WELCOME TO CODING ROUND TABLE WEBINAR 142: Coding Hot Spots

The webinar will begin shortly

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Round Table 142

Navigating ICD-10-CM Diagnosis Coding Hot Spots

January 18, 2021

Navigating ICD-10-CM Diagnosis Coding Hot Spots Agenda

- Principal Diagnosis Selection
- Examples of Breaking the “with” guideline
- Updated Guideline : Laterality (and specificity)

Principal Diagnosis Selection

Case 1 Principal Diagnosis Selection

Scenario:

Elderly female with past medical history of A. fib, HFpEF, CKD, hypertension, and dementia, presents with acute hypoxemic respiratory failure.

Day 1: Dr. (HOSP) "…We will do CT chest to get better images of the lungs and rule out pleural effusion/pneumonia..."

Day 2 DR. (HOSP) "…was admitted for acute hypoxemic respiratory failure, likely secondary to volume overload secondary to CHF exacerbation as her BNP was elevated and had hyponatremia, however not much improvement with IV Lasix and unfortunately creatinine getting worse, CT chest findings concerning for multifocal pneumonia, started on antibiotics-vancomycin and aztreonam…".

Day 4 Dr. (HOSP) "…speech therapy evaluation confirms she is silently aspirating to thin and mildly thick liquids, s/p video swallow study….."

Day 6 Dr. (HOSP) "...Acute hypoxemic respiratory failure-acute Suspect primarily secondary to aspiration pneumonia in the setting of dysphagia, continue ceftriaxone and Flagyl for 7 days, strict n.p.o. for now, until transitioning to comfort care -Dysphagia…n.p.o., aspiration precautions, support with IV fluids-Chronic systolic heart failure with depressed EF 25 and 30% and diastolic heart failure secondary valvular heart disease-severe MR Suspected decompensation on admission, having good urine output, continue Lasix as tolerated and I am not suspecting CHF as the primary etiology, as even with significant diuresis, no change in her oxygen requirements and in fact got worse...".

Day7 and Day 8 Dr. (HOSP) "...Acute hypoxemic respiratory failure-acute - Suspect primarily secondary to aspiration pneumonia in the setting of dysphagia, s/p ceftriaxone and Flagyl for 5 days.. Chronic systolic heart failure with depressed EF 25 and 30% and diastolic heart failure secondary valvular heart disease-severe MR; mild decompensation on admission, having good urine output, continue Lasix as tolerated and I am not suspecting CHF as the primary etiology.".".

What are the <u>possible</u> Pdx options for this case that we are going to consider?

Case 1 Principal Diagnosis Selection DRG OPTIONS based on original coding

DRG Options Medicare

Select a new Principal Diagnosis if supported by documentation, or click Cancel

PDX	PPX	DRG	Weight	ALOS	GLOS	Reimb $	PDX Description
J9601	5A0935A	189	1.2261	4.60	3.60	$5343.37	Acute respiratory failure with hypoxia
I5023	5A0935A	291	1.2683	4.90	3.80	$5524.71	Acute on chronic systolic (congestive) heart failure
J690	5A0935A	177	1.8491	6.80	5.40	$8020.69	Pneumonitis due to inhalation of food and vomit
I130	5A0935A	291	1.2683	4.90	3.80	$5524.71	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
N179	5A0935A	682	1.4727	5.70	4.30	$6403.13	Acute kidney failure, unspecified

Case 1 Principal Diagnosis Selection

Initial DRG	Reworked DRG
291	177
1.2683	1.8491
HEART FAILURE AND SHOCK W MCC	RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC
Discharge Code 51	Discharge Code 51
SOI 4 ROM	SOI ROM

	Initial Codes						Audited Codes					
	Code	POA	CC/MCC	HCC	Description	Root Cause	Code	POA	CC/MCC	HCC	Description	Root Cause
D1	I130	Y		HCC	Hypertensive heart and chronic kidney disease with...		J690	Y		HCC	Pneumonitis due to inhalation of food and vomit...	Official Coding Guidelines not followed; Optimal sequencing based on 'two or more' guideline
D2	I5023	Y	MCC	HCC	Acute on chronic systolic (congestive) heart failu...		I5023	Y	MCC	HCC	Acute on chronic systolic (congestive) heart failu...	
D3	J9601	Y	MCC	HCC	Acute respiratory failure with hypoxia...		J9601	Y	MCC	HCC	Acute respiratory failure with hypoxia...	
D4	J690	Y	MCC	HCC	Pneumonitis due to inhalation of food and vomit...		I130	Y	CC	HCC	Hypertensive heart and chronic kidney disease with...	Official Coding Guidelines not followed; Alternative sequencing available based on 'two or more' guideline
D5	I4820	Y	CC	HCC	Chronic atrial fibrillation, unspecified...		I4820	Y	CC	HCC	Chronic atrial fibrillation, unspecified...	
D6	N184	Y	CC	HCC	Chronic kidney disease, stage 4 (severe)...		N184	Y	CC	HCC	Chronic kidney disease, stage 4 (severe)...	
D7	F05	Y	CC		Delirium due to known physiological condition...		F05	Y	CC		Delirium due to known physiological condition...	
D8	N179	Y	CC	HCC	Acute kidney failure, unspecified...		N179	Y	CC	HCC	Acute kidney failure, unspecified...	
D9	N1330	Y	CC		Unspecified hydronephrosis...		N1330	Y	CC		Unspecified hydronephrosis...	
D10	E873	Y	CC		Alkalosis...		E873	Y	CC		Alkalosis...	
P1	5A0935A				Assistance with Respiratory Ventilation, Less than...		5A0935A				Assistance with Respiratory Ventilation, Less than...	
P2	5A09357				Assistance with Respiratory Ventilation, Less than...		5A09357				Assistance with Respiratory Ventilation, Less than...	

RED = Code Removal; BLUE = Code Promoted to PDX; ORANGE = Code Demoted to SDX; GREEN = Code Added; YELLOW HIGHLIGHT = Query Required

Case 1 Principal Diagnosis Selection

Recommendation:

Sequence current principal diagnosis I130 for Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease as a secondary diagnosis.

Sequence secondary diagnosis J690 for Pneumonitis due to inhalation of food and vomit as the new principal diagnosis

Rationale: Based on the definition of principal diagnosis, circumstances of admission, and sequencing guidelines, the medical record supports another optimal principal diagnosis according to either the ICD-10-CM general sequencing guideline of “two or more” or “two or more interrelated” conditions.

90-year-old female with past medical history of A. fib, HFpEF, CKD, hypertension, and dementia, presents with acute hypoxemic respiratory failure. Patient diagnosed with CHF exacerbation and after study, aspiration pneumonia. Either diagnosis may be sequenced as principal diagnosis.

ICD-10-CM Official Guidelines for Coding and Reporting, 2022, Section II.C. Selection of Principal Diagnosis: Two or more diagnoses that equally meet the definition for principal diagnosis

This will result in a MS-DRG increase from 291 to 177

Does anyone see anything wrong with this specific recommendation?

“Chronic systolic heart failure with depressed EF 25 and 30% and diastolic heart failure secondary valvular heart disease-severe MR Suspected decompensation on admission “

Initial Codes

	Code	POA	CC/MCC	HCC	Description	Root Cause
D1	I130	Y		HCC	Hypertensive heart and chronic kidney disease with...	
D2	I5023	Y	MCC	HCC	Acute on chronic systolic (congestive) heart failu...	
D3	J9601	Y	MCC	HCC	Acute respiratory failure with hypoxia...	
D4	J690	Y	MCC	HCC	Pneumonitis due to inhalation of food and vomit...	
D5	I4820	Y	CC	HCC	Chronic atrial fibrillation, unspecified...	
D6	N184	Y	CC	HCC	Chronic kidney disease, stage 4 (severe)...	
D7	F05	Y	CC		Delirium due to known physiological condition...	
D8	N179	Y	CC	HCC	Acute kidney failure, unspecified...	
D9	N1330	Y	CC		Unspecified hydronephrosis...	
D10	E873	Y	CC		Alkalosis...	
P1	5A0935A				Assistance with Respiratory Ventilation, Less than	
P2	5A09357				Assistance with Respiratory Ventilation, Less than	

RED = Code Removal; BLUE = Code Promoted to PDX; ORANGE = Code Demoted to SDX; GREEN = C

Initial DRG

291
1.2683
HEART FAILURE AND SHOCK W MCC

Discharge Code 51

SOI 4 ROM

Audited Codes

Code	POA	CC/MCC	HCC	Description	Root Cause
J690	Y		HCC	Pneumonitis due to inhalation of food and vomit...	Official Coding Guidelines not followed; Optimal sequencing based on 'two or more' guideline
I5023	Y	MCC	HCC	Acute on chronic systolic (congestive) heart failu...	
J9601	Y	MCC	HCC	Acute respiratory failure with hypoxia...	
I130	Y	CC	HCC	Hypertensive heart and chronic kidney disease with...	Official Coding Guidelines not followed; Alternative sequencing available based on 'two or more' guideline
I4820	Y	CC	HCC	Chronic atrial fibrillation, unspecified...	
N184	Y	CC	HCC	Chronic kidney disease, stage 4 (severe)...	
F05	Y	CC		Delirium due to known physiological condition...	
N179	Y	CC	HCC	Acute kidney failure, unspecified...	
N1330	Y	CC		Unspecified hydronephrosis...	
E873	Y	CC		Alkalosis...	
5A0935A				Assistance with Respiratory Ventilation, Less than...	
5A09357				Assistance with Respiratory Ventilation, Less than...	

Reworked DRG

177
1.8491
RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC

Discharge Code 51

SOI ROM

Principal Diagnosis Case Study 2….

“with’ Guideline

Section I.A.15 Conventions, general coding guidelines and chapter specific guidelines, Conventions for the ICD-10-CM, "With"

The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index (either under a main term or subterm), or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis").

For conditions not specifically linked by these relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions in order to code them as related. The word "with" in the Alphabetic Index is sequenced immediately following the main term or subterm, not in alphabetical order.

HTN“with” Example

Scenario

60 year old male with an LVAD presents due to cough, chest congestion, sob and fluid overload. Hx of HFrEF secondary to ICM, (EF 18%)--The patient is on home milrinone, HTN, CVA, HLD, pre-diabetes, OSA.

The DS states HFrEF 2/2 ICM per CC ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2017 Page: 47. The hypertensive link is broken. The PDX should be I5023 Acute on chronic systolic (congestive) heart failure.

Recommend deleting the current PDX I130 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease as the link has been broken. Recommend Adding I129 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease as a secondary code.

This is an APR DRG payer and the APRDRG will NOT change. The MSDRG changes from 291 HEART FAILURE AND SHOCK WITH MCC RW 1.2683 to 292 HEART FAILURE AND SHOCK WITH CC RW 0.8635

	ORIGINAL	RECOMMENDED
PDX	I130 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I5023 Acute on chronic systolic (congestive) heart failure
SDX	I5023 Acute on chronic systolic (congestive) heart failure Z95.811, Presence of heart assist device	I129 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease as a secondary code Z95.811, Presence of heart assist device
DRG	291 HEART FAILURE AND SHOCK WITH MCC	292 HEART FAILURE AND SHOCK WITH CC
RW	1.2683	RW 0.8635

BREAKING THE “WITH OR IN” LINK

Commonly-encountered Diagnoses

BREAKING THE “WITH” LINK

Hypertension with diabetic nephropathy and chronic kidney disease

ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2019 Page: 3 Effective with discharges: October 1, 2019

Question:

The patient presented for renal transplantation due to end stage renal disease (ESRD), and the provider's final diagnostic statement listed, "ESRD due to diabetic nephropathy on dialysis, diabetic retinopathy, diabetic peripheral neuropathy, and hypertension." The Official Guidelines for Coding and Reporting (I.C.9.a.2.) state, "CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension." In this case, since the provider documented ESRD due to diabetic nephropathy, would this statement be sufficient to indicate that the CKD is not related to hypertension?

Answer:

When the patient has diabetes, hypertension and chronic kidney disease (CKD) and the provider documents CKD due to diabetes or diabetic CKD, diabetic nephropathy or other similar terminology a causal relationship is indicated, and denotes the CKD is not related to the hypertension. In this case, assign a code for diabetic chronic kidney disease. Do not assign a code for hypertensive CKD, as the hypertension would be coded separately.

In addition, it would be redundant to assign codes for both diabetic nephropathy (E11.21) and diabetic chronic kidney disease (E11.22) as diabetic chronic kidney disease is a more specific condition.

Takotsubo syndrome with hypertension

ICD-10-CM/PCS Coding Clinic, Second Quarter ICD-10 2018 Pages: 9-10 Effective with discharges: June 6, 2018

Question:

A patient with hypertension is admitted due to suspected acute coronary syndrome. The provider's final diagnostic statement listed, "Takotsubo syndrome and hypertension." Based on the guideline regarding hypertension with heart disease and the Tabular list, it appears that code I11.9, Hypertensive heart disease without heart failure, is appropriate since the provider has not indicated a different cause for the Takotsubo syndrome. Additionally, based on the Excludes1 note found at category I51-, Complications and ill-defined descriptions of heart disease, it appears that Takotsubo Syndrome must be coded as hypertensive. Providers at our facility are concerned that code I11.9 does not fully capture the patient's condition, nor the severity of the case. What is the appropriate code assignment for Takotsubo syndrome with hypertension?

Answer:

Assign code I51.81, Takotsubo Syndrome, as the principal diagnosis. Assign code I10, Essential (primary) hypertension, as an additional diagnosis. The provider's documentation of "Takotsubo Syndrome" indicates Takotsubo as the underlying etiology of the cardiomyopathy, not hypertension. Takotsubo syndrome by definition is stress-related. Therefore, it is not appropriate to assign code I11.9, Hypertensive heart disease without heart failure. The guideline regarding hypertension and heart disease specifically states, "The same heart conditions (I50.-, I51.4 - I51.9) with hypertension are coded separately if the provider has specifically documented a different cause."

Commonly-encountered Diagnoses

Hypertension with diabetic nephropathy and chronic kidney disease

ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2019 Page: 3 Effective with discharges: October 1, 2019

Question:

The patient presented for renal transplantation due to end stage renal disease (ESRD), and the provider's final diagnostic statement listed, "ESRD due to diabetic nephropathy on dialysis, diabetic retinopathy, diabetic peripheral neuropathy, and hypertension." The Official Guidelines for Coding and Reporting (I.C.9.a.2.) state, "CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension." In this case, since the provider documented ESRD due to diabetic nephropathy, would this statement be sufficient to indicate that the CKD is not related to hypertension?

Answer:

When the patient has diabetes, hypertension and chronic kidney disease (CKD) and **the provider documents CKD due to diabetes or diabetic CKD, diabetic nephropathy or other similar terminology a causal relationship is indicated, and denotes the CKD is not related to the hypertension**. In this case, assign a code for diabetic chronic kidney disease. Do not assign a code for hypertensive CKD, as the hypertension would be coded separately.

In addition, it would be redundant to assign codes for both diabetic nephropathy (E11.21) and diabetic chronic kidney disease (E11.22) as diabetic chronic kidney disease is a more specific condition

~~**Hypertension, diabetes mellitus and chronic kidney disease**~~

~~ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2018 Pages: 88-89 Effective with discharges: October 8, 2018~~

~~**Question:**~~

~~Since ICD-10-CM presumes a relationship between both chronic kidney disease (CKD) and hypertension as well as diabetes mellitus and CKD, what are the appropriate code assignments when the provider documents type 2 diabetic mellitus with chronic kidney disease and the patient also has a diagnosis of hypertension?~~

Superseded

~~**Answer:**~~

~~Assign codes E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease, I12.9, Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease and N18.9, Chronic kidney disease, unspecified. The classification presumes a cause and effect relationship between both diabetes and CKD and hypertension and CKD. CKD is most likely related to both hypertension and diabetes when the patient has all three conditions. Both high blood sugar and high pressure in the blood vessels will cause the vessels to deteriorate, which can then damage the kidneys.~~

Advice

~~As of October 1, 2018, the ICD-10-CM Official Guidelines for Coding and Reporting have been revised to read "Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension."~~

Commonly-encountered Diagnoses

Necrotic pressure ulcer of heel with diabetic peripheral vascular disease and neuropathy

ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2018 Pages: 3-4 Effective with discharges: September 24, 2018

Question:

A 63-year-old diabetic patient, who has been diagnosed with a gangrenous decubitus ulcer of the left heel, is admitted to the hospital and undergoes excisional debridement of a foul-smelling necrotic pressure ulcer of the left heel. The provider's final diagnostic statement listed, "Stage 3 necrotic decubitus ulcer of left heel associated with diabetic neuropathy and peripheral vascular disease." Since the provider has documented an association between the diabetes and decubitus ulcer, which condition is sequenced as principal diagnosis?

Answer:

Assign code I96, Gangrene, not elsewhere classified, as the principal, because of the "code first" note under category L89, Pressure ulcer. Assign code L89.623, Pressure ulcer of left heel, stage 3, as a secondary diagnosis. In this case, the gangrene is associated with the pressure ulcer rather than the diabetes mellitus, and ICD-10-CM instructs to code first any associated gangrene. The primary reason for the admission was for treatment of the gangrenous pressure ulcer. This was not a diabetic ulcer. Diabetic ulcers typically involve the foot starting on the toes and moving upward. Pressure ulcers typically develop in tissue near bony prominences, such as the elbows, tailbone, greater trochanters or heels. Although diabetes mellitus may increase the risk of pressure ulcers because of its association with neuropathy and angiopathy, ICD- 10-CM does not classify pressure ulcers the same as diabetic ulcers. The classification does not provide index entries for diabetes with pressure ulcer as the code categories for diabetes were not intended to describe pressure ulcers.

In addition, assign codes E11.51, Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, and E11.40, Type 2 diabetes mellitus with neurological complications, as additional diagnoses

BREAKING THE “WITH OR IN” LINK
GI BLEEDING

GI bleeding “with” Example

Documentation	
PN Patient is a direct transfer for GI bleed. Drop in hgb from 11.9 to 7.8. GI consulted. Colonoscopy yesterday was unrevealing. Possibly from hemorrhoids. Responding to Procrit 60k units once weekly and IV venofer 300mg daily x 3 days -- today is D3. Can resume apixiban and discharge home with outpatient follow up - she only wants to follow up with her PCP and will see them this week. #GIB #brbpr #anemia #Jehovah's Witness - 12/23/21: Hb was 7.8, MCV 87 after passage of numerous bloody bowel movements - Hb on admission , stable at 7.8 - brbpr for approximately 1 week duration, w/ Hb drop from 11.9 to 7.9 in 3 days - CT at OSH: diverticulosis, possible colitis, mild distention of the small loops of the bowel - most likely lower gi bleed given hematochezia, RF include AC, past GIB, not up to date with colon cancer screening - access: peripheral IV - pt has document refusing all blood products even if life threatening conditions - Colonoscopy 12/25 with no e/o active bleed. Likely source is her external hemorrhoids. Plan: - GI consulted, appreciate recs - Restarted apixaban, aspirin - PO PPI daily - procrit 60,000 units once - IV venofer 300 x 3 days - DVT ppx with SCDs **DS** DETAILS OF HOSPITAL STAY Patient presented to hospital as a direct transfer for GI bleed.	Regarding her outside hospital course, she presented OSH with abdominal pain and rectal bleeding. A CT AP revealed diverticulosis, and possible colitis, with mild distention of the bowel loops of small bowel. Patient's Hb was 11.9 on admission which dropped to 9.3 and then to 8, eight hours later, after a couple bloody bowel movements. Patient was seen by GI who did not feel comfortable to scope pt without angiography, and requested transfer due to bloodless medicine services. Her last hemoglobin at OSH was 7.8. Upon arrival, vitals were significant for BP 100/57, HR 96, T 97.7, RR 18 and SpO2 97% on RA. Labs on admission, Hgb 7.8, WCC 10.7. Of note, patient does not accept blood products. She was admitted to the heme/onc service for further workup and management. Hospital Course by Problem: #Lower GI Bleed #Anemia On admission, Hgb noted to be 7.8 where her baseline is typically in the 12's range. She presented initially with bright red blood per rectum for about one week. As patient is a bloodless medicine patient, she received Epogen infusion as well as IV Iron Infusion x3 days. She was made NPO and started on IV PPI infusion, which was eventually transitioned to PO PPI twice daily. GI was consulted and patient underwent colonoscopy on 12/24 which revealed no evidence of active bleed, diverticulosis, and external hemorrhoids. She was restarted on her aspirin and apixaban. Her hemoglobin remained stable at discharge at 8.0. She was instructed to obtain a CBC in 3-4 days and follow up with her PCP. #HTN #CAD Given significant cardiac past medical history, cardiology was consulted for risk stratification. She underwent TTE on 12/23 which was consistent with moderate concentric hypertrophy, EF 50%, severe LV diastolic dysfunction and severe aortic stenosis. Initially her carvedilol was held in the setting of bleeding, however was restarted on 12/24. Her ASA was restarted on 12/25, Xarelto was restarted on 12/24 and Losartan was restarted on 12/25.

GI bleeding “with” Example—Breaking the “with” link

Recommendation

Recommend deleting the current PDX of K625 Hemorrhage of anus and rectum and adding the new PDX of K644 Residual hemorrhoidal skin tags. The working differential was diverticulosis, ischemic colitis and hemorrhoids. After study per the last PN 12/25 date of discharge felt the bleeding was due to the hemorrhoids.

The Diverticulosis should be coded; however, it should be coded to Diverticulosis without bleeding as the specific source was documented as being the external hemorrhoids and therefore the "with" link is broken with the bleeding and the Diverticulosis.

Recommend Adding K5732 Diverticulosis of large intestine without perforation or abscess without bleeding and NOT adding the MCC of K5731 Diverticulosis of large intestine without perforation or abscess with bleeding.

	ORIGINAL	RECOMMENDED
PDX	K625 Hemorrhage of anus and rectum	K644 Residual hemorrhoidal skin tags
SDX	D62 Acute posthemorrhagic anemia	D62 Acute posthemorrhagic anemia
DRG	378 GASTROINTESTINAL HEMORRHAGE WITH CC	394 OTHER DIGESTIVE SYSTEM DIAGNOSES WITH CC
RW	.9935	.9409

GI Bleeding

Common Coding Errors

Common Coding Errors

1. A specific Causal relationship was not stated but the GI bleed was coded without the combination code in the presence of a condition where the "with" guideline applies
2. Causal relationship was stated in the documentation, but the combination code was not utilized
3. We had instances where a probable, possible, suspected cause diagnosis/cause was stated after study but was not coded
4. Coding a hemorrhage (melena) with colitis
    a. Hemorrhage is a nonessential modifier for colitis
5. Sequencing errors
    a. Esophageal Varices in Cirrhosis
6. Coding or not coding coagulation disorders either drug induced or due to an underlying disease process

Commonly Missed Query Opportunities

✓ Missed possible query for ABLA

Unspecified anemia documented with active acute bleeding and/or symptomatic anemia in the setting of a hemorrhage

Transfused for low hemoglobin and/or iron administered

Monitoring hemoglobin over a period of days

✓ Pathological findings

Patient had a bleeding mass, identified as cancer on the pathology report, coder did not query for the neoplasm, and assigned the cancer as PDx and/or coded mass and did not query for final pathology

✓ Corresponding Dx or Severity of Malnutrition (not all criteria listed below)

On TPN/Tube feeds or insufficient calorie intake

Low BMI (does not always need to be present)

Weight loss

Muscle wasting/weakness/reduced grip strength

Low albumin (providers still use)

Dry skin, poor wound healing, edema, anemia, dehydration or other electrolyte abnormalities, renal impairment

✓ Specifity for ischemic colitis

Acute/Fulminant=MCC

Chronic/Unspecified=CC

Missed coding (or sequencing errors) D68.32, Hemorrhagic Disorder due to extrinsic circulating anticoagulants with hemorrhagic disorders

GI Bleeding

Summary

- ✓ If a patient presents with GI bleeding and it's not linked to a specific condition, it would be appropriate to assume a relationship between two conditions if they are linked by the terms "with" or "in" in the Alphabetic Index or Tabular index unless the provider documents a different cause of the bleeding or states the conditions are unrelated.
- ✓ A word of caution, some GI conditions (such as hemorrhoids, polyps) do not have a linking statement in the Alphabetic Index or Tabular index, "with" hemorrhage.
  - If multiple possible sources are found during work up, we can still assume the relationship if "with" hemorrhage is applicable
  - A query may be appropriate if a condition without a linking "with" is possibly the source of the bleed (i.e. suspect "lower gi bleeding" and the patient has hemorrhoids on colonoscopy and mild gastritis noted on EGD, no causal relationship established in documentation)
    - Can possibly have DRG implications
- ✓ If there is a linking statement to a specific condition without the term "with" and no combination exists in the classification then be sure to check for nonessential modifiers or instructional notes to guide in code assignment (i.e. colitis, gastric varices vs. esophageal varices in cirrhosis, portal gastropathy)
  - If nothing excludes the codes from being used together then a code for the condition and a separate code for hemorrhage can be assigned
    - Check for nonessential modifiers
    - Do they include terms such as hemorrhage or hemorrhagic?
    - If not we can capture an additional code for the type of hemorrhage (melena, hematemesis, rectal bleeding, etc.)
- ✓ Always check for instructional notes, such as code first underlying disease
- ✓ When the patient is admitted with a GI bleed and the bleeding is not demonstrated at the time of endoscopy but the source is suspected (such as a gastric ulcer) then it is appropriate to code as "with hemorrhage"
  - "Non-bleeding" at time of endoscopy does not preclude the diagnosis if determined after study to be the source

GI Bleeding

Gastrointestinal bleeding due to multiple possible sources

ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2018 Pages: 21-22 Effective with discharges: September 24, 2018

Question:

A patient admitted with hematochezia underwent colonoscopy. The provider's diagnostic impression included non-thrombosed and non-bleeding internal hemorrhoids, sigmoid diverticulosis, colonic angiodyplasia, and adenomatous cecum polyp. Coding professionals understand that active bleeding does not have to be demonstrated during the hospital stay for the physician to clinically diagnose bleeding, and that the classification makes a linkage between bleeding and angiodysplasia, and diverticulosis with bleeding. Is it appropriate to assign codes for multiple bleeding sites when more than one finding/possible cause is linked, because of indexing in the classification?

Answer:

Assign code K57.31, Diverticulosis of large intestine without perforation or abscess with bleeding, and code K55.21, Angiodysplasia of colon with hemorrhage, for the diverticulosis and colonic angiodysplasia with GI bleeding. Either condition may be sequenced as the principal diagnosis. Assign also codes D12.0, Benign neoplasm of cecum, and K64.8, Other hemorrhoids, for the polyp and internal hemorrhoids. The fact that bleeding is not seen during colonoscopy does not preclude the assignment of a code describing hemorrhage. ICD- 10-CM makes a linkage between gastrointestinal hemorrhage and diverticulosis and angiodyplasia; therefore, the provider does not have to link the conditions in the documentation.

<u>This is similar to out case study. However, in our case study they link the bleed to the hemorrhoids</u>

Hematemesis due to ulcerative esophagitis and duodenitis

ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2018 Pages: 22-23 Effective with discharges: September 24, 2018

Question:

A patient presents with coffee ground hematemesis and has esophagogastroduodenoscopy (EGD) performed. The provider's final diagnostic statement lists, "Acute upper gastrointestinal (GI) hemorrhage, ulcerative esophagitis, and duodenitis." Is it appropriate to assign combination codes for ulcerative esophagitis with bleeding and duodenitis with bleeding, to capture multiple bleeding sites?

Answer:

Yes. Assign codes K22.11, Ulcer of esophagus with bleeding, and K29.81, Duodenitis with bleeding, for the ulcerative esophagitis and duodenitis with hematemesis. Since the classification links the hemorrhage in both conditions, it is appropriate to assign the combination codes indicating "with bleeding."

GI Bleeding

Other References:

Other CM Concepts related to GI bleeding

Uncertain diagnosis with presumed related condition in outpatient setting
ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2021 Pages: 11-12 Effective with discharges: March 10, 2021

Hemoccult positive stool finding
ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2021 Pages: 9-10 Effective with discharges: March 10, 2021

Gastrointestinal bleeding secondary to gastric ulcer
ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2017 Page: 27 Effective with discharges: July 27, 2017

Hematemesis due to ulcerative esophagitis and duodenitis
ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2018 Pages: 22-23 Effective with discharges: September 24, 2018

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

GI Bleeding

Other References:

Missed Related Procedures

Kcentra

Argon plasma coagulation of duodenal arteriovenous malformation
ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2018 Page: 19 Effective with discharges: February 18, 2018

Control of gastrointestinal bleeding

ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2017 Page: 105 Effective with discharges: October 1, 2017

Esophagogastroduodenoscopy with epinephrine injection for control of bleeding
ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Pages: 24-25 Effective with discharges: October 7, 2015

Cardiophrenic vein embolization
ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2020 Pages: 44-45 Effective with discharges: September 8, 2020

Endovascular embolization using microcoils
ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2014 Page: 24 Effective with discharges: March 31, 2014

Microbead embolization for gastrointestinal bleeding
ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2014 Page: 24 Effective with discharges: March 31, 2014

Endoscopic banding of esophageal varices
ICD-10-CM/PCS Coding Clinic, Fourth Quarter 2013 Pages: 112-113 Effective with discharges: October 21, 2013

Principal Diagnosis Case Study 2….

Principal Diagnosis Case 2 Missed MCC

Scenario

91-year-old male with history of CKD 3, cognitive impairment, BPH, ambulatory dysfunction presents after a fall today at home.

11/11 MRI Lumbar Spine IMPRESSION: “Redemonstration of acute discitis/osteomyelitis at L4-L5 with endplate erosions and loss of theL5 vertebral body height. There is moderate anterior paravertebral phlegmon which infiltrates the right greater than left L4 neural foramina. There is mild ventral epidural phlegmon at L5. No epidural abscess. An 11 mm abscess is identified in the left psoas muscle…Multifactorial severe spinal canal stenosis at L4-L5…Left L3, right L4,and bilateral L5 subarticular recess stenosis with nerve root encroachment…Severe right L3 and bilateral L4 neural foraminal stenosis with nerve root impingement”.

11/11 Dr. (HOSP) “CT of the lumbar spine showed possible osteomyelitis/discitis, is confirmed on MRI of the lumbar spine, the MRI also showed severe L4-5 stenosis with nerve impingement and 11 mm psoas abscess for which neurosurgery consulted”.

11/13 DR.(HOSP) “Lumbar osteomyelitis/phlegmon/psoas abscess: Status post CT-guided lumbar biopsy, procedure findings noted, soft tissue noted…Antibiotics were started empirically after the biopsy. Will need 6 to 8 weeks of IV antibiotics…Severe pain with flexion and internal rotation of the left hip, I suspect this is due to psoas abscess, on imaging only noted to be 11 mm, I do not think it is big enough to place a drain in but I will have VIR evaluate and see if it is feasible since patient is with severe pain”.

11/15 D/C Summary IR Request PSOAS ABSCESS…reviewed by Dr. He indicates the psoas abscess site is too small to drain. Dr. “Osteomyelitis/discitis…He was seen by infectious disease. They recommended IV ceftriaxone 2 g every 24 hours and IV daptomycin 500 mg every 24 hours till December 23, 2021”.

Original Codes

Initial DRG
478
2.3584
BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE W CC
Discharge Code 03
SOI 2 ROM 2

Initial Codes						
	Code	POA	CC/MCC	HCC	Description	Root Cause
D1	M4626	Y		HCC	Osteomyelitis of vertebra, lumbar region...	
D2	N390	Y	CC		Urinary tract infection, site not specified...	
D3	N12	Y	CC		Tubulo-interstitial nephritis, not specified as ac...	
D4	M4646	Y			Discitis, unspecified, lumbar region...	
D5	R2689	Y			Other abnormalities of gait and mobility...	
D6	N401	Y			Benign prostatic hyperplasia with lower urinary tr...	
D7	N1830	Y		HCC	Chronic kidney disease, stage 3 unspecified...	
D8	Z20822	Y			Contact with and (suspected) exposure to COVID-19...	
D9	R0902	Y			Hypoxemia...	
D10	Z66	Y			Do not resuscitate...	
P1	0QB03ZX				Excision of Lumbar Vertebra, Percutaneous Approach...	
P2	009U3ZX				Drainage of Spinal Canal, Percutaneous Approach, D...	
P3	02HV33Z				Insertion of Infusion Device into Superior Vena Ca...	

What is the Missed MCC?

Case 2 MCC Awareness

Recommendation

Add secondary diagnosis K6812: Psoas muscle abscess

ICD-10-CM Official Guidelines for Coding and Reporting, 2022,Section III: Reporting Additional Diagnoses: General Rules for Reporting Other (Additional) Diagnoses This will result in a MS-DRG increase from 478 to 477.

Original Codes

	Initial Codes					
	Code	**POA**	**CC/MCC**	**HCC**	**Description**	**Root Cause**
D1	M4626	Y		HCC	Osteomyelitis of vertebra, lumbar region...	
D2	N390	Y	CC		Urinary tract infection, site not specified...	
D3	N12	Y	CC		Tubulo-interstitial nephritis, not specified as ac...	
D4	M4646	Y			Discitis, unspecified, lumbar region...	
D5	R2689	Y			Other abnormalities of gait and mobility...	
D6	N401	Y			Benign prostatic hyperplasia with lower urinary tr...	
D7	N1830	Y		HCC	Chronic kidney disease, stage 3 unspecified...	
D8	Z20822	Y			Contact with and (suspected) exposure to COVID-19...	
D9	R0902	Y			Hypoxemia...	
D10	Z66	Y			Do not resuscitate...	
P1	0QB03ZX				Excision of Lumbar Vertebra, Percutaneous Approach...	
P2	009U3ZX				Drainage of Spinal Canal, Percutaneous Approach, D...	
P3	02HV33Z				Insertion of Infusion Device into Superior Vena Ca...	

Initial DRG

478
2.3584
BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE W CC

Discharge Code 03

SOI 2 ROM 2

	Audited Codes					
	Code	**POA**	**CC/MCC**	**HCC**	**Description**	**Root Cause**
	M4626	Y		HCC	Osteomyelitis of vertebra, lumbar region...	
	K6812	Y	MCC	HCC	Psoas muscle abscess...	Stated & clinically supported but not coded (omission); Official Coding Guidelines not followed
	N390	Y	CC		Urinary tract infection, site not specified...	
	N12	Y	CC		Tubulo-interstitial nephritis, not specified as ac...	
	M4646	Y			Discitis, unspecified, lumbar region...	
	R2689	Y			Other abnormalities of gait and mobility...	
	N401	Y			Benign prostatic hyperplasia with lower urinary tr...	
	N1830	Y		HCC	Chronic kidney disease, stage 3 unspecified...	
	Z20822	Y			Contact with and (suspected) exposure to COVID-19...	
	R0902	Y			Hypoxemia...	
	0QB03ZX				Excision of Lumbar Vertebra, Percutaneous Approach...	
	009U3ZX				Drainage of Spinal Canal, Percutaneous Approach, D...	
	02HV33Z				Insertion of Infusion Device into Superior Vena Ca...	

Reworked DRG

477
3.3589
BIOPSIES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH MCC

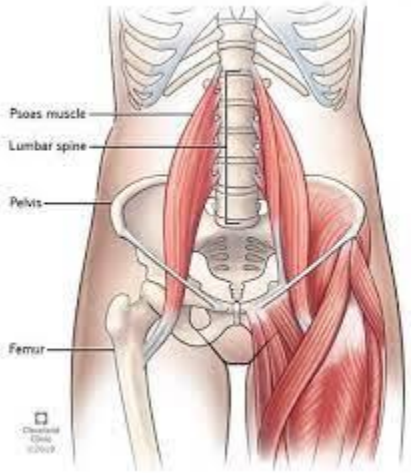
Discharge Code 03

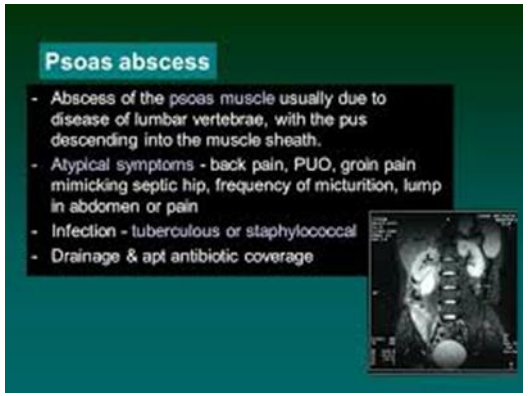
SOI 3 ROM 3

Code Book Index and Tabular

Abscess, Psoas

gonococcal (acute) (chronic) A54.22
psoas muscle K68.12
puerperal - code by site under Puerperal, abscess
pulmonary - see Abscess, lung
pulp, pulpal (dental) K04.01
irreversible K04.02
reversible K04.01





K68	Disorders of retroperitoneum
K68.1	Retroperitoneal abscess
K68.11	Postprocedural retroperitoneal abscess
EXCLUDES 2	infection following procedure (T81.4-)
K68.12	Psoas muscle abscess
K68.19	Other retroperitoneal abscess
K68.9	Other disorders of retroperitoneum

Case 3 Query Opportunity/MISSED MCC

Recommendation: The supervisor disagreed with adding the code and thought a Query should be submitted for confirmation of acute pancreatitis

Add secondary diagnosis K8590: Acute pancreatitis without necrosis or infection, unspecified.

Rationale: :This secondary diagnosis is appropriate based on the UHDDS definition and reportability of other diagnoses Review of the medical record reveals: Lipase: 11/29 61, 12/12 919, 12/13 454 12/2 Dr (Surgical Oncology) "…some mild abdominal discomfort…Abd: Soft, mildly tender in mid-epigastric area. Non-distended…IVF, IV abx..."

12/2 Addendum Dr. "...Patient feels better this evening he had some discomfort this morning likely some post ERCP pancreatitis and his lipase level was slightly elevated. Continue clears but, tomorrow if his pain is resolved, and his lipase is starting to normalize he can be on a low-fat diet..." 12/3 Dr. (Surgical Oncology) "...Patient did have some evidence of post-ERCP pancreatitis but he is improved this morning-likely can advance diet further today to LFD if lipase okay...". 12/3 Addendum Dr. "...Overall patient doing much better today he says he is not having much abdominal pain. Liver function tests have decreased significantly. Lipase level is normalizing. He has tolerated clear liquids he could be on a low-fat diet he says he is not very hungry but is interested in eating…If he tolerates a low fat diet, and his liver function tests continue to improve he can go home tomorrow..." ICD-10-CM Official Guidelines for Coding and Reporting, 2022, Section III: Reporting Additional Diagnoses: General Rules for Reporting Other (Additional) Diagnoses This will result in a MS-DRG increase from 446 to 444.

For clarification, the organization thought that a query should be submitted before adding the code for confirmation of acute pancreatitis (see next slide)

Original Codes

	Initial Codes					
	Code	POA	CC/MCC	HCC	Description	Root Cause
D1	K8309	Y			Other cholangitis...	
D2	E806	Y			Other disorders of bilirubin metabolism...	
D3	R7401	Y			Elevation of levels of liver transaminase levels...	
D4	E785	Y			Hyperlipidemia, unspecified...	
D5	I10	Y			Essential (primary) hypertension...	
D6	K219	Y			Gastro- esophageal reflux disease without esophagit...	
D7	K317	Y			Polyp of stomach and duodenum...	
D8	Z20822	Y			Contact with and (suspected) exposure to COVID-19...	
D9	K648	Y			Other hemorrhoids...	
D10	N400	Y			Benign prostatic hyperplasia without lower urinary...	
P1	0DB98ZX				Excision of Duodenum, Via Natural or Artificial Op...	
P2	0FC98ZZ				Extirpation of Matter from Common Bile Duct, Via N...	
P3	BF111ZZ				Fluoroscopy of Biliary and Pancreatic Ducts using ...	
P4	BF35ZZZ				Magnetic Resonance Imaging (MRI) of Liver...	
P5	BF4CZZZ				Ultrasonography of Hepatobiliary System, All...	
P6	0F798DZ				Dilation of Common Bile Duct with Intraluminal Dev...	

RED = Code Removal; BLUE = Code Promoted to PDX; ORANGE = Code Demoted to SDX; GREEN = Code Added; YELLOW HIGHLIGHT = Query Requi

Initial DRG

446

0.8166

DISORDERS OF THE BILIARY TRACT W/O CC/MCC

Discharge Code 01

SOI 2 ROM 1

Revised Codes

Audited Codes					
Code	POA	CC/MCC	HCC	Description	Root Cause
K8309	Y			Other cholangitis...	
K8590	N	MCC		Acute pancreatitis without necrosis or infection, ...	Stated & clinically supported but not coded (omission); Official Coding Guidelines not followed
E806	Y			Other disorders of bilirubin metabolism...	
R7401	Y			Elevation of levels of liver transaminase levels...	
E785	Y			Hyperlipidemia, unspecified...	
I10	Y			Essential (primary) hypertension...	
K219	Y			Gastro- esophageal reflux disease without esophagit...	
K317	Y			Polyp of stomach and duodenum...	
Z20822	Y			Contact with and (suspected) exposure to COVID-19...	
K648	Y			Other hemorrhoids...	
0DB98ZX				Excision of Duodenum, Via Natural or Artificial Op...	
0FC98ZZ				Extirpation of Matter from Common Bile Duct, Via N...	
BF111ZZ				Fluoroscopy of Biliary and Pancreatic Ducts using ...	
BF35ZZZ				Magnetic Resonance Imaging (MRI) of Liver...	
BF4CZZZ				Ultrasonography of Hepatobiliary System, All...	
0F798DZ				Dilation of Common Bile Duct with Intraluminal Dev...	

Reworked DRG

444

1.6716

DISORDERS OF THE BILIARY TRACT WITH MCC

Discharge Code 01

SOI 2 ROM 1

Case 3 Missed MCC/Query Opportunity

Scenario:

76 year old male presents to emergency department noted to be febrile, tachycardic, labs demonstrating leukocytosis and direct hyperbilirubinemia.

12/2 Dr. (Surgical Oncology) "some mild abdominal discomfort Abd: Soft, mildly tender in mid-epigastric area. Non-distended IVF, IV abx..."

12/2 Addendum "Patient feels better this evening he had some discomfort this morning likely some post ERCP pancreatitis and his lipase level was slightly elevated. Continue clears but, tomorrow if his pain is resolved, and his lipase is starting to normalize he can be on a low-fat diet..."

12/3 Dr. (Surgical Oncology) "Patient did have some evidence of post-ERCP pancreatitis but he is improved this morning-likely can advance diet further today to LFD if lipase okay."

12/3 Addendum Dr. "Overall patient doing much better today he says the is not having much abdominal pain. Liver function tests have decreased significantly. Lipase level is normalizing. He has tolerated clear liquids he could be on a low-fat diet he says he is not very hungry but is interested in eating. If he tolerates a low fat diet, and his liver function tests continue to improve he can go home tomorrow."

DS: "After this procedure, the patient had excellent downtrend of his liver tests, and felt significantly better. He tolerated a diet and had full return of bowel function."
Labs: Lipase:
11/29 61
12/12 919
12/13 454

Query:
Please clarify if the diagnosis below has been ruled in or ruled out.
* Acute pancreatitis without necrosis or infection has been ruled in
* Acute pancreatitis without necrosis or infection has been ruled in and resolved during this admission
* Acute pancreatitis without necrosis or infection has been ruled out
*
Other diagnosis indicated, please specify
* Cannot rule in or out, clinically strongly suspected (please explain why)
* Clinically unable to determine

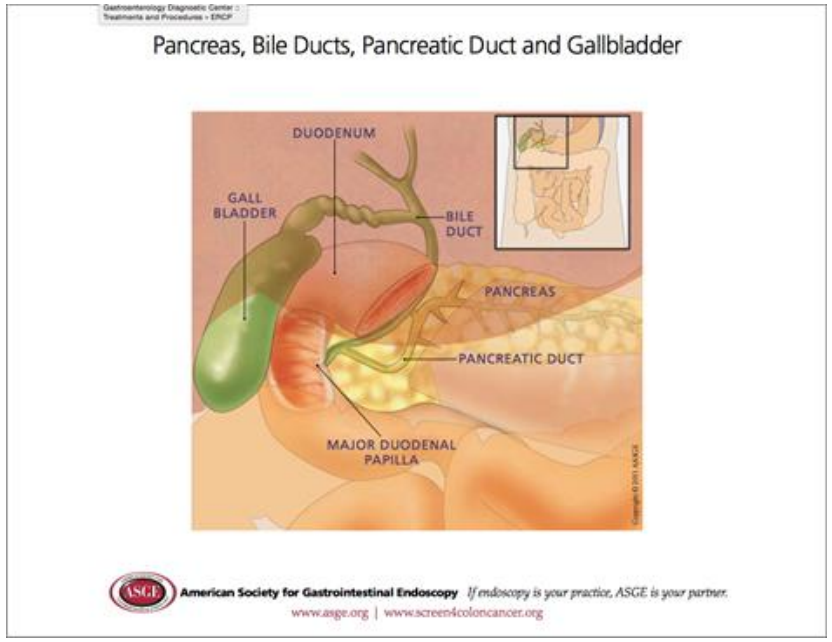
Enter Your Response Below:

The patient had acute post ERCP pancreatitis without necrosis or infection. This was procedure related

POST-ERCP PANCREATITIS

See RT 130 for more information about Post-ERCP pancreatitis

AKA Pancreatitis due to ERCP, Post ERCP induced Pancreatitis, PEP



Background

Acute pancreatitis remains the most common complication of endoscopic retrograde cholangiopancreatography (ERCP). In one study, It is reported to occur in 2–10% of patient samples and up to 40% of high-risk patients. In another study it was reported to be 5%-16%

Pancreatitis due to an ERCP may occur if the patient experiences mechanical injury during the procedure. This may include prolonged manipulation of the ducts or surrounding organs, injections of a contrast medium to aid X-ray results, and difficulty during cannulation. The provider will consider other possibilities such as perforation.

Serum amylase levels may be elevated after ERCP in up to 75% of patients, regardless of symptoms. A few different consensus criteria have been developed to try to standardize the definition of post-ERCP pancreatitis.

Risk Factors

young age, female sex, suspected sphincter of Oddi dysfunction, a history of post-ERCP pancreatitis or recurrent pancreatitis, a normal bilirubin level

Table 1 General Consensus of Risk Factors for PEP[9,22-26]

Patient-related factors	Procedure-related factors	Operator-related factors
Female sex	Ampullectomy	Inadequate training
Normal serum bilirubin level	Biliary balloon sphincteroplasty	Lack of experience
History of PEP	Difficult cannulation	
Recurrent pancreatitis	Minor papilla sphincterotomy	
Sphincter of Oddi dysfunction	Pancreatic duct injection	
Younger age (<60 y)	Pancreatic sphincterotomy	
	Precut sphincterotomy	
	Sphincter of Oddi manometry	
	Trainee involvement	

PEP = post–endoscopic retrograde cholangiopancreatography pancreatitis.

See RT 130 for more information about Post-ERCP pancreatitis
The recording can be found here: https://www.gotostage.com/channel/ciox-webinars

Pathogenesis of PEP

The pathogenesis is poorly understood but it is thought that it is an activation of inflammatory pathways

Mechanical

Mechanical includes obstruction of the papilla or pancreatic sphincter by instrumentation and/or prolonged manipulation of the papillary orifice, difficult cannulation of the biliary tree, and repeated inadvertent instrumentation of the pancreatic duct result in ductal injury or injury

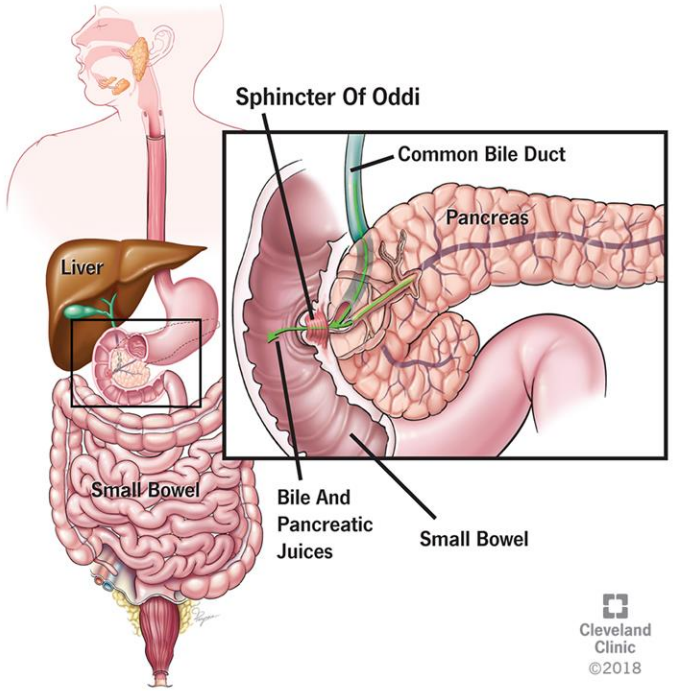
Thermal

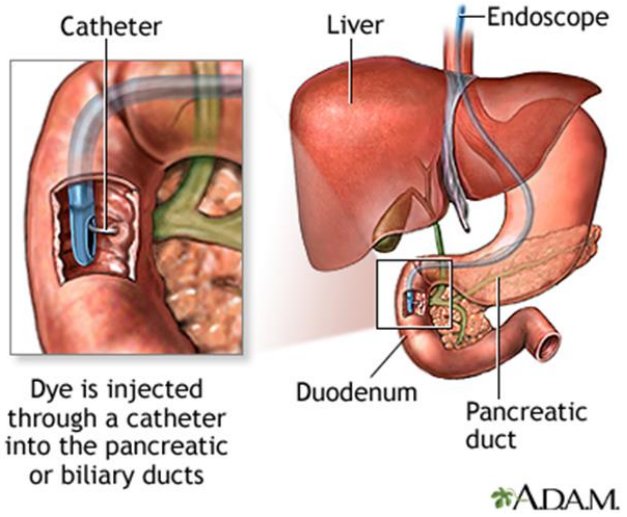
Thermal injury may result from electrocautery current used during sphincterotomy (biliary or pancreatic), endoscopic papillectomy, or ablation of neoplastic lesions in the region of the ampulla of Vater

Resultant papillary edema caused by mechanical or thermal injury is thought to obstruct the outflow of pancreatic secretion, resulting in pancreatitis.

Chemical

Contrast agents could potentially lead to PEP by causing chemical injury or allergic injury from contrast injection. These are thought to be possible mechanisms that may occur during ERCP.





Pathogenesis of PEP (Cont.)

Hydrostatic
Hydrostatic injury, which results from over injection of the pancreatic duct or infusion of water or saline through manometry catheters.
Enzymatic

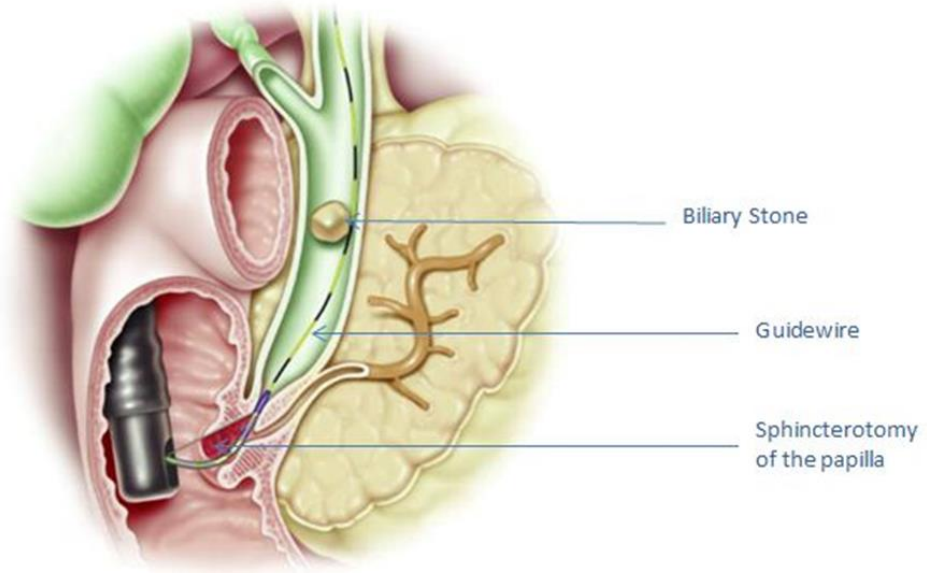
Introduction of foreign material into the pancreatic duct results in the intraluminal activation of proteolytic enzymes, which subsequently results in enzymatic injury. In addition, the reflux pathogenesis describes the introduction of intestinal enzymes into the pancreatic ductal tree by ERCP.
Microbiologic

Bacterial translocation and subsequent activation of the inflammatory process is also thought to contribute to the pathogenesis

The resultant cascade of inflammation release of inflammatory mediators and cytokines. This cascade can be limited to local inflammation or initiate a systemic inflammatory response syndrome (SIRS).

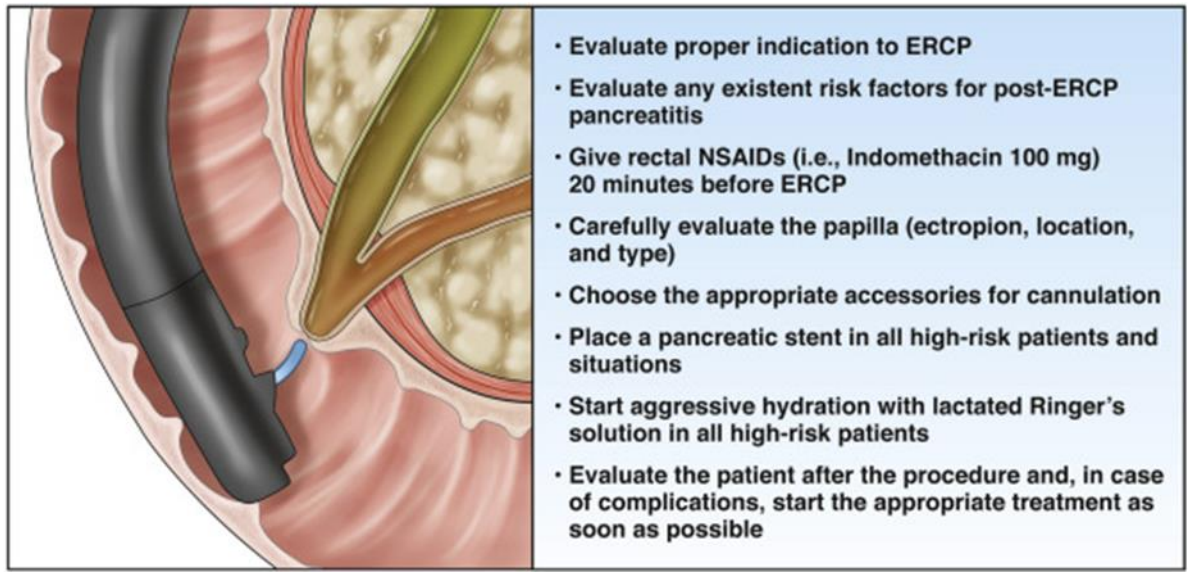
Mitigate risk
The use of a guide wire for cannulation, minimizing the number of cannulation attempts, avoiding contrast injections or trauma to the pancreatic duct, and placement of a temporary pancreatic duct stent is thought to mitigate the chance of PEP in high-risk patients.

Administration of rectal non-steroidal anti-inflammatory agents (NSAIDs)(indomethacin, diclofenac) in high-risk patients is the proven pharmacological measure for prevention of post-ERCP pancreatitis. Research has shown this to be case in all studies. Other drugs include somatostatin analogs (octreotide) and calcium channel blockers, and PPI's. (Still ongoing clinical trials and research studies still being done)



Nitroglycerin is a smooth muscle relaxant thought to promote pancreatic blood flow and decrease sphincter of Oddi pressures (conflicting data), rectal indomethacin and sublingual nitrates

In a 2019, studies showed that more endoscopists use rectal NSAID's more often than pancreatic duct stent for prophylaxis. Future studies should not only further clarify the optimal PEP prophylaxis strategy, but should also focus on strategies to improve the implementation of evidence-based PEP prophylaxis techniques



https://www.gastrojournal.org/article/S0016-5085(20)30359-0/fulltext

Treatment and Management of Acute Pancreatitis

IV fluids
Pain Medicine
Antibiotics
NPO (fasting), Progresses to clear liquids and bland diet once inflammation has subsided, feeding tube (severe cases)
CT scan/MRI to look for pancreas inflammation (pseudocyst, abscess, or other causes)
Monitoring of pancreatic enzymes (amylase and lipase)

Coding Complications

- The condition is more than a routinely expected condition or occurrence – there must be a cause-and-effect relationship between care provided and the condition and must specifically be documented.
- In this case "POST-ERCP pancreatitis" is a specific diagnosis and indicating a cause-and-effect relationship—
  - Example: Patient is seen as an outpatient for ERCP for follow-up on benign biliary stricture s/p stenting-ERCP exam is normal with a patent stent
  - Post-ERCP the patient developed severe abdominal pain and n/v and is admitted to IP status. Labs showed and elevated of pancreatic enzymes. After study the final diagnosis is "Post-ERCP Pancreatitis"

Code K91.89 [Other postprocedural complications and disorders of digestive system], add additional code for the pancreatitis, K85.90 [Acute pancreatitis without necrosis or infection, unspecified]**

** **ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 Page 90 of 126** *Intraoperative and postprocedural complication codes are found within the body system chapters with codes specific to the organs and structures of that body system.* ***These codes should be sequenced first, followed by a code(s) for the specific complication, if applicable.***

Complication codes from the body system chapters should be assigned for intraoperative and postprocedural complications (e.g., the appropriate complication code from chapter 9 would be assigned for a vascular intraoperative or postprocedural complication) unless the complication is specifically indexed to a T code in chapter 19

POST-ERCP PANCREATITIS Consensus Criteria

See RT 130 for more information about Post-ERCP pancratitis

1991 Cotton et al Criteria (most commonly used)

Please note the information presented here is to aid in understanding and discussion of clinical criteria are not meant to replace provider documentation.

Mild post-ERCP pancreatitis was defined as abdominal pain suggestive of pancreatitis requiring new hospitalization or extension of hospital stay for 2–3 days and a serum amylase at least three times the upper limit of normal, 24 hours after the procedure, a normal CT finding does not exclude mild pancreatitis

Modifications to this definition have been proposed to allow lipase as an alternative to amylase and defining clinical pancreatitis specifically as “new (de novo within 24 hours of ERCP) or worsened abdominal pain” to account for patients who undergo ERCP for pre-existing pain from acute and/or chronic pancreatitis

Moderate severity is defined by the need to stay in hospital for between 4 and 10 days. Severe post-ERCP pancreatitis is defined as the need for a hospital stay longer than 10 days, or by the development of a complication such as necrosis or pseudocyst, or need for intervention (drainage or surgery)

2014 European Society of Gastrointestinal Endoscopy
recommends that either of the two definitions be used

Table 2 Severity of Post–Endoscopic Retrograde Cholangiopancreatography Pancreatitis[32]

Factor	Mild	Moderate	Severe
Length of hospitalization (d)	<3	4-10	>10
Other defining characteristics	None	None	Hemorrhagic pancreatitis Pancreatic necrosis or pseudocyst Necessity for intervention (percutaneous drainage or surgery)

2012 Atlanta Classification

An international consensus statement, in which the diagnosis of acute pancreatitis requires two of three features:
(i) abdominal pain consistent with acute pancreatitis,
(ii) serum lipase or amylase greater than three times the upper limit of normal and
(iii) characteristic findings of acute pancreatitis on contrast-enhanced computerized tomography (CT) scan, magnetic resonance imaging (MRI), or transabdominal ultrasound

Mild acute pancreatitis is characterized by absence of accompanying organ failure, local complications, or systemic complications

Moderate acute pancreatitis includes transient organ failure (<48 hours) or local or systemic complications without persistent organ failure (e.g., fever, leukocytosis, exacerbation of chronic lung disease).

Severe acute pancreatitis is characterized by persistent organ failure (>48 hours) or the presence of a systemic inflammatory response syndrome (SIRS) at any time, given the high risk of progression to persistent organ failure

This definition is limited, in that it was not developed primarily for post-ERCP pancreatitis, but for all-cause pancreatitis. Most of the studies described here used the Cotton- or similar criteria to define and classify post-ERCP pancreatitis, but the variables in the revised Atlanta Classification are increasingly used in research studies

Laterality and specificity

Guideline updates for 2022

13. Laterality (OCG 2022, p. 15)—Bold text is new for 2022
Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

When a patient has a bilateral condition and each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides), including for the encounter to treat the first side. For the second encounter for treatment after one side has previously been treated and the condition no longer exists on that side, assign the appropriate unilateral code for the side where the condition still exists (e.g., cataract surgery performed on each eye in separate encounters). The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously-treated site. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.

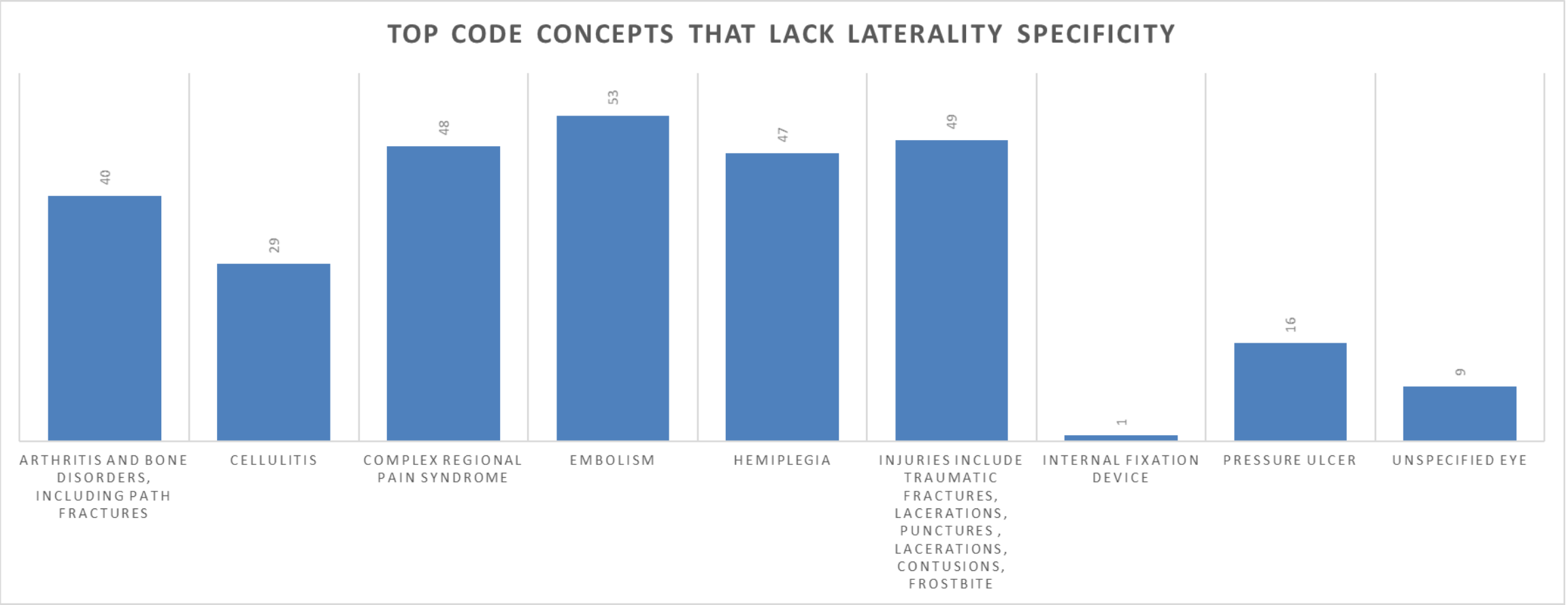
When laterality is not documented by the patient's provider, code assignment for the affected side may be based on medical record documentation from other clinicians. If there is conflicting medical record documentation regarding the affected side, the patient's attending provider should be queried for clarification. Codes for "unspecified" side should rarely be used, such as when the documentation in the record is insufficient to determine the affected side and it is not possible to obtain clarification.

14. Documentation by Clinicians Other than the Patient's Provider
Code assignment is based on the documentation by the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions **when** code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). **In this context, "clinicians" other than the patient's provider refer to healthcare professionals permitted, based on regulatory or accreditation requirements or internal hospital policies, to document in a patient's official medical record.**

These exceptions include codes for:
- **Body Mass Index (BMI)**
- **Depth of non-pressure chronic ulcers**
- **Pressure ulcer stage**
- **Coma scale**
- **NIH stroke scale (NIHSS)**
- **Social determinants of health (SDOH)**
- **Laterality**
- **Blood alcohol level**

This information is typically**, or may be,** documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, pressure ulcer, **or a condition classifiable to category F10, Alcohol related disorders**) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.
The BMI, coma scale, NIHSS, **blood alcohol level** codes and **codes for social determinants of health** should only be reported as secondary diagnoses.
See Section I.C.21.c.17 for additional information regarding coding social determinants of health.

Sample Case Review-Top Code Concepts



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.

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.

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*Ciox Employees please refer to the Yammer group for guidelines.

Thank You