ICD-10 Troubleshooting: Inpatient/Outpatient
Tips from Coders to Coders

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About the Presenter

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Approved ICD 10 CM/PCS Trainer

Connie is RMC’s Director of Hospital Coding and Review Services. In this role, she is ultimately responsible for the quality of services supplied by RMC and the excellence in the work provided to RMC clients. Connie has over 20 years of experience in HIM and enjoys coaching and mentoring staff, conducting audits, researching coding issues, developing coding tools, and providing education to coders as well as providers. Clinical Documentation is a particular passion and as such, Connie obtained her CCDS in 2011. She is active in AHIMA, SCHIMA, and ACDIS, and is an AHIMA ICD-10-CM & PCS Trainer.
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So... How are YOU doing??

Photo Credit: Connie Calvert
ICD 10 Post Implementation

F43.20
Adjustment disorder
ICD-10 – Does the Fun Ever Stop?

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

**Be prepared for revisions – changes to advice**
Guidelines and Conventions
Excludes 1

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

We have received several questions regarding the interpretation of Excludes1 notes in ICD-10-CM when the conditions are unrelated to one another. Answer: If the two conditions are not related to one another, it is permissible to report both codes despite the presence of an Excludes1 note.

Ref: Coding Clinic, Fourth Quarter 2015: Page 40
Every effort was made to carry over the ICD-9-CM guidelines and concepts into ICD-10-CM, unless there was a specific change in ICD-10-CM that precluded the incorporation of the same concept into ICD-10-CM. However, some of the guidelines in ICD-9-CM included information that may have been clinical in nature and therefore not appropriate for coding guidelines.

However, there are no plans to translate all previous issues of Coding Clinic for ICD-9-CM into ICD-10-CM/PCS since many of the questions published arose out of the need to provide clarification on the use of ICD-9-CM and would not be readily applicable to ICD-10-CM/PCS.

- Care should be exercised as ICD-10-CM has new combination codes as well as instructional notes that may or may not be consistent with ICD-9-CM.
Applying Past Issues of Coding Clinic for ICD-9-CM to ICD-10-CM

• In general, clinical information and information on documentation best practices published in Coding Clinic were not unique to ICD-9-CM, and remain applicable for ICD-10-CM with some caveats. For example, Coding Clinic may still be useful to understand clinical clues when applying the guideline regarding not coding separately signs or symptoms that are integral to a condition. Users may continue to use that information, as clues—not clinical criteria.

• As far as previously published advice on documentation is concerned, documentation issues would generally not be unique to ICD-9-CM, and so long as there is nothing new published in Coding Clinic for ICD-10-CM and ICD-10-PCS to replace it, the advice would stand.

• Every attempt was made to remain as consistent with the ICD-9-CM guidelines as possible, unless there was a change inherent to the ICD-10-CM classification.

For more information Ref: Coding Clinic, Fourth Quarter 2015: Page 20
ICD-10.1

There were no new/revised ICD-10-CM diagnosis codes, or changes to ICD-10-CM for FY 2016, because of the partial code set freeze in preparation of ICD-10 implementation. On October 1, 2016 (one year after implementation of ICD-10), regular updates to ICD-10-CM and ICD-10-PCS will begin. So, get ready…

According to Journal of AHIMA, “A total of 1,943 new ICD-10-CM codes were released by the CDC, and 3,651 new ICD-10-PCS codes were released by the Centers for Medicare and Medicaid Services (CMS). In addition to the new codes, the update also includes revisions and deletions. In the ICD-10-CM proposed update, 422 codes were revised and 305 were deleted. In the proposed ICD-10-PCS update, 351 codes were revised and 313 were deleted. Once finalized following a public review period currently underway, the healthcare industry must start using the updated codes by October 1, 2016.”
DRG Shift

DRG 795 Normal Newborn

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

DRG 794 Neonate with other significant problems

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

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

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

- MDD no longer a CC
- Malignant HTN no longer MCC
- Schatzki’s ring not MCC
  - Now defaults to “Acquired” – opposite of I-9
  - “Congenital” is still an MCC
- New CCs: Persistent A Fib, Mild malnutrition, nicotine withdrawal
ICD-10-CM
Retained Myringotomy Tubes

When myringotomy tubes are placed it is expected that they will eventually fall out on their own without any intervention as part of the natural course. However occasionally these tubes do not fall out and will require removal by the provider. Therefore documentation of “retained” myringotomy tube would be coded as a mechanical complication - T85.698A would be the appropriate code.
Alcohol Intoxication without Documentation of Abuse

Alcohol intoxication automatically defaults to alcohol abuse with intoxication per the Alphabetic Index. Follow index for guidance. If ETOH intoxication is solely documented, this leads to F10.129, Alcohol Abuse with Intoxication. However, if alcohol dependence was documented then based on the hierarchy (Use/Abuse/Dependence), dependence would be used which is coded to F10.229.
Grind ham-then cheese and butter, add remaining ingredients. Place bottom 1/2 in casing and place top back on cheese. Place top back on cheese. Bake 20 minutes. Can be doubled.

For: 1962

Address:

Whisky: 1 tsp
Lemon juice: 1 tsp
Honey: 1 Tbsp

1 tsp water honey if needed for cough.

M.D.
Alcohol withdrawal with Documentation of Abuse

Per Coding Clinic 2\textsuperscript{nd} Q 2015, pg. 15 “In ICD-10-CM, alcohol withdrawal is categorized as alcohol dependence, by default. The classification provides a combination code for alcohol dependence with alcohol withdrawal. Therefore Query the provider for clarification, when alcohol abuse and alcohol withdrawal are both documented in the health record.”
Pneumonia with Hemoptysis

ICD-9

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

ICD-10

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

ICD-9

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

ICD-10

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

ICD-9

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

ICD-10

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

ICD-9

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

ICD-10

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

• In ICD-10 there is no equivalent for V57.89
• The sequelae of the CVA would be the principal diagnosis
• If patient is admitted to rehab following an injury, the fracture code would be assigned as the principal diagnosis with the appropriate 7th character (subsequent encounter). Do not assign an aftercare Z code.
• If a patient is admitted to a nursing home for deconditioning, code the symptoms of the deconditioning, such as gait disturbance, weakness, etc.
Rehab

• If the admission to rehab is strictly for convalescence and there is no other definitive diagnosis, assign code Z51.89 (Encounter for other specified aftercare), as the first-listed diagnosis.

• If the patient was transferred to a nursing home for convalescence and strengthening following coronary artery bypass surgery assign code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system), as the principal diagnosis. The condition that was treated surgically if still present would be coded. Assign also codes for any symptoms such as weakness, gait disturbance, pain, etc., as additional diagnoses. You may also assign Z95.1, presence of aortocoronary bypass graft, to indicate the surgery for which aftercare is being performed.

See Coding Clinic, Fourth Quarter 2012 page 90 and Fourth Quarter 2013 page 127 for other examples
Decompensated

Question:

*Coding Clinic*, Third Quarter 2008, p. 12, states “decompensated indicates that there has been a flare-up (acute phase) of a chronic condition.”

Should this general definition of decompensated be applied when assigning ICD-10-CM codes as well? For example, what is the appropriate ICD-10-CM code assignment for a diagnosis of chronic systolic heart failure, currently decompensated?
Answer:
Assign code I50.23, Acute on chronic systolic heart failure, for decompensated systolic heart failure.
As previously stated, “decompensated” indicates that there has been a flare-up (acute phase) of a chronic condition.
Cor Pulmonale

• Per AHA Coding Clinic, Fourth Quarter 2014, page 21 the physician documents “right heart failure, decompensated cor pulmonale secondary to severe pulmonary hypertension” in his final diagnostic statement. How should acute cor pulmonale be coded when there is no documentation of pulmonary embolism?
Cor Pulmonale

- Assign secondary diagnosis code I27.81 (Cor pulmonale, chronic) and I27.2
- ICD-10-CM’s Index references code I27.2 under “pulmonary hypertension with cor pulmonale.” Unfortunately the Index under “pulmonary hypertension with acute cor pulmonale” leads to code I26.09, Other pulmonary embolus with acute cor pulmonale. In this case, code I26.09 is not appropriate since the patient does not have a pulmonary embolism.
- The National Center for Health Statistics (NCHS), the organization responsible for ICD-10-CM, will consider a future C&M proposal to modify the codes describing pulmonary embolism with cor pulmonale.
Ulcers of Skin with Gangrene

L89 & L97

***Assign I96 first when gangrene is present***

Ex) I96 + L89.153 – Sacral PU stg 3 w/ gangrene

When gangrene present with ulcer or injury, code gangrene 1st, followed by code for ulcer/injury as additional code. See Instructional Notes in Tabular

Cellulitis described as gangrenous is classified to I96.
### Tabular Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L89</td>
<td><strong>Pressure ulcer</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Includes:</strong> bed sore</td>
</tr>
<tr>
<td></td>
<td>decubitus ulcer</td>
</tr>
<tr>
<td></td>
<td>plaster ulcer</td>
</tr>
<tr>
<td></td>
<td>pressure area</td>
</tr>
<tr>
<td></td>
<td>pressure sore</td>
</tr>
</tbody>
</table>

*Code first any associated gangrene ([I96](#))*. 
Non-pressure chronic ulcer of lower limb, not elsewhere classified

Includes: chronic ulcer of skin of lower limb NOS
non-healing ulcer of skin
non-infected sinus of skin
trophic ulcer NOS
tropical ulcer NOS
ulcer of skin of lower limb NOS

Code first any associated underlying condition, such as:
any associated gangrene (I96)
atherosclerosis of the lower extremities (I70.23-, I70.24-, I70.33-, I70.34-, I70.43-, I70.44-, I70.53-, I70.54-, I70.63-, I70.64-, I70.73-, I70.74-)
chronic venous hypertension (I87.31-, I87.33-)
postphlebitic syndrome (I87.01-, I87.03-)
postthrombotic syndrome (I87.01-, I87.03-)
varicose ulcer (I83.0-, I83.2-)

Excludes2: pressure ulcer (pressure area) (L89.-)
skin infections (L00-L08)
specific infections classified to A00-B99
I96  Gangrene, not elsewhere classified
Gangrenous cellulitis
Excludes1: gangrene in atherosclerosis of native arteries of the extremities (I70.26)
gangrene in diabetes mellitus (E08-E13)
gangrene in hernia (K40.1, K40.4, K41.1, K41.4, K42.1, K43.1-, K44.1, K45.1, K46.1)
gangrene in other peripheral vascular diseases (I73.-)
gangrene of certain specified sites - see Alphabetical Index
gas gangrene (A48.0)
pyoderma gangrenosum (L88)
Do you have questions about ICD-10?

YES
That's all I have
Osteomyelitis, Toe

How is Osteomyelitis of the Toe coded?
Index Example

Osteomyelitis (general) (infective) (localized) (neonatal) (purulent) (septic) (staphylococcal) (streptococcal) (suppurative) (with periostitis) **M86.9**

- acute **M86.10**
  - toe **M86.17**
- chronic (or old) **M86.60**
  - toe **M86.47**
Osteomyelitis, Toe

If only Osteomyelitis of the Toe is documented, the correct code would be Osteomyelitis unspecified - M86.9.

Unfortunately since not documented as acute or chronic, ability to specify toe is not an option.
Reversal of Lordosis

The anatomy of the neck features a lordotic curvature in its typical and healthy state. Reversal of the curvature means that part or all the cervical spine develops a kyphotic profile. Lordosis is normal and expected in the cervical spine, as opposed to other areas of the spine (thoracic, lumbar). Because there are many conditions which could cause reversal of lordosis, such as scoliosis, spondylolisthesis, and because reversal of lordosis is not an actual diagnosis, the most appropriate code in this case would be R93.7, Abnormal findings on diagnostic imaging of other parts of musculoskeletal system.
Disc Osteophyte Complex

RMC Question:
• How are we supposed to code “disc osteophyte complex para-centrally on the left at C6-C7”
Disc Osteophyte Complex

Answer:

• Disc osteophyte complex occurs when soft disc tissue between vertebrae begins to breakdown. The tissue can calcify, harden and place pressure on bone.

• Code Osteophyte, spine/vertebra - M25.78 would not be appropriate as the growth is not of the vertebrae itself, but a result of the disc/soft tissue between the vertebrae. Therefore, at this time, it appears the most appropriate code is M50.92, Cervical disc disorder, unspecified, mid cervical region.
Foreign Body External Cause

RMC Question:
Which E code would you assign for foreign body in the eye?
Foreign Body External Cause

RMC Internal Answer:
The most appropriate code we could find is X58.XXXA
Coding Index: External cause, Injury, NOS
Agree, also be sure to review the entire record for clues to code more specific external cause
Code Numbers

There are regulatory and accreditation directives that require providers to supply documentation in order to support code assignment. It is not appropriate for providers to list the code number or select a code number from a list of codes in place of a written diagnostic statement. ICD-10-CM is a statistical classification, per se, it is not a diagnosis. Some ICD-10-CM codes include multiple different clinical diagnoses and it can be of clinical importance to convey these diagnoses specifically in the record. Also some diagnoses require more than one ICD-10-CM code to fully convey the patient's condition. It is the provider's responsibility to provide clear and legible documentation of a diagnosis, which is then translated to a code for external reporting purposes.

While we're aware that some payers may allow submission of code numbers on lab orders, Coding Clinic recommends that physicians provide narrative diagnoses/signs/symptoms as the reason for ordering the test.

Ref: Coding Clinic, Fourth Quarter 2015: Page 34
C-Section with Vacuum Delivery

ICD-9

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

ICD-10

- According to AHA Coding Clinic, Fourth Quarter 2014, page 43, vacuum assistance used with cesarean delivery is not separately coded.
- Code only the C-section
I DON'T ALWAYS GET SUCKED INTO A JET ENGINE

BUT WHEN I DO, I USE ICD-10 CODE: V97.33XD
• Per AHA Coding Clinic, First Quarter 2014 page 23, the advice from Coding Clinic, First Quarter 2010 page 5 is still valid ↓

• Hemiplegia is not inherent to an acute cerebrovascular accident (CVA). Therefore, it should be coded even if the hemiplegia resolves, with or without treatment. The hemiplegia affects the care that the patient receives. Report any neurological deficits caused by a CVA even when they have been resolved at the time of discharge from the hospital.
Unilateral Weakness

• When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia. Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia, unless it is associated with some other brain disorder or injury.

• Ref: CC 1 Q 2015, pg 25
ICD-10-PCS
Fresh Frozen Plasma

RMC Question:
In ICD-10-PCS, how would you code fresh frozen plasma (FFP) transfusion? The 4th digit has a substance character that identifies frozen plasma or fresh plasma. Would one or two codes be used to accurately capture the blood transfusion?
Fresh Frozen Plasma

Fresh Frozen Plasma:

- Table 302-No single substance value for fresh frozen plasma.
- No official ICD-10-PCS guidelines for this situation.
- Creating many questions in coding community.
Fresh Frozen Plasma

RMC Internal Answer:
Fresh Frozen plasma is synonymous with frozen. The fresh in the abbreviation refers to the product being frozen immediately.
Correct ICD-10 code would be 30233K1 (assuming its peripheral)
Seeking facility input
## TruCode Encoder

### Search Results
- **Section**: Administration
- **Body System**: Circulatory
- **Operation**: Transfusion - Putting in blood or blood products

**Selected Code: 30233K1**

Transfusion of Nonautologous Frozen Plasma into Peripheral Vein, Percutaneous Approach

### Current book is ICD-10-PCS Procedure Tabular

<table>
<thead>
<tr>
<th>Body System / Region</th>
<th>Approach</th>
<th>Substance</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral Vein</td>
<td>Open</td>
<td>Stem Cells, Embryonic</td>
<td></td>
</tr>
<tr>
<td>4 Central Vein</td>
<td>Open</td>
<td>Bone Marrow</td>
<td></td>
</tr>
<tr>
<td>5 Peripheral Artery</td>
<td>Open</td>
<td>Whole Blood</td>
<td></td>
</tr>
<tr>
<td>6 Central Artery</td>
<td>Open</td>
<td>Serum Albumin</td>
<td></td>
</tr>
<tr>
<td>7 Products of Conception, Circulatory</td>
<td>Open</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Vein</td>
<td>Open</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percutaneous</td>
<td>Frozen Plasma</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fresh Plasma</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plasma Cryoprecipitate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Red Blood Cells</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frozen Red Cells</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>White Cells</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Platelets</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Globulin</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fibrinogen</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Antihemophilic Factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Factor IX</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stem Cells, Cord Blood</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stem Cells, Hematopoietic</td>
<td></td>
</tr>
</tbody>
</table>
Vascular access device is a rather generic term to describe sterile catheter systems used to access a vascular structure either an artery or a vein. Selection of the body part value for insertion of a vascular access device is based on the end placement of the device rather than the point of entry.

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

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

PICC lines:

- A PICC line is generally inserted in a peripheral vein in the arm (cephalic vein, basilic vein, or brachial vein, and then advanced proximally toward the heart through larger veins, until the tip rests in the distal superior vena cava or cavoatrial junction.
  - Coding Clinic allows the use of imaging reports for confirmation of placement.
Cavoatrial Junction

- There is no entry in the Alphabetic Index for “insertion of device in, cavoatrial junction”
- Body part key also has no entry for “cavoatrial junction” in the table.
Cavoatrial Junction Defined

• The cavo-atrial junction is defined as the area between the right superior vena cava and the right atrium.
• The cavo-atrial junction has not yet reached the atrium.
TruCode Encoder

Search for: 02HV33Z

Section: Medical and Surgical
Body System: Heart and Great Vessels
Operation: Insertion - Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

Selected Code: 02HV33Z

Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach

Current book is ICD-10-PCS Procedure Tabular

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Vein</td>
<td>Open</td>
<td>Monitoring Device, Pressure Sensor</td>
<td></td>
</tr>
<tr>
<td>Atrium, Right</td>
<td>Percutaneous</td>
<td>Monitoring Device</td>
<td></td>
</tr>
<tr>
<td>Atrium, Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventricle, Right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventricle, Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pericardium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Trunk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Artery, Right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Artery, Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Superior Vena Cava</td>
<td></td>
<td>Infusion Device</td>
<td>No Qualifier</td>
</tr>
<tr>
<td>Thoracic Aorta</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Research

- Coding Clinic: ICD-10-CM/PCS
  - Clarification: Totally Implantable Central Venous Access Device (Port-a-Cath), Second Quarter 2015
  - Use of Imaging Report to Confirm Catheter Placement, Third Quarter 2014
  - Device Character for Port-A-Cath Placement, Fourth Quarter 2013
  - Placement of Peripherally Inserted Central Catheter (PICC), Third Quarter 2013

- ICD-10 Official Guidelines
  - Root Operation, General Guidelines, ICD-10-PCS Official Coding Guidelines
  - Body Part, General Guidelines, ICD-10-PCS Official Coding Guidelines
  - Device, General Guidelines, ICD-10-PCS Official Coding Guidelines
  - Root Operation, Multiple Procedures, ICD-10-PCS Official Coding Guidelines
  - Root Operation, Discontinued Procedures, ICD-10-PCS Official Coding Guidelines

Coding Advice

- The correct coding of venous catheters (percutaneous insertion central catheter) depends on the end placement of the catheter, meaning the site where the device ended up. For example, a PICC line where the infusion catheter is initially placed in the right internal jugular and then threaded into the superior vena cava would be coded as insertion of infusion device into superior vena cava, percutaneous approach (02HV33Z). Coding Clinic for ICD-10-CM, 2012-30 pg 18

- For infusion devices (e.g., PICC line), the body part character is based on the site in which the device ended up. When the provider’s documentation does not specify the site of placement of an infusion device, the imaging report may be used to identify the body part. Coding Clinic for ICD-10, 2014-30 pg 5

- During the same operative episode, multiple procedures are coded if: A) the same root operation is performed on different body parts as defined by distinct values of the body part character, B) the same root operation is repeated. Coding Clinic for ICD-10-CM, 2012-30 pg 5
Lysis of Adhesions

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

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

1. Recurrent incisional hernia repair with some adhesions of the omentum & abdominal wall
2. Emergent laparoscopic repair of incarcerated ventral hernia due to significant adhesions
3. Extensive adhesiolysis during a TAH-BSO for uterine adenocarcinoma
4. Exploratory laparotomy with lysis of adhesions and repair of umbilical hernia
Colectomy with End to End Anastomosis

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

• This guideline would apply regardless of whether the procedure is an end-to-end or a side-to-side anastomosis.
Multiple Procedures

B3.2

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

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

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

B3.2

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

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

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

ICD-9

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

ICD-10

- For a total (open) hysterectomy, 2 codes are assigned in ICD-10 (resection of uterus and resection of cervix)
- A total hysterectomy includes the removal of the uterus and cervix. Therefore, code both the resection of uterus and cervix. This is supported by the ICD-10-PCS Official Guidelines for Coding and Reporting, which state, “During the same operative episode, multiple procedures are coded if:
  - The same root operation is performed on different body parts as defined by distinct values of the body part character.”
  - Coding Clinic, Third Quarter 2013, page 28
Root Operation-Control

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

• If an attempt to stop post procedural bleeding is initially unsuccessful and to stop the bleeding requires performing any of the definitive root operations Bypass, Detachment, Excision, Extraction, Reposition, Replacement, or Resection, then that root operation is coded instead of Control.
  – Ex: Resection of spleen to stop post procedural coding is coded to resection instead of control
  • *ICD-10 Guidelines-Section B3.7
Coding Example of When Not to Code Control

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

Pre-Operative Diagnosis: Post-tonsillectomy bleeding

Post-Operative Diagnosis: Post-tonsillectomy bleeding

Operative Procedure: Operative Control of postoperative bleeding

Findings: Patient with an arterial bleeder from right tonsillar fossa.

Description of procedure: The patient was taken to the operating room and general anesthesia was administered. A Crowe-Davis mouth gag was placed, and clots were suctioned from the pharynx. An arterial bleeder was noted and was controlled with suction artery. The stomach was then suctioned and about 200-300 mL of blood was noted. The patient was awakened and extubated and transported to the recovery room in stable condition.
Coding Example of When to Code Control

RMC Internal Answer:

ICD-10-PCS code: 0W33XZZ (Control Bleeding in Oral Cavity and Throat, External Approach)

- The root operation control is coded because the bleeder is the result of a previous procedure. When cautery is used to stop post-op bleeding, control is the appropriate root operation. The tonsillar area is coded to the body part value 3. The approach is X (external)
Fusion

• The objective of the procedure is to make the joint immobile by fusing the articular parts.

• Fusion root operations are only performed on joints with the objective of making them immobile. Therefore, the only code tables available for Fusion procedures are in the joint body systems—the upper joints (0RG) and the lower joints (0SG).
  – When building codes for spinal fusion, these tables are consulted based on the level of the spine involved in the fusion procedure. The number of body parts is based on the joint; however, and not the vertebrae.
Questions to ask yourself while building the most appropriate procedure code:

1. What spinal approach is being done?
   - Posterior approach, posterior column is when the incision is made from the back side of the patient to perform a procedure on the vertebral foramen, spinous processes, facets and/or lamina
   - Posterior approach, anterior column is when access is made through the back of the body to perform a procedure on the body of the vertebra or the disc
   - Anterior approach, anterior column is when the incision is made in the front to perform a procedure on the body of the vertebra or the disc
Questions to ask yourself while building the most appropriate procedure code:

2. What area of the spine is being worked on?
   – Lumbar, Thoracic, Cervical, etc.

3. Why are they operating?
   – Fracture, scoliosis, tumor, stenosis, etc.
Decision Tree for Spinal Fusion

4. Was a device used? Peek cage, bone graft, etc.

- When combinations of devices are used on the same vertebral joint, the device values coded for the procedure is as follows:
  - If an interbody fusion device is used to render the joint immobile (alone or containing other material like bone graft), the procedure is coded with the device value Interbody Fusion Device.
  - If bone graft is the only device used to render the joint immobile, the procedure is coded with the device value Nonautologous Tissue Substitute or Autologous Tissue Substitute.
  - If a mixture of autologous and nonautologous bone graft (with or without biological or synthetic extenders or binders) is used to render the joint immobile, code the procedure with the device value Autologous Tissue Substitute.
Decision Tree for Spinal Fusion

Examples:

– Fusion of a vertebral joint using a cage style interbody fusion device containing morsellized bone graft is coded to the device Interbody Fusion Device.

– Fusion of a vertebral joint using a bone dowel interbody fusion device made of cadaver bone and packed with a mixture of local morsellized bone and demineralized bone matrix is coded to the device Interbody Fusion Device.

– Fusion of a vertebral joint using both autologous bone graft and bone bank bone graft is coded to the device Autologous Tissue Substitute. ICD-10-Coding Guidelines B3.10c
Spinal Fusion Devices

Interbody Fusion Device

Autologous Tissue Substitute

Nonautologous Tissue Substitute

Synthetic Substitute

Synthetic Substitute
Coding Tip

Guideline B3.10b states:

• “If multiple vertebral joints are fused, a separate procedure is coded for each vertebral joint that uses a different device and/or qualifier.”
  – For example, if L2-L3 are fused with a bone graft and L3-L4 are fused with an interbody fusion device, two codes are assigned, each identifying a different device used at each vertebral level.
  – If the anterior column of L4-L5 is fused from both a posterior approach and an anterior approach, two codes are assigned with different qualifiers for each spinal approach.
Coding Tip Continued

• The internal fixation/instrumentation (rods, plates, screws) are included in the fusion root operation, and no additional code is assigned. *Coding Clinic, 3rd Quarter 2014, page 30*

• Discectomy is almost always performed at the same time as spinal fusion. A discectomy can be coded separately.

• Review the documentation carefully to determine if it a total discectomy (resection) or partial discectomy (excision).
Question:
The patient presents for decompressive lumbar laminectomy. The surgeon performed an open complete decompressive laminectomy of L3-L4, as well as superior partial laminectomy of L5, and inferior partial laminectomy of L2. What is the appropriate root operation, “Excision” or “Release”? How is this surgery coded in ICD-10-PCS?

Answer:
Decompressive laminectomy is done to release pressure and free up the spinal nerve root. Therefore the appropriate root operation is “Release.” Assign the following ICD-10-PCS code:

01NB0ZZ Release lumbar nerve, open approach
Coding Clinic: Decompressive Laminectomy

_Coding Clinic_, Fourth Quarter 2013, page 116, advised the assignment of the root operation “Excision” for decompressive laminectomy procedures. This advice was based on the ICD-10-PCS’ Index entry “Laminectomy,” which instructs see Excision. The Editorial Advisory Board for Coding Clinic revisited this advice and determined that the root operation “Release” is more appropriate.
Contrast

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

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

CASE STUDIES
Spinal Case Study

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

Procedures:
1. Anterior cervical discectomy at C3-C4, C4-C5, and C5-C6.
2. Anterior cervical cage at C3-C4, C4-C5, and C5-C6.
3. Anterior cervical fusion at C3-C4, C4-C5, and C5-C6.
4. Anterior cervical hardware at C3-C4, C4-C5, and C5-C6.
5. Microdissection with operative microscope.
Findings: Intraoperative findings were consistent with cervical stenosis and kyphosis.

Procedure:
The patient is a 55 year old female who presents with significant signs and symptoms of severe cervical stenosis. She now has progressive myelopathy and significant symptoms. Once anesthesia was induced, we then prepped and draped the left side of the neck in a standard sterile fashion. We then did a left-sided approach. We then opened the prevertebral fascia, and got on the anterior cervical spine. We then did a discectomy of C3 and C4.
Spinal Case Study (Continued)

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

Description of Procedure (Continued):

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

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

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

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

Procedure: Primary PTCA and stent placement

Indications: Acute myocardial infarction

Procedure Description: Following left heart catheterization, a 6-French JR4 guiding catheter with side holes provided adequate support. The mid-right coronary artery occlusion was crossed with little difficulty using a 0.0014 BMW wire. Next the lesion was dilated using a 2 x 20 Maverick balloon. Next a 3 x 23 Vision stent was deployed in the mid right coronary artery. A second 3.0 x 12 Vision stent was deployed proximal to the first stent with an intentional degree of overlap. Following successful primary PTCA and stent of the right coronary artery, there was a 0 percent residual stenosis with excellent antegrade flow. Perclose was utilized for vascular access site closure.
PTCA/Stent Case Study: Answers

ICD-10-CM: I21.3 (ST elevation myocardial infarction of unspecified site)

ICD-10-PCS: 02703DZ (Dilation of Coronary Artery, One Site with Intraluminal Device, Percutaneous Approach)

- Vision is a bare metal stent
- 2 stents but only one distinct site (mid right coronary artery)
- Coronary arteries are classified by number of distinct sites treated, rather than number of coronary arteries or anatomic name of coronary artery.

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

Pre-Op Diagnosis: Bilateral ptosis interfering with vision
Pre-Op Diagnosis: Same
Procedure: Bilateral levator resection
Anesthesia: IV
Operative Description: Under IV sedation, a 50/50 mixture of 2 percent Xylocaine with 1:100,000 epinephrine and Wydase, 0.5 percent Marcaine with epinephrine and sodium bicarbonate was injected into the area of the right and left upper lids via the skin surface. Attention was first directed to the upper eyelids, where a marking pen and caliper were used to mark the intended skin incision. Then 0.5 Cassidy’s and Brown-Adson forceps were used to delineate the skin to be excised. Curved Stevens’s scissors were used to excise the skin and orbicularis.
Operative Description: Hemostasis was maintained with monopolar cautery. A 4-0 Silk suture was placed in the lid margin, and the lid was placed on downward tension. The orbital septum was incised and opened for the full horizontal length of the eyelid. Then, the levator palpebrae superioris muscle was reflected from its insertion on the underlying tarsus and dissected from underlying Muller’s muscle. Multiple interrupted 5-0 Dexon sutures on a 01 needle were then positioned to fashion the tarsus and brought up the levator so that the appropriate height and contour of the eyelid were achieved. The excess levator was excised. The wound was closed with a running 6-0 mild chromic suture.
Ophthalmology Case Study (Answers)

ICD-10-CM
H02.403 (Unspecified ptosis of bilateral eyelids)

ICD-10-PCS
08BP0ZZ (Excision of Left Upper Eyelid, Open Approach)
08BN0ZZ (Excision of Left Upper Eyelid, Open Approach)

Explanation: A medical indication is given for the procedure (interfering with vision); therefore, the root operation would not be Alteration. The root operation Excision is used to code the removal of a piece of levator muscle from each eyelid. The index directs to code the eyelid body part for the levator palpebrae superioris muscle. The body part values are P, Upper Eyelid, Left and N, Upper Eyelid, Right. The approach is open and no device or qualifier values are appropriate.
A 35 year old female driver was involved in a car crash on Mukilteo Speedway. Patient collided with a SUV. Patient was talking on cellular phone prior to accident. Patient brought to ER in a coma where she is diagnosed with TBI with loss of consciousness of one hour. Glasgow coma scale was 5 on arrival in ED.

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

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

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

ICD-10-PCS

0BH17EZ (Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening)

5A1935Z (Respiratory Ventilation, Less than 24 Consecutive Hours)
Anemia Question

I have a patient admitted for chronic blood loss anemia due to a bleeding mass from esophageal cancer. Nothing can be done for the cancer. Admitted due to the anemia for transfusions. Would I code D63.0 for the anemia? Or D50.0 for chronic blood loss anemia? Would the principal diagnosis be the cancer or the anemia?
Coding Guideline 2.c.1

Admission for Complications Associated with a Malignant Neoplasm

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

The exception to this guideline is anemia. When the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis, followed by code D63.0, Anemia in neoplastic disease.
Anemia exists because of the malignancy, therefore the cancer would be the principal diagnosis followed by the D50.0 and the D63.0 as secondary diagnoses.
Blood Evacuated from Hemorrhoid
Case Study: Question

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

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

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

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

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

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

Thank you for expressing concern with the ICD-10 Medicare Code Editor (MCE) Age Conflict- Pediatric Diagnosis code edit for ICD-10-CM code F98.8 (Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence). We are addressing this issue as part of our annual MCE updates for the FY 2017 inpatient PPS proposed rule. This proposed rule will be published in April/May 2016. Please contact your local MAC to make them aware of any claims that have been denied or rejected in error. If you need help determining contact information for the MAC serving your jurisdiction, please refer to the following link: https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-Provider-Contact-Table.pdf.
Tumor of Cecum Case Study: Question

This patient admitted with previously biopsied low grade tumor of cecum and underwent a resection. Path showed well-differentiated neuroendocrine CA with LN met. I submitted a query and the attending documented “Well differentiated neuroendocrine (Carcinoid) tumor of cecum.” Per Alpha index, we have to choose between benign and malignant carcinoid tumor. From previous facilities I’ve worked at, they recommended to assign the malignant unless they specifically document benign tumor. I asked him to add the met site but he didn’t do that either. Would you please share your thoughts?
Original Query posed by Coder

Query:

Dear Dr.,

Carcinoid tumor of cecum is documented in the discharge summary. Path report includes the final diagnosis of well-differentiated neuroendocrine carcinoma with lymph node metastasis, pT3 N1.

As low grade tumor and well-differentiated neuroendocrine carcinoma are classified to different diagnosis codes, we'd appreciate if you could clarify and document the final diagnosis after study (with metastatic site, if applicable) to the discharge summary as addendum.
(PROVIDER REPLY:) The final diagnosis has been amended to "Well differentiated neuroendocrine (carcinoid) tumor of the cecum" which accurately reflects the pathologic diagnosis.
**Tumor of Cecum Case Study: Answer**

Typically benign tumors do not metastasize. The pathology report indicates that there was lymph node metastasis, thereby a malignant tumor, however the pathological findings have not been confirmed by the attending physician. It would be inappropriate to assume malignant until the provider has clarified.

**It is important to query with terms that are easily indexable in the ICD10 code book. Trainers suggest re-query to the provider with terms such as "benign" or "malignant" for a clear response from the attending physician.**
Recommended Query

Query:

(Part 1) Dear provider, Please document in summary addendum if the carcinoid tumor is 1. Benign, 2. Malignant, 3. Other, 4. Undetermined

(Part 2) Please document in summary addendum if you agree with the diagnosis of lymph node metastasis, as coders are unable to code from the pathology report.
Tumor of Cecum Case Study: Provider Update

Provider replied to query with "malignant carcinoid tumor"
Mismatched Body Part in Screening Colonoscopy Case Study: Question

Example account, screening colonoscopy, polyp was found at the hepatic flexure. In ICD-10 hepatic flexure codes to transverse colon (D12.3), but according to the PCS body part key hepatic flexure codes to the ascending colon. So the problem on this account is that we have a dx of transverse polyp not matching the procedure of excision of ascending colon. What to do, what to do??
Mismatched Body Part in Screening Colonoscopy Case Study: Answer

Recommend coding as is, sometimes the codes do not match. However the coder needs to verify that site of excision and site of polyp are indeed accurate.
Lysis of Adhesions Case Study: Question

I was wondering how to code lysis of adhesions of the heart. I came up with 02NN0ZZ. (this is pericardium, not sure if I am using the correct Body Part)  The surgeon says “extremely dense adhesions were divided with the scissors and electrocautery. Adhesions were unusually severe all over the heart. They were divided."
TruCode Encoder
RMC Internal Trainers recommend a query to decipher which part of the heart is being freed (i.e., Right or left atrium, right or left ventricle, pericardium or other internal structure)
What and How

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

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

• Review coding AND documentation quality
• Feedback to CDI/Providers AND Coders
• Educate! Discuss! Educate!
• Resource for staff questions
...AND THAT IS WHY WE LIFT ON THREE...

COMMUNICATION
Resources

AHA Coding Clinic
ICD 10 CM and PCS Coding Handbook 2016
ICD-10-PCS: An Applied Approach, 2015, Kuehn, Lynn
Ref 1: http://www.healthcareitnews.com/sites/default/files/companion_images/icd10_2.png
Ref 2: http://www.memes.com/meme/717099
Ref 4: http://legacy.owensboro.kctcs.edu/gcaplan/anat/images/Image256.gif
Ref 5: http://englishwithatwist.com/wp-content/uploads/2013/05/Blog-communication-cartoon.jpg
Ref 6: https://www.pinterest.com/pin/440297301041910386/
Ref 7: https://www.google.com/search?q=icd-10+images&rlz=1C1EODB_enUS584US586&espv=2&biw=1366&bih=667&source=lnms&tbm=isch&sa=X&sqi=2&ved=0ahUKEwjl_v_gzdnLAhUT2GMKHXMgBngQ_AUIBigB#tbm=isch&q=icd-10+questions+images&imgrc=8i2o71Xrf8px4M%3A
Thank you!

Email: ccalvert@rmcoinc.org