

Question

A 74-year-old patient with a history of coronary artery disease (CAD), who is status post coronary artery bypass graft (CABG), presented to the emergency room with complaints of increasing chest pain over the last 3 days. The patient described intermittent chest pain lasting for approximately 20 minutes that started as back pain and bilateral shoulder pain, then radiated to the center of the chest. A proximal stenosis of the vein graft to the obtuse marginal branches with extensive thrombus was seen in the distal graft, which was likely the culprit lesion causing a non-ST elevation myocardial infarction (NSTEMI). It was noted that the patient also had severe native multi-vessel disease and the other vein grafts appeared to be patent. In this case, is it appropriate to assign a code for CAD with angina for the severe native multi-vessel disease that resulted in the MI?

Answer

Assign code I21.4, Non-ST elevation (NSTEMI) myocardial infarction, as the principal diagnosis. Assign code I25.10, Atherosclerotic heart disease of native coronary artery without angina pectrois, for the multi-vessel native CAD, as an additional diagnosis. It would be inappropriate to assign a code for angina in the setting of an MI.

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Coding Clinic Q & A's

Question

We are seeking clarification of the guidance published in *Coding Clinic* Second Quarter 2017, page 10, and First Quarter 2022, page 25, regarding the coding of posterior artery infarction without mention of occlusion, stenosis, embolism, or thrombus. Both cases had a patient with a posterior cerebral artery infarction, with no mention of occlusion, stenosis, embolism, or thrombosis. However, *Coding Clinic* Second Quarter 2017, advised to assign code I63.532, Cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery, while *Coding Clinic* First Quarter 2022, advised to assign code I63.89, other cerebral infarction. What is the correct diagnosis code for posterior cerebral artery infarction without mention of occlusion, stenosis, embolism, or thrombosis?

Answer

Assign code I63.89, other cerebral infarction, for a diagnosis of posterior artery infarction when there is no mention of occlusion, stenosis, embolism, or thrombus.

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The Importance of Accurate Coding

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The Importance of Accurate Coding

- Clean claims
- Decreased risk of being out of the norm and getting records requests (ADRs)
- Decreased denials
- Being able to justify accurate payment
- Quality data monitoring for outcomes
- Specific data for research purposes
- Helps to ensure the patient's treatment is appropriate for them
- Decreased potential to get charges of fraud, waste, or abuse.

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Questions?

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Thank You

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