Goals

• Understand what Coding Clinic for ICD-10-CM is, why it is important, and how to access it

• Review pertinent Coding Clinic entries from 2012 Through Q1 2017 so that we can code compliantly

• Due to the amount of materials to be covered, we won’t be able to go over associated A&P

• All ICD-10-CM references from ICD-10 Coding Clinic onset are included here for reference, but we won’t have time to discuss them all. Those not discussed have 🐻 in the upper left corner.
What’s Coding Clinic?

- Cooperative effort between American Hospital Association, National Center for Health Statistics, AHIMA, and Centers for Medicare and Medicaid Services

- Includes rules not addressed in Official Guidelines for Coding and Reporting in ICD-10-CM

- Enforced for all CMS claims, provider, hospital, risk adjustment, etc.

- Sometimes lead to new Guidelines. Sometimes, not
What’s Coding Clinic?

• Provides data on new ICD-10-CM codes, much like Insider’s View provides data on new CPT codes. Example:

Q4 2016 “Irritable bowel syndrome

Codes K58.1, Irritable bowel syndrome with constipation, K58.2, Mixed irritable bowel syndrome, and K58.8 Other irritable bowel syndrome, have been created to distinguish types of irritable bowel syndrome.

Irritable bowel syndrome (IBS) is characterized by abdominal pain and discomfort, bloating and changes in bowel movement. There are four types of IBS that are based on the predominant alteration in stool consistency: IBS-C, with constipation; IBS-D, with diarrhea; IBS-M, mixed IBS; and IBS-U, unsubtyped IBS (diarrhea and constipation less than 25% of the time).

IBS is a functional gastrointestinal disorder that affects 10% to 15% of the adult population. A thorough history and examination are important in obtaining the diagnosis. Colonoscopy and imaging are necessary to rule out other conditions.

The type of IBS and symptoms determines the treatment. Medication may reduce constipation and diarrhea. Medications that affect serotonin levels or serotonin receptons have been noted to improve symptoms by working on the nerves of the bowel.”
What’s Coding Clinic?

- Often embedded into software, for example, Encoder Pro, for an added fee, and linked to codes

- Available through AHA for $375 a year (single user)
  - Essential to: inpatient and risk adjustment coding
  - Very useful in all other coding environments – will become increasingly important for compliance

- Published quarterly
What’s Coding Clinic?

• Contents of Coding Clinic are copyrighted, so all slides today contain the references in my own language.

• Coding Clinic entries are referenced by year and quarter, for easy access.

• Lots to cover so let’s get started!
General Advice
The Official Guidelines for Coding and Reporting, Section IV.I. state, ‘Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

<table>
<thead>
<tr>
<th>This is a definitive diagnosis: CODE IT</th>
<th>This is a probable diagnosis: CODE SYMPTOMS INSTEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Evidence of” in a radiology report</td>
<td>“Appears to be” in a radiology report</td>
</tr>
</tbody>
</table>

Coding Clinic for ICD-10-CM, Q1 2014
Coding from Path/Lab reports

- Consistency with the provider diagnosis is key to using more granular diagnoses found in pathology or laboratory reports:

<table>
<thead>
<tr>
<th>USE THE LAB/RAD REPORT TO CODE</th>
<th>USE THE PROVIDER DIAGNOSIS TO CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology provides a DX that is more granular than the provider (ie, “displaced fracture of neck of right scapula” vs provider’s “scapula fracture”)</td>
<td>Radiology provides a DX that is different from the provider (ie, “displaced fracture of neck of right scapula” vs provider’s “scapular sprain”)</td>
</tr>
<tr>
<td>Lab provides a DX that is more granular than the provider (ie, “pneumococcal pneumonia” vs provider’s “pneumonia”)</td>
<td>Lab provides a DX that is different from the provider (ie, “pneumococcal pneumonia “vs provider’s “bronchitis”</td>
</tr>
<tr>
<td>Radiology provides the exact site of a cerebral infarct or hemorrhagic stroke; provider only documents “cerebral infarct” or “hemorrhagic stroke”</td>
<td></td>
</tr>
</tbody>
</table>

Coding Clinic for ICD-10-CM, Q3 2016; Q3 2014
Code number instead of diagnosis

- Issue exists because of EHRs
- Documentation must support code assignment
- Codes alone are **not** sufficient documentation

<table>
<thead>
<tr>
<th>IF THE PROVIDER DOCUMENTS THIS</th>
<th>CODER REPORTS THIS</th>
<th>BECAUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E10.9</td>
<td>nothing</td>
<td>there is no documentation</td>
</tr>
<tr>
<td>E10.9 Diabetes</td>
<td>E11.9 Type 2 Diabetes, uncomplicated</td>
<td>the default for “diabetes” is type 2, uncomplicated</td>
</tr>
<tr>
<td>E10.9 Type 1 diabetes</td>
<td>E10.9 Type 1 diabetes, uncomplicated</td>
<td>We have enough information in the code description to select uncomplicated diabetes</td>
</tr>
</tbody>
</table>
Using prior encounters

• Code only the current encounter

• Each date of service or inpatient admission must stand alone

• Past conditions may not be clinically relevant (can’t code from PMH)

• Coders need to educate their providers on this point.
Arrows in documentation

- Up and down arrows cannot be the basis for a diagnosis
- May indicate a change, not necessarily an abnormal condition
“Code first”

- “Code first” refers to the pairing of codes, not necessarily the final order of all codes on a claim.

- For example, a patient with sepsis and hypertensive heart failure, being treated for sepsis:
  - A note under I50 Heart failure says to “code first” the hypertension.
  - Coders should sequence the sepsis, then HTN (I11.0), then heart failure.

Coding Clinic for ICD-10-CM, Q1 2016
Guideline clarification

"The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis."

- Has nothing to do with clinical documentation improvement efforts
- Simply means a coder’s responsibility is, for example, to code sepsis if sepsis is documented, regardless of whether the provider is using new clinical criteria, old clinical criteria, the ICD-10-CM definition, or his or her own judgment.
- Coders are not to disregard documentation after making a clinical assessment. It is not their role.

Coding Clinic for ICD-10-CM, Q4 2016
“With”

- A causal relationship is assumed between two disorders linked by “with” in the Index

- It is not required that the two disorders linked by “with” in the Index be listed together in the medical documentation, ie, in A&P or even on the same page

- Causal relationships between two disorders that are not linked by the word “with” in the Index must be documented as etiology and manifestation in the medical record in order for them to be linked in the coding

Coding Clinic for ICD-10-CM, Q1 2016
“With”

- Requires study!

- Abuse
  - alcohol
  - with
  - anxiety disorder
  - mood disorder
  - psychosis
  - sexual dysfunction
  - sleep disorder

- Dementia
  - with
  - Parkinsonism
  - Parkinson’s disease

- Hematuria
  - with glomerular lesion

Coding Clinic for ICD-10-CM, Q1 2016
“With”

- Requires study!

- Diabetes
  with
    
    ....
    dermatitis E11.620
    foot ulcer E11.621
    gangrene E11.52

    ....

Coding Clinic for ICD-10-CM, Q1 2016
Infectious disease
Viral Sepsis

- Use code A41.89 Other specified sepsis to report viral sepsis (even though A30-A49 classified as bacterial disorders)
- Report a code from B97 Viral agents as the cause of diseases classified elsewhere (to identify virus)

Coders cannot assign sepsis codes based on clinical criteria (provider must diagnose sepsis)
Neoplasms
Neobladder cancer coding

A neobladder created from small intestine develops carcinoma. Is this reported as cancer of the bladder or cancer of the small intestine?

• Code bladder cancer, as the intestine is acting as bladder in this case.

C67.9 Malignant neoplasm of bladder, unspecified

Coding Clinic for ICD-10-CM, Q1 2016
Blood and blood-forming organs
Immunosuppressants can help patients with autoimmune disorders like lupus, Crohn’s, RA, or myasthenia gravis, or for patients with transplants. An immunocompromised state due to medication is a therapeutic state and therefore is not reported. The long term use of immunosuppressants is reported with:

- **Z79.899** Other long-term (current) drug therapy

If the immunocompromised state exists without immunosuppressants or a documented underlying cause (ie, AIDS, etc), report:

- **D89.9** Disorder involving the immune mechanism, unspecified
Trapped temporal horn

- Woman with enlarging right temporal horn and right cavity near the lateral ventricle had been previously diagnosed with pilocytic astrocytoma is status post intraventricular tumor resection, endoscopic membrane lysis, and ventricular peritoneal shunt placement. The patient was admitted for trapped right temporal horn and was also diagnosed with recurrent astrocytoma, hydrocephalus, and encephalopathy.

AC71.9 Malignant neoplasm of brain, unspecified
G91.4 Hydrocephalus in diseases classified elsewhere

Entrapment of the temporal horn is a form of focal hydrocephalus caused in this case by the brain tumor, and is therefore represented by the code for the astrocytoma.
Endocrine and nutrition
Diabetic cataracts

- Although we have all been trained otherwise, it is now believed there IS a link between cataracts and diabetes.

- The causal relationship between diabetes and cataracts is established, along with many other manifestations, in the Index under Diabetes/with
Diabetic gastroparesis

• Be specific when coding autonomic (poly)neuropathy in diabetes. Use a second code, for example K31.84 Gastroparesis, to identify the type of autonomic (poly)neuropathy, with a diabetes code ending in .43

• This may help reduce queries from payers and provides granularity to the codes reported in the claim.
Diabetes with hyperglycemia

• A patient with diabetes mellitus and hyperglycemia is experiencing a complication of diabetes, and the hyperglycemia is reported with .65, for example:

E11.65  Type 2 diabetes with hyperglycemia

• The hyperglycemia must be documented by the provider

• “Uncontrolled” is not the same as hyperglycemia.

Coding Clinic for ICD-10-CM, Q3 2013; Q1, 2017
Diabetic ketoacidosis

- Hyperglycemia is inherent in DKA. Do not code in addition to DKA

- The default for DKA, unspecified type is Type 1. Nearly all DKA is type 1. This is different from guidelines regarding unspecified type.

- ICD-10-CM does not allow Type 2 diabetes with DKA to be reported. If a patient is documented as having Type 2 diabetes with DKA, use:
  - E13.10 Other specified DM with DKA without coma, or
  - E13.11 Other specified DM with DKA with coma

- Watch for change

Coding Clinic for ICD-10-CM, Q1, 2013; Q3 2013; Q2 2016
DM and metabolic encephalopathy

- Acute metabolic encephalopathy secondary to hypoglycemia is reported with a diabetic code ending in .641 or .649, for hypoglycemia with or without coma; and G93.41 Metabolic encephalopathy.

- Never report E16.2, Hypoglycemia, unspecified, found in the Index under "encephalopathy, hypoglycemic," as this code is not for diabetics.

- Any note in the record indicating adverse effect, underdosing, and/or poisoning would lead to additional codes.

Coding Clinic for ICD-10-CM, Q3 2016
Mental and Behavioral
Nicotine induced disorders

- Do not report F17.218 Nicotine dependence, with other nicotine-induced disorders, for a current smoker with COPD unless a causal link is documented by the provider.

- The provider must document whether nicotine dependence is in remission, or is a past history.

- In Index: Smoker – see Dependence, drug, nicotine
Prolonged remission

• If the provider documents “prolonged remission” for substance dependence, report it as a personal history since there are no remission codes in substance dependence
Alcohol abuse and withdrawal

- Alcohol withdrawal in ICD-10-CM can only be reported with dependence, not with abuse.

- By definition, withdrawal would mean dependence, but there is no guidance from Coding Clinic to assume dependence. Instead, if the provider documents alcohol abuse and withdrawal, query the provider.
Chronic depression

- Documented “chronic depression” or “depression” is reported as:

  F32.9 Major depressive disorder, single episode, unspecified.
Speech therapy

• For a patient undergoing speech therapy for echolalia and other speech disorders due to the patient’s autism, sequence the codes as follows:

  F80.89  Other developmental disorders of speech and language
  R48.8   Other symbolic dysfunctions
  F84.0   Autism disorder

Autism would not be sequence first because of the range of manifestations of autism. The guideline about signs and symptoms therefore does not apply to autism.

Coding Clinic for ICD-10-CM, Q1, 2017
Complicated bereavement

• “Complicated bereavement” should be reported with F43.21 Adjustment disorder with depressed mood. This can be used for any bereavement, family or otherwise.

• “Bereavement” should be reported with Z63.4, Disappearance and death of family member, and can only be used for a family member.
Nervous System
Alzheimer’s disease

Dementia is inherent in Alzheimer’s disease. If the provider does not document dementia, but documents Alzheimer’s disease, report:

**G30.9** Alzheimer’s disease, unspecified

**F02.80** Dementia in other diseases classified elsewhere without behavioral disturbance

- This is based on the Index entry requiring two codes, one bracketed.

- **Sheri’s note:** This convention also affects Lewy body and Pick’s disease when dementia is not noted
Neurological deficits due to stroke

- Hemiplegia is not inherent to stroke or acute cerebrovascular accident (CVA) and should be reported separately.

- If the hemiplegia resolves, with or without treatment, before the conclusion of the episode of care (ie, discharge) the hemiplegia should be reported. The hemiplegia affects the care that the patient receives.

- This rule applies to any neurological deficit(s) caused by a CVA.

Coding Clinic for ICD-10-CM, Q1, 2014
Acute cerebral infarct with left-sided weakness

- If “right-sided weakness” or “left-sided weakness” is linked in documentation to a cerebral infarct or cerebral hemorrhage, it should be reported as hemiplegia. For example an acute infarct:
  I63.9  Cerebral infarction, unspecified.
  G81.94  Hemiplegia, unspecified affecting left nondominant side

- The linkage cannot be assumed
- If the weakness is described, as “residual right arm weakness” or lower limb weakness, choose the appropriate monoplegia code from I69.34-.

Coding Clinic for ICD-10-CM, Q1 2015; Q1 2017
A dural tear existing from a previous epidural injection is reported with:

**G96.11  Dural tear**

In ICD-10-CM, “Non-traumatic dural tear” is indexed to G96.11. Also report:

**Y84.8  Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure**

The tear happened before the procedure and is not related to the procedure.

**G97.41** is assigned if the durotomy occurs during a current procedure.

Coding Clinic for ICD-10-CM, Q4, 2014
Acute inflammatory demyelinating polyneuropathy

- Report acute inflammatory demyelinating polyneuropathy with:

  G61.0  Guillain-Barre syndrome
Anti-MAG peripheral neuropathy

- Anti-myelin-associated glycoprotein (anti-MAG) peripheral neuropathy is reported with:

  **G62.89** Other specified polyneuropathies
Eye and Ear
Bilateral cataracts

- When a patient has bilateral cataracts, and comes in for surgery on the first one, the diagnosis could reflect the bilateral condition.

- CPT reporting will capture laterality.

- For the second cataract surgery, a unilateral condition is reported, since the first eye no longer has a cataract.

Coding Clinic for ICD-10-CM, Q1, 2016
Circulatory system
Q1 2013 Default for MI

- Report I21.3 ST elevation (STEMI) myocardial infarction of unspecified site, for unspecified myocardial infarct, even though this specifies STEMI

- If the MI is documented by vessel without reporting STEMI/NSTEMI, report the STEMI code for that vessel

- If the MI is documented by vessel and as NSTEMI, report the NSTEMI code, I21.4 Non-ST elevation (NSTEMI) myocardial infarction
Atrial appendage thrombus

An atrial appendage thrombus is reported with:

I51.3  Intracardiac thrombosis, not elsewhere classified
The American College of Cardiology and American Heart Association has designated “Stage A heart failure” as a risk of heart failure.

Stage A heart failure is NOT heart failure, and should not be reported with I50.9.

Instead, report:

Z91.89 Other specified personal risk factions, not elsewhere classified
Heart failure with pleural effusion

- Pleural effusion is often seen in CHF, and should be reported secondarily to CHF only if the pleural effusion is the subject of therapeutic intervention or diagnostic testing. Report the pleural effusion with:

  J91.8 Pleural effusion in other conditions classified elsewhere

Coding Clinic for ICD-10-CM, Q2, 2015
Heart failure

The coder may interpret documentation as diastolic or systolic heart failure based on this nomenclature:

<table>
<thead>
<tr>
<th>Alternative nomenclature for DIASTOLIC HEART FAILURE</th>
<th>Alternative nomenclature for SYSTOLIC HEART FAILURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HFpEF</td>
<td>HFrEF</td>
</tr>
<tr>
<td>Heart failure with preserved ejection fraction</td>
<td>Heart failure with reduced systolic function</td>
</tr>
<tr>
<td></td>
<td>Heart failure with low ejection fraction</td>
</tr>
<tr>
<td></td>
<td>Heart failure with reduced ejection fraction</td>
</tr>
</tbody>
</table>

Coding Clinic for ICD-10-CM, Q1, 2016
Decompensated heart failure

- Decompensated heart failure indicates an acute on chronic condition, and should be reported as such.
Linkage in CHF

If the provider documents congestive heart failure and also documents either systolic or diastolic dysfunction, but does not link the dysfunction to the CHF, report:

I50.9 Heart failure, unspecified

Report a linkage between CHF and hypertension even when it is not documented.
For catecholaminergic polymorphic ventricular tachycardia (CPVT), report:

**I47.2  Ventricular tachycardia**

- Catecholaminergic identifies arrhythmias initiated during emotional stress or physical exertion, when the nervous system uses natural adrenaline to stimulate physical performance. Polymorphic means that the arrhythmia is coming from multiple locations in the heart’s conduction system. In most cases, normal rhythm is reestablished when the VT stops spontaneously. In some cases, the VT can degenerate into ventricular fibrillation, causing sudden death.
Respiratory system
Acute respiratory failure

For a patient who presents with smoke inhalation and acute respiratory failure, report:

**J96.00** Acute respiratory failure, unspecified whether with hypoxia or hypercapnia

**T59.811A** Toxic effect of smoke, accidental (unintentional), Initial encounter

**J70.5** Respiratory conditions due to smoke inhalation

Coding Clinic for ICD-10-CM, Q4, 2013
Respiratory failure

- For documentation stating “respiratory distress” in a child or adult, code
  R06.00    Dyspnea
Acute exacerbation of COPD

For documented acute exacerbation of COPD due to acute bronchitis, report:

- J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
- J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
- J20.9 Acute bronchitis, unspecified

Influenza is excluded from “acute lower respiratory infection” in J44.0, because influenza involves upper and lower respiratory infections. Report the infections separately.

Coding Clinic for ICD-10-CM, Q3, 2016
Acute exacerbation of COPD

For documented acute exacerbation of COPD with acute exacerbation of moderate persistent asthma, report:

**J44.1** Chronic obstructive pulmonary disease with (acute) exacerbation

**J45.41** Moderate persistent asthma with (acute) exacerbation

Coding Clinic for ICD-10-CM, Q1, 2017
Pneumonia and COPD

- Aspiration pneumonia with COPD is NOT reported with
  
  **J44.0** Chronic obstructive pulmonary disease with acute lower respiratory infection

- Instead, assign codes
  
  **J44.9** COPD, unspecified
  **J69.0** Pneumonitis due to inhalation of food and vomit
Pneumonia and hemoptysis

- Because “hemorrhagic” is no longer a nonessential modifier in the Index for pneumonia, it should be reported separately when it occurs, with:
  - J18.9 Pneumonia, unspecified organism
  - R04.2 Hemoptysis
A patient with pulmonary hypertension, COPD and cor pulmonale is diagnosed with “right heart failure, decompensated cor pulmonale secondary to severe pulmonary hypertension” in this encounter.

- Unfortunately the Index under “pulmonary hypertension with acute cor pulmonale” leads to:
  - I26.09 Other pulmonary embolus with acute cor pulmonale.
    - I26.09 is not appropriate since the patient does not have a pulmonary embolism.

Correct coding is:
- I50.9 Heart failure, unspecified
- I27.81 Cor pulmonale (chronic)
- I27.2 Other secondary pulmonary hypertension
- J44.9 Chronic obstructive pulmonary disease, unspecified, as additional diagnoses.

NCHS will consider modifying the codes describing pulmonary embolism with cor pulmonale.

Coding Clinic for ICD-10-CM, Q4, 2014
Digestive system
Q4 2012 Crohn’s disease

When a patient presents with Crohn’s disease of the small intestine with a rectal abscess, report:

K50.014 Crohn’s disease of small intestine with abscess

K61.1 Rectal abscess

Codes in category K50 describe intestinal abscess only, and rectum is not part of intestine.

Coding Clinic for ICD-10-CM, Q4, 2012
Shock liver

Report “shock liver” with either:

K72.00  Acute and subacute hepatic failure, without coma
K72.01  Acute and subacute hepatic failure, with coma
Nontraumatic acute liver injury

- Sometimes, the liver is documented as having an injury with no sign of trauma. Acute nontraumatic liver injury is reported as the exact nature of the liver problem, for example, liver failure.
Hyperplastic polyp in descending colon

Report hyperplastic polyp in the descending colon with:

**K63.5  Polyp of colon**
Typically hyperplastic polyps of the colon are slow-growing and not pre-cancerous – they are not neoplastic in nature.

For encounters following removal of the hyperplastic polyp, report **Z87.19  Personal history of other diseases of the digestive system**

Do not report **Z806.01-** because a hyperplastic polyp is not neoplastic in nature.
Also report a history of rectal polyps with **Z87.19.**

Coding Clinic for ICD-10-CM, Q2, 2015, Q1 2017
Foreign body in esophagus

A foreign body in the esophagus may present with no inflammation, tissue damage, or signs of injury. When this occurs, report:

T18.198- Other foreign object in the esophagus causing other injury

An esophageal FB is a medical emergency, due to the potential of serious complications to the airway, esophagus, and digestive tract.
Follow-up after polyp removal

A patient has ad adenomatous polyps removed from his colon, and is being seen six months later for a follow-up exam. This is reported as:

Z09 Encounter for follow up examination after completed treatment for conditions other than malignant neoplasm
Z86.010 Personal history of colonic polyps
Hepatic encephalopathy

- Hepatic encephalopathy is not synonymous with hepatic failure with hepatic coma. The default is:
  
  **K72.90** Hepatic failure, unspecified without coma

- A patient with hepatic encephalopathy of chronic Hep C would be reported as:
  
  **B18.2** Chronic viral hepatitis  
  **K72.10** Chronic hepatic failure without coma

Coding Clinic for ICD-10-CM, Q2, 2016 and Q1, 2017
Cyclical vomiting syndrome

- For documented cyclical vomited syndrome, report

**K31.89** Other diseases of the stomach and duodenum
And a code from R11 Nausea and vomited to identify the symptoms.

It is appropriate to capture an additional code to describe symptoms when reporting a nonspecific code.

Coding Clinic for ICD-10-CM, and Q1, 2017
Skin and subcutaneous
A pressure injury is reported as a pressure ulcer and is coded to the site and stage. This is just new terminology from the National Pressure Ulcer Advisory Panel.
Subcutaneous radionecrosis

- There is no code specific to soft tissue radionecrosis.

- Do not report codes for skin necrosis.

- Instead, report

- **L59.8** Other specified disorders of skin and subcutaneous tissue

- **Y84.2** Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient or later complication without mention of misadventure at the time

Coding Clinic for ICD-10-CM, Q1, 2017
Musculoskeletal system
Cervical disc disorders

- The instructional note at category M50, Cervical disc disorders reads, "Code to the most superior level of disorder."

- This direction is to code to the most superior level (e.g., the lowest disc number) only for each fourth digit subcategory describing a unique disorder. For example, if C3-C4 and C7-C8 have radiculopathy, report:

  **M50.11** Cervical disc disorder with radiculopathy, high cervical region

  - M50.11 includes C2-C-4
  - Do not also report M50.13 (radiculopathy of C7-T1)

Coding Clinic for ICD-10-CM, Q1, 2016
Primary osteoarthritis as default

- When the type of osteoarthritis is not documented, primary is the default
- It is the most common form of osteoarthritis
Comminuted fracture of distal tibia and fibula

- For comminuted fracture of the left distal tibia and fibula, report:
  S82.392- Other fracture of lower end of left tibia
  • for comminuted fracture of distal tibia

S82.832- Other fracture of upper and lower end of left fibula
  • for comminuted fracture of distal fibula

Coding Clinic for ICD-10-CM, Q1, 2015
Genitourinary system
ESRD in polycystic kidney disease

- The Official Coding Guidelines Section I.C.9.a.2., states that ICD-10-CM presumes a cause-and-effect relationship and classifies hypertension with chronic kidney disease (CKD) as hypertensive chronic kidney disease.

- How to report a patient’s HTN due to ESRD with ESRD due to congenital polycystic kidney disease:

  N18.6   End stage renal disease

  Q61.3   Polycystic kidney, unspecified

  I15.1   Hypertension secondary to other renal disorders

Coding Clinic for ICD-10-CM, Q3, 2016
If a calculus migrates from the ureter to the bladder, report the diagnoses as ureteral stones, but the procedure (at least, for PCS) as bladder stones. It is not necessary that the diagnosis and procedure codes match when reporting about calculi, since they often move.

..good luck with this one.
Prostate cancer and hematuria

• In ICD-9-CM, we were instructed to sequence hematuria first for the patient with prostate cancer and hematuria who was being admitted to the hospital with a significant drop in hemoglobin.

• In ICD-10-CM, we are to report the prostate cancer as the first-listed diagnosis, with the hematuria reported secondarily.
Transplant failure with CKD

- Kidney transplant failure with chronic kidney disease, stage IV is reported as:

  T86.12  Kidney transplant failure
  N18.4  Chronic kidney disease, stage 4 (severe), for the CKD
Default for Gustilo-Anderson

- When abstracting a chart in which a patient is being seen for a subsequent encounter for an open fracture, and there is no known information regarding the original Gustilo-Anderson classification, report a seventh character for open fracture Type 1 or II (E, H, M Q).

Coding Clinic for ICD-10-CM, Q1, 2016
Pregnancy and childbirth
If the physician documents twins as fetus A and B, it is appropriate to convert those A and B designations to 1 and 2, according to the 7th character fetal identification system in ICD-10-CM.

• Just be consistent.
Meconium staining

The presence of meconium indicates fetal stress and fetal stress does not need to be so documented in order to use the meconium code in category 077 Other fetal stress complicating labor and delivery.

O77.0 Labor and delivery complicated by meconium in amniotic fluid
42 weeks gestation

- Greater than 42 weeks gestation, for the purposes of Z3A.49, means at least 43 weeks and 0 days gestation. Z3A.42 would be reported for pregnancies from 42 weeks, 0 days to 42 weeks, 6 days.

Z3A.42 42 weeks gestation of pregnancy

Z3A.49 greater than 42 weeks gestation of pregnancy
2\textsuperscript{nd} degree perineal laceration

- Documentation of degree of perineal laceration is sufficient for code selection for obstetrical laceration. It is not necessary that the provider describe the type of tissue (for second degree, the perineum muscle).
Do not assign supervision codes in category O09 during an episode of care that includes delivery. If an elderly gravida has a normal delivery, report:

**O80** Encounter for full-term uncomplicated delivery

- Effective October 1, 2016, Guideline 15.b.2 of the ICD-10-CM Official Guidelines for Coding and Reporting states, in part:

- "Codes from category O09, Supervision of high-risk pregnancy, are intended for use only during the prenatal period. For complications during the labor or delivery episode as a result of a high-risk pregnancy, assign the applicable complication codes from Chapter 15. If there are no complications during the labor or delivery episode, assign code O80, Encounter for full-term uncomplicated delivery."

Coding Clinic for ICD-10-CM, Q1, 2016
Weeks gestation

- Report the weeks of gestation in pregnancy at the time of admission and not at the time of discharge, if they differ.
Chemotherapy in the postpartum

- A patient diagnosed with cancer during pregnancy is undergoing chemotherapy two weeks postpartum. This is reported with:

  **Z51.11** Encounter for antineoplastic chemotherapy

  **O9A.13** Malignant neoplasm complicating the puerperium

- And the specific neoplasm code

- It is the provider's responsibility to document that a condition being treated is not affecting a pregnancy.

Coding Clinic for ICD-10-CM, Q3, 2015
Rh incompatibility status

• An Rh negative mother delivers at term without complication, and is administered Rhogam prophylactically during the admission. This is reported with:

O26.893 Other specified pregnancy related conditions, third trimester

Z67.91 Unspecified blood type, Rh negative (or more specific code)

• Codes in category O36 Maternal care for Rh isoimmunization, are not appropriate since the patient does not have isoimmunization. Prophylaxis is being given to prevent isoimmunization. Z31.82 Encounter for Rh incompatibility status, is not appropriate either, as this code may only be reported as the principal or first-listed diagnosis

Coding Clinic for ICD-10-CM, Q3, 2015
Triamniotic Trichorionic Triplets

- There is no specific code addressing number of placenta and chorion in a triamniotic trichorionic pregnancy (three fetuses each with their own amniotic sac and placenta). Until a unique code is created for this situation, report:

O30.10- Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs
Perinatal
Perinatal period

• The Official ICD-10-CM Guidelines for Coding and Reporting in the chapter on the perinatal period state, “For coding and reporting purposes the perinatal period is defined as before birth through the 28th day following birth.”

• The World Health Organization considers the patient’s date of birth as day zero
Gestational age discrepancy

- Use the gestational age provided by the pediatrician if it differs from the gestational age provided by the obstetrician, when reporting for the newborn.

- Gestational abnormalities (pre- or post-) should only be reported on the baby’s chart when documented by the baby’s provider. Notation of a post term pregnancy on the mother’s chart is not sufficient documentation to report post-term infant.
Infant feeding problems

If infant feeding problems extend beyond the 28 days associated with perinatal problems in the newborn, report the perinatal code, for example:

P92.5 Neonatal difficulty in feeding at breast

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

Coding Clinic for ICD-10-CM, Q3, 2016
Newborn coding

• For physician coding and reporting, category Z38 codes are not limited to only the day the baby was born. A physician may report a code from category Z38 for each visit during the birth admission.
Newborn ABO incompatibility

• Report ABO incompatibility on the newborn record if the baby’s provider documents ABO incompatibility, regardless of whether a positive Coombs test is charted.

P55.1 ABO isoimmunization of newborn
Signs and symptoms
Finding of dense breasts

- If a patient is discovered to have dense breasts, requiring further investigation, during a screening mammogram, report:

  Z12.31  Encounter for screening mammogram for malignant neoplasm

- For the follow-up encounter, report

  R92.2  Inconclusive mammogram
Glasgow coma scales

- Guidelines have been revised so that the coma scale codes may also be used to assess the status of the central nervous system for other non-trauma conditions, for example monitoring patients in the intensive care unit regardless of the medical condition.

- Provider documentation of numeric values is sufficient for coding specific components of the coma scale, but not tallying a total score. For total score, the total score itself must be documented.

- EMT and other non-physician documentation can be used for these scores.

Coding Clinic for ICD-10-CM, Q4, 2016; Q2 2015
Injuries
Q4 2012 Malunion

• When the first medical encounter reveals an old fracture with malunion, report initial encounter for closed fracture
Q4 2012 Open dislocation

- Report an open dislocation of the elbow by reporting the dislocation first, then reporting an unspecified open wound of the elbow
7th character in injuries

- Choice of the 7th character is based on whether the patient is undergoing active treatment, for example, surgery, ER care, evaluation of the injury, or consultation of the injury. Choice is not based on whether the provider is seeing the patient for the first time.

- For complication codes, “active treatment” may refer to antibiotic therapy for an infection.
7\textsuperscript{th} character in injuries

- A patient coming in for a wound check or suture removal would be reported as undergoing a subsequent visit

- Do not use aftercare Z codes for injuries or poisonings

- Injuries discovered following initial treatment are reported as initial encounters (example: slow brain bleed discovered days after forehead laceration has been treated)

- Subsequent encounters are appropriate for new patients, if the treatment phase of the injury is complete
7th character in injuries

- A sequela is a direct result of a condition, so stated in documentation.
For a patient with a symptomatic labral tear of the left hip and femoroacetabular impingement, report:

S73.192A  Other sprain of left hip, initial encounter

M25.852  Other specified joint disorders, left hip

Sprains can include tears, and a tear is equivalent to a third degree sprain, which is a complete disruption.

ICD-10-CM does not provide a specific code for femoroacetabular impingement. Code M25.85- can be referenced in the Index under Disorder, joint specified type NEC, hip.

Coding Clinic for ICD-10-CM, Q1, 2014
External causes
Activity codes in subsequent encounters

- The 7th character for initial encounter in injuries is assigned while the patient is receiving active treatment for the condition, regardless how many visits or how much time passes.

- **Activity codes can only be used once**, the first encounter, and it does not need to correlate to the assignment of the 7th character for "initial encounter" in the injury code.

Coding Clinic for ICD-10-CM, Q3, 2015
Warfarin induced skin necrosis

- Warfarin induced skin necrosis is reported:

I96  Gangrene, not elsewhere classified

T45.515A  Adverse effect of anticoagulants, initial encounter

Coding Clinic for ICD-10-CM, Q2, 2013
Health status and contact
Second-hand smoke from eCigs

- Report adverse effects of second-smoke from electronic cigarettes with:

  **Z77.29** Contact with and (suspected) exposure to other hazardous substances

- Symptoms as appropriate

- Electronic cigarettes don’t produce tobacco smoke. However, electronic cigarette vapors and exhaled gases may contain certain fine particulate matter and substances that can constitute hazards.

  Coding Clinic for ICD-10-CM, Q2, 2016
Adult physical exam

- A patient with known comorbidities who undergoes a physical with no new findings. Report:
  
  **Z00.00** Encounter for general adult medical examination without abnormal findings

  - Also report existing comorbidities addressed during the physical

- A patient with known comorbidities has worsening symptoms for those comorbidities, or with new disorder found during his physical exam, report:
  
  **Z00.01** Encounter for general adult medical examination with abnormal findings

  - Also report existing comorbidities addressed during the physical

Coding Clinic for ICD-10-CM, Q1, 2016
An adult BMI of 19.5 is reported with Z68.1 BMI, 19 or less, adult
Newborn hearing exam

- For newborn hearing exam with normal results, report:
  
  **Z13.5**  
  Encounter for screening for eye and ear disorders

- For newborn hearing exam with abnormal results, report:
  
  **Z01.118**  
  Encounter for examination of ears and hearing with other abnormal findings

  **R94.120**  
  Abnormal auditory function study

Coding Clinic for ICD-10-CM, Q3, 2016
D50C
Thank you!
Sheri Poe Bernard, CPC, COC, CDEO, CCS-P
Sheri.p.bernard@gmail.com