

THE CODE

The Official Medical Coding Newsletter of MiraMed, A Global Services Company

Emergency Room Medical Decision Making

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Throughout the country, physicians have been taught to make sure that they capture all of the elements of history of present illness (HPI), review of systems (ROS), past family and social history (PFSH) and physical exam (PE); however, either they have not been taught or have been failed to show that the driver of an evaluation and management code (E&M) is the medical decision making (MDM). So let me try to show this through an example.

A patient is seen in the emergency room (ED) for left flank pain down to the groin associated with nausea and the final E&M code assignment was CPT code 99285 (problem(s) indicative of high severity and did it pose an immediate significant threat to life or physiologic function). The patient was assessed in triage and documentation showed that the patient did not appear to be in any apparent distress. The triage nurse assessed the patient as emergency severity index (ESI) 3 (urgent) and documented that the patient was comfortable without any clinical suspicions of infection. The patient’s temperature was 97.6 and pain assessment measured as 5/10.

Although, the provider did not do all “i’s” and cross all “t’s” with the history being comprehensive and the exam detailed, the MDM based on the presenting signs and symptoms, tests ordered and risk was the driver of the final code for this ED visit.

Now, I don’t pretend to like the entire methodology of E&M and until CMS decides to do away with the entire thing (there has been prior movement and attempts at going to a single E&M level much like the clinic level G code), we are stuck with the current way of episode coding and chart auditing which is based on CMS guidelines and the audit sheet known as the Marshfield tool. For those of you who don’t know, the Marshfield tool was designed in the early 1990’s by the Marshfield Clinic (located throughout Wisconsin) in conjunction with their regional Medicare carrier while beta-testing Medicare’s 1995 Evaluation and Management Documentation

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If you have an article or idea to share for *The Code*, please submit to:
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The invariable mark of wisdom is to see the miraculous in the common.

Ralph Waldo Emerson

Emergency Room Medical Decision Making *(Continued from page 1)*

Guidelines. Although the Marshfield audit sheet never made it to the official documentation guidelines, this tool is still used today to audit E&M level assignment and evaluate the complexity of the MDM. The tool was designed so that all three areas (history, PE and MDM) would be measured equally. However, from an auditing standpoint, the medical decision making component has evolved to represent a litmus test of the other two key elements. What does this mean? It means that it may not be necessary to do a full history or a full PE if there is no clinical indication that warrants the undertaking of the elements in each area.

So, with the patient above, it turns out that the patient had a history of kidney stones and now the provider, as part of the differential diagnosis (non-renal causes of flank pain, such as musculoskeletal problems, parenchymal problems, which involve the actual kidney tissue (e.g., infection, inflammation) and non-parenchymal problems, which often relate to impaired kidney drainage), needs to include recurrence of kidney stones due to prior history. The provider ordered lab tests which included a urinalysis and straining of urine along with a CT scan without contrast. However, simply noting that a lab test was ordered is insufficient documentation to support the ordering of the lab test. The



provider also ordered Toradol and Zofran via intravenous push (IVP). However, the documentation did not include that the Toradol was ordered for pain and that the Zofran was ordered to treat the patient's nausea. Subsequently, in the differential diagnosis the physicians considerations include renal stones (nephrolithiasis) and the flank pain radiating to the groin in the absence of fever is pathognomonic of kidney stones, the documentation in the chart must note the provider's train of thought.

The auditor, who is not involved in the direct care of the patient, should not be expected to interpret that any clinical testing ordered is to assess a particular condition. Nor is the auditor expected to know that any medication ordered is to treat a particular diagnosis unless documented as such. The provider needs to note explicitly as to the intention of the test and medication in the chart documentation. Therefore, it would also be necessary for the provider to note that the intention of the urine straining is to look for "sludge" (the buildup of tiny crystallized minerals in the kidney which block the flow of urine), which could lead to a conclusive diagnosis. The provider can't write "CT scan" and expect a reviewer to know what she/he was thinking. If clinical documentation is present which warrants the test being done and if the CT is noted as "unremarkable," that is accepted documentation based on fact that a renal calculus and other non-calculus diagnosis, which may have been contemplated and documented in the medical record, were ruled out. An ordered test and the documentation not only supports medical necessity, but helps an auditor determine the level of medical decision making in reference to the provider's line of thinking in the differential diagnosis considered. If the provider needs to review the patient's prior records, again, checking off a box is insufficient documentation in justifying the request. The guidelines ask that the provider document the reason to review any additional information and, if the additional information has been obtained, what results were derived from the information? Why is this necessary? Because any information obtained implies an increase in the complexity and volume of the data. If additional information is obtained from the family simply stating "additional history obtained from family" is ***not*** enough for documentation verification. The provider needs to cite relevant findings or document explicitly that there were no findings.

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Emergency Room Medical Decision Making (Continued from page 2)

Dr. Emily Hirsh, in her June 5, 2012 article titled "Let's Play a Game: Emergency Medical Documentation Coding for Emergency PHYSICIANS (not coders)" said it best about documentation to meet medical decision making:

Diagnoses and/or management options (DMO): *If someone is being admitted for further workup, state it in your chart*

- *DMO: If someone is being discharged with further workup planned, state that in your chart.*
- *Data: If you visualize a study yourself, state it in your chart ("electrocardiogram (ECG) which I ordered and visualized myself shows....; chest x-ray (CXR) which I ordered and visualized myself shows....").*
- *Data: If you obtained history from someone else, or reviewed an old chart, state it in your note ("Review of the old chart shows...." or "I spoke with the patient's daughter, who provided further history of....").*
- *Risk: If you give IV/IM narcotics, state it in your chart ("IV morphine given for pain"); demonstrates HIGH level of risk.*
- *Risk: If someone is at high risk based on his/her presentation (as seen on the risk table), state it ("patient was at high level of risk because this was an motor vehicle crash (MVC) that could pose threat to life", or "patient had acute change in neurologic status," or "patient has a psychiatric illness and is at risk to himself," etc.).*

<http://www.drhem.com/education/wp-content/uploads/2015/04/Lets-Play-a-Game-Emergency-Medical-Documentation-Emily-Hirsh-MD.pdf>

Again, in our patient example above, the final diagnosis was renal colic and the patient's pain assessment prior to discharge was assessed at 2/10 and additional outpatient follow-up was not documented in the medical record reviewed. The combined final result for MDM was high complexity and, therefore, the final E&M arrived at during the audit was 99284 (problems are high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function). So, before assigning CPT code 99285, simply ask yourself, was the problem(s) indicative of high severity and did it pose an immediate significant threat to life or physiologic function?

In conclusion, per CMS Manual System Publication 100-04 Medicare Claims Processing Transmittal 178 (CHANGE REQUEST 2321), "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record."

Although the above pertains to CMS, non-Medicare payers who audit E&M services do not necessarily follow contractor-specific guidelines but, rather, general CMS guidelines.

A strong and positive attitude creates more miracles than any other thing because life is 10 percent how you make it and 90 percent how you take it.

Shubham Joshi

Comparing E&M Coding: Professional Physician VS. Outpatient Facility

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Both the physician and the facility can bill for evaluation and management (E&M) services. It is important to be able to understand and explain why the services billed may be appropriate, but not identical, across professional and facility claims for the same episode of care. If the physician is not paying rent in the facility where he is providing the services, then the facility can bill for the services. The rules of coding are different between professional physician versus outpatient facility. Below are the differences between the coding and what each of the coders, the professional physician coder and the outpatient facility coders look for.

Physician E&M Services

New Patient vs. Establish Patient

CMS states that a "new patient" means a patient who has not received any professional services, i.e., evaluation and management service or other face-to-face service (e.g., surgical procedure), from the physician or physician group practice (same physician specialty) within the previous three years.

Procedure Codes and Coding: Evaluation and Management

Professional: The 1995 or 1997 Documentation Guidelines for Evaluation and Management Services from Medicare are used to select the appropriate type of visit and level of service with the three key elements of history, exam and medical decision making.

Since 1992, E&M codes have been defined in terms of three key components (history, examination, and medical decision making). In order to report a given level of E&M service, the physician must document key components that meet or exceed those specified in the code's definition (there is an exception for encounters that consist primarily of counseling or coordination of care). Depending on the category of service, the code may require either two or three of the key components. For example, a level three new patient office/outpatient clinic visit (99203) requires all three of the key components at the same level (detail history, detail exam and low medical decision); but for the 99213 a level three establish patient office/outpatient clinic visit (99213) only requires two out of three of the key components at the same level. Here the coder is looking for the patient being seen within three years by the same provider, any provider with same specialty from their office, by the same specialty within the group.

Diagnosis Codes

Professional: The claim includes diagnosis codes relevant to the encounter by a single provider, and pointers on the claim form (paper or electronic) are used to link specific ICD-10 codes to each CPT procedure code to show medical necessity. Professional coding designates the primary reason for the encounter as a "first-listed" code. For professional physician coding, the rest of the codes are designated as secondary listed diagnosis. Sequencing of the ICD-10 coding occurs by following ICD-10 guidelines. A physician coder only codes for any signs or symptoms if a definitive diagnosis is not documented in the medical record or if unrelated to another documented condition. If the patient has a history of a condition and it is related to the diagnosis then the physician coder will also code the history diagnosis.

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Comparing E/M Coding: Professional Physician versus Outpatient Facility *(Continued from page 4)***Outpatient Facility E/M Services****New Patient vs. Establish Patient**

The outpatient facility rules are the same as far as the three years for a new patient designation, but are different on what services are counted. If the patient had a face-to-face service anywhere in the facility such as: lab, surgery, x-rays or other facility clinic visits within three years, then the patient would be considered an established visit/patient for the facility. The outpatient coder looks for any service provided by the hospital or facility provided within the three years.

Procedure Codes and Coding: Evaluation and Management

Facility: For the Centers for Medicare & Medicaid Services (CMS), there is a single E&M code, G0463 (Hospital outpatient clinic visit for assessment and management of a patient), for related facility claims, except for the emergency department, therefore for Medicare the E&M clinic will always be G0463. This code reflects the hospital resources utilized and the care provided by the nursing staff, it should never be utilized to reflect the physician work involved and, therefore, an H&P by the provider is not the correct documentation to substantiate rendered services.



Hospitals use CPT and HCPCS level 2 codes to report outpatient services. These codes are the basis for hospital reimbursement under the Medicare Outpatient Prospective Payment System (OPPS). In particular, hospitals use CPT E&M codes to report clinic visits, emergency department visits and outpatient critical care services. CMS acknowledged that the E&M codes "were defined to reflect the activities of physicians and do not describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters." Depending upon the circumstances, two clinic visits where the physician documented the same E&M service might reflect very different levels of hospital resources. For other payers, hospitals

develop and follow their own internal guidelines that should, "reasonably relate the intensity of hospital resources to the different levels of effort represented."

Many hospitals used a classification system developed by the American Health Information Management Association (AHIMA) as a starting point or the American College of Emergency Physicians (ACEP) for ED services, customizing it to fit their own needs. In 2008 OPPS Final Rule, CMS issued some general guidelines for hospital visit classification systems. For example, the hospital's system must "reasonably relate" the intensity of hospital resources to the different levels of E&M services, so that the more hospital resources are used, the higher the E&M level will be.

Here are a few examples of factors that hospitals might consider in determining the level of a visit:

The hospital's system must "reasonably relate" the intensity of hospital resources to the different levels of E&M services, so that the more hospital resources that are used, the higher the E&M level will be.

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Comparing E&M Coding: Professional Physician versus Outpatient Facility *(Continued from page 5)*

Here are a few examples of factors that outpatient coder might consider in determining the level of a visit:

- Administration of medication, IV infusions, hydration, therapeutic or prophylactic IM, vaccinations, etc.
- Bedside testing, such as dip stick urinalysis.
- Bedside treatments, fracture care.
- Insertion of nasogastric tube.
- Catheter care.
- Frequent monitoring (e.g., vital signs every 15 minutes).
- Social service intervention.
- Supervision of patient threatening self-harm.
- Extended patient education.
- Application of an elastic bandage or sling.

The above factors are very different than those that determine the level of the physician E&M service.

Diagnosis Codes

Facility: The claim includes diagnosis codes relevant to all services for a single patient for each date of service at the same facility. This may include services performed in multiple areas (e.g., lab, radiology and clinic). There are no pointers on the claim form to assign diagnosis codes to individual lines, but the ICD-10 codes must follow ICD-10 guidelines and show medical necessity for all services provided or billed.

The facility coders capture diagnosis codes in two areas: the admission Dx code to indicate the reason the patient is seeking treatment, and the final codes with a “first-listed” code and the rest are designated as secondary codes. Here is where the facility differs from the professional diagnostic coding. The facility coder will list in the admission diagnosis the signs and symptoms even if there is a definitive diagnosis. The outpatient coders will code for all diagnosis that are present at the time of service and in the patient history as these diagnoses might be necessary to show medical necessity for other services that were performed the same day within the facility (i.e., lab, x-rays, etc.).

Conclusion

E&M codes are used by both physicians and hospitals (facilities); there are dramatic differences in the way they are assigned. There are many instances when both the hospital and the physician will choose an E&M code for the same encounter, such as patient being seen in an outpatient clinic or emergency room, but frequently the E&M codes will not be the same. The differences in the E&M levels are entirely appropriate and should not come as a surprise to anyone who has a working knowledge of both coding for physician, and facility coding.

References:

Verisk Health: [Comparing Professional and Facility Healthcare Claims](#); Edie Hamilton, CPC
E/M: [Physician versus Facility](#); Jackie Miller, RHIA, CCS-P, CPC, PCS, from the March/April issue of HBMA Billing
CMS-Center for Medicare and Medicaid-CMS.gov; [Evaluation and Management Services Guide \(August 2015\)](#)
American College of Emergency Physicians (ACEP) www.acep.org
American Health Information Management Association: AHIMA Home www.ahima.org

Physician Quality Reporting System

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What is PQRS reporting?

The Physician Quality Reporting System (PQRS) is a quality reporting program that uses incentives and penalties to encourage eligible professionals to report quality measures to Medicare. PQRS was formerly known as the Physician Quality Reporting Initiative (PQRI).

Who can participate?

1. Medicare Physicians

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Oral Surgery
- Doctor of Dental Medicine
- Doctor of Chiropractic

2. Practitioners

- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant)
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist

3. Therapists

- Physical Therapist
- Occupational Therapist
- Qualified Speech-Language Therapies

Why PQRS?

Eligible physicians (EPs) are provided the opportunity to assess the quality of care provided to patients, helping ensure patients get the right care at the right time.

EPs are able to quantify how often particular care metrics are met.

EPs receive feedback reports comparing their performance on a given measure with other participating EPs.

The following factors should be considered when deciding which measures to select for PQRS reporting:

- Clinical condition usually treated review diagnosis coding in the measure's denominator, if applicable.
- Settings where care is usually delivered (e.g., office, emergency department [ED], surgical suite).
- Quality action (numerator) intended to be captured by the measure.
- Reporting mechanism of the measure.
- Domain associated with the measure.
- Individual clinical quality improvement goals for 2016.
- Other quality reporting programs in use or being considered.

Example of a PQRS Measure

PQRS Measure #236 - Controlling High Blood Pressure

Description

The percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.

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Physician Quality Reporting System *(Continued from page 7)*Instruction

This measure is to be reported a minimum of once per reporting period for patients with hypertension seen during the reporting period. The performance period for this measure is 12 months. The most recent quality code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Do not include blood pressure readings that meet the following criteria:

- Blood pressure readings from the patient's home (including readings directly from monitoring devices).
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).

If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled."

Denominator

- Patients 18 through 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.
- Diagnosis for hypertension (ICD-10-CM): I10.
- Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

Numerator

Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.

Numerator Instructions: To describe both systolic and diastolic blood pressure values, each must be reported separately. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Most recent blood pressure measurement performed.

Systolic pressure, and;

- Performance met: G8752: Most recent blood pressure < 140 mmHg; or
- Performance not met: G8753: Most recent systolic blood pressure \geq 140 mmHg.

Diastolic pressure, or;

- Performance met: G8754: Most recent diastolic blood pressure < 90 mmHg; or
- Performance not met: G8755: Most recent diastolic blood pressure \geq 90 mmHg.

Patient not eligible for recommended blood pressure parameters for documented reasons, or;

- Other performance exclusion: G9231: Documentation of end stage renal disease (ESRD), dialysis, renal transplant or pregnancy.

Blood pressure measurement not documented, reason not given

- Performance not met: G8756: No documentation of blood pressure measurement, reason not given.

Resources:

<http://www.practicefusion.com/pqrs/what-is-pqrs/>

<https://www.aapmr.org/docs/default-source/protected-advocacy/cms-2016-pqrs-reporting-presentation-for-aapm-r.pdf?sfvrsn=0>

https://www.pqrspro.com/cmsmeasures/2016/controlling_high_blood_pressure_pqrs-2016/

ICD-10-CM 2017 Coding Guidelines Updates

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The Centers for Medicare and Medicaid Services (CMS) released the ICD-10-CM Official Coding Guidelines for coding and reporting for the fiscal year 2017. These updated guidelines have been approved by the cooperating parties for ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS and National Center for Health Statistics (NCHS). The following are some of most significant changes for ICD-10-CM 2017, effective October 1st.

Section I. Conventions, General Coding Guidelines and Chapter Specific Guidelines

A. Conventions for the ICD-10-CM

Excludes1: New instructions have been added from the previous guideline where the Excludes1 made an exception which was also provided last October 19, 2015, weeks after commencing the utilization of ICD-10 code sets.

“An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider. For example, Code F45.8, Other somatoform disorders, has an Excludes1 note for "sleep related teeth grinding (G47.63)," because "teeth grinding" is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However psychogenic dysmenorrhea is also an inclusion term under F45.8 and a patient could have both this condition and sleep related teeth grinding. In this case, the two conditions are clearly unrelated to each other, and so it would be appropriate to report F45.8 and G47.63 together.”

Etiology/manifestation convention (“code first,” “use additional code” and “in diseases classified elsewhere” notes): The addition of “if applicable” provide clarification on the sequencing rules when there is an underlying condition and manifestation codes.

“Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD- 10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.”

“With”: The addition of definition and instructional direction provides the coder knowledge on interpreting the word “with” in alphabetic index, instructional notes or in tabular list.

The classification presumes a causal relationship between the two conditions linked by these terms in the alphabetic Index or tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.

Code Assignment and Clinical Criteria: This is new addition under the Section 1 of ICD-10-CM Official Coding Guidelines

The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

B. General Coding Guidelines

Laterality: The additional definition and example will help the coder apply the laterality of a certain condition appropriately.

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ICD-10-CM 2017 Coding Guidelines Updates *(Continued from page 9)*

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

Documentation for BMI, Depth of Non-Pressure Ulcers, Pressure Ulcer Stages, Coma Scale and NIH Stroke Scale: New addition where the documentation may get through non-physicians.

“For the body mass index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification. The BMI, coma scale, and NIHSS codes should only be reported as secondary diagnoses.”

C. Chapter Specific Guidelines

Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99): Because of the significant phenomena that Zika virus brought into the United States, coding the said condition has been added to the guideline:

“Code only confirmed cases code only a confirmed diagnosis of Zika virus (A92.5, Zika virus disease) as documented by the provider. This is an exception to the hospital inpatient guideline section II, H.

In this context, “confirmation” does not require documentation of the type of test performed; the physician’s diagnostic statement that the condition is confirmed is sufficient. This code should be assigned regardless of the stated mode of transmission.

If the provider documents "suspected," "possible" or "probable" Zika, do not assign code A92.5. Assign a code(s) explaining the reason for encounter (such as fever, rash, or joint pain) or Z20.828, contact with and (suspected) exposure to other viral communicable diseases.”

Chapter 9: Diseases of the Circulatory System (I00-I99): There is a significant change when coding for hypertension regarding “with” documentation, revised heart disease guideline, additional instruction to chronic kidney disease documentation and coding for hypertensive crisis.

“The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For hypertension and conditions not specifically linked by relational terms such as “with,” “associated with” or “due to” in the classification, provider documentation must link the conditions in order to code them as related.”

- **Hypertensive Chronic Kidney Disease:** “Hypertension with heart disease hypertension with heart conditions classified to I50.- or I51.4- I51.9, are assigned to a code from category I11, Hypertensive heart disease. Use an additional code from category I50, heart failure, to identify the type of heart failure in those patients with heart failure.”

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ICD-10-CM 2017 Coding Guidelines Updates *(Continued from page 10)*

- **Hypertensive Chronic Kidney Disease:** The same heart conditions (I50.-, I51.4-I51.9) with hypertension are coded separately if the provider has specifically documented a different cause. Sequence according to the circumstances of the admission/encounter.
- **Hypertensive Heart and Chronic Kidney Disease:** Hypertensive chronic kidney disease assign codes from category I12, hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, chronic kidney disease (CKD), are present. CKD should not be coded as hypertensive if the physician has specifically documented a different cause.
- Assign codes from combination category I13, hypertensive heart and chronic kidney disease, when there is hypertension with both heart and kidney involvement. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.
- **Hypertensive Crisis:** Assign a code from category I16, hypertensive crisis, for documented hypertensive urgency, hypertensive emergency or unspecified hypertensive crisis. Code also any identified hypertensive disease (I10-I15). The sequencing is based on the reason for the encounter.

Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00-L99): Further information in coding pressure ulcer's condition during hospitalization:

- Patients admitted with pressure ulcers documented as healing.
- For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer at the time of admission.
- Patient admitted with pressure ulcer evolving into another stage during the admission.
- If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, two separate codes should be assigned; one code for the site and stage of the ulcer on admission and a second code for the same ulcer site and the highest stage reported during the stay.

Chapter 15: Pregnancy, Childbirth and the Puerperium (O00-O9A): The new guideline reiterated the proper applications of supervision of high-risk pregnancy, the appropriate principal diagnosis when deliver occurs and conditions when not to code the long term use of medications.

- **Supervision of High-Risk Pregnancy:** Codes from category O09, Supervision of high-risk pregnancy, are intended for use only during the prenatal period. For complications during the labor or delivery episode as a result of a high-risk pregnancy, assign the applicable complication codes from Chapter 15. If there are no complications during the labor or delivery episode, assign Code O80, Encounter for full-term uncomplicated delivery.
- **When a Delivery Occurs:** When an obstetric patient is admitted and delivers during that admission, the condition that prompted the admission should be sequenced as the principal diagnosis. If multiple conditions prompted the admission, sequence the one most related to the delivery as the principal diagnosis. A code for any complication of the delivery should be assigned as an additional diagnosis. In cases of cesarean delivery, if the patient was admitted with a condition that resulted in the performance of a cesarean procedure that condition should be selected as the principal diagnosis. If the reason for the admission was unrelated to the condition resulting in the cesarean delivery, the condition related to the reason for the admission should be selected as the principal diagnosis.
- **Gestational (Pregnancy Induced) Diabetes:** The codes under subcategory O24.4 include diet controlled, insulin controlled and controlled by oral hypoglycemic drugs. If a patient with gestational diabetes is treated with both diet and insulin, only the code for insulin-controlled is required. If a patient with gestational diabetes is treated with both diet and oral hypoglycemic medications, only the code for "controlled by oral hypoglycemic drugs" is required. Code Z79.4, long-term (current) use of insulin or code Z79.84, long-term (current) use of oral hypoglycemic drugs, should not be assigned with codes from subcategory O24.4.

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ICD-10-CM 2017 Coding Guidelines Updates *(Continued from page 11)*

Chapter 16: Certain Conditions Originating in the Perinatal Period (P00-P96): This chapter discussed the appropriate usage of Z05 when there is an observation to newborns for suspected conditions.

- **Observation and Evaluation of Newborns for Suspected Conditions Not Found:** Assign a code from category Z05, Observation and evaluation of newborns and infants for suspected conditions ruled out, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from category Z05 when the patient has identified signs or symptoms of a suspected problem; in such cases code the sign or symptom.

A code from category Z05 may also be assigned as a principal or first-listed code for readmissions or encounters when the code from category Z38 code no longer applies. Codes from category Z05 are for use only for healthy newborns and infants. Z05 on a birth record – A code from category Z05 is to be used as a secondary code after the code from category Z38, live born infants according to place of birth and type of delivery.

Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99):

- **Coma Scale:** The coma scale codes (R40.2-) can be used in conjunction with traumatic brain injury codes, acute cerebrovascular disease or sequelae of cerebrovascular disease codes. These codes are primarily for use by trauma registries, but they may be used in any setting where this information is collected. The coma scale may also be used to assess the status of the central nervous system for other non-trauma conditions, such as monitoring patients in the intensive care unit regardless of medical condition. The coma scale codes should be sequenced after the diagnosis code(s).
- **NIHSS Stroke Scale:** The NIH stroke scale (NIHSS) codes (R29.7- -) can be used in conjunction with acute stroke codes (I63) to identify the patient's neurological status and the severity of the stroke. The stroke scale codes should be sequenced after the acute stroke diagnosis code(s). At a minimum, report the initial score documented. If desired, a facility may choose to capture multiple stroke scale scores.

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88): The new guideline further discuss the importance of Gustilo open classification for open fracture, when documented, and further discuss the appropriate coding for undetermined intent in poisoning.

- **Open Fracture and Gustilo Open Fracture Classification:** The open fracture designations in the assignment of the 7th character for fractures of the forearm, femur and lower leg, including ankle are based on the Gustilo open fracture classification. When the Gustilo classification type is not specified for an open fracture, the 7th character for open fracture type I or II should be assigned (B, E, H, M, Q).
- **Poisoning:** When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate code from categories T36-T50. The poisoning codes have an associated intent as their 5th or 6th character (accidental, intentional self-harm, assault and undetermined.) If the intent of the poisoning is unknown or unspecified, code the intent as accidental intent. The undetermined intent is only for use if the documentation in the record specifies that the intent cannot be determined. Use additional code(s) for all manifestations of poisonings.

Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99): Observation: The observation codes are to be used as principal diagnosis only. The only exception to this is when the principal diagnosis is required to be a code from category Z38, Live born infants according to place of birth and type of delivery. Then a code from category Z05, Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out, is sequenced after the Z38 code. Additional codes may be used in addition to the observation code, but only if they are unrelated to the suspected condition being observed.

It is imperative in a coding organization to have an educational plan for its coding staff ahead of time to make sure they are in compliance to the new updates of ICD-10-CM 2017.

Source: <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2017-ICD-10-CM-Guidelines.pdf>

Correct Answer For August Are You a Good Auditor?

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	ICD-10-CM	Audit Remark
Principal Diagnosis	E10.621	Assigned as principal diagnosis since the patient was admitted because of a skin ulcer of the heel, which is part of the foot. There is a specific code for diabetic foot ulcer, so it is more appropriate to code this rather than the diabetic skin ulcer.
Secondary Diagnosis	L97.419	Assigned as SDX since there is a convention in E10.621 to use an additional code to report the specific site and severity of the foot ulcer.
Secondary Diagnosis	J44.1	Assigned as SDX, since the patient's COPD is at decompensation.
Secondary Diagnosis	J44.0	Assigned as SDX, since the patient has COPD and acute bronchitis.
Secondary Diagnosis	J20.9	Assigned as SDX for acute bronchitis.
Secondary Diagnosis	J96.91	Assigned as SDX for the patient's respiratory failure, with hypoxia.
	ICD-10-PCS	Audit Remark
Principal Procedure	0HDMXZZ	Assigned as PDX for nonexcisional debridement of the skin of the right heel.
Secondary Procedure	5A1955Z	Assigned as SPX for mechanical ventilation of greater than 96 hours.
Secondary Procedure	0BH17EZ	Assigned as SPX for intubation of endotracheal tube.

Correct Answer for August Coding Case Scenario

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	ICD-10-CM	Coding Remark
Principal Diagnosis	N40.1	Assign code as principal diagnosis because the reason for admission is severe urinary retention. There is a convention in R33.8, which is the code for urinary retention, to code first benign prostatic hypertrophy.
Secondary Diagnosis	R33.8	Assign code as secondary diagnosis since the convention in N40.1, says to use additional code for urinary retention.
Secondary Diagnosis	I10	Assigned as secondary code for hypertension.
Secondary Diagnosis	T46.5X6A	Assigned as secondary code for underdosing of antihypertensive medication. Since the patient is noncompliant in taking his antihypertensive meds, there is a convention to code first underdosing T-code.
Secondary Diagnosis	Z91.120	Assigned as secondary code for patient's noncompliance in taking medications because of financial hardship.
	ICD-10-PCS	Coding Remark
Principal Procedure	0VT07ZZ	Assign code as principal procedure since the patient's prostate was resected with TURP.