Coding Clinic Update

Audio Seminar/ Webinar

November 13, 2007

Practical Tools for Seminar Learning
Disclaimer

The American Health Information Management Association makes no representation or guarantee with respect to the contents herein and specifically disclaims any implied guarantee of suitability for any specific purpose. AHIMA has no liability or responsibility to any person or entity with respect to any loss or damage caused by the use of this audio seminar, including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this program. AHIMA makes no guarantee that the use of this program will prevent differences of opinion or disputes with Medicare or other third party payers as to the amount that will be paid to providers of service.

As a provider of continuing education, the American Health Information Management Association (AHIMA) must assure balance, independence, objectivity and scientific rigor in all of its endeavors. AHIMA is solely responsible for control of program objectives and content and the selection of presenters. All speakers and planning committee members are expected to disclose to the audience: (1) any significant financial interest or other relationships with the manufacturer(s) or provider(s) of any commercial product(s) or service(s) discussed in an educational presentation; (2) any significant financial interest or other relationship with any companies providing commercial support for the activity; and (3) if the presentation will include discussion of investigational or unlabeled uses of a product. The intent of this requirement is not to prevent a speaker with commercial affiliations from presenting, but rather to provide the participants with information from which they may make their own judgments.
**Faculty**

**Joanne M. Becker, RHIT, CCS, CCS-P**
Ms. Becker is associate director, Joint Office for Compliance, at the University of Iowa Healthcare, Iowa City, IA. She is also an independent HIM consultant specializing in hospital and physician coding, education, and compliance. Joanne has over 20 years experience in HIM, including education, compliance, physician office, long-term care, and acute care hospital settings.

**Susan Von Kirchoff, MEd, RHIA, CCS, CCS-P**
Ms Kirchoff is a member of the BKD Health Care Group. Susan has 11 years of health information experience in the areas of ICD-9-CM and CPT coding for inpatient and outpatient coding and reimbursement. She has conducted seminars nationally on compliance, coding, documentation, audits, and billing topics. She is currently president of the Arkansas Health Information Management Association.
Table of Contents

Disclaimer .................................................................................................................... i
Faculty ....................................................................................................................... ii
Application of Diagnostic Principles from Coding Clinic.................................................. 1
  Coding Clinic Provides ........................................................................................................ 1
The ICD-9-CM Official Guidelines for Coding and Reporting.................................................. 2
ICD-9-CM Coordination and Maintenance Committee.......................................................... 3
ICD-9-CM Official Coding Guidelines.................................................................................. 3
Clarification of Pain Codes ................................................................................................. 4
  Polling Question #1 ............................................................................................................ 13
Coding Chronic Conditions ................................................................................................. 14
  Polling Question #2 ............................................................................................................ 16
Fractures – Acute vs. Aftercare ......................................................................................... 17
  Polling Question #3 ............................................................................................................ 25
Fluid Overload .................................................................................................................... 25
Post Operative Anemia .................................................................................................... 26
Aborted Stroke .................................................................................................................... 27
Surgical Tears ...................................................................................................................... 28
Lymphoma with Malignant Pleural Effusion ........................................................................ 29
Chest Pain ............................................................................................................................ 30
Vaccination Not Carried Out Because of Parent’s Refusal .................................................... 31
Avian Influenza .................................................................................................................. 33
Coding Clinic Information ................................................................................................. 34
Resource/Reference List .................................................................................................... 35
Audience Questions
Appendix ............................................................................................................................ 38
  CE Certificate Instructions ................................................................................................ 39
Application of Diagnostic Principles from Coding Clinic

- The only official publication for ICD-9-CM coding guidelines and advice as designated by the four Cooperating Parties for ICD-9-CM: AHA, AHIMA, CMS, NCHS
- Quarterly newsletter
- Content developed and approved by the Editorial Advisory Board

Coding Clinic Provides

- Official coding advice and official coding guidelines
- Correct code assignments for new technologies and newly identified diseases
- Articles and topic which will offer practical information and improve data quality
- A conduit for the dissemination of coding changes and/or corrections
- Also available in CD-ROM format, including nearly 20 years of previous advice
The ICD-9-CM Official Guidelines for Coding and Reporting

- Developed to provide assistance in coding and reporting in situations where the ICD-9-CM manual does not provide direction
  - Last updates effective October 1, 2007
  - National Center for Health Statistics (NCHS) www.cdc.gov/nchs/icd9.htm
  - See Coding Clinic, Fourth Quarter 2007, pages 127 through 245.

- Coding and sequencing instructions in ICD-9-CM manual take precedence

The ICD-9-CM Official Guidelines for Coding and Reporting

- “Official” because they have been approved by the Cooperating Parties (AHA, AHIMA, CMS, NCHS)

- The guidelines were named along with the major code sets in the HIPAA final rule (coding and transactions) August 17, 2000 FR
ICD-9-CM Coordination and Maintenance Committee

- The Coordination and Maintenance Committee for ICD-9-CM code development meets twice annually.
- Meetings serve as a public forum to discuss proposed code changes.
- Location: CMS Auditorium; 7500 Security Boulevard; Baltimore, MD.

ICD-9-CM Official Coding Guidelines

- “These guidelines should be used as a companion document to the official version of the ICD-9-CM as published on CD-ROM by the U.S. Government Printing Office (GPO).”
- “These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself.”
Clarification of Pain Codes

- Refer to the updated coding guidelines
  - General pain guidelines
    - Codes from category 338 may be used in conjunction with codes from other categories
    - If the pain is not specified as acute or chronic, do not assign codes from category 338, EXCEPT for post-thoracotomy pain, postoperative pain, neoplasm pain or central pain syndrome

Clarification of Pain Codes

- Pain codes include:
  - Central pain syndrome
  - Acute pain
  - Chronic pain
  - Neoplasm related pain
  - Chronic pain syndrome
Clarification of Pain Codes

- 338.1x - Acute pain
- 338.2x - Chronic pain
  - A code from subcategories 338.1 and 338.2 should NOT be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/management and not management of the underlying condition.

Clarification of Pain Codes

- When the admission/encounter is for a procedure (e.g., spinal fusion, kyphoplasty) aimed at treating the underlying condition (e.g., vertebral fracture, spinal stenosis.) No code from category 338 is assigned.
- When the admission/encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same encounter. The appropriate pain code should be assigned as a secondary diagnosis.
Clarification of Pain Codes

- 338 Codes as principal or first-listed
  - When pain control or pain management is the reason for the admission/encounter
  - The underlying cause of the pain should be reported as an additional diagnosis, if known.

Clarification of Pain Codes

- When an admission or encounter is for a procedure aimed at treated the underlying condition, the condition should be assigned as principal/first-listed.
- No code from category 338 should be assigned.
Clarification of Pain Codes

- When a patient is admitted for insertion of a neurostimulator for pain control, the appropriate pain code is principal/first-listed
- When a patient is admitted for a procedure aimed at treating the underlying cause of the pain and a neurostimulator is inserted during the encounter, a code for the underlying condition is principal/first-listed

Clarification of Pain Codes

- Codes from category 338 may be used with codes that identify the specific site of the pain, if the category 338 code provides additional information
Clarification of Pain Codes

- The sequencing of codes from category 338 with site specific pain codes depends upon the circumstances of the encounter
  - If the encounter is for pain control or pain management, assign the code from category 338 first
  - If the encounter is for any other reason except pain control, and a definitive diagnosis has not been established assign the code for the specific site of pain first

Clarification of Pain Codes

- Pain due to devices, implants, grafts
  - Pain associated with devices, implants or grafts (e.g., painful hip prosthesis) is assigned the appropriate complication code
  - An additional code from category 338 to identify acute or chronic pain
Clarification of Pain Codes

- Postoperative pain
  - Routine or expected postoperative pain immediately after surgery should not be coded
  - Postoperative pain not associated with a specific postoperative complication
  - Postoperative pain associated with a specific postoperative complication

When postoperative pain is reported as a secondary diagnosis:
  - The provider's documentation must support
  - Consider coding guidelines when patients are admitted to inpatient care following outpatient surgery or observation
Clarification of Pain Codes

- Neoplasm related pain
  - Code 338.3 is assigned to pain documented as being related to, associated with, or due to cancer
  - This code is assigned whether the pain is acute or chronic

- Chronic pain syndrome

Clarification of Pain Codes

- 43 year old patient admission for diagnostic work-up to identify the etiology of excruciating disabling lower back pain with severe pain in both lower extremities. Physician thought the pain was related to a motor vehicle accident that the patient had been involved in several years ago.

- Final diagnostic statement: Chronic pain syndrome and chronic lower back pain with acute exacerbation of lower back pain and lower extremity pain.
Clarification of Pain Codes

Answer:

724.2 - Lumbago
729.5 - Pain in limb
338.19 - Chronic pain syndrome
907.3 - Late effect of injury to nerve root(s)

Clarification of Pain Codes

- Patient was involved in a motorcycle accident two months ago and sustained multiple trauma. History of pelvic fracture with external fixator. Patient complains of severe hip pain.
Clarification of Pain Codes

- 719.45 - Hip pain
- 905.1 - Late effect of injury
- V54.19 - Follow-up healing fracture

Example: Patient with stage IV metastatic rectal carcinoma is admitted for pain control and to establish palliative care. She was started on a morphine PCA on admission and transitioned to PO morphine after 24 hours.

She was also started on Dexamethasone for bone pain. Patient is not interested in further radiation treatment at this time; arrangements were made with the local hospice.
Clarification of Pain Codes

- 338.3 - Neoplasm related pain
- 199.1 - Metastatic rectal carcinoma
- 154.1 - Rectal carcinoma
- 733.90 - Disorder of bone/cartilage (bone pain)

Polling Question #1

Which of the following code should be used when the physician states “localized pain”

* 1 338.0 Central pain syndrome
* 2 338.2 Chronic pain
* 3 338.19 Other acute pain
* 4 None of the above
Coding Clinic Update

Coding Chronic Conditions

• Question: QIOs not allowing coding of chronic conditions (COPD)
• Guidelines for selecting “other diagnoses” include
  • Severity of the condition
  • Consideration of alternative measures in the treatment of the principal diagnosis
  • Increased nursing care
  • Use of diagnostic or therapeutic services
  • Close monitoring of medications
  • Modifications of nursing care plans

Coding Chronic Conditions

• If there is documentation in the medical record to indicate that the patient has a chronic condition, it should be coded.
• For outpatient services, chronic conditions that require or affect patient care treatment or management should be coded.

Coding Clinic, Third Quarter, 2007
Coding Chronic Conditions

- Examples of chronic conditions:
  - Hypertension
  - Parkinson’s disease
  - Chronic obstructive pulmonary disease
  - Diabetes mellitus

Coding Chronic Conditions

- Guidelines for outpatient services:
  - Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)
  - Code all conditions that coexist at the time of the encounter and require or affect patient care, treatment or management
Coding Chronic Conditions

- Do not code conditions that were previously treated and no longer exist
- Conditions that do not require treatment or management, or affect patient care are not reported.

Polling Question #2

Which of the following chronic conditions should be coded for an inpatient admitted for Myocardial infarction?

*1 Osteoarthritis, diabetes mellitus
*2 Bunion, history of pneumonia, s/p hiatal hernia
*3 Atrial Fib, Lupus, CAD
*4 Both 1 & 3
Fractures - Acute vs. Aftercare

- Coding guidelines were revised in 2006 for coding pathological and traumatic fractures.
  - Key points to remember...

Fractures - Acute vs. Aftercare

- Pathological fractures are reported using subcategory code 733.1x when the fracture is newly diagnosed
- May be used while the patient is receiving active treatment for the fracture
- Active treatment includes surgical treatment, ER encounter, E/M and treatment by a new physician
Fractures - Acute vs. Aftercare

- Traumatic fractures are coded using the acute fracture codes (800 - 829) while the patient is receiving active treatment for the fracture
- Active treatment includes surgical treatment, ER encounter, E/M and treatment by a new physician

Fractures - Acute vs. Aftercare

- Aftercare codes are not assigned when treatment is directed at a current acute disease or injury
- Assigned after active treatment of the fracture is completed and for routine care of the fracture during the healing or recovery phase.
Fractures - Acute vs. Aftercare

- Examples of fracture aftercare:
  - Cast change or removal
  - Removal of external/ internal fixation device
  - Medication adjustment
  - Follow up visits following fracture treatment

Fractures - Acute vs. Aftercare

- Care for complications of surgical treatment or orthopedic device should be coded with the appropriate complication codes
- Codes that are described as “malunion” or “nonunion” should be coded with the appropriate codes
Fractures - Acute vs. Aftercare

• Guidelines for E codes were revised in November, 2006
  • E-codes (external cause of injury codes) may be assigned while the acute fracture codes are applicable.
  • Exception: reporting injuries other than fractures
    • For other types of injuries, poisonings, and adverse effect of drugs, assign the appropriate E Code only for the initial encounter, not for encounters for subsequent treatment

Example:
• Patient is admitted to Hospital A with severe fracture of shaft of the femur; transferred to Hospital B for treatment.
• Both hospital A and B would assign 821.01 and the appropriate E code
Fractures - Acute vs. Aftercare

- **Example:** At hospital A, a patient presents with severe traumatic fracture and soft tissue injury. The physician applies an external fixation device and discharges the patient to allow the soft tissue swelling to resolve. The patient is later readmitted for ORIF.
- The acute fracture is assigned for both admissions, along with the appropriate E code(s)

Fractures - Acute vs. Aftercare

- **Aftercare management**
  - Patients who have had fracture treatment usually require aftercare for removal of wires, pins, plates or external fixation devices.
  - Aftercare can also include cast change or removal, medication adjustments or follow-up visits for healing fractures.
Fractures - Acute vs. Aftercare

- V codes are provided for admissions/encounters for these situations:
  - V53.7 - Admission for fitting/adjustment of orthopedic device (brace, cast, etc.)
  - V54.01 - Encounter for removal of internal fixation device
  - V54.02 - Encounter for lengthening/adjustment of growth rod
  - V54.89 - Other orthopedic aftercare

Fractures - Acute vs. Aftercare

- Codes V54.10 - V54.29 are used to provide greater specificity in identifying the fracture site being treated, as well as differentiating between traumatic and pathologic fractures
**Fractures - Acute vs. Aftercare**

- *Example:* Patient presents with a comminuted fracture of the distal radius and ulna. In the office the physician performed closed reduction and casting. The patient was later admitted to the hospital for ORIF. Several weeks later the patient returns to the physician’s office for x-rays, cast change and post-op examination.

For both the initial physician’s office visit and the hospital admission, assign the code 813.44, fracture of radius with ulna, lower end, along with the appropriate E codes.

- For the office visit for aftercare, assign code V53.7, Fitting and adjustment of other orthopedic devices, and V54.12, aftercare for healing traumatic fracture of the lower arm.
Fractures - Acute vs. Aftercare

- Insufficiency fracture
  - An insufficiency fracture is a pathological fracture
  - Patient was admitted for treatment of insufficiency fracture of the sacrum and severe osteoporosis. How should this be coded?

Fractures - Acute vs. Aftercare

- Assign code 733.13 - pathological fracture of the vertebrae as the first listed diagnosis
- Assign code 733.00 - osteoporosis as an additional diagnosis
Polling Question #3

Typical routine healing time for an adult fracture and pediatric fracture is which one of the following?

* 1 8 weeks for both an adult and pediatric
* 2 12 weeks for both an adult and pediatric
* 3 12 weeks for an adult and 8 weeks for a pediatric
* 4 None of the above

Fluid Overload

- Fluid overload and CHF
  - Patient is admitted in congestive heart failure due to fluid overload and noncompliance with dialysis treatment, assign the CHF code
  - Patient is admitted with ESRD and treatment for fluid overload and no evidence of current CHF (patient has a history of CHF), assign the fluid overload code

*Coding Clinic, Third Quarter, 2007, page 11*
Post Operative Anemia

- Previous *Coding Clinic* advice stated:
  - “If the physician documents postoperative anemia in the medical record, but does not label the condition as a complication, assign code 285.1, Acute posthemorrhagic anemia.”
  - Question: Is this advice still valid?

Post Operative Anemia

- When postoperative anemia is documented without mention of acute blood loss, code 285.9
- When documentation supports postoperative anemia due to acute blood loss, code 285.1 is assigned.
- Revisions were made in the Alphabetic Index in 2004

Anemia
postoperative
  due to ? acute?  blood loss 285.1
  other 285.9
Post Operative Anemia

• Hints:
  - Some blood loss is expected after surgery and not described as a complication or anemia - do not code
  - If “anemia” is documented following surgery, query the physician
  - The fact that the patient received blood transfusions is not sufficient to code post operative anemia

Aborted Stroke

• Aborted stroke vs. aborted MI
  - Aborted MI – 411.1, Intermediate coronary syndrome
  - Aborted stroke – 434.91, Cerebral artery occlusion with cerebral infarction

Coding Clinic, First Quarter, 2007, page 23
Coding Clinic, Third Quarter, 2007, page 13
Surgical Tears

• Question: Patient presented with a left upper quadrant retroperitoneal cystic mass; the patient underwent radical excision of retroperitoneal cystic mass with adrenalectomy. During the procedure the surgeon noted, “a small capsular injury of the spleen, which was hemostatic.” The injury did not require repair. A follow-up EGD was performed that did show a serosal injury to the stomach, which was repaired.

Answer: Query the provider
• Omit codes if not clinically significant
• When a tear is documented in the OP note, the surgeon should be queried as to whether the small tear was an incidental occurrence or whether the tear should be considered a complication
**Surgical Tears**

- **Dural tear during surgery**
  - A dural tear is always clinically significant due to the potential for cerebrospinal fluid leakage

*Coding Clinic*, First Quarter, 2006, page 15

---

**Lymphoma with Malignant Pleural Effusion**

- **Question:** How should a diagnosis of lymphoma with malignant pleural effusion be coded?

*Coding Clinic*, Third Quarter, 2007, page 3
**Lymphoma with Malignant Pleural Effusion**

- **Answer:** Assign code 202.80, Other lymphoma and code 197.2, Secondary malignant neoplasm of respiratory and digestive systems
- There are no guidelines that prohibit assigning these codes together.

**Chest Pain**

- **Question:** Patient was admitted to the hospital with chest pain. The physician documents chest pain, most likely of gastrointestinal (GI) origin. Would code 786.59, Chest pain, other, or 536.9, Unspecified functional disorder of the stomach, be the correct code assignment?

_Coding Clinic, First Quarter, 2007, page 19_
Chest Pain

- Answer: Query the physician regarding the specific GI condition.
- If the physician cannot provide a definitive answer regarding the nature of the GI condition, assign 786.50, Chest pain as the principal diagnosis.

Vaccination Not Carried Out Because of Parent’s Refusal

- Question: What is the correct code assignment when a child’s vaccination is not carried out because of parental refusal?
Vaccination Not Carried Out Because of Parent’s Refusal

- Answer: Assign code V64.05, Vaccination not carried out because of caregiver refusal, when a vaccination is not provided because of the parent’s refusal.
- Revised text in 2008

Vaccination Not Carried Out Because of Parent’s Refusal

- The V64.0x category, Vaccination not carried out because of contraindication, was expanded and retitled in October, 2005.
- All codes under V64.0x are additional codes only.
Avian Influenza

- Influenza due to identified avian influenza (avian influenza)
  - Code only confirmed cases of avian influenza. This is an exception of the hospital inpatient guidelines on unconfirmed diagnoses.
  - “Confirmation” does not require documentation of a positive lab test specific for avian influenza

Avian Influenza

- If the provider records “suspected”, “possible” or “probable” avian influenza, use a code from the 487 category.
- Code 488, Influenza due to identified avian influenza virus, should not be assigned
Coding Clinic

• Submitting questions to Coding Clinic
  • www.ahacentraloffice.org
  • Download the form
  • Fax or mail your question

Central Office on ICD-9-CM
Coding Advice
American Hospital Association
One North Franklin
Chicago, IL 60606

Request for Coding Advice
Please formulate and submit the specific question you have regarding appropriate
ICD-9-CM coding. No more than one (1) question may be submitted per request.
Pertinent documentation that will provide information to assist the Central Office in
determining the appropriate code for diagnosis or procedure must be included. Such
documentation may include copies of discharge summaries, history and physical
examinations, consultations, diagnostic reports, operative reports, or journal articles.
Please submit other relevant information in a typed format (i.e., physician notes,
nursing notes). Questions submitted without supporting documentation will be
returned unanswered.
Resource/Reference List

- AHA Coding Clinic: First Quarter 2007
  Second Quarter 2007
  Third Quarter 2007
  Fourth Quarter 2007
- National Center for Health Statistics; ICD-9-CM Coordination and Maintenance Committee:
  http://www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm
  Register for the Meetings:
  http://www.cms.hhs.gov/apps/events/
  Also see:
  http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes

Audience Questions
Audio Seminar Discussion

Following today’s live seminar
Available to AHIMA members at
www.AHIMA.org
Click on Communities of Practice (CoP) - icon on top right
or sign on to MyAHIMA
AHIMA Member ID number and password required - for members only

Join the Coding Community from your Personal Page then under Community Discussions you will be able to:
- Discuss seminar topics
- Network with other AHIMA members
- Enhance your learning experience

AHIMA Audio Seminars/Webinars

Visit our Web site
http://campus.AHIMA.org
for information on the seminar schedule.
While online, you can also register for seminars or order CDs and pre-recorded Webcasts of past seminars.

2008 Seminar/Webinar schedule now posted
**Upcoming Seminars/Webinars**

- **Compliance Programs for Physician Practices**  
  *Faculty: Dianne Wilkinson, RHIT*  
  *November 15, 2007*

- **Coding Urology (Male) Procedures**  
  *Faculty: Jean Jurek, MS, RHIA, CPC and Jerome Ndayishimiye, MS, RHIA, CIIC*  
  *November 29, 2007*

---

**Thank you for joining us today!**

Remember – sign on to the AHIMA Audio Seminars Web site to complete your evaluation form and receive your CE Certificate online at:


Each person seeking CE credit must complete the sign-in form and evaluation in order to view and print their CE certificate.

Certificates will be awarded for AHIMA and ANCC Continuing Education Credit.
Appendix

CE Certificate Instructions ................................................................. 26
To receive your

**CE Certificate**

Please go to the Web site


click on

“Complete Online Evaluation”

You will be automatically linked to the CE certificate for this seminar after completing the evaluation.

*Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.*