Industry Collaboration Effort
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Communication for Collaboration

Coding Hints 2nd Edition

Medicare's guidelines state," Code all documented conditions which co-exist at the time of the visit that require or affect patient care or treatment".

Beyond the Basics

Incomplete coding leads to losing opportunities for intervention of a beneficiary's overall disease burden.

Example:

250.40 Diabetes with Renal Manifestations: Reminder to doctors of what clinical and lab data are required to support this specific ICD-9 code.

- Specifically that "renal manifestations" may include microalbuminuria (microalbumin to creatinine ratio > 30) with diminished kidney function, such as GFR or filtration rate < 60 which is 50% of normal. One specific "renal manifestation" is diabetic nephropathy which is clinically suspected in longstanding diabetics with progressively worsening proteinuria who have either a biopsy showing diabetic kidney damage or who have renopathy. If the kidney function is < 50% normal for more than 3 months (acute vs. chronic), physicians may also consider if 585.3 Chronic Kidney Disease, Stage III
- Chronic microalbuminuria or proteinuria may qualify as CKD stage 1 or 2 and should not be overlooked.

Myocardial Infarction (MI)

- A *common* documentation problem for MI is that the site of the infarction isn't identified. For accurate code selection, the site of the infarction should be documented.
- The 4th digit in the 410 category identifies the site of the acute MI as identified on the EKG.
  Example:

  410.0x Acute MI of anterolateral wall
  410.1x Acute MI of other anterior wall
  410.2x Acute MI of inferolateral wall –STEMI
  410.3x Acute MI of inferoposterior wall –STEMI
  410.7x Acute MI-NSTEMI

Coding Neoplasms:

- All malignant neoplasms risk adjust with the exception of skin and lip.
- Malignant melanoma also risk adjusts
- Be sure to document all primary, secondary and unknown sites.

1. Location
2. Behavior (Primary, Secondary, InSitu)
   - Malignant Solid Tumors
3. Active vs. history of under surveillance
4. Evaluate, document, and code status each year
   - The anatomic site of the neoplasm
   - Current and being treated?
   - "History of" (V10.xx Codes)
   - Unknown site - **199.1** is used to indicate an unknown or unspecified primary or secondary malignancy. If there is a known secondary site, a code must be assigned to the primary site or the history of a primary site. It is possible for a primary site to be unknown.
   - Contiguous site: When the point of origin cannot be determined because the neoplasm overlaps the boundaries of two or more contiguous sites – classified to a fourth digit of **.8.**

Old Healed MI

- Documentation of a patient that is outside of the 8 week recovery period is coded to 412.

  *Example**:***
  - Hx of MI in '04

  ICD-9 states "Past MI diagnosed on EKG or other special investigation, but currently presenting no symptoms". This refers to symptoms related to the previous MI, not cardiac symptoms in general.

- Any condition documented to 412 but presenting **with** symptoms after 8 weeks from date of infarction is coded to 414.8 (Chronic Ischemic Heart Disease) if the documentation states that it is the lasting affect of the MI.

Heart Failure Documentation

- There are 15 codes for the different types of heart failure

  - **Categories include:**

428.0 CHF	428.3x Diastolic heart failure
428.1 Left heart failure	428.4x Combined Sys/Dia failure
428.2x Systolic heart failure	428.9 Heart failure, unspecified

- All codes for heart failure include any associated pulmonary edema; no additional code is assigned.
- More than one code from category 428 may be assigned if the patient has systolic or diastolic failure with CHF.

Heart Failure and HTN

- Heart failure may be associated with hypertension. When a causal relationship between these two conditions is stated, hypertensive heart disease is coded to category 402
- The cause and effect relationship between heart failure and HTN should not be assumed.
  Example:

  - Patient has CHF due to (causal relationship) diastolic dysfunction due to HTN
  - codes: 402.91, 428.30 and 428.0

- When documentation mentions the conditions but without a stated causal relationship, each condition will be coded separately.
  Example:

  - Patient has CHF and HTN.
  - codes: 428.0 and 401.9

- Pedal Edema can be related to Diastolic Heart Failure but documentation need to show a cause and effect of the two conditions.

Depression: 311 and 296.xx

- Category **311** (Depression) is reserved for depressive disorders not assigned a more specific diagnosis

- Category **296.xx** is reserved for patients having single or recurrent episodes of:
  - ✓ Depressive psychosis
  - ✓ Monopolar depression
  - ✓ Psychotic depression
  - ✓ Manic-depressive
  - ✓ Psychosis or reaction
  - ✓ Major depression
  - ✓ Grieving – Long Term: Consider major depression if documented

Specified Heart Arrhythmias

- **426.0 Atrioventricular block, complete**
  Third degree atrioventricular block
- **427.0 Paroxysmal supraventricular tachycardia**
  Rapid atrial rhythm
- **427.1 Paroxysmal ventricular tachycardia**
  Rapid ventricular rhythm
- **427.2 Paroxysmal tachycardia, unspecified**
  NOS essential
- **427.31 Atrial Fibrillation**
  Irregular, rapid atrial contractions
- **427.32 Atrial Flutter**
  Regular, rapid atrial contractions
- **427.81 Sinoatrial node dysfunction**
  Appears as severe sinus bradycardia, sinus bradycardia with tachycardia, or sinus bradycardia with atrioventricular block aka sick sinus syndrome (SSS)

Hypoxemia: 799.02 and Pulmonary

- ✓ Values under 90 are considered low. Severe hypoxemia occurs when oxygen saturation drops below 80 percent.
- ✓ End Stage COPD – while there is no code for end stage COPD but you can code hypoxemia or chronic respiratory failure if documented
- ✓ Consider chronic respiratory failure for patients that have continuous oxygen use who have underlying chronic lung disease. Be sure to list CRF on the progress note.
- ✓ If a patient is oxygen dependant then the reason for the oxygen also needs to be documented and coded.
- ✓ There is a new code for Chronic Pulmonary Embolism for 2010 - 416.2. This can be documented and coded if the patient is under treatment with Coumadin for the condition.

Protein-Calorie Malnutrition

- Category **262 – 263.x -** Other and unspecified protein–calorie malnutrition is often under-reported. It is often times a secondary condition caused by a chronic or acute condition such as those listed below:

- Factors that limit nutrient ingestion and absorption:
  - Cancer
  - Pancreatitis
  - Alcohol abuse and/or dependence
  - Liver disease
  - Obesity (post-bariatric surgery)
  - Anemia
  - ESRD
  - Alcoholic hepatitis
  - Cirrhosis
  - Celiac disease
  - Cystic fibrosis
  - Depression

- Subjective Global Assessment (SGA) for protein energy malnutrition (PEM) includes 6 clinical parameters, followed by a Personal Judgment as to whether the patient has no, mild, moderate or severe malnutrition or cachexia.
  - Unremitting, involuntary weight loss that is greater than 10% in the previous months, and especially in the last few weeks
  - Food intake is severely curtailed
  - Muscle wasting and fat loss, with attention to the presence of edema, or ascites present on physical exam
  - Persistent, essentially daily gastrointestinal symptoms such as anorexia, nausea, vomiting, or diarrhea in the previous 2 weeks
  - Marked reduction in physical capacity
  - Presence of metabolic stress due to trauma, inflammation or infection

- If there is a more definitive diagnosis do not report:
  - Abnormal Weight Loss
  - Loss of Appetite
  - Underweight
  - Failure to Thrive

- Consider the following:

  - Malnutrition, Mild Degree [263.1]
  - Malnutrition, Moderate Degree [263.0]
  - Cachexia (Severe) [799.4]
  - If degree of malnutrition is not stated, code to moderate degree

More Coding Scenarios

SUBJECTIVE: 68 y/o male c/o finger pain, triggering. No chest pain, taking Zocor
Nocturia x2-3 not taking Flomax because leg cramp. Lost weight
SOCIAL Hx: 1/3 PPD – smoker, 20 pack-yr smoker, quit 2008; non drinker
PMH: None Past Surgical: None Family History: No cancer

OBJECTIVE:
Vital signs: BP: 140/90, Pulse: 72, Resp: 16, Temp: F
General Appearance: Well developed, well nourished, no distress
Head: Normocephalic
Eyes: Pupils are equal, PERLA, EOMI, conjuntiva: pink, sclera: anicteric
Ears: Normal, otoscopy: normal tympanic membrane
Nose: Normal
Throat: Normal
Neck: Supple, No JVD, No mass, No LN palpable, Trachea midline, No thyroidmegaly, No bruit over carotid artery
Lungs: Clear
Heart: Regular, No gallop, No murmur, No Cardiomegaly
Abdomen: Soft, No hepatosplenomegaly, No mass, No bruit, Normal bowel sound
Back: Normal, No CVA tenderness, No tenderness over spine
Extremities: Tender MCP index finger, No ulcer, No cyanosis, pulse equal, No edema
Rectal: Prostate mod enlargement 01/08
Genitalia: Blusih soft nodude compressed flat over glans penis

ASSESMENT:

1. HTN w/RI
2. CKD stage 3
3. COPD
4. Varicose Vein penis
5. Hypercholesterolemia
6. BPH
7. Nocturia
8. Fissure Hand

Last Sig or BE:
Last Colonoscopy: 03/07
Last Rectal Ex & PSA: 01/08

PLAN: Test: Chem, Lipid 09/09/08 BT Referral: Vision Care
Follow up: Three months
Medications: Diovan 160 mg daily, Flomax 0.4 mg BID d/c, Zocor 40 mg h.s., Avodart 0.5 mg qd, Proventyl, Pulmocort
Allergy: Zestril,

Office Coding:

272.0 – Pure Hypercholesterolemia
403.90 – HTN CKD w CKD I-IV
491.20 – Obst Chr Bronc w/o Exac
585.3 – CKD stage III

***Codes with supporting documentation*:**

456.8 – Varicose Veins
600.00 – BPH
727.03 – Trigger finger

No Supporting Documentation for:

1. RI (e.g. lab results)
2. CKD (e.g. lab results),
   Does member have RI or CKD?
3. COPD (e.g. smoker's cough)
4. Hypercholesterolemia (e.g. lab results)

SUBJECTIVE: 86 y/o male F/U cough for one week. No chest pain, No SOB, No fever, Right shoulder pain, Had hypoglycemic Sx, Hunger felling last month.
Social Hx: Non - smoker, non - drinker
PMH: Herpes Zoster 08/2007 Sciatica
Past Surgical: None
Family History: No cancer

OBJECTIVE:
Vital signs: BP: 120/50, Pulse: 84, Resp: 16, Temp: F
General Appearance: Well developed, well nourished, no distress, non-toxic
Head: Norcephalic
Eyes: Pupils are equal, PERLA, EOMI, conjuntiva: pink, sclera: anicteric
Nose: Normal
Throat: Gap reflex present, no ulcer, no mass
Neck: Supple, No mass, No LN enlargement, thyroid no mass, No nodule, Size normal, No Bruit over carotid artery
Lungs: Clear, no wheezing, no raled
Heart: Regular, No murmur, No gallop
Abdomen: Soft, No mass, No hepatosplenomegaly,
Extremities: No edema, No ulcer, No cyanosis, pulse palpable
Foot: No ulcer, sensory to filment normal
Neurological: Alert, Oriented, No focal deficit
Skin: No Ulcer

Last Colonoscopy: 2000 Dr. Lai
Last Sig or BE:
Last HgA1c: 05/09 6.9

ASSESMENT:
1. Bronchitis, Acute
2. DM w RI controlled
3. CKD stage 2
4. Aortic Atherosclerosis
5. Fracture spine L1
6. HTN w RI
7. Osteoporosis
8. Kyphosis lumbar due Fx spine
9 Stage 1 decubitus lumbar

PLAN:
Test: CBC, Chem., Lipid, HgA1c UA Urine Microalbumin 08/26/09
Referral: Vision Care
Follow up: Three months
Education & Discussion: Exercise regularly, low fat diet, hypoglycemic reaction management
Medications: Diovan 80mg daily, Diabeta 1.25mg qd decreased, Fosamax 70mg weekly, Celebrex 200mg qd, Ecotrin 81mg qd
Allergy: None

Office Coded:
250.40 – DM II Renal
403.90 – HTN CKD w CKD I-IV
424.1 – Aortic Valve Dis
466.0 – Acute Bronchitis

Codes supported by documentation:
466.0 Acute Bronchitis

No supporting documentation for
1. DM (e.g. controlled on insulin) and RI (e.g. lab results). Not linking Diagnosis.
2. CKD (e.g. lab results). CKD Vs. RI
3. Aortic Atherosclerosis (e.g. CXR results)
4. Fx spine L1 (e.g. XR results)
5. HTN (e.g. Elevated B/P >140/90)
6. Osteoporosis (e.g. DEXA scan)
7. Kyphosis lumbar (No supporting documentation for cause Fx spine)
8. Stage 1 decubitus (Notes states skin no ulcer)

SUBJECTIVE: 69 y/o male F/U AF converted to sinus on Plavix now
Social Hx: Non - smoker, non - drinker
PMH: HTN, Hypercholesterolemia
Past Surgical: None
Family History: No cancer

OBJECTIVE:
Vital signs: BP: 120/80, Pulse: 72, Resp: 18, Temp: F
General Appearance: Well developed, well nourished, no distress, non-toxic
Head: Normocephalic
Eyes: Pupils are equal, PERLA, EOMI, conjuntiva: pink, sclera: anicteric
Neck: Supple, No JVD, No mass, No LN, No bruit over carotid arteries, Trachea Midline, Thyriod no mass No nodule, Size normal
Lungs: Clear
Heart: Regular, No gallop, No murmur, No Cardiomegaly
Abdomen: Soft, No hepatomegaly
Extremities: No ulcer, No cyanosis, pulse equal, No edema, Sensory normal
Neurology: Normal, Alert and oriented, No Focal deficit
Skin: Increased pigmentation both mid legs

Last Rectal Ex & PSA: 04/07
Last Colonoscopy:
Last Sig or BE: 2002

ASSESMENT:
1. AF paroxysmal converted
2. HNT w/RI
3. NIDDM w RI
4. CKD stage 2
5. Chronic Unspecify Hepatitis
6. Fatty Liver
7. Elevated SGOP/SGPT

Flu Vaccine 0.5ml IM

PLAN:
Test: CBC chem., HgA1c lipid UA urine microalbimin PSA EKG 08/25/09
X-ray: None
Referral: Colonoscopy, Opth
Follow up: 2 months
Education & Discussion: Exercise regularly, discussed about anticoagulation vs. antiplatelet pros and cons, Declined coumadin
Medications: Diovan 160/hct 12.5mg daily, Norvasc 5mg daily, Januvia 100mg qd, Propecia 1mg daily, Protonix 40mg qd, Plavix 75mg qd, Ecotrin 81mg qd,
Allergy: None

Office Coded:
250.40 – DM II Renl Nt St Uncntrld
403.90 – Hy Kid NOS w Cr Kid I-IV
427.31 – Atrial Fib
585.2 – CKD II

Codes supported by documentation:
427.31 – A-Fib
571.40 – Chronic Hep, Uns.
If type of Hep .known need to document (e.g. Hep C w/o Hep coma – 070.54)
571.8 – Fatty Liver w/o Ment. of Alcohol

No supporting documentation for:
1. HTN (e.g. Elevated B/P >140/90) RI (e.g. lab results)
2. DM (e.g. controlled on insulin), not linking diagnosis
3. CKD (e.g. GFR rate) RI vs. CKD
4. Elevated SGOP/SGPT (e.g. lab results)