HCPro, Inc., presents

**Coding Clinic for ICD-9-CM and Documentation Improvement Opportunities: Best Practices for CDI and Coding Compliance**

A 120-minute interactive audio conference

**Friday, October 28, 2011**

1:00 p.m.–3:00 p.m. (Eastern)
12:00 p.m.–2:00 p.m. (Central)
11:00 a.m.–1:00 p.m. (Mountain)
10:00 a.m.–12:00 p.m. (Pacific)
Dear Program Participant,

Thank you for participating in our “Coding Clinic for ICD-9-CM and Documentation Improvement Opportunities: Best Practices for CDI and Coding Compliance” audio conference, featuring speakers Gloryanne Bryant, BS, RHIA, RHIT, CCS, CCDS, and James S. Kennedy, MD, CCS, and moderated by Melissa Varnavas.

Our team is excited about the opportunity to interact with you directly. We encourage you to ask our experts your questions during the program. If you would like to submit a question before the audio conference, please send it to the producer, Wendy Walsh, at wwalsh@hcpro.com and provide the program date in the subject line. We cannot guarantee that your question will be answered during the program, but we will do our best to include a good cross section of questions.

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At HCPro, we appreciate hearing from our customers. So if you have comments, suggestions, or ideas about how we can improve our programs, or if you have any questions about today’s show, please do not hesitate to contact me. And if you would like any additional information about our other products and services, please contact our customer service department at 800/650-6787.

Thank you, again, for attending the HCPro program today. We hope you found it to be informative and helpful and that you will continue to rely on HCPro programs as an important resource for pertinent and timely information.

Sincerely,

Leokadia Marchwinski
Director of Multimedia Production
HCPro, Inc.
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*Please note: Continuing education credits are available for this program. For instructions on how to claim your credits, please visit the materials download page at www.hcpro.com/downloads/9735.*
Agenda

I. Use/misuse of Coding Clinic for ICD-9-CM

II. ICD-9-CM Official Guidelines for Coding and Reporting

III. Coding hierarchy

IV. 2010/2011 Coding Clinic examples and interpretation
   A. Stroke
   B. Pulmonary conditions
   C. Renal conditions
   D. SIRS
   E. Arteriosclerotic leukoencephalopathy
   F. Drug-induced pancytopenia
   G. Postoperative hemorrhage and postoperative hematoma
   H. Deep vein thrombosis and thrombophlebitis
   I. Adhesions

V. Live Q&A
Speaker Profiles

Gloryanne Bryant, BS, RHIA, RHIT, CCS, CCDS

Gloryanne Bryant is the regional managing director of HIM (Revenue Cycle N. California) for Kaiser Permanente in Oakland, CA, and is responsible for coding, education, HIM operations, and advisory to CDI for 21 acute care hospitals. Previously, she was senior director of SystemWide coding HIM compliance for Catholic Healthcare West in San Francisco. She is a member of the editorial advisory board for Briefings on Coding Compliance Strategies, and has more than 30 years of experience in the HIM profession providing education to coders, physicians, and other hospital staff on IPPS, DRGs, HCCs, ICD-9-CM, CPT coding, and clinical documentation improvement. In April 2006, she provided testimony in support of ICD-10 implementation for the House Ways and Means Committee, and in 2007, she was awarded the AHIMA Triumph “Champion” award.

James S. Kennedy, MD, CCS

James S. Kennedy is a managing director in the FTI Healthcare group of FTI’s Corporate Finance practice and is based in Brentwood, TN. Dr. Kennedy’s experience includes the private practice of medicine along with successful, entrepreneurial, healthcare-related business startups in the public and private sector. His expertise includes physician and hospital leadership, healthcare systems improvement, healthcare documentation and coding compliance, and government relations. He regularly educates physicians and hospital staffs on these topics, promoting physician data quality, the facilitation of outcomes measurement and physician re-credentialing, reductions in payment denials, and averting legal and compliance issues for healthcare entities. He is board certified by the American Board of Internal Medicine (licensed in Tennessee) and is active in the Healthcare Financial Management Association and the American Health Information Management Association among others.
Exhibit A

Presentation by Gloryanne Bryant, BS, RHIA, RHIT, CCS, CCDS, and James S. Kennedy, MD, CCS
Coding Clinic for ICD-9-CM and Documentation Improvement Opportunities: Best Practices for CDI and Coding Compliance

An HCPro audio conference on
October 28, 2011

Speakers

• Gloryanne Bryant, BS, RHIA, RHIT, CCS, CCDS
  – Regional Managing Director HIM, NCAL Revenue Cycle
  – Kaiser Foundation Health Plan, Inc. & Hospitals
  – Oakland, CA
• James S. Kennedy, MD, CCS
  – Managing Director
  – FTI Consulting
  – Brentwood, TN and Atlanta, GA
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Disclaimer

- The information presented reflects the speakers’ understanding of the ICD-9-CM and their wish that all medical conditions addressed during a clinical encounter are documented accurately in the medical record by providers and coded compliantly by the coding staff.
- The speakers wholeheartedly support ICD-9-CM, its Guidelines, its interpretations through Coding Clinic for ICD-9-CM, and other applicable laws or practice standards. Coders, clinical documentation specialists, and physicians are expected to be familiar with applicable rules, regulations, and laws, implementing them in their daily work.
- It is not the intent or desire of the speakers or their affiliated entities that any physician, case manager, or coder promote diagnosis terminology that is not supported by a reasonable standard of care or appropriate physician literature, nor is it their intent to encourage coding or query practices that fraudulently or abusively incur incorrect payments under government or private insurance programs.

Goals

- Review specific 2010–2011 AHA Coding Clinic for ICD-9-CM advice applicable to clinical documentation and coding integrity
  - Special emphasis on clarifying imprecise, incomplete, inconsistent, and conflicting documentation
  - Where applicable, demonstrate its impact on MS-DRG and APR-DRG assignment
- Demonstrate how AHA Coding Clinic advice integrates with ICD-9-CM conventions and the ICD-9-CM Official Guidelines for Coding and Reporting
- Provide suggested strategies that negotiate clinically congruent provider documentation and defendable ICD-9-CM code assignment
The AHA Central Office (on ICD-9-CM)

- Created through a written Memorandum of Understanding between the American Hospital Association (AHA) and the National Center for Health Statistics (NCHS) in 1963 to:
  - Serve as the U.S. clearinghouse for issues related to the use of ICD-9-CM
  - Work with NCHS, the Centers for Medicare & Medicaid Services (CMS), and the American Health Information Management Association (AHIMA)—known as the Cooperating Parties—to maintain the integrity of the classification system
  - Recommend revisions and modifications to the current and future U.S. versions of the ICD-9-CM (and soon for ICD-10-CM & ICD-10-PCS)
  - Develop educational material and programs on ICD-9-CM
- AHA publishes Coding Clinic for ICD-9-CM (quarterly)
  - This source is deemed by the four Cooperating Parties as the official publication for ICD-9-CM coding guidelines and advice
  - Coding Clinic (CC), First Quarter 2007, p. 19
  - The guidelines and directives in the ICD-9-CM manual take precedence over advice published in Coding Clinic

ICD-9-CM Official Guidelines for Coding and Reporting

- A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.
  - The definition of CDI
  - These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported
- The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved.
- The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.
**AHA Coding Clinic Is the Official Source**

- Recovery Audit Contractors (RAC) use AHA Coding Clinic for ICD-9-CM advice in their coding and DRG compliance activities
  - Other auditors should be using Coding Clinic as well
- Educate your CDI and coding staff
  - Review quarterly and discuss
    - Partner and collaborate
  - Be proactive rather than reactive

**Hierarchy for ICD-9-CM Diagnosis Code Assignment: Basics**

1. ICD-9-CM Index to Diseases (Volume 1)
   - The term must be looked up here first, but it must make sense
     *CC, Second Quarter 1991, p. 20 – “A basic rule of coding is that further research is done if the title of the code suggested by the index clearly does not identify the condition correctly.”*
2. ICD-9-CM Table of Diseases (Volume 2)
   - The code identified by Volume 1 must be examined in Volume 2 for other rules, such as “excludes,” “code in addition,” “code first,” and other similar notes.
3. ICD-9-CM Official Guidelines for Coding and Reporting
4. Advice from the Coding Clinic for ICD-9-CM
5. Review court opinions or other payer-specific regulations
Hierarchy for ICD-9-CM Procedure Code Assignment: Basics

1. ICD-9-CM Index to Procedures (Volume 3)
   - The term must be looked up here first.

2. ICD-9-CM Table of Procedures (Volume 3)
   - The code that was noted in Index to Procedures must be examined in the Table of Procedures for other rules, such as “excludes,” “code in addition,” “code first,” and other similar notes.

3. Advice from the Coding Clinic for ICD-9-CM

4. Court opinions or other payer-specific regulations

5. MD-DRG assignment may depend on “rerouting” of a similar (same MDC) but more resource-intensive secondary procedure into the principal procedure position

Coding Clinic Definitions Are Educational in Nature Only!

- **CC, Third Quarter 2008, p. 15**
  - Clinical information published in Coding Clinic does not constitute clinical criteria for establishing a diagnosis, substitute for the provider’s clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of a patient's medical condition.

- **CC, First Quarter 2008, p. 3**
  - The establishment of clinical parameters for code assignment is beyond the scope of authority of the Editorial Advisory Board for Coding Clinic for ICD-9-CM.
  - All code assignment is based on provider documentation.
Clinical Documentation

- Justifies treatment, supports the diagnosis
- Advances regulatory compliance
- Patient safety
- Increases accuracy of publicly reported patient care outcomes
- Captures patient severity and acuity
- Kicks off the revenue cycle and improves reimbursement

Clinical Documentation Is So Important

- Legal ramifications:
  - Disciplinary action by licensing body for unprofessional conduct
  - Criminal prosecution by the District Attorney, the Department of Justice, or the Office of Inspector General
  - Altering medical records or creating false medical data is a misdemeanor
  - Loss of accreditation from various agencies
  - Loss of funding/reimbursement for the care provided
  - Patient/client loses benefits they are otherwise entitled to
  - Adverse impact on defense in malpractice case
Don’t Forget the UHDDS Guidelines

- Diagnoses: All diagnoses that affect the current hospital stay are to be reported
  - Code to the highest degree of certainty
- Principal diagnosis is defined as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care"

UHDDS Guidelines (cont.)

- UHDDS item #11-b Other Diagnoses: "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded."
Goals for CDI Staff

- Establish positive working relationships with physicians
  - Build trust and credibility
  - Create a supportive presence
- Establish positive working relationships with HIM coding professionals
  - Foster collaborative collegial interactions
  - Foster a climate of mutual trust and respect

CDI May Need to Query the Physician

- Lack of sufficient documentation or no documentation to support the healthcare claim/charges
- Documentation and charges did not meet medical necessity
- Documentation that is conflicting, contrasting, or ambiguous
- Documentation is nonspecific
3M™ APR-DRG™

All-Patient Refined Diagnosis Related Groups:
• An expansion of the basic DRG concept to better reflect the attributes of non-Medicare patients combined with the subdivision of each APR-DRG into four severity and risk of mortality subclasses
• Severity of illness (SOI) and risk of mortality (ROM) are dependent on the patient’s documented underlying problem
• High severity of illness and risk of mortality are characterized by multiple serious diseases and the interaction of those disorders

Note: permission was obtained from AHA to publish the actual Coding Clinic issues in this presentation.
**CC, First Quarter 2010, p. 5**

**Stroke (Temporary) Manifestations**

- **Question:** According to *Coding Clinic*, Second Quarter 1989, p. 8, hospitals are not to report hemiplegia as an additional diagnosis for patients who present with acute CVA if the hemiplegia resolves prior to hospital discharge. Therefore, hemiplegia is not being reported even though these patients receive physical therapy or other treatment, which would ordinarily signify reporting the hemiplegia based on the General Rule for Reporting additional diagnoses. Could consideration be given to allow coding this clinically significant diagnosis?

- **Answer:** 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.** This current advice supersedes information previously published in *Coding Clinic.*

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**Common Neurological Consequences of Stroke (Clinical)**

- **Motor weakness (a symptom)**
  - Monoparesis (a diagnosis)
    - Arm or leg
  - Hemiparesis (a diagnosis)
    - Arm and leg
  - Quadriplegia (a diagnosis)
    - Both arms and legs

- **Seizures (a symptom)**
  - Usually not the result of an acute stroke (but may occur in embolic stroke)
  - Not seizure disorder

- **Aphasia – Impairment of language ability**
  - Broca's (expressive)
    - Speech is difficult to initiate, halting, stuttering, and labored
  - Wernicke's (sensory)
    - Can speak with normal grammar, syntax, rate, intonation, and stress, but their language content is incorrect
  - Speech apraxia
    - A person has trouble saying what he or she wants to say correctly and consistently
  - Anomia
    - Inability to name objects
Acute Altered Mental States or Levels of Consciousness (Clinical)

- Stupor
  - 780.09 – Other Alterations of Consciousness
  - Deep sleep or similar unresponsiveness
- Coma
  - 780.01 – Coma
  - State of unresponsiveness in which the patient lies with eyes closed and cannot be aroused, even with vigorous stimulation
- Locked-in syndrome
  - Code 344.81
  - A fully conscious individual with paralysis of all four limbs and lower cranial nerves
  - Able to move eyelids and move eyes vertically, which is how they communicate
  - Occurs with brain stem stroke, primarily in the pons


Common Neurological Consequences of Stroke (Clinical)

- Cerebral edema
  - NIHSS scores > 15 in right brain & > 20 in left brain within 6 hrs. of Sx
  - Predicted by hypodensity of the affected territory, loss of gray/white junction, or a hyperdense MCA sign on CT less than 6 hours from stroke onset
  - Demonstrated by mass effect with compression of the lateral ventricle and midline shift and reduction of level of consciousness after 24 hours

- Cerebral herniation

CC, First Quarter 2010, p. 8
Cerebral Edema Due to Stroke

- **Question:** A patient is admitted and diagnosed with intracerebral hemorrhage (ICH). The provider also documented "vasogenic edema." Is it appropriate to code the vasogenic edema?

- **Answer:** Assign code 431, Intracerebral hemorrhage, as the principal diagnosis. Assign code 348.5, Cerebral edema, as an additional diagnosis. It is appropriate to code the cerebral edema separately since it is not inherent in cerebral hemorrhage.

- **Treatment**
  - Intensive care
  - Likely intubation
  - Hyperventilation
  - Mannitol or hypertonic saline
  - Glycerol
  - Diuretics
  - High-dose steroids (e.g., Decadron)
  - Possibly surgery

CC, Third Quarter 2010, p. 5
Hemorrhagic Conversion of Stroke

- **Question:** A 77-year-old patient was admitted with expressive aphasia secondary to acute cerebral infarction. The patient was given intravenous (IV) tissue plasminogen activator (tPA) within 4.5 hours of the onset of symptoms with significant improvement of aphasia. Brain MRI showed acute left temporoparietal infarct with asymptomatic hemorrhagic conversion. The provider stated that the hemorrhagic conversion was caused by the tPA therapy. What are the code assignments for hemorrhagic conversion of the temporoparietal infarction due to tPA?

- **Answer:** Assign codes
  - 434.91, Cerebral artery occlusion, unspecified, with cerebral infarction, as the principal diagnosis.
  - **Code 997.02,** iatrogenic cerebrovascular infarction or hemorrhage,
  - **Code 431,** Intracerebral hemorrhage, for the cerebral hemorrhagic conversion due to the thrombolytic therapy.
  - Code 784.3, Aphasia
  - Code E934.4, Drugs, Medicinal and Biological Substances Causing Adverse Effects in Therapeutic Use, Fibrinolysis-affecting drugs, as additional diagnoses.
Coding of Adverse Events From Drugs That Are Properly Administered

- ICD-9-CM Guidelines
- **Adverse effect:** When the drug was correctly prescribed and properly administered, code the reaction plus the appropriate code from the E930–E949 series
  - The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is coded and followed by the appropriate code from the E930–E949 series

‘Medical Intervention’ Guidelines and tPA

- A cerebrovascular hemorrhage or infarction that occurs as a result of medical intervention is coded to 997.02, iatrogenic cerebrovascular infarction or hemorrhage.
  - Medical record documentation should clearly specify the cause-and-effect relationship between the medical intervention and the cerebrovascular accident in order to assign this code. A secondary code from the code range 430–432 or from a code from subcategories 433 or 434 with a fifth digit of “1” should also be used to identify the type of hemorrhage or infarct.
- This guideline conforms to the “use additional code” note instruction at category 997. Code 436, Acute, but ill-defined, cerebrovascular disease, should not be used as a secondary code with code 997.02.

What if heparin or warfarin lead to a cerebral hemorrhage?
What if oral contraceptives/hormones lead to a cerebral infarction?
If tPA is a medical intervention, these would seem to be also. Additional questions for Coding Clinic to address.
**CC, Third Quarter 2010, pp. 5–6**

**Hemorrhagic Conversion of Stroke**

- **Question:** A patient sustained a left frontal cerebral infarction with hemorrhagic conversion. The provider documented that the patient had presented with expressive aphasia due to an acute cerebral infarct and later developed hemorrhagic conversion of the infarct. When queried, the provider stated that the hemorrhagic conversion had occurred spontaneously. What are the correct code assignments for spontaneous hemorrhagic conversion of a cerebral infarction?

- **Answer:** Assign both code 434.91, Cerebral artery occlusion, unspecified, with cerebral infarction, and code 431, Intracerebral hemorrhage. Hemorrhage can spontaneously occur after the original infarct.

**Acute Respiratory Failure 2° Stroke**

**ICD-9-CM Official Guidelines**

- **Sequencing of acute respiratory failure and another acute condition**
  - When a patient is admitted with respiratory failure and another acute condition (e.g., myocardial infarction, *cerebrovascular accident*, aspiration pneumonia), the principal diagnosis will not be the same in every situation
    - This applies whether the other acute condition is a respiratory or nonrespiratory condition
    - *Selection of the principal diagnosis will be dependent on the circumstances of admission*
    - If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis (*Section II, C*) may be applied in these situations
  - If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification
Brain Death
348.82 – New Code for FY 2012

- Uniform Determination of Death Act
  - An individual is dead who has sustained either
    - Irreversible cessation of circulatory and respiratory functions, or
    - Irreversible cessation of all functions of the entire brain, including the brain stem
  - A determination of death must be made in accordance with accepted medical standards

- In declaring brain death:
  - Confounding factors must be ruled out
  - A complete and detailed clinical neurologic examination includes documentation of coma, the absence of brain stem reflexes, and apnea
    - These are integral (related) to the diagnosis, thus should not be coded if documented
    - Ancillary studies, such as CT angiography or nuclear flow studies, may add additional support

http://www.neurology.org/content/74/23/1911.long

Effect of Certain Secondary Diagnoses on MS-DRGs and APR-DRGs

- 431 – Intracerebral hemorrhage
  - MCC
  - APR-DRG SOI – 4
- 784.3 – Aphasia
  - A CC with hemorrhage
  - Not a CC with other strokes
  - APR-DRG SOI – 2
- 342.90 – Hemiparesis
  - Not weakness
  - A CC
  - APR-DRG SOI – 2
- 348.82 – Brain death
  - An MCC in MS-DRGs
  - APR-DRG designation not available

- 786.04 – Cheyne-Stokes respiration (progressively faster breathing alternating with apnea)
  - A CC
  - APR-DRG SOI – 2
- 348.5 – Cerebral edema
  - An MCC
  - APR-DRG SOI – 3
- 348.4 – Cerebral herniation
  - An MCC
  - APR-DRG SOI – 4
- 780.01 – Coma
  - An MCC
  - APR-DRG SOI – 4

SOI = Severity of illness  ROM = Risk of mortality
Challenge in Documentation Integrity

- Why is this important to CDI?
  - Many physicians document cause of death or decline but not a mechanism of death or decline
  - Need to reflect on SOI & ROM as a component to CDI work
  - Blending of coding practice with clinical aspects is critical as part of the relationship promoted in the ICD-9-CM Official Guidelines

Conclusion

- Physicians must define and document all consequences of stroke
  - Cerebral edema, cerebral herniation, acute respiratory failure, hemiparesis, aphasia, stupor, and coma are commonly left out
- Cause-and-effect documentation
- Consider reasons why stroke patients decompensate and/or die
- Determine whether any stroke is a consequence of a medical intervention, warranting code 997.02 and its appropriate sequencing
COMPENSATED RESPIRATORY ACIDOSIS

CC, First Quarter 2010, pp. 5–6 Compensated Respiratory Acidosis With COPD

- **Question:** What is the correct code assignment for a diagnosis of "compensated respiratory acidosis" in a patient with chronic obstructive pulmonary disease (COPD)?

- **Answer:** Assign only code 496, Chronic airway obstruction, not elsewhere classified, for the COPD. It would be inappropriate to separately report a code for compensated respiratory acidosis.
  - Note that it didn’t prohibit the coding of uncompensated respiratory acidosis, nor did it prohibit the coding of documented chronic hypercapnic respiratory failure. Thus, we appear to need some additional clarification.
Chronic Respiratory Failure (Clinical)

- **Hypoxemic**
  - Failure to oxygenate
    - 2010 Murray & Nadel Pulmonary Textbook – pO₂ < 60 mm Hg
  - Medicare criteria – Home O₂
    - Resting PaO₂ < 55 mm Hg or O₂ saturation < 88%
    - Resting PaO₂ of 56–59 mm Hg or O₂ sat of 89% in the presence of any of the following:
      - Dependent edema suggesting congestive heart failure
      - P pulmonale on the electrocardiogram

- **Hypercapnic**
  - Failure to ventilate
  - pCO₂ over 50 with pH that is:
    - Normal or
    - Slightly low pH (between 7.33 and 7.35)
  - Because of the chronic respiratory acidosis, the serum HCO₃ will likely be high (over 28) as part of a compensatory metabolic alkalosis

CDI may need to query the physician in the setting of “compensated respiratory acidosis.”

ACUTE RESPIRATORY FAILURE
CC, First Quarter 2010, p. 18
POA for Acute Respiratory Failure

- **Question:** A 70-year-old female with chronic obstructive pulmonary disease (COPD) was admitted with an acute exacerbation of COPD. The patient presented to the hospital with acute respiratory distress and hypoxia. On day two, she was transferred to the intensive care unit (ICU) and placed on mechanical ventilation to treat acute respiratory failure. What are the appropriate POA indicators?
- **Answer:** For coding and reporting purposes, both the COPD exacerbation and the acute respiratory failure would be separately coded.
  - If the health record documentation is not clear regarding whether respiratory failure was present on admission, query the provider for clarification.
    - If the provider responds that the respiratory failure developed after admission, assign a POA indicator of "N."
    - If the provider cannot determine whether the respiratory failure was present on admission, assign a POA indicator of "W."

Just because it quacks, waddles, has feathers, and flies south for the winter, it's not a duck unless the physician documents that it's a duck, hence the need for CDI.

Why Is This Important?
*CMS Quarterly Compliance Newsletter – 7/2011*

- Regulatory audits
- An 81-year-old female was admitted with complaints of dry cough for a couple of weeks
  - The patient was admitted through the emergency department and was assessed for wheezing and coughing
  - H&P impression is acute respiratory failure secondary to exacerbation of chronic obstructive pulmonary disease (COPD)
  - Progress notes through the stay also document the diagnosis of acute respiratory failure secondary to exacerbation of COPD
  - Final diagnosis on the discharge summary is acute respiratory failure secondary to COPD exacerbation
  - **Acute respiratory failure was not listed on the attestation sheet**

[http://www.tinyurl.com/43qsagm](http://www.tinyurl.com/43qsagm)
Why Is This Important?

CMS Quarterly Compliance Newsletter – 7/2011

- Auditor finding: After physician and auditor review, it was determined that the clinical evidence in the medical record did not support respiratory failure, despite physician documentation of the condition.
- Action: The auditor deleted acute respiratory failure and changed the principal diagnosis to COPD exacerbation.
  - The auditor deleted respiratory failure code 518.81 and changed the principal diagnosis to hypoxemia code 799.02.
  - This resulted in an MS-DRG change from 189 to 192, Chronic obstructive pulmonary disease without CC/MCC. This change resulted in an overpayment.

http://www.tinyurl.com/43gsagm

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Why Is This Important?

CMS Quarterly Compliance Newsletter – 7/2011

- Regulatory audits
- The condition chiefly responsible for a patient’s admission to the hospital should be sequenced as the principal diagnosis, and the other diagnoses identified should represent all CCs/MCCs present during the admission that affect the stay. Code only those conditions documented by the physician.
- Refer to the Coding Clinic guidelines and query the physician when clinical validation is required. Also, inquire about conflicting documentation.

http://www.tinyurl.com/43gsagm
ACUTE RENAL FAILURE

CHRONIC KIDNEY DISEASE

END-STAGE RENAL DISEASE

CC, Third Quarter 2010, p. 15
Acute Renal Failure With ESRD

- **Question:** What is the appropriate code assignment for a patient with documented acute kidney failure and end-stage renal disease (ESRD) during the same admission? Is acute kidney failure an acute exacerbation of chronic kidney failure?

- **Answer:** No, acute kidney failure is not an acute exacerbation of chronic kidney failure. Acute kidney failure and chronic kidney failure are two separate and distinct conditions.
  - Acute renal failure has an abrupt onset and is potentially reversible.
  - Chronic kidney failure progresses slowly over time and can lead to permanent kidney failure. The causes, symptoms, treatments, and outcomes of acute and chronic are different.
  - End-stage renal disease is when the kidneys permanently fail to work.
  - If both acute and chronic kidney failure are clearly documented, code both.
**CC, Second Quarter 2011, pp. 15–16**

Clarification of Previous Advice

- **Question:** It is our belief that a patient cannot have end-stage renal disease and acute kidney failure, since the patient has no kidney function. Is it possible for a patient to have both acute renal failure and end-stage renal disease during the same encounter?

- **Answer:** Yes, acute renal failure and end-stage renal disease (ESRD) can occur during the same encounter in the presence of trauma or some other insult, such as an adverse effect of medication, infection, volume depletion, etc. When ARF and ESRD are both documented, code each condition separately.

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**Impact on CDI and Coding Integrity**

- Much confusion regarding the differences in the definitions of ESRD and kidney failure
  - ESRD is an administrative term, not a clinical term
  - Kidney failure is a clinical term
Clinical Criteria of Acute Kidney Injury – Acute Renal Failure

- Two prevailing definitions of AKI/ARF exist, as outlined in the following table:

<table>
<thead>
<tr>
<th>ADQIG (RIFLE)</th>
<th>Criteria</th>
<th>AKIN</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SCr change from baseline</td>
<td>UOP</td>
<td>SCr change from baseline</td>
</tr>
<tr>
<td>Risk</td>
<td>↑ 150%</td>
<td>&lt; 0.5 mg/dl/hr x 6 hr</td>
<td>1</td>
</tr>
<tr>
<td>Injury</td>
<td>↑ 200%</td>
<td>&lt; 0.5 mg/dl/hr x 12 hr</td>
<td>2</td>
</tr>
<tr>
<td>Failure</td>
<td>↑ 300% or, if SCr &gt; 4.0 mg/dl, acute ↑ by 0.5 mg/dl</td>
<td>&lt; 0.5 mg/dl/hr x 24 hr or anuria x 12 hr</td>
<td>3</td>
</tr>
</tbody>
</table>

RIFLE: risk, injury, failure, loss, end-stage kidney disease; AKIN: Acute Kidney Injury Network;
SCr: serum creatinine; UOP: urine output.

Source: Adapted from the AKIN and ADQIG criteria referenced in the article.

http://ccforum.com/content/11/2/R31—AKIN;  http://ccforum.com/content/8/4/R204—ADQIG
Note: AKIN criteria requires 2 creatinine levels 48 hours apart and presumes that fluid resuscitation has occurred. Neither require that the patient receives dialysis.
Note: Most nephrologists equate “RISK” in RIFLE to be Acute Kidney Injury, even if it is not labeled as such. Further clarification from these authors is forthcoming.

Chronic Kidney Disease (Clinical)

- Kidney damage for more than 3 months, as defined by structural or functional abnormalities of the kidney with or without decreased GFR, manifested by either:
  - Pathological abnormalities
  - Markers of kidney damage, including abnormalities of the blood or urine, or abnormalities of imaging tests
- GFR < 60 for more than 3 months, with or without kidney damage

http://www.kidney.org/professionals/kdoqi/guidelines_ckd/p4_class_g1.htm

Table 12. Definition and Stages of Chronic Kidney Disease

<table>
<thead>
<tr>
<th>GFR (mL/min/1.73 m²)</th>
<th>With Kidney Damage*</th>
<th>Without Kidney Damage*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With HBP**</td>
<td>Without HBP**</td>
</tr>
<tr>
<td></td>
<td>With HBP**</td>
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<tr>
<td>≥90</td>
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<td>60–89</td>
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<td>45–59</td>
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<tr>
<td>15–29</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>&lt;15 (or dialysis)</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

“High blood pressure” “Normal”
“High blood pressure with ↓ GFR”

http://www.kidney.org/professionals/kdoqi/guidelines_ckd/p4_class_g1.htm
KDOQI Definition of ESRD

- **End-stage renal disease (ESRD).** End-stage renal disease (ESRD) is an administrative term in the United States, based on the conditions for payment for health care by the Medicare ESRD Program, specifically the level of GFR and the occurrence of signs and symptoms of kidney failure necessitating initiation of treatment by replacement therapy.
  - ESRD includes patients treated by dialysis or transplantation, irrespective of the level of GFR.
  - The KDOQI definition of kidney failure (a clinical term) differs in two important ways from the definition of ESRD:
    - First, not all individuals with GFR <15 mL/min/1.73 m² or with signs and symptoms of kidney failure are treated by dialysis and transplantation. Nonetheless, such individuals should be considered as having kidney failure.
    - Second, among treated patients, kidney transplant recipients have a higher mean level of GFR (usually 30 to 60 mL/min/1.73 m²) and better average health outcomes than dialysis patients. Kidney transplant recipients should not be included in the definition of kidney failure, unless they have GFR <15 mL/min/1.73 m² or have resumed dialysis.

Source: [http://www.kidney.org/professionals/kdoqi/guidelines_ckd/p4_class_g1.htm](http://www.kidney.org/professionals/kdoqi/guidelines_ckd/p4_class_g1.htm)

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Medicare Definition of ESRD

- End-stage renal disease (ESRD) is a kidney impairment that is irreversible and permanent and requires either a regular course of dialysis or kidney transplantation to maintain life
  - If an individual has a kidney transplant, he or she appears to still have ESRD
  - Medicare based on ESRD ends with:
    - The last day of the 36th month after the month the individual receives a kidney transplant
    - The last day of the 12th month after the month in which an individual stops dialysis, most generally for return of kidney function

Source: Federal Register / Vol. 73, No. 73, page 20371; [https://www.cms.gov/employerservices/04_endstagerenaldisase.asp](https://www.cms.gov/employerservices/04_endstagerenaldisase.asp)
Anticipated Conundrum
ICD-9-CM Official Guidelines

- The ICD-9-CM classifies CKD based on severity
  - Stage I, code 585.1 (eGFR > 90)
    - Omitted by the ICD-9-CM Official Guidelines
  - Stage II, code 585.2, equates to mild CKD (eGFR 60–89)
  - Stage III, code 585.3, equates to moderate CKD (eGFR 30–59)
  - Stage IV, code 585.4, equates to severe CKD (eGFR 15–29)
  - Stage V, code 585.5 (eGFR < 15)
    - Omitted by the ICD-9-CM Official Guidelines
- Code 585.6, End-stage renal disease (ESRD), is assigned when the provider has documented end-stage renal disease (ESRD)
- If both a stage of CKD and ESRD are documented, assign code 585.6 only

Anticipated Conundrum
ICD-9-CM Official Guidelines

- Patients who have undergone kidney transplant may still have some form of CKD because the kidney transplant may not fully restore kidney function
  - Assign the appropriate 585 code for the patient’s stage of CKD and code V42.0
  - Note that there is no prohibition to coding 585.6 if ESRD is documented by the provider
- What’s the CDI specialist or the coder to do if a physician documents:
  - ESRD, s/p renal transplant, with CKD stage 3 based on e-GFR of 45?
  - ESRD, s/p renal transplant, with no evidence of CKD?
- Key question we need answered: When does the diagnosis of ESRD start and stop?
- CDI ...
Again: CC, Third Quarter 2010, p. 15
Acute Renal Failure With ESRD

- **Question:** What is the appropriate code assignment for a patient with documented acute kidney failure and end-stage renal disease (ESRD) during the same admission? Is acute kidney failure an acute exacerbation of chronic kidney failure?

- **Answer:** No, acute kidney failure is not an acute exacerbation of chronic kidney failure. Acute kidney failure and chronic kidney failure are two separate and distinct conditions.
  - Acute renal failure has an abrupt onset and is potentially reversible.
  - Chronic kidney failure progresses slowly over time and can lead to permanent kidney failure. The causes, symptoms, treatments, and outcomes of acute and chronic are different.
  - End-stage renal disease is when the kidneys permanently fail to work.
  - If both acute and chronic kidney failure are clearly documented, code both.

**OTHER CONDITIONS**
CC, Fourth Quarter 2010, p. 135

Hypertensive Urgency (Emergency)

- **Question**: What is the appropriate code assignment for hypertensive urgency?
- **Answer**: Query the physician for the specific type of hypertension when only hypertensive urgency is documented.
  - As of October 1, 2010, revisions to the index have been made and the coder is directed to "See hypertension," when "urgency, hypertensive" is referenced.
  - Options: Benign, Malignant, or Unspecified
    - However, if upon clarification by the physician the hypertension is still not further specified, code 401.9, Essential hypertension, unspecified, should be assigned.

Hypertensive Emergency vs. Urgency

- Hypertensive emergencies are characterized by severe elevations in BP (>180/120 mmHg) complicated by evidence of impending or progressive target organ dysfunction. They require immediate BP reduction (not necessarily to normal) to prevent or limit target organ damage.
  - Examples include hypertensive encephalopathy, intracerebral hemorrhage, acute MI, acute left ventricular failure with pulmonary edema, unstable angina pectoris, dissecting aortic aneurysm, or eclampsia.
- Hypertensive urgencies are those situations associated with severe elevations in BP without progressive target organ dysfunction.
  - Examples include upper levels of stage II hypertension associated with severe headache, shortness of breath, epistaxis, or severe anxiety.
  - The majority of these patients present as noncompliant or inadequately treated hypertensive individuals, often with little or no evidence of target organ damage.

Source: Joint National Commission on Detection, Evaluation, and Treatment of High Blood Pressure

http://tinyurl.com/JNCTFull
Hypertension – Benign vs. Malignant
The Role of Hypertensive Retinopathy

- Malignant hypertension denotes the presence of Keith-Wagener grade IV retinal changes (papilledema)
- Accelerated hypertension traditionally has been used to define hypertension accompanied by grade III retinopathy (hemorrhages, cotton wool spots, and hard exudates without papilledema)
- Accelerated and malignant hypertension code to the same code (401.0)
  - Coding Clinic, First Quarter 1991, p. 16
  - In ICD-10, there will be no differentiation between benign or malignant HTN
- Malignant hypertension is a CC, whereas benign or unspecified hypertension is not a CC
- Source: http://www.tinyurl/MalignantHTN

CC, First Quarter 2010, p. 10
SIRS Due to ‘Noninfectious’ Causes

- **Question:** The guideline states that systemic inflammatory response syndrome (SIRS) can develop as a result of certain noninfectious disease processes, such as trauma, malignant neoplasm, or pancreatitis. A physician at our hospital stated that acute pancreatitis is an inflammation of the pancreas that can occur with infection. Acute pancreatitis is usually caused by gallstones or by drinking too much alcohol, but these aren’t the only causes. **If the guideline is accurate, could it be applied to other inflammatory conditions, such as diverticulitis, cholangitis, orchitis, and cetera?**

- **Answer:** Yes, the guideline for noninfectious SIRS can be applied to other types of inflammatory conditions as well as pancreatitis. Therefore it would be appropriate to report code 995.93, Systemic inflammatory response syndrome due noninfectious process without acute organ dysfunction, or code 995.94, Systemic inflammatory response syndrome due to noninfectious process with acute organ dysfunction, for SIRS due to any noninfectious condition.

  One cannot assume that every “-itis” is an infection, even if treated with antibiotics, thus the need for CDI.
The Clinical Conundrum With ‘-itis’ Conditions

- ‘-itis’ is a Greek suffix indicating inflammation, burning sensation; by extension, disease associated with inflammation
- Origins can be:
  - Infectious
  - Noninfectious
- Many physicians treating conditions ending in ‘-itis’ with antibiotics presume that they are infectious, even if they do not document it, e.g.:
  - Diverticulitis
  - Pyelonephritis
  - Appendicitis

The Clinical Conundrum With ‘-itis’ Conditions

- Systemic inflammatory response syndrome (SIRS) generally refers to the systemic response to infection, trauma/burns, or other insult (such as cancer) with symptoms including fever, tachycardia, tachypnea, and leukocytosis
  - Very important that the clinical indicators supporting SIRS not be explained by another credible condition, such as hypovolemia, steroids, leukemia, etc.
The Clinical Conundrum With ‘-itis’ Conditions

- Sepsis generally refers to SIRS due to infection
  - Sadly, many physicians use the term “SIRS” in setting of an infectious condition without linking it to the condition
  - If a provider documents “SIRS” due to diverticulitis, pyelonephritis, appendicitis, or other similar conditions, unless clarified, it cannot be coded as sepsis since these are documented to be infectious conditions

- Exceptions:
  - Pneumonia
  - Cellulitis

- ICD-9-CM Official Guidelines for Coding and Reporting
  - If the reason for admission is both sepsis, severe sepsis, or SIRS and a localized infection, such as pneumonia or cellulitis, a code for the systemic infection (038.xx, 112.5, etc.) should be assigned first, then code 995.91 or 995.92, followed by the code for the localized infection

Clarification of This Advice
CC, First Quarter 2011, p. 22

- Question: We are requesting clarification of the advice published in First Quarter 2010, p. 10, in which coders were instructed to assign code 995.93, Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction, for SIRS due to a noninfectious condition, such as pancreatitis. Since the etiology of pancreatitis can either be infectious or noninfectious, shouldn’t the provider be queried? Could Coding Clinic clarify this issue further?

- Answer: Pancreatitis can have various etiologies; however, the majority of cases of pancreatitis are noninfectious.
  - In 10%–30% of cases, the cause is unknown, although studies have suggested that approximately 70% of idiopathic pancreatitis may be due to biliary microlithiasis.
  - In those rare circumstances where the provider documents SIRS due to infectious pancreatitis, use the infectious SIRS code rather than the noninfectious one.
  - Query the provider regarding the cause of pancreatitis, if the health record documentation is not clear. This advice is consistent with previously published information.
Conclusion and Bottom Line

- SIRS remains a controversial term
  - No consensus among providers of its definition
  - No reliable biomarker
- SIRS should not be diagnosed if a clinical indicator can be readily explained by another condition (e.g., leukemia causing a high white count)
- Conditions ending in “itis” may not be assumed to be infectious unless documented by the provider
  - Cellulitis and pneumonia appear to be exclusions
- If the provider means sepsis (“SIRS due to infection”), encourage him or her to write sepsis and NOT SIRS

CC, Third Quarter 2010, pp. 15–16
Arteriosclerotic Leukoencephalopathy

- **Question:** The patient is a 68-year-old male who has been diagnosed with arteriosclerotic leukoencephalopathy. What is the appropriate code assignment for arteriosclerotic leukoencephalopathy?
  - Indexing of leukoencephalopathy leads to code 323.9, Unspecified causes of encephalitis, myelitis, and encephalomyelitis.
  - Indexing of encephalopathy, arteriosclerotic directs to code 437.0, Cerebral atherosclerosis.
  -Binswanger’s disease is classified to code 290.12, Presenile dementia.
  - However, none of these codes seem appropriate.
- **Answer:** Assign code 437.0, Cerebral atherosclerosis, and code 323.81, Other causes of encephalitis and encephalomyelitis, for arteriosclerotic leukoencephalopathy. Assign also codes for any other manifestations present.
Index to Diseases

- Leukoencephalopathy (see also Encephalitis)
  323.9 (an MCC)
  - acute necrotizing hemorrhagic (postinfectious) 136.9 [323.61]
  - postimmunization or postvaccinal 323.51
  -Binswanger's 290.12
  - metachromatic 330.0
  - multifocal (progressive) 046.3
  - progressive multifocal 046.3
  - reversible, posterior 348.5

- Leukoaraiosis (hypertensive)
  437.1 – Other generalized ischemic cerebrovascular diseases (a CC)

- Binswanger disease or leukoencephalopathy
  290.12 – Presenile dementia with delusional features (a CC)

- Caution ...

Leukoencephalopathy vs. Leukodystrophy vs. Leukoaraiosis

- Leukoencephalopathy is a broad term for leukodystrophy-like diseases
  - Leukodystrophy is a progressive degeneration of the white matter of the brain due to imperfect growth or development of the myelin sheath, the fatty covering that acts as an insulator around nerve fiber
  - Leukoencephalopathy is a white matter brain disease that does not have to be related to growth and development
Leukoaraiosis

- Leukoaraiosis – *(from the Greek leuko, white, and araiosis, rarefaction)* was introduced in 1986 to designate bilateral and symmetrical areas in the periventricular and centrum semiovale white matter that appeared hypodense on CT scans and hyperintense on T2-weighted MRI
  - [http://stroke.ahajournals.org/content/39/5/1401.full.pdf](http://stroke.ahajournals.org/content/39/5/1401.full.pdf)
- Binswanger disease is characterized by cerebrovascular lesions in the hemispherical white matter
  - The term should probably be avoided, given that there is controversy of its meaning in light of more specific pathological terms
  - [http://stroke.ahajournals.org/content/18/1/2.full.pdf](http://stroke.ahajournals.org/content/18/1/2.full.pdf)

Why This Is Important

- Leukoencephalopathy is a broad term to mean any form of white matter disease
- There is significant overlap between:
  - Arteriosclerotic leukoencephalopathy
  - Arteriosclerotic leukoaraiosis
  - Binswanger leukoencephalopathy
- Exercise **caution** when the only manifestation of these is an abnormal x-ray
CC, First Quarter 2011, p. 6
Pancytopenia Due to Drugs

- **Question:** There has been some confusion about coding drug-induced pancytopenia. Coding Clinic advised how to code chemotherapy-induced aplastic anemia but did not address pancytopenia secondary to drugs.
  - In ICD-9-CM, pancytopenia is indexed to code 284.1, Pancytopenia. However, code 284.1 is excluded from pancytopenia due to or with aplastic anemia (284.9) as well as that which is drug induced (284.89).
  - If the provider documents "pancytopenia due to chemotherapy" and there is no documentation of "aplastic anemia," how is this coded?
- **Answer:** Based on the current instructional note under code 284.1, assign code 284.89. Other specified aplastic anemias, along with the appropriate E-code to identify the drug.
  - Although there is no medical record documentation of aplastic anemia, the instructional note indicates that drug-induced pancytopenia is classified to code 284.89.

FY 2011 the Table of Diseases Affects Code Assignment

- **284.1 Pancytopenia**
  - Excludes pancytopenia (due to) (with):
    - aplastic anemia NOS (284.9)
    - bone marrow infiltration (284.2)
    - constitutional red blood cell aplasia (284.01)
    - **drug induced (284.89)**
    - hairy cell leukemia (202.4)
    - human immunodeficiency virus disease (042)
    - leukoerythroblastic anemia (284.2)
    - malformations (284.09)
    - myelodysplastic syndromes (238.72–238.75)
    - myeloproliferative disease (238.79)
    - other constitutional aplastic anemia (284.09)

- **Note how pancytopenia due to chemotherapy is coded**
- **284.89 Other specified aplastic anemias**
  - Aplastic anemia (due to):
    - chronic systemic disease
drugs
infection
radiation
toxic (paralytic)
Pancytopenia
New Codes Effective 10/1/2011

- 284.11 – Antineoplastic chemotherapy-induced pancytopenia
- 284.12 – Other drug-induced pancytopenia

Key issue:
Does pancytopenia or its components meet the definition of additional diagnosis?
Use caution ...

- Anemia:
  - Hemoglobin < 13.5 g/dL (male) or 12 g/dL (female)
- Neutropenia:
  - Absolute Neutrophil Count (ANC) < 1.5×10³/microliter
- Thrombocytopenia:
  - Platelet count < 150×10⁹/L

Complications
Official Coding Guidelines

- Chapter 17, Complications of Care
- (a) Documentation of complications of care
- As with all procedural or postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the condition and the procedure

Time Frame for Postoperative Period

- Clinically:
  - AHA Coding Clinic (see Second Qtr 2002) provides specific guidance regarding what constitutes a postoperative period
    - AHA Coding Clinic says there is NO time frame
    - A complication can occur during the hospital stay, shortly thereafter, or even years after
    - All surgical procedures and interventions have complications and clinical risks
CC, First Quarter 2011, pp. 13–14
Complications

- **Question:** We are concerned about the inconsistency in hospital coding of postoperative hemorrhage and postoperative hematoma because the coding of these conditions affect data quality.
  - For example, when a surgical wound is slightly oozing blood and is treated with pressure, it is being coded as a postoperative hemorrhage.
  - By the same token, if a small hematoma is noted after surgery, but not treated, it is still being coded as postoperative hematoma.
  - Could you provide us with guidance so that we can consistently code these conditions?

CC, First Quarter 2011, pp. 13–14
Complications

- **Answer:** The Official Coding Guidelines state in relation to complications of care: "As with all procedural or postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the condition and the procedure" (Section I.C. 17.f.1.a).
  - In addition, the Guidelines specify that “for reporting purposes, the definition for ‘other diagnoses’ is interpreted as additional conditions that affect patient care in terms of requiring clinical evaluation; or therapeutic treatment; or diagnostic procedures; or increased nursing care and/or monitoring.”
CC, First Quarter 2011, pp. 13–14

Complications

- It is important to note that not all conditions that occur during or following surgery are classified as complications.
  - First, there must be more than a routinely expected condition or occurrence.
  - In addition, there must be a cause-and-effect relationship between the care provided and the condition, and
  - An indication in the documentation that it is a complication.
- The coder cannot make the determination whether something that occurred during surgery is a complication or an expected outcome.
- The physician is the primary provider to diagnose a condition, and the designation of the complication should be made by the physician. *However, sometimes the indexing may lead one to a complication code.*
- If it is not clearly documented, the coder should query the physician for clarification.

Why This Is Important

- Complications must meet the definition of additional diagnosis to be coded
  - Just because a physician documents respiratory failure immediately after heart surgery does not mean it is extraordinary or significantly adds to the length of stay or need for resources
- Perioperative/postoperative complications must be due to the procedure and not to a medical condition or injury
- Routine expected consequences are not complications
- Physicians must explicitly document whether conditions are complications for them to be coded as such *unless the index leads to complication due to terminology i.e., postoperative*
CC, First Quarter 2011, pp. 17–18
Up and Down Arrows

- **Question:** Is it appropriate to assign a diagnosis code for a condition listed with up and down arrows?
  - For example, the provider documents ↑ cholesterol, or ↑ lipids, or ↓ hemoglobin and hematocrit. Should a code be assigned for hypercholesterolemia, or hyperlipidemia, or low H&H, etc.?
  - Does the advice change depending on whether this is an outpatient encounter versus an inpatient admission?

- **Answer:** It is not appropriate for the coder to report a diagnosis based on up and down arrows. Diagnosing a patient’s condition is solely the responsibility of the provider. Up and down arrows can have variable interpretations and do not necessarily mean "abnormal."

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CC, Second Quarter 2011, p. 17
Adhesions

- **Question:** A 69-year-old man with recurrent incisional hernia is admitted to undergo an incisional herniorrhaphy with mesh.
  - An incision was made in the midline and carried through the skin and subcutaneous tissue. A large hernia sac was encountered.
  - The fascia was dissected off both the right and left of the midline and the hernia sac was divided and removed.

- The surgeon documented within the operative report that the patient had some adhesions of the omentum and abdominal wall, which were freed as well.
  - There was no separate documentation of the presence of adhesions.

- Is it appropriate to assign a diagnosis code for adhesions and a procedure code for lysis in this case?
**CC, Second Quarter 2011, p. 17**

**Adhesions**

- **Answer:** No, do not assign codes for the adhesions of the omentum and abdominal wall nor the adhesiolysis, since there was no indication of their clinical significance documented by the surgeon within the body of the operative report.
- **As stated in Coding Clinic, Fourth Quarter 1990, pp. 18–19:**
  - "Coders should not code adhesions and lysis thereof, based solely on mention of adhesions or lysis in an operative report. Determination as to whether the adhesions and the lysis are significant enough to code and report must be made by the surgeon."
  - 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.

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**CC, Second Quarter 2011, p. 18**

**Adhesions**

- **Question:** A 65-year-old man was admitted and underwent emergent surgery secondary to incarcerated ventral hernia due to adhesions. The surgeon carried out laparoscopic ventral hernia repair with mesh.
  - According to the operative report, at surgery the patient was found to have significant adhesions to the anterior abdominal wall consisting mostly of the omentum, which were carefully and slowly taken down exposing the entire defect. The hernia was then repaired with mesh.
  - The physician also documented a diagnosis of adhesions and the procedure of adhesiolysis in the diagnostic statement of the operative report.
- **In this case, should the adhesions and adhesiolysis be coded?**
CC, Second Quarter 2011, p. 18
Adhesions

- **Answer:** Yes, code both the adhesions and the adhesiolysis. Assign code 552.20, Ventral, unspecified, with obstruction, as the principal diagnosis. Assign code 568.0, Peritoneal adhesions, as an additional diagnosis. Assign codes 53.63, Other laparoscopic repair of other hernia of anterior abdominal wall with graft or prosthesis, and 54.51, Laparoscopic lysis of peritoneal adhesions, for the procedures performed.

- In this case, the obstruction was documented within the operative report as being due to a band of significant abdominal adhesions requiring careful lysis to free the obstruction.
  - In addition, the physician documented the diagnosis of adhesions and the adhesiolysis procedure in the diagnostic statement.
  - The clinical significance of the condition and the procedure performed were clearly documented by the physician.

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CC, Second Quarter 2011, p. 19
Adhesions

- **Question:** The patient had uterine adenocarcinoma and was admitted for surgery.
  - The surgeon noted in the dictated report that numerous adhesions between the abdominal wall and uterus were carefully and thoroughly dissected.
  - Following extensive lysis, a total abdominal hysterectomy and bilateral salpingo-oophorectomy were carried out. In this case should the adhesions be coded?

- **Answer:** Code 614.6, Pelvic peritoneal adhesions, female, should be assigned as an additional diagnosis for the pelvic adhesions.
  - In this case, extensive lysis of numerous adhesions was required before the definitive surgery, total abdominal hysterectomy, could be carried out.
  - Both the diagnosis of pelvic adhesions and the adhesiolysis are appropriately coded.
HOW CAN I, AS A CDI SPECIALIST, BENEFIT FROM CODING CLINIC?

Benefits of Coding Clinic

- Provides written guidance to specific scenarios as well as others
- Recognized nationally
- HIM coding professional source document
- Helps improve consistency and continuity
- Helps identify when to query the physician
- Open communication to submit questions
Send Your Own Questions to Coding Clinic

Obtain the required form from the AHA Coding Clinic for ICD-9-CM website

Get Your Own Subscription!

- Subscriptions available:
  - Paper
  - Electronic

Know that Coding Clinic will start all over again once ICD-10 is implemented on October 1, 2013.
Use an Encoder as a Tool

- 3M
- Quadramed
- Ingenix
- TruCode
- Others

- CDI specialists optimally should have laptop computers with encoder software as to emulate the coding environment.

Read the ACDIS CDI Journal

Coding Clinic Update
Cancer staging forms, pressure ulcer guidance, and more in second quarter 2010

White Paper

Editor's note: The following article is provided as a supplement to the July 2010 CDI Journal.

At first glance, the 2nd Quarter 2010 Coding Clinic for ICD-9-CM, effective for discharges on or after July 7, 2010, appears light on content relevant to CDI specialists and inpatient coders. But closer inspection reveals some entries that offer new guidance as well as controversial advice that may require further clarification from the AHA.

For example, Coding Clinic, 2nd Quarter 2010, rendered an opinion that permits ICD-9-CM coding of pathological diagnoses documented by attending physicians on cancer staging forms, a potential solution for admissions when the pathology report is not available at the time of discharge. Coding Clinic also issued clear, definitive guidance that allows coders to report body mass index codes.
References/Resources

- CMS Quarterly Compliance Newsletter – July 2011
- ACDIS CDI Journal, available to members at:
  - http://www.cdiassociation.com
- AHA Central Office
  - http://www.ahacentraloffice.org
- Official ICD-9-CM Guidelines for Coding and Reporting

Questions?

To ask our speakers questions today, press *1 on your telephone keypad. This will place you in our electronic queue. We will un-mute you and notify you when it is time to ask your question.

When asking a question, please be sure to un-mute your speakerphone. You may also submit a question to the following e-mail address: wwalsh@hcpro.com.

This information is also listed in the instruction e-mail where you found the dialin information for the program.
Thank you!

Please note: Continuing education credits are available for this program. For instructions on how to claim your credits, please visit the materials download page at www hcpro com downloads 9735 .
Exhibit B

List of useful industry acronyms

Source: HCPro, Inc.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AAPC</td>
<td>American Academy of Professional Coders</td>
</tr>
<tr>
<td>ABN</td>
<td>Advance beneficiary notice</td>
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<td>ACDIS</td>
<td>Association of Clinical Documentation Improvement Specialists</td>
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<td>ADR</td>
<td>Additional documentation request</td>
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<td>American Hospital Association</td>
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<td>AHIMA</td>
<td>American Health Information Management Association</td>
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<td>AHRQ</td>
<td>Agency for Healthcare Research and Quality</td>
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<td>AMI</td>
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<td>AOA</td>
<td>American Osteopathic Association</td>
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<td>APCs</td>
<td>Ambulatory payment classifications</td>
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<td>ARRA</td>
<td>American Recovery and Reinvestment Act of 2009</td>
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<td>ASP</td>
<td>Average sales price</td>
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<tr>
<td>AWP</td>
<td>Average wholesale price</td>
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<td>CAH</td>
<td>Critical access hospital</td>
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<td>CC</td>
<td>Complication and comorbidity</td>
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<td>CCHIT</td>
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<td>CCR</td>
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<td>CDM</td>
<td>Charge description master</td>
</tr>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
</tr>
<tr>
<td>CPI</td>
<td>Consumer price index</td>
</tr>
<tr>
<td>CMI</td>
<td>Case-mix index</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>CMSA</td>
<td>Consolidated Metropolitan Statistical Area</td>
</tr>
<tr>
<td>CPI</td>
<td>Consumer price index</td>
</tr>
<tr>
<td>CPT</td>
<td>Current procedural terminology</td>
</tr>
<tr>
<td>CRNA</td>
<td>Certified registered nurse anesthetist</td>
</tr>
<tr>
<td>CT</td>
<td>Computed tomography</td>
</tr>
<tr>
<td>CY</td>
<td>Calendar year</td>
</tr>
<tr>
<td>DED</td>
<td>Dedicated emergency department</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis-related group</td>
</tr>
<tr>
<td>DSH</td>
<td>Disproportionate share hospital</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency department</td>
</tr>
<tr>
<td>EDMS</td>
<td>Electronic Document Management System</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td>EHR</td>
<td>Electronic health records</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic medical records</td>
</tr>
<tr>
<td>EOB</td>
<td>Explanation of benefits</td>
</tr>
<tr>
<td>ePHI</td>
<td>Electronic protected health information</td>
</tr>
<tr>
<td>FDA</td>
<td>U.S. Food and Drug Administration</td>
</tr>
<tr>
<td>FFY</td>
<td>Federal fiscal year</td>
</tr>
<tr>
<td>FI</td>
<td>Fiscal intermediary</td>
</tr>
<tr>
<td>FY</td>
<td>Fiscal year</td>
</tr>
<tr>
<td>GAF</td>
<td>Geographic adjustment factor</td>
</tr>
<tr>
<td>GME</td>
<td>Graduate medical education</td>
</tr>
<tr>
<td>H&amp;P</td>
<td>History and physical</td>
</tr>
<tr>
<td>HAC</td>
<td>Hospital-acquired condition</td>
</tr>
<tr>
<td>HCFA</td>
<td>Health Care Financing Administration</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HCRIS</td>
<td>Hospital Cost Report Information System</td>
</tr>
<tr>
<td>HHA</td>
<td>Home health agency</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>HIC</td>
<td>Health insurance card</td>
</tr>
<tr>
<td>HIMSS</td>
<td>Healthcare Information and Management Systems Society</td>
</tr>
<tr>
<td>HINN</td>
<td>Hospital-Issued Notice of Non-Coverage</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
</tr>
<tr>
<td>HIS</td>
<td>Health information system/services</td>
</tr>
<tr>
<td>HIT</td>
<td>Healthcare information technology</td>
</tr>
<tr>
<td>HITECH Act</td>
<td>Health Information Technology for Economic and Clinical Health Act</td>
</tr>
<tr>
<td>HMO</td>
<td>Health maintenance organization</td>
</tr>
<tr>
<td>HSA</td>
<td>Health savings account</td>
</tr>
<tr>
<td>HSRVcc</td>
<td>Hospital-specific relative value cost center</td>
</tr>
<tr>
<td>HQA</td>
<td>Hospital Quality Alliance</td>
</tr>
<tr>
<td>HQI</td>
<td>Hospital quality initiative</td>
</tr>
<tr>
<td>ICD-9-CM</td>
<td>International Classification of Diseases, 9th Revision, Clinical Modifications</td>
</tr>
<tr>
<td>ICD-10-PCS</td>
<td>International Classification of Diseases, 10th Revision, Procedure Coding System</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive care unit</td>
</tr>
<tr>
<td>IHS</td>
<td>Indian Health Service</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>IPF</td>
<td>Inpatient psychiatric facility</td>
</tr>
<tr>
<td>IPPS</td>
<td>Inpatient prospective payment system</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>IRF</td>
<td>Inpatient rehabilitation facility</td>
</tr>
<tr>
<td>IT</td>
<td>Information technology</td>
</tr>
<tr>
<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations</td>
</tr>
<tr>
<td>LCD</td>
<td>Local coverage determination</td>
</tr>
<tr>
<td>LTC-DRG</td>
<td>Long-term care diagnosis-related group</td>
</tr>
<tr>
<td>LTCH</td>
<td>Long-term care hospital</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractors</td>
</tr>
<tr>
<td>MCC</td>
<td>Major complication and comorbidity</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed care organization</td>
</tr>
<tr>
<td>MCV</td>
<td>Major cardiovascular</td>
</tr>
<tr>
<td>MDC</td>
<td>Major diagnostic category</td>
</tr>
<tr>
<td>MDH</td>
<td>Medicare dependent hospital (small rural)</td>
</tr>
<tr>
<td>MedPAC</td>
<td>Medicare Payment Advisory Commission</td>
</tr>
<tr>
<td>MedPAR</td>
<td>Medicare Provider Analysis and Review</td>
</tr>
<tr>
<td>MIC</td>
<td>Medicaid Integrity Contractors</td>
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<tr>
<td>MRHFP</td>
<td>Medicare Rural Hospital Flexibility Program</td>
</tr>
<tr>
<td>MS-DRG</td>
<td>Medicare Severity DRG</td>
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<tr>
<td>NAHIT</td>
<td>National Alliance for Health Information Technology</td>
</tr>
<tr>
<td>NCCI</td>
<td>National Correct Coding Initiative</td>
</tr>
<tr>
<td>NCD</td>
<td>National coverage determination</td>
</tr>
<tr>
<td>NCHS</td>
<td>National Center for Health Statistics</td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>NCVHS</td>
<td>National Committee on Vital and Health Statistics</td>
</tr>
<tr>
<td>NHIN</td>
<td>National Health Information Network</td>
</tr>
<tr>
<td>NICU</td>
<td>Neonatal intensive care unit</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>NQF</td>
<td>National Quality Forum</td>
</tr>
<tr>
<td>NVHRI</td>
<td>National Voluntary Hospital Reporting Initiative</td>
</tr>
<tr>
<td>OCE</td>
<td>Outpatient code editor</td>
</tr>
<tr>
<td>OCR</td>
<td>Office for Civil Rights</td>
</tr>
<tr>
<td>OES</td>
<td>Occupational employment statistics</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
<tr>
<td>OMB</td>
<td>Office of Management and Budget</td>
</tr>
<tr>
<td>OPPS</td>
<td>Outpatient prospective payment system</td>
</tr>
<tr>
<td>OR</td>
<td>Operating room</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>OSCAR</td>
<td>Online Survey Certification and Reporting (System)</td>
</tr>
<tr>
<td>PHR</td>
<td>Personal health record</td>
</tr>
<tr>
<td>PO</td>
<td>By mouth</td>
</tr>
<tr>
<td>POA</td>
<td>Present on admission</td>
</tr>
<tr>
<td>PPI</td>
<td>Producer price index</td>
</tr>
<tr>
<td>PPS</td>
<td>Prospective payment system</td>
</tr>
<tr>
<td>PRA</td>
<td>Per resident amount</td>
</tr>
<tr>
<td>PRM</td>
<td>Provider Reimbursement Manual</td>
</tr>
<tr>
<td>PRRB</td>
<td>Provider Reimbursement Review Board</td>
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<tr>
<td>PS&amp;R</td>
<td>Provider Statistical and Reimbursement (System)</td>
</tr>
<tr>
<td>QIO</td>
<td>Quality Improvement Organization</td>
</tr>
<tr>
<td>RA</td>
<td>Remittance advice</td>
</tr>
<tr>
<td>RAC</td>
<td>Recovery Audit Contractor</td>
</tr>
<tr>
<td>RBC</td>
<td>Red blood cell</td>
</tr>
<tr>
<td>RC</td>
<td>Revenue code</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural health clinic</td>
</tr>
<tr>
<td>RHIO</td>
<td>Regional health information organization</td>
</tr>
<tr>
<td>ROI</td>
<td>Release of information (OR return on investment)</td>
</tr>
<tr>
<td>RY</td>
<td>Rate year</td>
</tr>
<tr>
<td>SAF</td>
<td>Standard analytic file</td>
</tr>
<tr>
<td>SCH</td>
<td>Sole community hospital</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled nursing facility</td>
</tr>
<tr>
<td>SOCs</td>
<td>Standard occupational classifications</td>
</tr>
<tr>
<td>SSA</td>
<td>Social Security Administration</td>
</tr>
<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
</tr>
<tr>
<td>ST</td>
<td>Status indicator</td>
</tr>
<tr>
<td>TAG</td>
<td>Technical Advisory Group</td>
</tr>
<tr>
<td>UHDDS</td>
<td>Uniform Hospital Discharge Data Set</td>
</tr>
<tr>
<td>WBC</td>
<td>White blood cell</td>
</tr>
<tr>
<td>ZPIC</td>
<td>Zone Program Integrity Contractor</td>
</tr>
</tbody>
</table>
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  - Corporate compliance
  - Credentialing/privileging
  - Executive leadership
  - Health information management/Coding
  - Home Health/Hospice
  - Hospital pharmacy
  - Infection control
  - Long-term care
  - Marketing
  - Medical staff
  - Nursing
  - Pharmaceutical
  - Physician practice
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  - Residency
  - Revenue Cycle
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Chief Executive Officer  
HCPro, Inc.

attended  
October 28, 2011

a 120-minute audio conference on

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