Live or Die by the Guidelines: ICD-9-CM

AAPC

Goals

Understand the importance of using ICD-9-CM coding guidelines.

Isn't it enough to get paid?

Six important reasons to code accurately

1. The inpatient regulatory trends regarding diagnostic coding accuracy and payment may evolve to an outpatient setting. Pick lists don't cut it. Medicare Risk Adjustment, for example, requires a sophisticated knowledge of the ICD-9-CM, and can change payments by as much as 10 percent.

2. The information needed for diagnostic coding is necessary for medicolegal reasons. It is in the best interest of your physician to have complete records.

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3. Today's codes become tomorrow's policies. Don't sell the future short by not taking the time to code properly today.

4. **As a professional, you want to Uphold a Higher Standard.**

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5. Your students won't pass the exam without a solid foundation in ICD-9-CM coding guideline use

6. A solid foundation in ICD-9-CM coding guidelines = ease in learning ICD-10-CM

Get out your book

Open to the Guidelines

- What is the effective date of the guidelines in your book?

- Download:
- http://www.cdc.gov/nchs/icd.htm

AIDS and HIV

- HIV coding
  - "Patients with any prior diagnosis of an HIV-related illness should be coded to 042. Once a patient has developed an HIV related illness, the patient should always be assigned code 042 on every subsequent admission/encounter."
  - "…If a patient with HIV disease is admitted for an unrelated conditions (such as traumatic injury), the code for the unrelated condition should be the principal diagnosis."

AIDS and HIV

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  - Patient with V08 status diagnosed with melanoma on chest

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    - AIDS – 042
    - Kaposi's – 176.0
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    - Kaposi's – 176.0
  - Patient with V08 status diagnosed with melanoma on chest
    - Melanoma – 172.5
    - HIV Positive – V08

AIDS and HIV

- Conditions always assumed to be related to HIV Disease:
  - Kaposi's sarcoma
  - Lymphoma
  - Pneumocystis carinii pneumonia (PCP)
  - Cryptococcal meningitis
  - Cytomegaloviral disease
- These diseases will always change an HIV-positive diagnosis to an AIDS diagnosis

AIDS and HIV

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- The PCP resolves, and the patient is asymptomatic for two years
- Then develops a melanoma on his chest.
- How would THIS be coded?

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  - 042 – AIDS
  - 172.5 – Melanoma

Neoplasms

"When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category V10 *Personal history of malignant neoplasm* should be used to indicate the former site of the malignancy."

Neoplasms

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Neoplasms

- CA or HX CA?
  - A staged reconstruction of the breast is undertaken for a patient two months post bilateral mastectomy. She is also undergoing chemotherapy for DCIS of the left breast.
  - An excisional biopsy result is positive for carcinoma in situ at its margins. A second surgery is scheduled for wide excision and repair.
  - Mohs is performed on the patient's nose to treat basal cell carcinoma. The open wound is dressed, and the patient is escorted down the hall to the office of a plastic surgeon for flap repair.
  - Post oophorectomy for ovarian CA, the MRI picks up secondary CA in the brain.

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Active – Brain CA, Hx - Ovarian CA

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Neoplasms

- Malignancy
  - "When admission/encounter is for the management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (285.22 Anemia in neoplastic disease) is designated the principal diagnosis"
  - "When the admission/encounter is for management of an anemia associated with chemotherapy, immunotherapy, or radiotherapy and the only treatment is for the anemia, the anemia is sequenced first (eg, 284.89 Other specified aplastic anemias)"

Neoplasms

- **Epogen/Procrit:** The FDA has issued specific warnings against off-label use of Epogen/Procrit in cancer patients whose anemia is not directly linked to chemotherapy

Neoplasms

- The chief complaint today is inflammation and discharge at the site of the patient's colostomy stoma. She has a temporary colostomy following her colectomy for colon cancer, and is still undergoing chemotherapy treatments with her oncologist. We have placed her on a Z pack and are also culturing a sample from the site, as we have seen a lot of MRSA lately. We should have the results Friday. A sample tube of palliative salve was supplied.
- What are the diagnosis codes?

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- What are the diagnosis codes?
  - 569.61 - Infection of colostomy and enterostomy
  - 153.9 – Malignant neoplasm of colon, unspecified site

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Guidelines tell us index rules

DON'T START IN TABULAR!

(1) look up key term in Index
(2) refer to tables if appropriate
(3) verify code in tabular section and by reading instructions

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Example: Polyp as benign neoplasm

Common usage:	Polyp/colon	211.3
	Polyp/stomach	211.1
But don't forget	Polyp/gallbladder	575.6
	Polyp/anus	569.0

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Example: Malignant adenoma

Index: **Adenoma**/ *see also* Neoplasm, by site, benign

"The guidance in the Index can be overridden if one of the descriptors mentioned above (malignant, benign, in situ, of uncertain behavior, unspecified nature) is present: e.g., malignant adenoma of colon is coded to 153.9 and not to 211.2 as the adjective 'malignant' overrides the Index."

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Guidelines tell us lookup rules

Neoplasm table

(1) look up key term in Index
(2) refer to tables if appropriate
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Carcinomas and adenocarcinomas of any type other an intraosseous or odontogenic, of the sites listed under "Neoplasm, bone" should be considered as constituting metastatic spread from an unspecified primary site and coded to 198.5 for morbidity coding.

Use your guidelines

Patient with sternal chest pain, possible angina. Physician rules out angina and documents probable costochondritis.

What's the diagnosis?

Unsubstantiated diagnoses

Rule out, probable, suspected

- **GUIDELINE:** Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

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What’s the diagnosis? 786.51 Precordial pain

Use your guidelines

How can we help when we are referring patients for lab or radiology studies?
Patient presents to radiology, rule out pneumonia.
X-ray is clear.
What‘s the diagnosis?

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Use your guidelines

Physician suspects the lesion removed from the patient's helix is basal cell carcinoma. Pathology report is pending.

Do you report…

173.21 Primary cancer
238.2 Uncertain
239.2 Unspecified

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Use your guidelines

- Unspecified
  - Codes of last resort
  - Be as specific as possible
  - Trending toward payers not accepting
  - Do not provide good data
  - Do not show medical necessity

- Example: Telling a payer the physician treated an unspecified joint
  - 719.8 Other specified disorders of joint
  - 719.9 Unspecified disorder of joint

Use your guidelines

PREOPERATIVE DIAGNOSIS: Pelvic pain with cyclic urgency and frequency

POSTOPERATIVE DIAGNOSIS: Interstitial cystitis

PROCEDURES PERFORMED: Cystoscopy , hydrodistention of the bladder, bladder instillation

Possible codes:

- 788.99 Pain/bladder
- 788.63 Frequency/urination
- 595.1 Cystitis/interstitial

Which codes should be reported?

Don't code symptoms

GUIDELINE: Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

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Coronary artery disease

CAD: Sometimes it's all we have to work with

414 Other forms of chronic ischemic heart disease
- 414.0 Coronary atherosclerosis
  - 414.00 Of unspecified type of vessel, native or graft
  - 414.01 Of native coronary artery
  - 414.02 Of autologous vein bypass graft
  - 414.03 Of nonautologous biological bypass graft
  - 414.14 Of artery bypass graft
  - 414.05 Of unspecified type of bypass graft
  - 414.06 Of native coronary artery of transplanted heart
  - 414.07 Of bypass graft (artery)(vein) of transplanted heart

Cardinal rule: Don't code what isn't documented. What's the best choice?

Coronary artery disease

CAD: Sometimes it's all we have to work with

Coding Clinic (1997, Q2)

Question: A patient has coronary artery disease. There is no mention of a past history of CABG. Should this be coded to 414.00, Coronary atherosclerosis of unspecified type of vessel, native or graft, or 414.01, Coronary atherosclerosis of native coronary artery?

Answer: Assign code 414.01, Coronary atherosclerosis of native coronary artery. Since there is no history of CABG, this is a native coronary vessel. However, if the documentation is unclear concerning prior bypass surgery, query the physician.

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Patient histories

Always read the medical documentation for context.

How many ways might context change how these are coded?

- Patient has a history of prostate cancer
  - (…and has been cancer free for 10 years)
  - (…and is scheduled for a seeding next week)
- Patient has a history of schizophrenia
- Patient has a history of pterygium
- Patient has a history of HIV
- Patient has a history of MRSA
- Patient has a history of Type II diabetes that responds well to oral medications

Chronic miscodes: diabetes

Diabetes

- Type I: Autoimmune dysfunction kills islet cells
  - Ultimately, no insulin is produced by the patient
  - Often occurs with other autoimmune disorders: thyroid, adrenal, gastric parietal cells
- Type II diabetes: Capacity defect
  - The insulin-producing cells are overworked, or the body's insulin receptors are malfunctioning or resistant due to age, obesity, or genetic predisposition
  - Pancreas still produces insulin, but cannot keep up with demands
  - 90 percent of diabetes in the United States is Type II
- Secondary
  - Use 249.xx unless post-pancreatectomy (251.3)

Chronic miscodes: diabetes

Diabetes

Common questions

The default for documented diabetes would be:

250.00 Type II, not stated as uncontrolled, without complications

Poorly controlled is not "uncontrolled."

Uncontrolled should be documented, and its definition changes from physician to physician. Get clarification from your physician regarding when to report uncontrolled diabetes.

Report V58.67 only with type II diabetes

ICD-9-CM does not permit a causal relationship between CAD and diabetes, so the diabetes is sequenced secondarily.

Chronic miscodes: diabetes

Insulin dependent diabetic patient with hypertension and a BMI of 36 undergoes a laparoscopic adjustable gastric banding without complication.

Physician services are reported as

278.01 Morbid obesity

V85.36 BMI 36.0-36.9

401.9 Hypertension, unspecified

250.01 Type I diabetes mellitus

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401.9	Hypertension, unspecified
250.01	Type I diabetes mellitus

CLAIM DENIED BY MEDICARE

Bariatric surgery a covered service for TYPE II DIABETES only, as Type II diabetes is considered a complication of obesity.

I hear, I know.
I see, I remember.
I do, I understand.

-- Confucius, 551-479 B.C.

Thank you!

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