WELCOME TO CODING ROUND TABLE WEBINAR 136: Anticipating the Unknown: Prepare Your Denials Team Now and Coding Quality Review Topics

The webinar will begin shortly

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Round Table 136

IP Coding Quality Review Topics

August 24, 2021

Coding Quality Review Topics Agenda

- Symptoms Integral to a disease process
- Abnormal Findings
- Level of detail/Specificity
- Non-essential Modifiers
- CHF and associated conditions

Symptoms Integral to a disease process

SYMPTOMS INTEGRAL OR NOT INTEGRAL TO DISEASE PROCESS

Conditions that are an integral part of a disease process
Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the Classification

Conditions that are not an integral part of a disease process
Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present

Use of symptom codes
Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider

Use of a symptom code with a definitive diagnosis 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 that diagnosis, such as the various signs and symptoms associated with complex syndromes. **The definitive diagnosis code should be sequenced before the symptom code. Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.**

PNEUMONIA WITH HYPOXEMIA

Scenario
Add R09.02, Hypoxemia, as the patient became hypoxemic during the ESWL procedure and it had to be aborted. Recommendation stands per final decision from coder. Reference coding clinic about mucous plugging that states to code pneumonia and hypoxia separately

Add R09.02, Hypoxemia, per documentation in the Discharge and H and P of hypoxia requiring supplemental oxygen

Bronchoscopy with suctioning of mucus plug
ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2019 Page: 15 Effective with discharges: October 1, 2019

Question:
A patient, who was admitted with hypoxia and pneumonia, had a diagnostic bronchoscopy, in which a distal mucous plug was suctioned from the lung. What is the correct ICD-10-CM code assignment for mucous plug of the lung without asphyxiation?

Answer:
Assign only codes J18.9, Pneumonia, unspecified organism, and R09.02, Hypoxemia. During the diagnostic bronchoscopy, a mucous plug was suctioned. However, mucus is always present in the respiratory tract and would not be considered clinically significant, or coded, unless the mucous plug was having some effect, such as airway obstruction or asphyxiation. If the provider had documented mucous plug with asphyxiation, code T17.990-, Other foreign object in respiratory tract, part unspecified in causing asphyxiation, would have been assigned as an additional diagnosis

PNEUMONIA WITH HYPOXEMIA

Hypoxemia with pneumonia

ICD-9-CM Coding Clinic, Second Quarter 2006 Page: 24 Effective with discharges: July 15, 2006

Question:

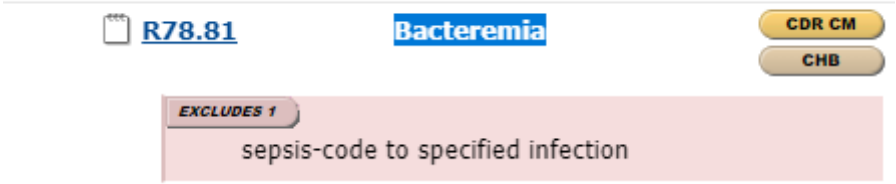
Is it appropriate to assign a code for hypoxemia as an additional diagnosis when it is associated with pneumonia?

Answer:

Yes, it is appropriate to assign code 799.02, Hypoxemia, as an additional diagnosis when it is present with pneumonia. Hypoxemia is not inherent in pneumonia. Hypoxemia indicates deficient oxygenation of the blood. If severe, it can be life threatening. Causes of hypoxemia include, but are not limited to severe pneumonia, congestive heart failure, chronic obstructive pulmonary disease, pulmonary embolism and pulmonary fibrosis. Shortness of breath is typically the chief symptom of hypoxemia. The underlying cause of the hypoxemia determines the treatment course.

BACTEREMIA

Scenario
Add R78.81, Bacteremia per documentation that patient has E.coli in blood culture due to UTI. No mention of sepsis. No clinical indicators to suggest sepsis.



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SYMPTOMS/CONDITIONS INTEGRAL TO DISEASE PROCESS

ISSUE	Comment
Proteinuria	Delete R809 Proteinuria unspecified based on proteinuria is a sign/symptom associated with CKD OCG Section I.C.18.b Use of a symptoms code with a definitive diagnosis code
Elevated Troponin	Delete R778 Other specified abnormalities of plasma proteins assigned for the elevated troponin. Elevated troponin is a symptom associated with the definitive diagnosis demand ischemia type 2 MI that is assigned I21A1. REF: OCG Section I.C.18.b Use of a symptoms code with a definitive diagnosis code
Leukocytosis	Recommend deleting secondary dx D72829, Leukocytosis as this is a sign/symptom of infection including septic joint/cellulitis and would not be captured separately

Abnormal Findings

ABNORMAL FINDINGS

ISSUE	Comment
EKG Findings	Delete R001 Bradycardia, unspecified based on documentation is from the EKG results imbedded in the dictated notes. These findings are not appropriate as source documentation unless the clinical significance is documented elsewhere by the attending physician. REF: OCG Section III.B. Abnormal Findings
CXR finding	Delete J9811 atelectasis that is only documented as a finding on CXR. Without clinical significance documented by the physician, the diagnosis does not meet criteria to be reported as an additional diagnosis. REF: OCG Section III. Reporting Additional Diagnoses
CT Head	Delete I672 Cerebral atherosclerosis based on documentation is only in the CT head. There is no clinical significance identified by the physician. REF: OCG Section III.B Reporting Additional Diagnoses
Imaging Findings	Delete N1330 Unspecified hydronephrosis based on lack of supporting documentation other than pelvicocaliectasis that is from Imaging report imbedded in the physician note. There is no clinical significance for this condition documented outside of the Imaging findings. REF: OCG Section III Reporting Additional Diagnoses B. Abnormal Findings
Imaging Findings	Delete K80.20 Calculus of gallbladder w/o cholecystitis w/o obstruction based on the only documentation is imbedded Imaging reports in the dictated reports that is not acceptable source documentation. There was no treatment, monitoring, or increased LOS associated with the Cholelithiasis therefore, it does not meet the criteria for Reporting Additional Diagnoses

Abnormal Findings

B. Abnormal findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

ICD-10-CM Official Guidelines for Coding and Reporting
FY 2021
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Using the X-ray report for specificity

ICD-10-CM/PCS Coding Clinic, First Quarter 2013 Pages:28-29 Effective with discharges: March 27, 2013

Question:
Please advise on the coding guidelines in ICD-10- CM regarding the coding of fractures and their specificity obtained from a radiology report. For example, in ICD-9-CM if the record describes a fracture of the leg and the radiology report identifies a specific site of the leg, we are allowed to code that more specific site. Will this be true also in ICD- 10-CM as well? For example, a patient is diagnosed with ankle sprain but when radiology reads the x-ray it shows a fracture. Previous advice stated that we can code the fracture. Is this still valid for I-10?

Can you also address if the following advice will apply in ICD-10: An outpatient encounter for pain with no site mentioned and an x-ray is done and we are instructed to code pain of that site of the x-ray. Will the same advice be true in I-10?

Answer:
The same advice would apply to more specific coding in ICD-10-CM. If the x-ray report provides additional information regarding the site for a condition that the provider has already diagnosed, it would be appropriate to assign a code to identify the specificity that is documented in the x-ray report.

Additionally, in the inpatient setting, abnormal findings are not coded and reported unless the provider indicates their clinical significance. If the finding are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provide whether the abnormal finding should be added.

In the outpatient setting, if the diagnostic tests have been interpreted by a physician, and the final report is available at the time of coding, it is appropriate to code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Abnormal Findings

Use of imaging reports for greater specificity

ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2014 Page: 5 Effective with discharges: September 15, 2014

Question:

Previous Coding Clinic advice has supported the assignment of a more specific fracture code in ICD- 9-CM and ICD-10-CM based on findings in imaging reports when a physician has documented a diagnosis of fracture. Does this advice hold true for other conditions that may be further specified based on imaging reports? For example, if a patient is diagnosed with a cerebral infarction or hemorrhagic stroke, can the imaging results be used to identify the specific vessel associated with these conditions?

Answer:

It is appropriate to utilize imaging reports to provide greater specificity of the anatomic site as documented by the physician. Therefore, if a patient is diagnosed with a cerebral infarction or hemorrhagic stroke, it would be appropriate to utilize the imaging report to determine the location of the stroke or infarction

Using the X-ray report for specificity

LEVEL OF DETAIL IN CODING

ISSUE	Comment
Fracture	PDX: REVISE: From S32.451A Displaced transverse fracture of right acetabulum to S32.454A NonDisplaced transverse fracture of right acetabulum. Procedure note states the fracture is nondisplaced "A partially threaded screw was placed down the anterior column providing further support to the nondisplaced acetabular fracture" Ortho PNs state the fracture is nondisplaced.
Diverticulosis	PDX: REVISE: from K57.91 Diverticulosis of intestine, part unspecified to K57.31 diverticulosis of large intestine. CT Abdomen indicated the diverticulosis is located in the colon. Imaging reports can be used to provide greater specificity of anatomic site. See CC 3Q 2014 pg.5.

Using the X-ray report for specificity

ICD-10-CM/PCS Coding Clinic, First Quarter 2013 Pages:28-29 Effective with discharges: March 27, 2013

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Additionally, in the inpatient setting, abnormal findings are not coded and reported unless the provider indicates their clinical significance. If the finding are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provide whether the abnormal finding should be added.

In the outpatient setting, if the diagnostic tests have been interpreted by a physician, and the final report is available at the time of coding, it is appropriate to code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Use of imaging reports for greater specificity

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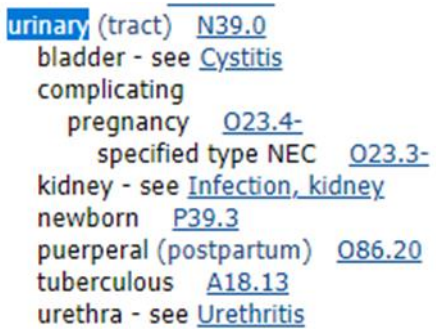
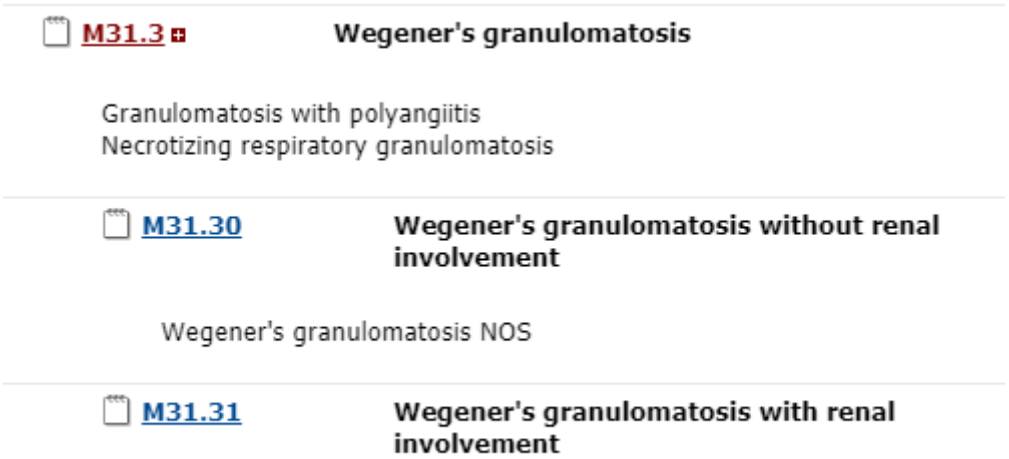
Level of detail/Specificity

LEVEL OF DETAIL IN CODING

ISSUE	Comment
UTI/Cystitis	N39.0 UTI, unspecified site to N30.90 Cystitis, unspecified without hematuria should not be coded together. The documentation specifies UTI is Cystitis which is noting the specific site of infection is the bladder
UTI/Pyelonephritis	Pt was diagnosed with pyelonephritis which is a kidney infection. The kidney would be a specific site of the urinary tract so unspecified code would not be assigned





Urinary tract infection not specified with acute cystitis

ICD-9-CM Coding Clinic, Second Quarter 1999 Page: 15 to 16 Effective with discharges: June 1, 1999

Question:

Is it appropriate to assign code 599.0, Urinary tract infection, site not specified, with code 595.0, Acute cystitis, when the physician documents both UTI and acute cystitis in the final diagnostic statement? Doesn't the term "cystitis" provide further specificity in regards to the UTI?

Answer:

Physicians may commonly use the term "urinary tract infection (UTI)" when referring to cystitis, urethritis and pyelonephritis. Lower urinary tract infections include urethritis and cystitis while pyelonephritis is an upper urinary tract infection. Cystitis, an inflammation of the bladder, is most commonly found in females while urethritis is generally confined to males. UTIs are assigned codes based on the site of the infection, if known, although it is usually not possible to distinguish between the three conditions on clinical grounds alone.

Assign only code 595.0, Acute cystitis, if the physician states that the bladder is the specific site of the acute infection. If the infection has spread to other sites, these may be coded as well. It should be noted that urinary tract infections that are due to sexually transmitted disease such as candidiasis or chlamydia would be coded elsewhere.

Code 599.0, Urinary tract infection, NOS, should be assigned only if the physician has not or is unable to identify the site of the UTI.

Code 599.0 should not be used in combination with codes that specifically identify the site(s) of the UTI. If the terms "acute cystitis" and "urinary tract infection" are both documented separately on the final diagnosis sheet, only the code for the acute cystitis should be assigned

LEVEL OF DETAIL IN CODING

ISSUE	Recommendation
Hashimoto's thyroiditis	Delete E03.9 Hypothyroidism, unspecified assigned with E06.3 Autoimmune thyroiditis. Hashimoto's thyroiditis is an autoimmune disease that attacks the thyroid gland causing hypothyroidism. The Alphabetic Pathway for Hypothyroidism due to autoimmune disorder is E06.3; therefore, E03.9 is redundant as hypothyroidism is part of the disease process
Opioid use disorder	Revise F1190 Opioid use unspecified, uncomplicated to F1120 Opioid dependence, uncomplicated based on documentation in the Psychiatry Consult Opioid use disorder, Moderate and Opioid use disorder moderate listed under the code in the Tabular Index.

F11.20 **Opioid dependence, uncomplicated**

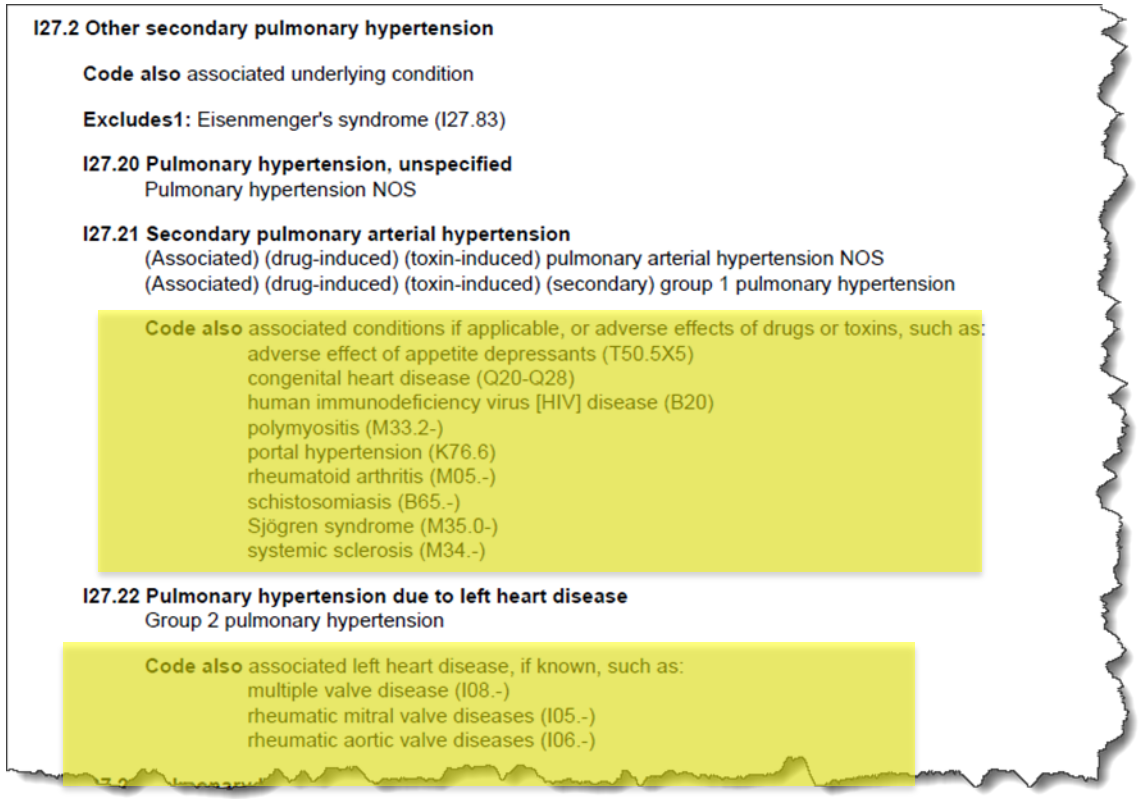
Opioid use disorder, moderate
Opioid use disorder, severe

Hypothyroidism (acquired) E03.9
- autoimmune - see Thyroiditis, autoimmune
- congenital (without goiter) E03.1
  - with goiter (diffuse) E03.0
- due to
  - exogenous substance NEC E03.2

odontogenesis NOS K00.9

opioid use
- with
  - opioid-induced psychotic disorder F11.959
    - with
      - delusions F11.950
      - hallucinations F11.951
- due to drug abuse - see Abuse, drug, opioid
- due to drug dependence - see Dependence, drug, opioid
- mild F11.10
  - with
    - opioid-induced
      - anxiety disorder F11.188
      - depressive disorder F11.14
      - sexual dysfunction F11.181
    - opioid intoxication
      - with perceptual disturbances F11.122
      - delirium F11.121
      - without perceptual disturbances F11.129
- in remission (early) (sustained) F11.11
- moderate or severe F11.20
  - with
    - opioid-induced
      - anxiety disorder F11.288
      - anxiety disorder . F11.988
      - depressive disorder F11.24
      - depressive disorder . F11.94
      - sexual dysfunction F11.281
      - sexual dysfunction . F11.981
    - opioid intoxication
      - with perceptual disturbances F11.222
      - delirium F11.221
      - without perceptual disturbances F11.229
- in remission (early) (sustained) F11.21

ISSUE	Comment
Pulmonary HTN	Revise I2720 Pulmonary hypertension unspecified to I2722 Pulmonary hypertension due to left heart disease as the documentation states "Pulmonary hypertension that appears hemodynamically (RHC) type 2, clinically type 2 given significant left heart disease



I27.2 Other secondary pulmonary hypertension

Code also associated underlying condition

Excludes1: Eisenmenger's syndrome (I27.83)

I27.20 Pulmonary hypertension, unspecified
Pulmonary hypertension NOS

I27.21 Secondary pulmonary arterial hypertension
(Associated) (drug-induced) (toxin-induced) pulmonary arterial hypertension NOS
(Associated) (drug-induced) (toxin-induced) (secondary) group 1 pulmonary hypertension

Code also associated conditions if applicable, or adverse effects of drugs or toxins, such as:
adverse effect of appetite depressants (T50.5X5)
congenital heart disease (Q20-Q28)
human immunodeficiency virus [HIV] disease (B20)
polymyositis (M33.2-)
portal hypertension (K76.6)
rheumatoid arthritis (M05.-)
schistosomiasis (B65.-)
Sjögren syndrome (M35.0-)
systemic sclerosis (M34.-)

I27.22 Pulmonary hypertension due to left heart disease
Group 2 pulmonary hypertension

Code also associated left heart disease, if known, such as:
multiple valve disease (I08.-)
rheumatic mitral valve diseases (I05.-)
rheumatic aortic valve diseases (I06.-)

Pulmonary hypertension

Pulmonary hypertension (PH) is now classified into five groups

Group 1: Pulmonary Arterial Hypertension (PAH), Secondary pulmonary arterial hypertension (I27.21)
Group 2: PH due to left heart disease (I27.22)
Group 3: PH due to lung diseases and/or hypoxia (I27.23)
Group 4: Chronic Thromboembolic PH (CTEPH)
Group 5: PH with unclear multifactorial mechanisms

ISSUE	Comment
Pulmonary HTN	Revise I2720 Pulmonary hypertension, unspecified to I2722 and I2723 Pulmonary hypertension due to lung diseases and hypoxia per documentation "This multifactorial PAH (Type II, Type III mixed) was managed with a bumetanide drip at 0.5 mg/hr, with which her respiratory status improved and her serum creatinine began to normalize, indicating an element of cardiorenal syndrome

Pulmonary hypertension

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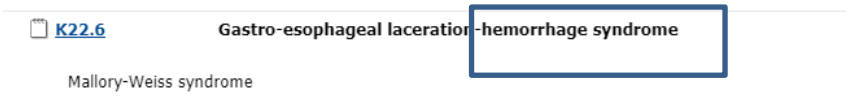
Group 4: Chronic Thromboembolic PH (CTEPH) (I27.24)
Group 5: PH with unclear multifactorial mechanisms (I27.29)

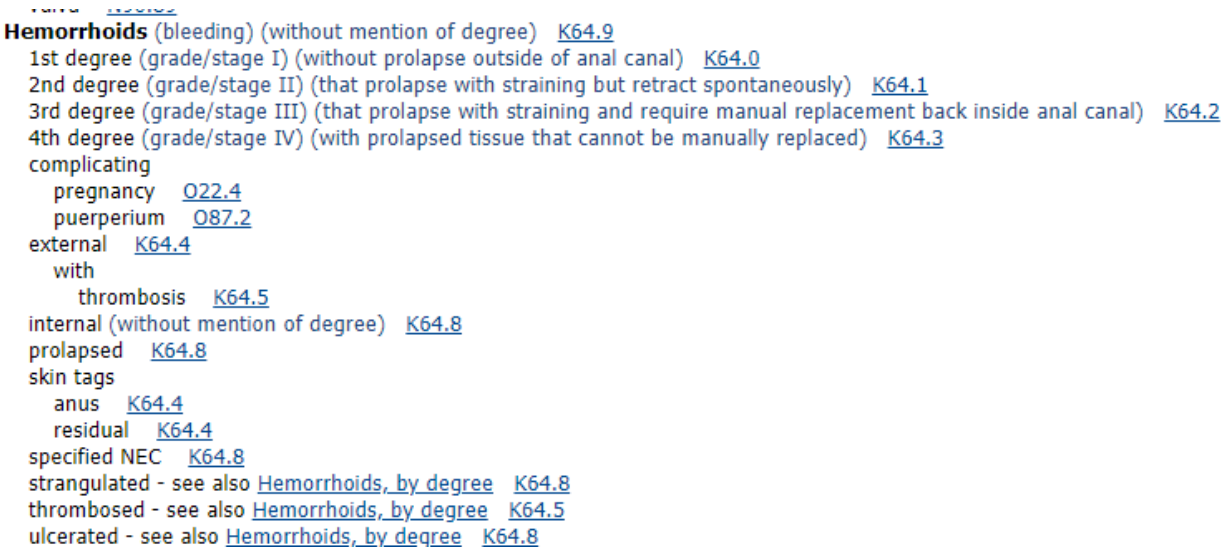
Non-essential Modifiers

NON-ESSENTIAL MODIFIERS

ISSUE	Comment
GI bleed	DX: DELETE: K92.0 Hematemesis. Pt was diagnosed with "hematemesis suspected Mallory-weiss tear" The hemorrhage is included in code title "gastro-esophageal laceration-hemorrhage syndrome "and would not be coded separately.
GI Bleed	CC: DELETE: K62.5 Hemorrhage of anus and rectum. Pt admitted with GI Bleed due to rectal hemorrhoids. Bleeding is a non-essential modifier(term in parentheses) with the term Hemorrhoids so an additional code would not be assigned for the bleed. OCG I.A.7 punctuation



Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers. The nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive, the subentry takes precedence. For example, in the ICD-10-CM Alphabetic Index under the main term Enteritis, “acute” is a nonessential modifier and “chronic” is a subentry. In this case, the nonessential modifier “acute” does not apply to the subentry “chronic”.



GI bleeding due to acute ischemic colitis

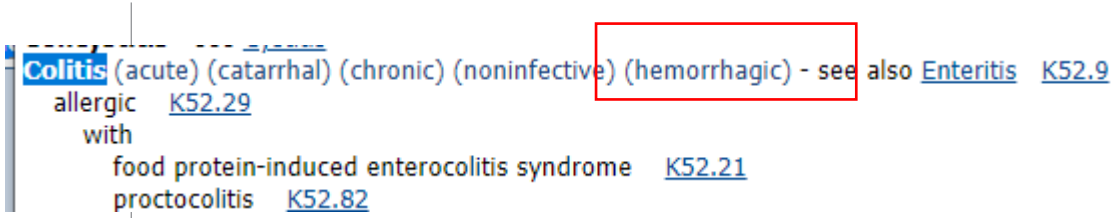
ICD-9-CM Coding Clinic, Second Quarter 2008 Page: 15 to 16 Effective with discharges: July 7, 2008

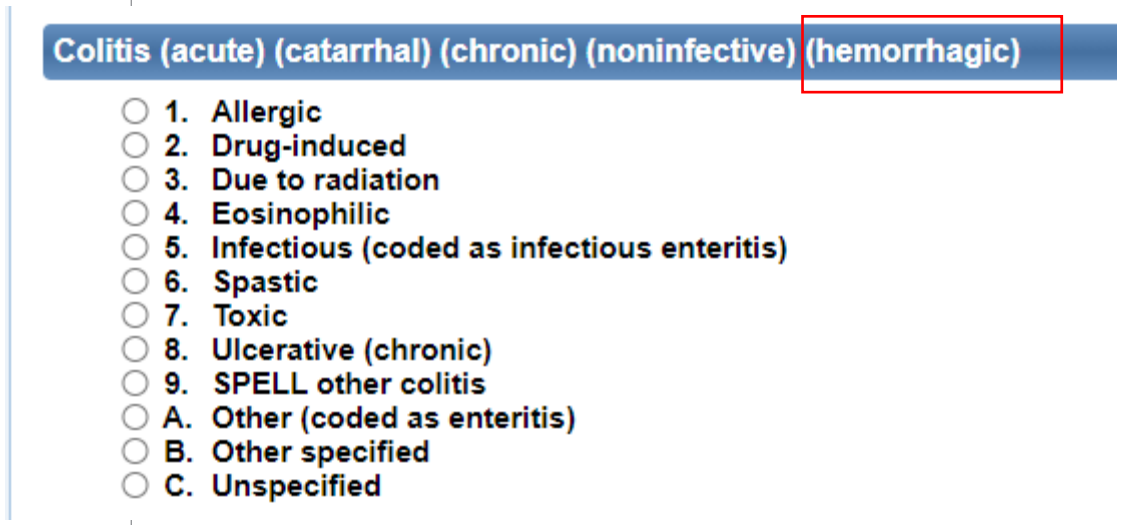
Question:

The physician listed "GI bleeding due to acute ischemic colitis." We think that since the gastrointestinal (GI) bleeding is related to the acute ischemic colitis, the GI bleeding would not be coded separately. However, coders have different opinions on this issue. How should this diagnostic statement be coded?

Answer:

Yes, you are correct. Assign only code 557.0, Acute vascular insufficiency of intestine, for the GI bleeding due to acute ischemic colitis. It would be inappropriate to assign an additional code for the GI bleeding, since hemorrhagic is an inclusion term under code 557.0.

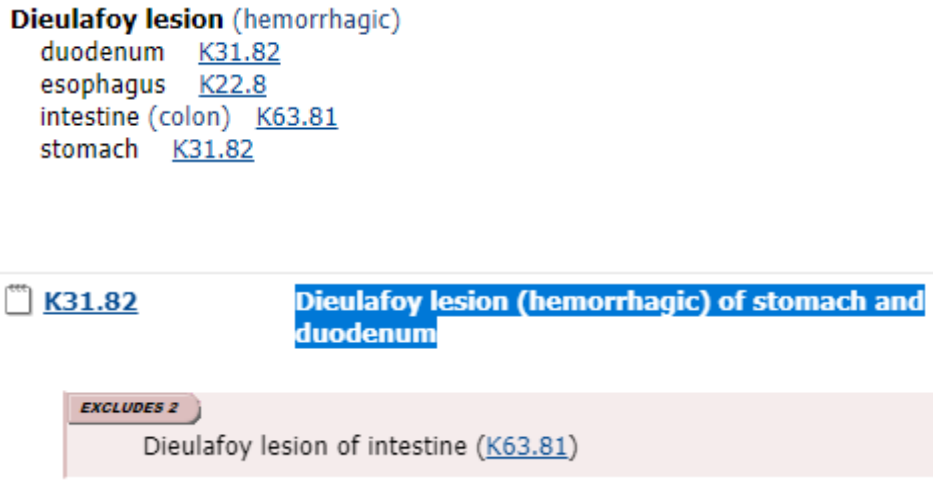




Inclusion terms

List of terms is included under some codes. These terms are the conditions for which that code is to be used. The terms may be synonyms of the code title, or, in the case of “other specified” codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code.

ISSUE	Comment
GI bleed	DELETE: K92.0 Hematemesis and K92.1 Melena. Pt admitted with GI Bleed and was found to have a bleeding Dieulafoy lesion in the stomach which was clipped and bleeding stopped. "hemorrhagic" is a non-essential modifier with code Dielafoy Lesion so additional code would not be assigned. OCG I.A.7 Punctuation .



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GI bleeding due to acute ischemic colitis

ICD-9-CM Coding Clinic, Second Quarter 2008 Page: 15 to 16 Effective with discharges: July 7, 2008

Question:

The physician listed "GI bleeding due to acute ischemic colitis." We think that since the gastrointestinal (GI) bleeding is related to the acute ischemic colitis, the GI bleeding would not be coded separately. However, coders have different opinions on this issue. How should this diagnostic statement be coded?

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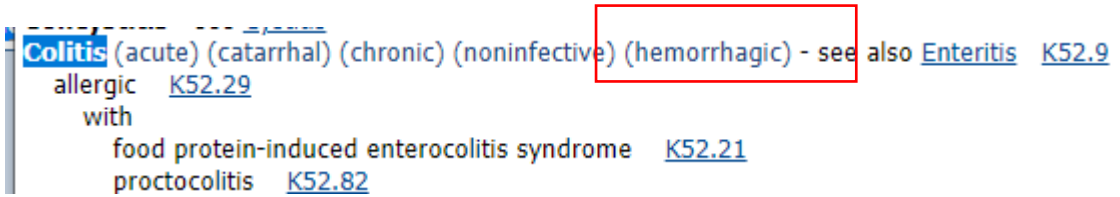

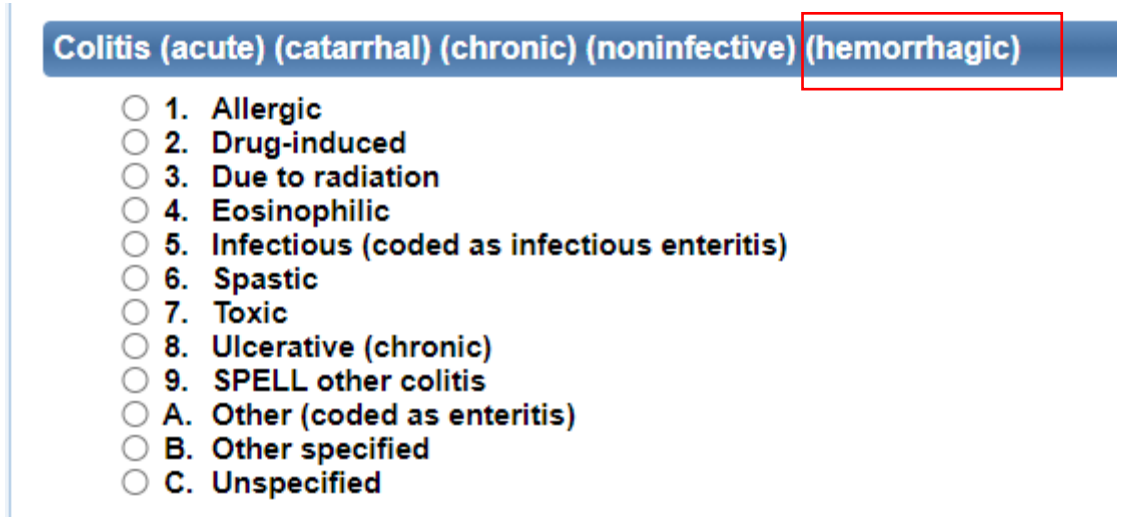

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CHF and associated conditions

ISSUE	Comment
CHF with pleural effusion	CC: DELETE: J90 Pleural Effusion. Pt with Acute on chronic CHF and pleural effusion but the pleural effusion did not require treatment. See CC 2Q 2015 pg.15
CHF with acute pulmonary edema	MCC: DELETE: J81.0 Acute Pulmonary Edema. Pt was found to have Acute Pulmonary Edema with acute combined congestive heart failure, treated with IV Lasix. Pulmonary edema is a manifestation of heart failure and included in codes I50. No additional code is assigned for pulmonary edema. See AHA Coding Handbook and alphabetic index.

Heart failure with pleural effusion

ICD-10-CM/PCS Coding Clinic, Second Quarter ICD-10 2015 Pages: 15-16
Effective with discharges: July 6, 2015

Question:

When assigning the ICD-10-CM code for heart failure, based on the Index, only code I50.9, Heart failure, unspecified, is reported. There are no instructions in the Index or Tabular at category I50, Heart failure, to assign code J91.8, Pleural effusion in other conditions classified elsewhere. However, there is an Excludes2 note at category J91, for pleural effusion in heart failure (I50) that indicates a code may be assigned.

Coding Clinic has previously advised that pleural effusion in congestive heart failure (CHF) is ordinarily minimal and not specifically addressed other than by more aggressive treatment of the underlying CHF. Is it appropriate to assign code J91.8, for pleural effusion due to CHF? How is pleural effusion in congestive heart failure coded?

Answer:

Code J91.8, Pleural effusion in other conditions classified elsewhere, is assigned as a secondary code only if the condition is specifically evaluated or treated. Pleural effusion is commonly seen with congestive heart failure with or without pulmonary edema. Ordinarily the pleural effusion is minimal and is not specifically addressed other than by more aggressive treatment of the underlying congestive heart failure. In this situation it should not be coded. However, it is acceptable to report pleural effusion (J91.8) as an additional diagnosis if the condition requires either therapeutic intervention or diagnostic testing.

ACUTE PULMONARY EDEMA

lung J81.1
with heart condition or failure - see Failure, ventricular, left
acute J81.0
chemical (acute) J68.1
chronic J68.1
chronic J81.1
due to
chemicals, gases, fumes or vapors (inhalation) J68.1
external agent J70.9
specified NEC J70.8
radiation J70.1

left (ventricular) - see also Failure, ventricular, left
combined diastolic and systolic - see Failure, heart, diastolic, combined with systolic
diastolic - see Failure, heart, diastolic
systolic - see Failure, heart, systolic
low output (syndrome) NOS I50.9
newborn P29.0

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