Effective 10/1/2019

Inpatient Prospective Payment System (IPPS)
4th Quarter Coding Clinic 2019
3rd Quarter Coding Clinic 2019

CIHIMA MEETING

November 2019

Speaker

Sarah Nehring, CCS, CCDS

Inpatient Lead Coder

Inpatient Prospective Payment System (IPPS)

What is IPPS?

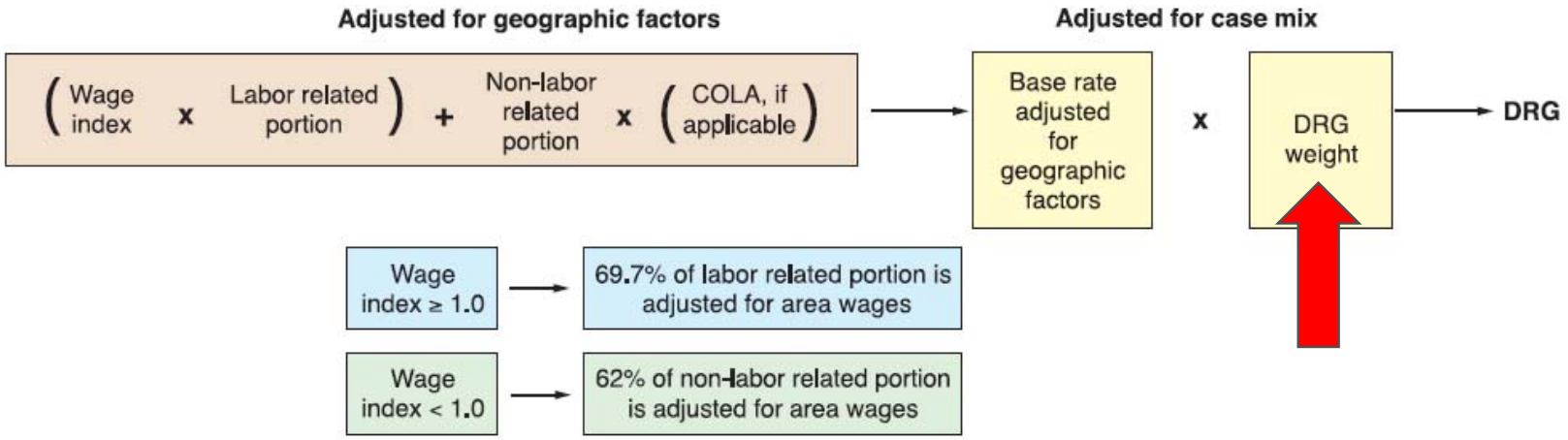
- "***A system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates***"
- Set forth in Section 1886(d) of the Social Security Act
- Each case is categorized into a **Diagnosis-Related Group (DRG)** *based on code assignment*
  - Each DRG has a relative weight (RW) assigned to it
  - RW is based on the average resources used to treat Medicare patients in that DRG
- **Base Payment Rate** is calculated/adjusted for geographical factors
- **This base payment rate is multiplied by the DRG relative weight, but that's not the end of the calculation…**

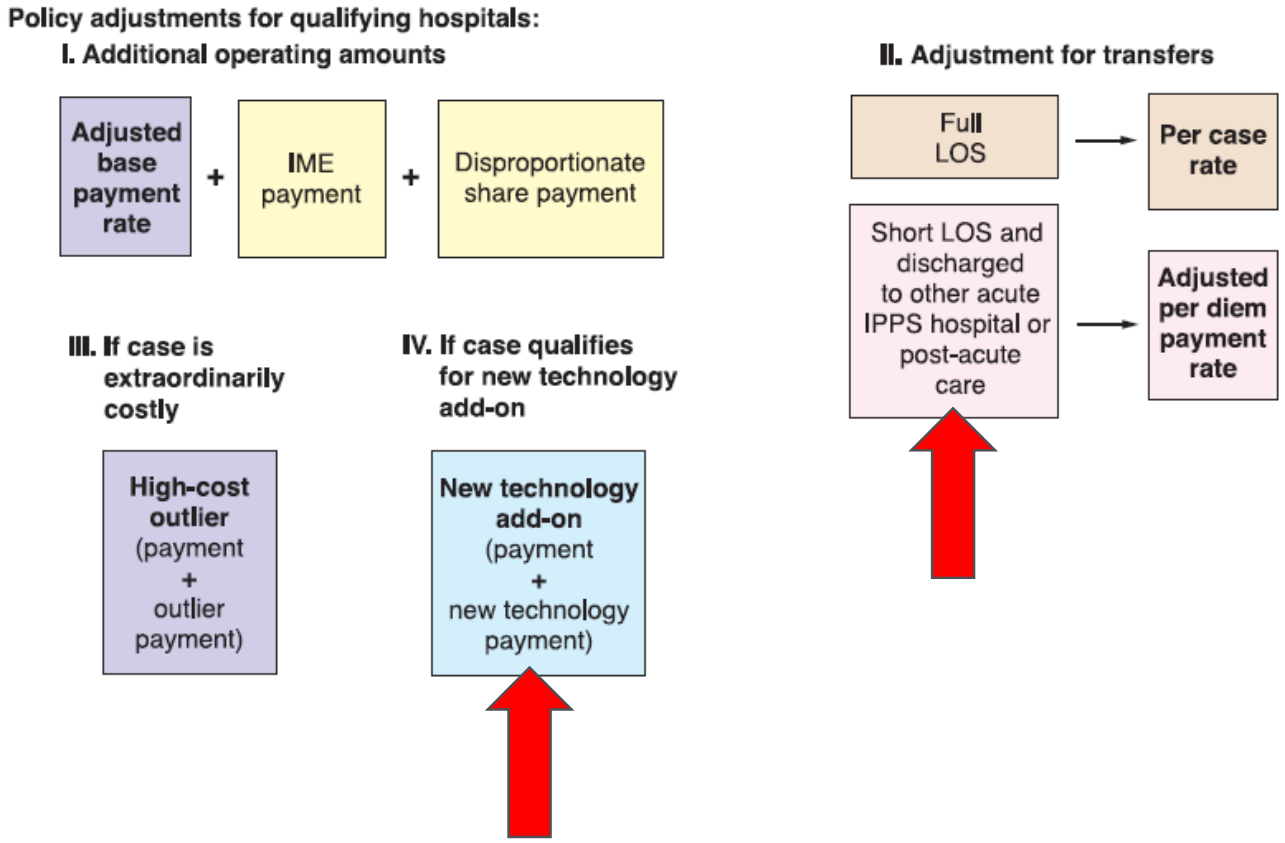
What is IPPS?

- **Disproportionate Share Hospital (DSH) adjustment**
  - A percentage add-on payment applied to the DRG-adjusted base payment rate for hospitals that treats a high-percentage of low-income patients
- **Indirect Medical Education (IME) adjustment**
  - Approved teaching hospitals receives a percentage add-on payment for each case paid through IPPS.
- **Outlier Cases**
  - Designed to protect the hospital from large financial losses due to unusually expensive cases.

Acute Inpatient Prospective Payment System

Operating Base Payment Rate




Policy adjustments for qualifying hospitals:
I. Additional operating amounts
Adjusted base payment rate
+
IME payment
+
Disproportionate share payment
II. Adjustment for transfers
Full LOS
Per case rate
Short LOS and discharged to other acute IPPS hospital or post-acute care
Adjusted per diem payment rate
III. If case is extraordinarily costly
High-cost outlier (payment + outlier payment)
IV. If case qualifies for new technology add-on
New technology add-on (payment + new technology payment)

FY 2020 Changes
From a Coder's Perspective

- MS-DRG creations and deletions
- Grouper logic corrections
- MCC/CC additions and deletions
- New technology add-on payments
- Transfer/special pay DRG changes

MS-DRG Updates

FY 2019

761 Total MS-DRG

FY 2020

+2 New MS-DRGs

- 2 Deleted MS-DRGs

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761 Total MS-DRGs

MS-DRG Updates: Cardiac Valve Procedures

2 New MS-DRGs

319 Other endovascular cardiac valve procedures w MCC

RW 4.1007

320 Other endovascular cardiac valve procedures w/o MCC

RW 2.3477

2 Revised Titles

266 Endovascular cardiac valve replacement *and supplement procedures* w MCC

RW 7.1214

267 Endovascular cardiac valve replacement *and supplement procedures* w/o MCC

RW 5.6756

MS-DRG Updates: Cardiac Valve Procedures

Transcath Mitral Valve Repair *with Graft* was the only valve procedure, only procedure involving implant of a synthetic substitute that grouped to MS-DRGs 228-229, so…

- **MS-DRGs 266-267 were renamed:** Endovascular cardiac valve replacement ***and supplement*** procedures
  - 02UG3JZ supplement mitral valve with synthetic substitute, percutaneous approach now groups here
- **MS-DRGs 319-320** *Other* endovascular cardiac valve procedures **were created**
  - Non-replacement, non-supplement endovascular procedures involving heart valves group here
    - Destruction
    - Dilation
    - Excision
    - Repair
    - Restriction
    - Revision

MDC 5 Surgical Hierarchies FY 2020	
215	Other heart assist system implant
216-221	Cardiac valve & other major cardiothoracic procedures
266-267	Endovascular cardiac valve *replacement* & *supplement* procedures
222-227	Cardiac defibrillator implant
228-229	Other cardiothoracic procedures
231-236	CABG
268-269	Aortic and heart assist procedures
New 319-320	Other endovascular cardiac valve procedures
270-272	Other major cardiovascular procedures

TMVR

MS-DRG Update: Extracorporeal Shock Wave Lithotripsy

Two Deleted MS-DRGs

691 Urinary stones with ESW lithotripsy w CC/MCC *RW 1.6242*

692 Urinary stones with ESW lithotripsy w/o CC/MCC *RW 1.1306*

- ESW Lithotripsy cases now group to renamed MS-DRGs 693-694 Urinary stones ~~w/o ESW lithotripsy~~ w/ or w/out MCC (RW 1.3533, 0.7404)
  - Fragmentation procedures (renal pelvis, ureter, bladder, bladder neck, urethra) have *no impact* on MS-DRG assignment

MS-DRG Update: Acute Cor Pulmonale

- MS-DRG 175 retititled: Pulmonary embolism w/ MCC *or acute cor pulmonale*
  - ~~I26.01 septic pulmonary embolism w/ acute cor pulmonale~~ *code first underlying infection*
  - I26.02 saddle pulmonary embolism w/ acute cor pulmonale
  - I26.09 other pulmonary embolism w acute cor pulmonale

176 Pulmonary embolism w/o MCC RW 0.8484

175 Pulmonary embolism w MCC *or acute cor pulmonale* RW 1.4444

- Codes for single and multiple segmental pulmonary embolism *without* acute cor pulmonale added for FY 2020→ *with acute cor pulmonale* is *not* an option with this type of PE

MS-DRG Update: Peripheral ECMO

- **Peripheral ECMO will be reassigned to the Pre-MDC MS-DRG 003**
  RW 18.9539

- **Four MS-DRG titles have been updated to reflect this change**

207 Respiratory system w ventilator support >96 hours ~~or peripheral ECMO~~ RW 5.7356

291 Heart failure & shock w MCC ~~or peripheral ECMO~~ RW 1.3458

296 Cardiac arrest, unexplained w MCC ~~or peripheral ECMO~~ RW 1.5704

870 Septicemia or severe sepsis w >96 hours ~~or peripheral ECMO~~ RW 6.3243

Grouper Logic Updates

- **Hematopoietic Cell Transplantation (HCT) using *autologous* cord blood stem cells (transfusion of *autologous* cord blood stem cells) reassigned**

FY 2019

MS-DRG 014 Allogenic *bone marrow transplant*

RW 11.9503

FY 2020

MS-DRG 016 Autologous bone marrow tranplant w CC/MCC or T-cell immunotherapy

RW 8.8852

MS-DRG 017 Autologous *bone marrow tranplant w/o CC/MCC*

RW 4.4474

Grouper Logic Updates

- **MS-DRGs 34- 36 *Carotid artery stent procedures***
  - *Removed* codes for procedures that that do not
    - Involve an intraluminal device
    - Are performed on arteries other than carotid
    - Are performed on a vein

- **MS-DRGs 37- 39 *Extracranial Procedures***
  - Removed procedures that describe dilation of *carotid artery* w/ intraluminal device→ all should go to MS-DRGs 34-36

Grouper Logic Updates

- **MS-DRGs 485-487 *Knee procedures w/ PDX infection***
  - *Removed* diagnosis codes not specific to knee

    examples:
    - M86.9 Osteomyelitis, unspecified
    - T84.51XA Infection/inflammatory reaction due to internal right HIP prosthesis, initial

  - *Added*
    - A18.02 Tuberculosis arthritis, other joint
    - A54.42 Gonococcal arthritis
    - M00.9 Pyogenic arthritis
    - M01.X61, M01.X62, M01.X69 direct infection, knee
    - M71.061, M71.062, M71.069 abscess bursa, knee
    - M71.161, M71.162, M71.169 other infective bursitis, knee

Grouper Logic Updates

- **MS-DRGs 260-262 *Cardiac pacemaker revision except device replacement***
  - *Added* 02H60JZ insertion of pm lead into right atrium, open approach

- **MS-DRGs 456-458 *Spinal fusion except cervical with spinal curvature, malignancy, infection or extension fusion***
  - *Added* dx codes for *non-cervical* neuromuscular scoliosis and other secondary scoliosis
  - *Removed* 34 codes involving the cervical spine

Unrelated →Related

FY 2019	FY 2020
Pressure ulcer with excision of scrum, pelvic bone, coccyx→ DRG 981-983 RW 4.502 * 2.438 * 1.6371	MS-DRG 579-581 Other skin , subQ, & breast procedures RW 2.9861 *1.6087 * 1.2548
Pdx from MDC 10 (endocrine, nutritional, metabolic) such as diabetes complication with excision LE muscle or tendon→DRG 981-983 RW 4.502 * 2.438 * 1.6371	MS-DRG 622-624 Skin grafts and wound debridement for endocrine, nutritional & metabolic disorders RW 3.7755 * 1.9526 *1.1020

Unrelated → Related

FY 2019

Pdx from MCD 1 (neuro) with 0DH60UZ Insertion of feeding device in stomach, open approach→DRG 981-983

RW 4.502 * 2.438 * 1.6371

Pdx MDC 10 (endocrine, nutritional,metabolic) with 0DH60UZ Insertion of feeding device in stomach, open approach→DRG 981-983

RW 4.502 * 2.438 * 1.6371

FY 2020

Pdx Stroke→ MS-DRG 40-42 Peripheral, cranial nerve & other nervous system procedures

RW 3.9404 * 2.3715 * 1.8483

Pdx Malntrition→ MS-DRG 628-630 Other endocrine, nutritional, metabolic OR procedure

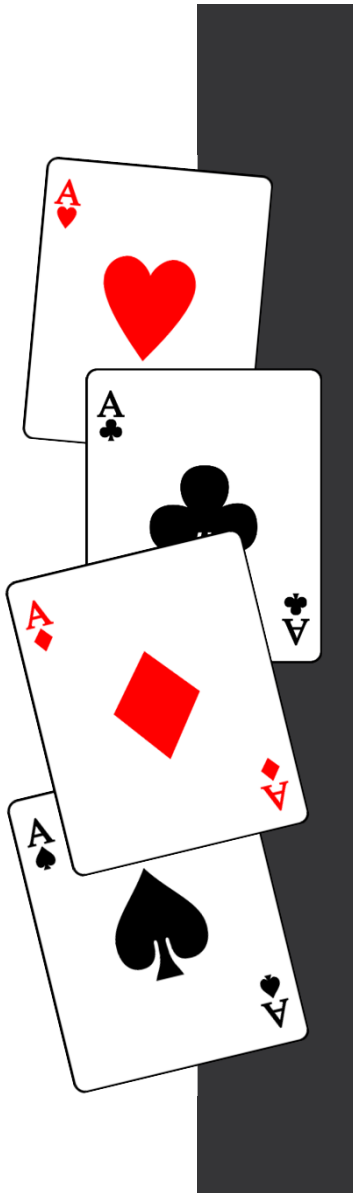
RW 3.6893 * 2.3228 *1.4488

O.R. vs Non-O.R.

Procedure Description	FY 2019	FY 2020
Bronchoalveolar lavage (14 lung codes, diagnostic & non-diagnostic)	OR	Non-OR
Percutaneous drainage of pelvic cavity	OR	Non-OR
Percutaneous removal of drainage device from pancreas	OR	Non-OR
Percutaneous occlusion of gastric artery	**Non-OR**	**OR**
Endoscopic insertion of endobronchial valves	Non-OR	Non-OR, but groups to MS-DRGs 163-165 Major Chest Procedure when Pdx is a respiratory system diagnosis

Some CC/MCC *Proposed* Changes

- E43 *Unspecified severe protein-calorie malnutrition* **downgrade** from an MCC to a CC
- R62.7 *Adult failure to thrive* **upgrade** to a CC
- L89.95 *Pressure ulcer of unspecified site, unstageable* **upgrade** to a CC
- Stage 3 and 4 pressure ulcers **downgrade** from MCCs to CCs
- ST and non-ST elevated myocardial infarctions (STEMI, NSTEMI) **downgrade** from MCCs to CCs
- Systolic, diastolic, and combined chronic heart failure **downgrade** from CCs to non-CCs
- Stage 4 and 5 chronic kidney disease **downgrade** from CCs to non-CCs
- End Stage Renal Disease (ESRD) **downgrade** from an MCC to a CC
- R65.11, *SIRS [systemic inflammatory response syndrome] of non-infectious origin with acute organ dysfunction* **downgrade** from an MCC to a CC
- Certain Body Mass Index (BMI) **downgrade** from CCs to non-CCs



CC/MCC Good News…for Now

- "***Postponing*** the adoption of comprehensive changes in severity level designations will allow us to incorporate review of additional ICD–10 claims data as it becomes available and to fully consider the technical feedback provided from the public on the proposed rule**.**"
- "In addition, we can consider further whether it is appropriate to propose to make such comprehensive changes ***all at once or in phases***, as suggested by some commenters."
- "…after consideration of the public comments we received, we are generally not finalizing our proposed changes to the severity level designations…"

MCC Classification

Additions

New Codes

Subsegmental pulmonary emboli-single or multiple (2 codes)

Traumatic orbital roof fracture, initial encounter (3 codes)

Deletions

CC Classification

Additions

New Codes

- **Expanded codes for**
- **Z16._ Resistance to**

Antibiotics

Antimicrobials

Antiparasitic

Antifungal

Antiviral

Deletions

Deleted due to code expansion

- D81.3 Adenosine Deaminase (ADA) deficiency
- I48.1 Persistent atrial fibrillation
- Q79.6 Ehler-Danlos syndrome
- Q87.1 Congenital malformation syndromes predominantly associated with short stature
- T67.0XXA Heatstroke & sunstroke, initial

New Technology Add-On Payment (NTAP)

- To quality, service or technology must
  - **Be new** (no more than 2-3 years)
  - **Cost a lot** (DRG rate is inadequate to cover)
  - **Be worth it** (substantial clinical improvement over existing services or technology)
- FY 2019: Full MS-DRG payment + *50% of cost*
- FY 2020: Full MS-DRG payment +
  - 65% of cost of new medical service of technology
  - 65% of amount by which costs of case exceed standard DRG payment
  - 75% if qualified infectious disease product (QIDPs)

New NTAP for FY 2020

Technology Name	Description	Indication	NTAP
AZEDRA® (iobenguane I 131)	IV antineoplastic	Pheochromocytoma & paragangioma	$98,150.00
BALVERSA™ (erdafitinib)	Oral antineoplastic	2nd line tx—advanced or metastatic urothelial CA	$3,563.23
Cablivi® (caplacizumab-yhdp	SubQ injection, platelet-protective	Acquired TTP	$33,215.00
Elzonris™ (tagraxofusp-erzs)	IV antineoplastic	Blastic plasmacytoid dendritic cell neoplasm	$125,448.05
ERLEADA® (apalutamide)	Oral antineoplastic	Non-mets castration-resistant prostate cancer	$1,858.15
Jakafi® (ruxolitinib)	Oral kinase inhibitor	Steroid-refractory acute graft-vs-host dz	$3,977.06
SPRAVATO™	Nasal spray	Treatment-resistant depression	$1,014.79
Xospata® (gilteritinib)	Oral antineoplastic	Relapsed or refractory AML w/ FLT3 mutation	$7,312.50
T2Bacteria® Panel	Multiple diagnostic lab panel	Aid in ID of bacteremia/sepsis precursor	$97.50

Continued NTAP

Technology Name	Indication	FY 2019	FY 2020
AndexXa ™ (andexanet alfa)	Anticoag reversal	$14,065.50	$18,281.25
Giapreza™ (angiotensin II)	BP in septic shock	$1,500.00	$1,950.00
KYMRIAH® (tisagenlecleucel)	T-cell Immunotherapy	$186,500.00	$242,450.00
remedē® System	Central sleep apnea	$17,250.00	$22,425.00
VABOMERE™ (Meropenem and Vaborbactam)	ABX for cUTI (QIDP!)	$5,544.00	$8,316.00
VYXEOS® (daunorubicin and cytarabine)	AML	$36,425.00	$47,352.50
Yescarta™ (Axicabtagene Ciloleucel)	T-cell Immunotherapy	$186,500.00	$242,450.00
ZEMDRI™ (plazomicin)	ABX for cUTI (QIDP!)	$2722.50	$4083.75
Aquabeam® System	BPH aquablation	$1250.00	$1625.00
Sentinel® Cerebral Protection System	TAVR embolic protection	$1400.00	$1820.00

Discontinued NTAP

Defitelio® (defibrotide) ~~$80,500.00~~

ZINPLAVA™ (bezlotoxumab) ~~$1900.00~~

STELARA® (ustekinumab) ~~$2,400.00~~

Transfer/Special Pay MS-DRGs

FY 2019		FY 2020	
• Transfer MS-DRGs	280	• Transfer MS-DRG	278
• Special Pay MS-DRGs	42	• Special Pay MS-DRG	40

MS-DRGs 273-274 *Percutaneous intracardiac procedures* removed from list

OPERATING ROOM PROCEDURES

02553ZZ	Destruction of Atrial Septum, Percutaneous Approach
02563ZZ	Destruction of Right Atrium, Percutaneous Approach
02573ZZ	Destruction of Left Atrium, Percutaneous Approach
02583ZZ	Destruction of Conduction Mechanism, Percutaneous Approa
02593ZZ	Destruction of Chordae Tendineae, Percutaneous Approach
025K3ZZ	Destruction of Right Ventricle, Percutaneous Approach
025L3ZZ	Destruction of Left Ventricle, Percutaneous Approach
025M3ZZ	Destruction of Ventricular Septum, Percutaneous Approach
027F44Z	Dilation of Aortic Valve with Drug-eluting Intraluminal Device
027F4DZ	Dilation of Aortic Valve with Intraluminal Device, Percutaneo
027F4ZZ	Dilation of Aortic Valve, Percutaneous Endoscopic Approach
027G44Z	Dilation of Mitral Valve with Drug-eluting Intraluminal Device
027G4DZ	Dilation of Mitral Valve with Intraluminal Device, Percutaneo
027G4ZZ	Dilation of Mitral Valve, Percutaneous Endoscopic Approach
027H44Z	Dilation of Pulmonary Valve with Drug-eluting Intraluminal D
027H4DZ	Dilation of Pulmonary Valve with Intraluminal Device, Percut
027H4ZZ	Dilation of Pulmonary Valve, Percutaneous Endoscopic Appro
027J44Z	Dilation of Tricuspid Valve with Drug-eluting Intraluminal De
027J4DZ	Dilation of Tricuspid Valve with Intraluminal Device, Percutar
027J4ZZ	Dilation of Tricuspid Valve, Percutaneous Endoscopic Approa
02B53ZZ	Excision of Atrial Septum, Percutaneous Approach
02B63ZZ	Excision of Right Atrium, Percutaneous Approach
02B73ZZ	Excision of Left Atrium, Percutaneous Approach
02B83ZZ	Excision of Conduction Mechanism, Percutaneous Approach
02B93ZZ	Excision of Chordae Tendineae, Percutaneous Approach
02BM3ZZ	Excision of Ventricular Septum, Percutaneous Approach
02T83ZZ	Resection of Conduction Mechanism, Percutaneous Approach
02U53JZ	Supplement Atrial Septum with Synthetic Substitute, Percuta
02U54JZ	Supplement Atrial Septum with Synthetic Substitute, Percuta

OR NON-OPERATING ROOM PROCEDURES

02573ZK*	Destruction of Left Atrial Appendage, Percutaneous Approach
02574ZK*	Destruction of Left Atrial Appendage, Percutaneous Endoscopic Approach
02B73ZK*	Excision of Left Atrial Appendage, Percutaneous Approach
02B74ZK*	Excision of Left Atrial Appendage, Percutaneous Endoscopic Approach
02K83ZZ*	Map Conduction Mechanism, Percutaneous Approach
02K84ZZ*	Map Conduction Mechanism, Percutaneous Endoscopic Approach
02L73CK*	Occlusion of Left Atrial Appendage with Extraluminal Device, Percutaneous
02L73DK*	Occlusion of Left Atrial Appendage with Intraluminal Device, Percutaneous
02L73ZK*	Occlusion of Left Atrial Appendage, Percutaneous Approach
02L74CK*	Occlusion of Left Atrial Appendage with Extraluminal Device, Percutaneous
02L74DK*	Occlusion of Left Atrial Appendage with Intraluminal Device, Percutaneous
02L74ZK*	Occlusion of Left Atrial Appendage, Percutaneous Endoscopic Approach
4A023FZ*	Measurement of Cardiac Rhythm, Percutaneous Approach
4A027FZ*	Measurement of Cardiac Rhythm, Via Natural or Artificial Opening
4A028FZ*	Measurement of Cardiac Rhythm, Via Natural or Artificial Opening Endoscc

4th Quarter Coding Clinic

A publication of the American Hospital Association (AHA)

" *The Centers for Medicare and Medicaid Services (**CMS**) and the National Center for Health Statistics (**NCHS**), two departments within the U.S. Federal Government's Department of Health and Human Services (**DHHS**) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)…*

*…These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (**AHA**), the American Health Information Management Association (**AHIMA**), **CMS**, and **NCHS**.*"

ICD-10-CM Guideline Changes

I.A.15 "With"

- "The word "with" in the alphabetic index is sequenced immediately following the main term **or subterm**, not in alphabetical order"

I.C.9.e.5 Type 2 MI

- "Type 2 myocardial infarction, (myocardial infarction due to demand ischemia or secondary to ischemic imbalance) is assigned to code I21.A1, myocardial infarction type 2 with a code for **the underlying cause coded first…**

  …~~sequencing of type 2 AMI or the underlying cause is dependent on the circumstances of admission~~"

See "code first" instruction in tabular list under I21.A1

ICD-10-CM Guideline Changes

I.C.12.a.2, I.C.12.a.4, I.C.12.a.7 Pressure ulcer stage

- **2) "**Unstageable Ulcer Stages…(e.g. the ulcer is covered by eschar or has been treated with skin or muscle graft ~~and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma~~")
- **4) "**No code is assigned if the documentation states hat the pressure ulcer is completed healed **at the time of admission."**
- 7) "**For pressure-induced deep tissue damage or deep tissue pressure injury, assign only the appropriate code for pressure-induced deep tissue damage**"

BE CAREFUL USING CODEBOOK & ENCODER!

Deep Tissue Pressure Injury

- Injury
  - Deep Tissue
    - Meaning Pressure *ulcer*—see Ulcer, pressure, unstageable, by site
- Damage
  - Deep Tissue, pressure-induced- see also L89 with final character .6
    - L89.006 pressure induced deep tissue damage of unspecified elbow
    - L89.016 pressure induced deep tissue damage of right elbow
    - L89.026 pressure induced deep tissue damage of left elbow

ICD-10-CM Guideline Changes

I.C.19.b.3 Iatrogenic injuries

- **"Injury codes from Chapter 19 should not be assigned for injuries that occur during, or as a result of, a medical intervention. Assign the appropriate complication code(s)."**

IC.19.g.5 Complications of care

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

Complications of Care

- Ileus **K**56.7
  - Post-operative **K**91.89

- Complication
  - Gastrointestinal
    - Post-operative
      - Specified NEC **K**91.89

- **K**91.89 Other postprocedural complications and disorders of digestive system

  Use additional code, if applicable, to further specify disorder

surgical procedure (on) T81.9
amputation stump (late) - see Complications, amputation stump
cardiac - see Complications, circulatory system
cholesteatoma, recurrent - see Complications, postmastoidectomy, recurrent cholesteatoma
circulatory (early) - see Complications, circulatory system
digestive system - see Complications, gastrointestinal
dumping syndrome (postgastrectomy) K91.1
ear - see Complications, ear
elephantiasis or lymphedema I97.89
postmastectomy I97.2
emphysema (surgical) T81.82
endocrine - see Complications, endocrine
eye - see Complications, eye
fistula (persistent postoperative) T81.83
foreign body inadvertently left in wound (sponge) (suture) (swab) - see Foreign body, accidentally left during a procedure
gastrointestinal - see Complications, gastrointestinal
genitourinary NEC N99.89

ICD-10-CM Guideline Changes

I.C.19.e.4 Adverse effects, poisoning, underdosing and toxic effects

- **"**If two or more drugs, medicinal or biological substances are ~~reported~~ **taken**, code each individually unless a combination code is listed in the Table of Drugs and Chemicals.
- **If multiple unspecified drugs, medicinal or biological substances were taken, assign the appropriate code from subcategory T50.91 Poisoning by, adverse effect of and underdosing of multiple unspecified drugs, medicaments and biological substances."**

ICD-10-CM Guideline Changes

I.C.21.c.3 Z68 Body mass index (BMI)

- **"**BMI codes should only be assigned when ~~the~~ **there is an** associate **reportable** diagnosis (such as ~~overweight or~~ obesity). ~~meets the definition of a reportable diagnosis~~…"

II.H, III.C Uncertain diagnosis

- "If the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," "**compatible with**," "**consistent with**," or other similar terms indicating uncertainty…

ICD-10-CM Guideline Supplement

Vaping Related Lung Injury

- If the provider specifies that injury is due to…
  - **Tobacco/nicotine product**→T65.291- Toxic effect of other nicotine and tobacco, accidental (unintentional)
  - **Tetrahydrocannabinol (THC)**→ T40.7X1- Poisoning by cannabis (derivatives), accidental (unintentional).

- If no specific substance is documented
  - T59.891A toxic effect of other specified gases, fumes, and vapors, accidental (unintentional), initial encounter

ICD-10-CM Guideline Supplement

Vaping Related Lung Injury

- An additional code is needed to specify the manifestation.
  - J68.0 *Bronchitis and pneumonitis due to chemicals, gases, fumes and vapors; includes chemical pneumonitis*
  - J69.1 *Pneumonitis due to inhalation of oils and essences; includes lipoid pneumonia*
  - J80 *Acute respiratory distress syndrome*
  - J82 *Pulmonary eosinophilia, not elsewhere classified*
  - J84.114 *Acute interstitial pneumonitis*
  - J84.89 *Other specified interstitial pulmonary disease*
- For patients with acute lung injury but without further documentation identifying a specific condition (pneumonitis, bronchitis)
  - J68.9, *Unspecified respiratory condition due to chemicals, gases, fumes, and vapors*

ICD-10-PCS Guideline Changes

- "**These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-PCS itself. They are intended to provide direction that is applicable in most circumstances. However, there may be unique circumstances where exceptions are applied**."

ICD-10-PCS Guideline Changes

Overlapping body layers

B3.5 "If root operations such as Excision, **Extraction**, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded."

General guidelines

B4.1b "If the prefix "peri" is combined with a body part to identify the site of the procedure, and the site of the procedure is not further specified, then the procedure is coded to the body part named. This guideline applies only when a more specific body part value is not available.

Examples…**A procedure site documented as involving the periosteum is coded to the corresponding bone body part**."

ICD-10-PCS Guideline Changes

General Guidelines

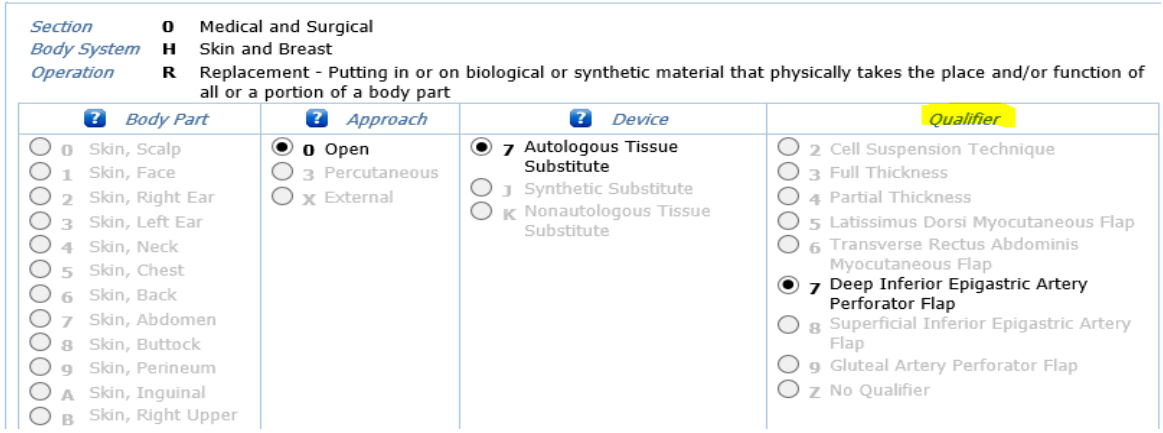
B3.1b "Components of a procedure specified in the root operation definition or explanation **as integral to that root operation** are not coded separately. Procedural steps necessary to reach the operative site and close the operative site, including anastomosis of a tubular body part, are also not coded separately….

…***Exceptions:*** **Mastectomy followed by breast reconstruction, both resection and replacement of the breast are coded separately**."

ICD-10-PCS Guideline Changes

Excision for graft

B3.9 "If an autograft is obtained from a different procedure site in order to complete the objective of the procedure, a separate procedure is coded, **except when the seventh character qualifier value in the ICD-10-PCS table fully specifies the site from which the autograft was obtained**."



Section **0** Medical and Surgical
Body System **H** Skin and Breast
Operation **R** Replacement - Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part

Body Part	Approach	Device	Qualifier
0 Skin, Scalp	**0 Open**	**7 Autologous Tissue Substitute**	2 Cell Suspension Technique
1 Skin, Face	3 Percutaneous	J Synthetic Substitute	3 Full Thickness
2 Skin, Right Ear	X External	K Nonautologous Tissue Substitute	4 Partial Thickness
3 Skin, Left Ear			5 Latissimus Dorsi Myocutaneous Flap
4 Skin, Neck			6 Transverse Rectus Abdominis Myocutaneous Flap
5 Skin, Chest			**7 Deep Inferior Epigastric Artery Perforator Flap**
6 Skin, Back			8 Superficial Inferior Epigastric Artery Flap
7 Skin, Abdomen			9 Gluteal Artery Perforator Flap
8 Skin, Buttock			Z No Qualifier
9 Skin, Perineum			
A Skin, Inguinal			
B Skin, Right Upper			

ICD-10-PCS Guideline Changes

Brachytherapy

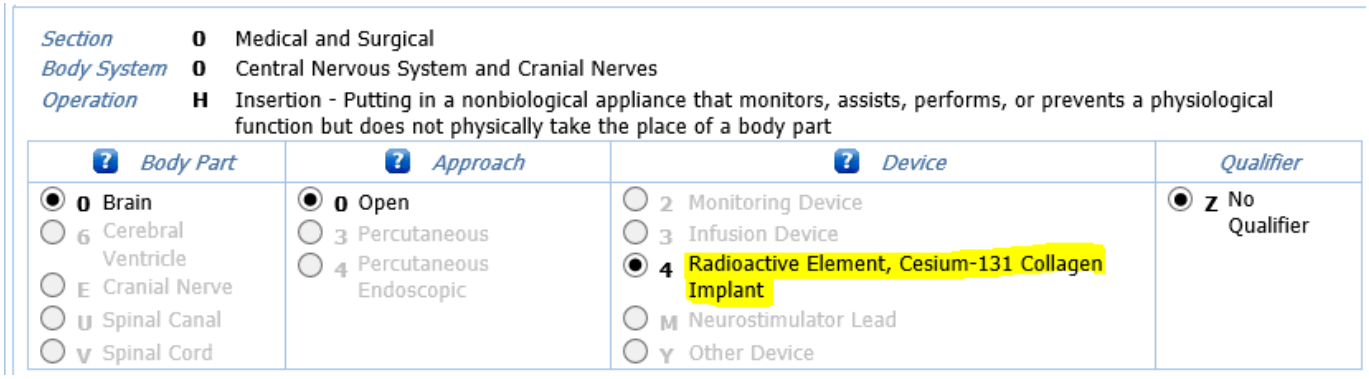
D1.a "Brachytherapy is coded to the modality Brachytherapy in the Radiation Therapy section. When a radioactive brachytherapy source is left in the body at the end of the procedure, it is coded separately to the root operation Insertion with the device value Radioactive Element."

DV1098Z ***High dose rate (HDR) brachytherapy or prostate using Iridium 192 (Ir-192)***

0VH031Z ***Insertion of radioactive element in prostate, percutaneous approach***

ICD-10-PCS Guideline Changes

"*Exception:* Implantation of Cesium-131 brachytherapy seeds embedded in a collagen matrix to the treatment site after resection of brain tumor is coded to the root operation Insertion with the device value Radioactive Element, Cesium-131 Collagen Implant. The procedure is coded to the root operation Insertion only, because the device value identifies both the implantation of the radioactive element and a specific brachytherapy isotope that is not included in the Radiation Therapy section tables."



Section	**0**	Medical and Surgical
Body System	**0**	Central Nervous System and Cranial Nerves
Operation	**H**	Insertion - Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

Body Part	*Approach*	*Device*	*Qualifier*
(•) **0** Brain	(•) **0** Open	( ) 2 Monitoring Device	(•) **Z** No Qualifier
( ) 6 Cerebral Ventricle	( ) 3 Percutaneous	( ) 3 Infusion Device	
( ) E Cranial Nerve	( ) 4 Percutaneous Endoscopic	(•) **4** Radioactive Element, Cesium-131 Collagen Implant	
( ) U Spinal Canal		( ) M Neurostimulator Lead	
( ) V Spinal Cord		( ) Y Other Device	

ICD-10-PCS Guideline Changes

D1.b "A separate procedure to place a temporary applicator for delivering the brachytherapy is coded to the root operation Insertion and the device value Other Device.

***Examples*: Intrauterine brachytherapy applicator placed as a separate procedure from the brachytherapy procedure is coded to Insertion of Other Device, and the brachytherapy is coded separately using the modality Brachytherapy in the Radiation Therapy section.**

Intrauterine brachytherapy applicator placed concomitantly with delivery of the brachytherapy dose is coded with a single code using the modality Brachytherapy in the Radiation Therapy section."

ICD-10-PCS Guideline Changes

General Guidelines

E1.a "~~Section X codes are standalone codes. They are not supplemental codes~~. Section X codes fully represent the specific procedure described in the code title, and do not require additional codes from other sections of ICD-10-PCS. When section X contains a code title which **fully** describes a specific new technology procedure, and it is the only **procedure performed, only the ~~that~~ section** X code is reported for the procedure. There is no need to report **an additional** ~~broader, non-specific~~ code in another section of ICD-10-PCS.

ICD-10-PCS Guideline Changes

General Guidelines

E1.b "When multiple procedures are performed, New Technology section X codes are coded following the multiple procedures guideline.

***Examples*: Dual filter cerebral embolic filtration used during transcatheter aortic valve replacement (TAVR), X2A5312 Cerebral Embolic Filtration, Dual Filter in Innominate Artery and Left Common Carotid Artery, Percutaneous Approach, New Technology Group 2, is coded for the cerebral embolic filtration, along with an ICD-10-PCS code for the TAVR procedure.**

Magnetically controlled growth rod (MCGR) placed during a spinal fusion procedure, a code from table XNS, Reposition of the Bones is coded for the MCGR, along with an ICD-10-PCS code for the spinal fusion procedure."

Ask the Editor

Q: "The coding hierarchy is clearly defined by the *Official Guidelines for Coding and Reporting* and within *Coding Clinic* (4Q 2018 pgs 90-91). However, it becomes confusing when *CC* advice deviates from the Alphabetic Index and Tabular List. … can you please provide additional clarification."

A: "*CC* strives to provide advice that is aligned with the classification instructions and the guidelines. However, sometimes there are inconsistencies and errors in the classification that may take time to resolve and *CC* has tried to provide guidance/interpretation in those situations until the classification can be revised. It is important to note that earlier CC advice may be superseded by any changes in the classification revised…"

Ask the Editor

A (continued): "…Conflicting Excludes 1 notes is one example. No matter what is published in *CC* in response to the conflict, some readers may have concerns that the coding advice will essentially be disregarding one of the classification instructions, as ***it is not possible to fully adhere to all the classification instructions if there are conflicting instructions***. Another example is Index entries that default to one etiology or part of the body, but the documentation clearly specifies a different etiology or organ. In such instances, *CC* has provided assistance on the correct code assignment, since the default code would clearly be incorrect."

'***Publishing advice on such guidance ensures that an official answer is established for national consistency of the coded data***."

Ask the Editor

Q: "Is it appropriate to utilize patient reported documentation to assign codes for social determinates of health, such as information found in categories Z55-Z65 *Persons with potential health hazards related to socioeconomic or psychosocial* circumstances?"

A: "**Yes**. If the patient self-reported information is signed-off and incorporated into the health record by either a clinician or provider…"

Ask the Editor

Q: "Please define "clinicians" in the context of the ICD-10-CM Official Guidelines for Coding and Reporting, which allow code assignment for social determinates of health codes based on medical record documentation from clinicians involved in the care of the patient…May coding professionals utilize documentation from social workers or community health workers in order to assign codes for social determinates of health?"

A: "…do not have a unique definition of the term "clinicians." In the context of code assignment for social determinates of health Z codes, **documentation deemed meeting the requirements for inclusion in the patient's official medical record based on regulatory or accreditation requirements or internal hospital policies, could be utilized** since the information pertains to social rather than medical information. "

3rd Quarter Coding Clinic
Highlights

A publication of the American Hospital Association (AHA)

DM W/ CKD & HTN

Q: "In this case, since the provider documented ESRD due to diabetic nephropathy, would this statement be sufficient to indicate that the CKD is not related to hypertension?"

A: "When the patient has DM, HTN, and CKD, and the provider documents CKD due to DM or Diabetic CKD, diabetic nephropathy or other similar terminology a causal relationship is indicated and denotes the CKD is not related to the HTN. In this case assign a code for diabetic CKD. Do not assign a code for hypertensive CKD, as the HTN would be coded separately.

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

DM W/ CKD & HTN

Active problem list:

- Diabetes, type II, non insulin dependent
- CKD 3
- Hypertension
- Chronic diastolic CHF

E11.22 type 2 DM with CKD

I13.0 Hypertensive heart and CKD with heart failure

N18.3 CKD 3

I50.32 chronic diastolic HF

Active problem list:

- **Diabetic nephropathy**
- CKD stage 3
- HTN
- HFpEF, chronic

E11.22 type 2 DM with CKD

N18.3 CKD 3

I11.0 hypertensive heart disease with heart failure

I50.32 chronic diastolic HF

Evacuation of Hematoma

Q: "A patient was admitted with a SDH and underwent craniotomy for evacuation of a large hematoma. During surgery, a bleeding artery causing the SDH was found, and this vessel was cauterized. Would the cauterization of the cortical artery be coded? How should this surgery be coded?"

A: "Assign the following procedure codes:

> 00C40ZZ Extirpation of matter from intracranial subdural space, open approach, for the evacuation of the hematoma
>
> 0W310ZZ Control bleeding in cranial cavity, open approach, for cauterization of the bleeding artery"

"…In this case, an arterial bleeder was discovered and a separate procedure was performed to control the hemorrhage and prevent a recurrent bleed; **multiple root operations were performed with distinct objectives**."

Evacuation of Hematoma

***Coding Clinic* 1Q 2015 pg 35**

Q: "A patient, who underwent left brachial reverse saphenous vein bypass, developed postoperative bleeding, and was returned to the operating room. At surgery, fresh blood and hematoma was evacuated from the wound of the bypass. Further exploration revealed a single bleeding branch from the bypass graft, which was tied. How is evacuation of a hematoma of the left upper extremity with control of bleeding coded? Is anything else coded besides control?"

A: "No other root operation besides "Control" is assigned for the procedure performed to control the postprocedural hemorrhage. "Control" is classified to the anatomical regions body systems, and the body part value is selected based on the documentation that specifies the region that was the site of the procedure. **Typically control of bleeding of postsurgical hemorrhage can include a return to the operative suite for the following: evacuation of hematoma; tying off or ligation; and/or cauterization of bleeding vessels**. Assign the following ICD-10- PCS code:

0X370ZZ Control bleeding in left upper extremity, open approach"

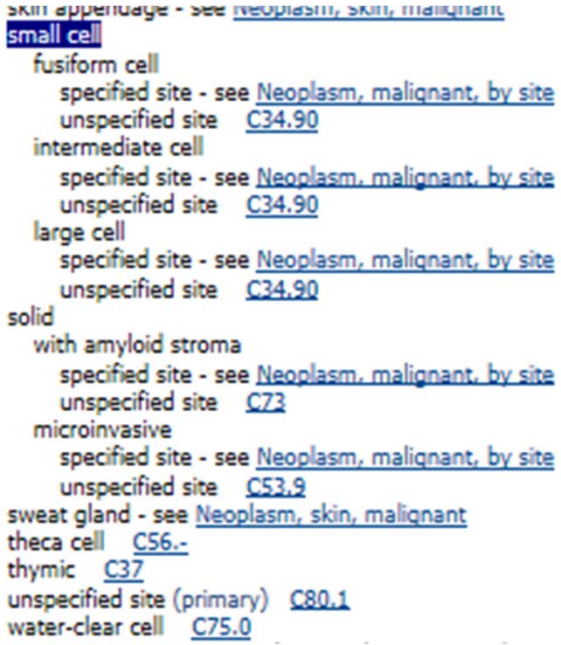
Neuroendocrine Tumor *with* Metastasis

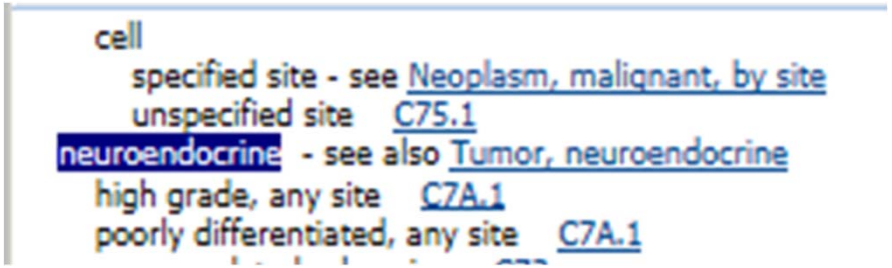
Q: "A patient is admitted with a neuroendocrine tumor of the colon with metastatic disease to the liver. What is the appropriate code assignment for a neuroendocrine tumor of the colon with liver metastasis? Is a carcinoid tumor the same as a neuroendocrine tumor? Should the coding professional assign a code for malignant neuroendocrine tumor since the tumor has metastasized from the colon to the liver?"

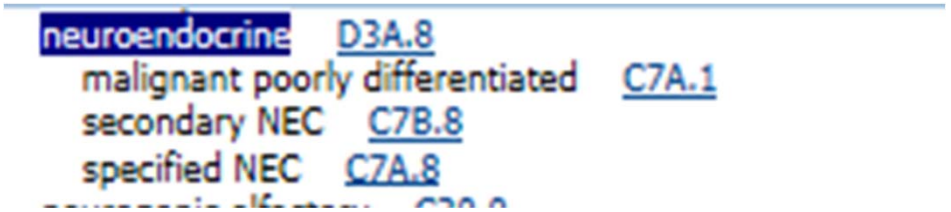
A: Assign code C7A.8 *Other malignant neuroendocrine tumor of the colon* for the malignant neuroendocrine tumor of the colon. Code C7B.8 *Other secondary neuroendocrine tumors*, should be assigned for metastatic disease to the liver… coding professionals should not assume that all neuroendocrine tumors are carcinoid tumors."

Neuroendocrine Tumor

- Small cell neuroendocrine carcinoma of lung, malignant, poorly differentiated with lymph node metastasis







Alcoholic Neuropathy

Q: "What is the appropriate code assignment for a diagnosis of "alcoholic neuropathy"? Would it be appropriate to assign codes from subcategory F10.2- *Alcohol dependence*, and code G62.1 *Alcoholic polyneuropathy*?"

A: "Assign code G62.1 *Alcoholic polyneuropathy*, for a diagnosis of alcoholic neuropathy. Query the provider as to whether alcohol dependence or alcohol abuse is present and assign the appropriate code from category *F10 Alcohol related disorders*. If the provider indicates the patient is not currently drinking, assign the appropriate "in remission" code.

If the pattern of alcohol use (dependence or abuse) is not known, assign code F1988 *Alcohol use, unspecified with other alcohol-induced disorder*."

Missed AB w/ Retained Placenta & ABLA

Q: "The patient presents at 19 weeks gestation for induction of labor due to intrauterine fetal demise. During delivery, the patient experiences a retained placenta with hemorrhage resulting in acute blood loss anemia. How is this encounter for missed abortion with complications coded in ICD-10-CM?

A: Assign code O02.1 *Missed abortion* as the principal diagnoses. Codes O04.6 *Delayed or excessive hemorrhage, following (induced) termination of pregnancy*, and D62 *Acute posthemorrhagic anemia*, should be assigned as additional diagnoses. The acute blood loss anemia resulted from the hemorrhage and was not a complication of the pregnancy.

Mild → Severe Pre-eclampsia

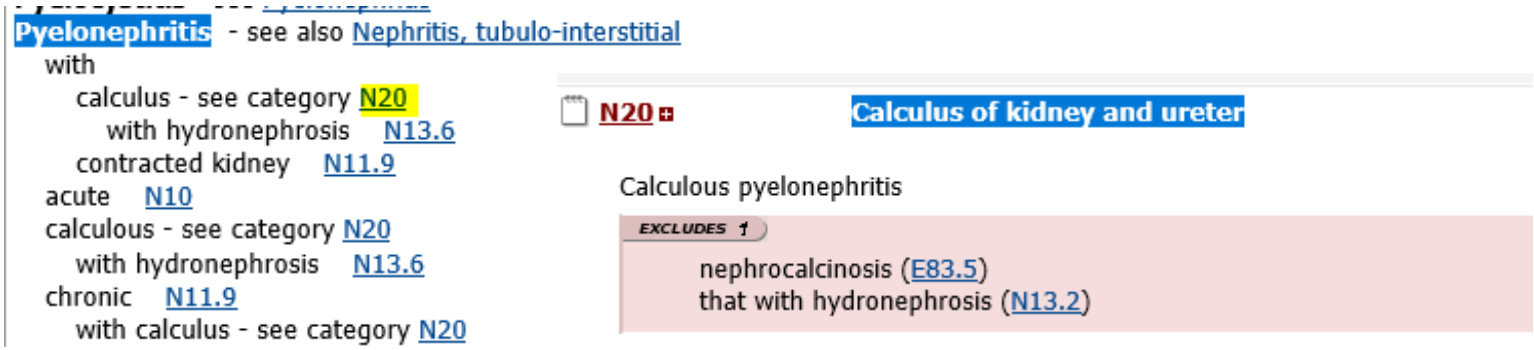
Q: "A patient was admitted with mild pre-eclampsia that progressed to severe pre-eclampsia during the stay. What would be the appropriate code assignment as well as the present on admission (POA) indicator?"

A: Assign code O14.1 Severe pre-eclampsia, with a POA indicator "Y" if the provider documents that mild pre-eclampsia has progressed to severe pre-eclampsia during the same admission. **When a patient experiences deterioration and worsening of pre-eclampsia, one code is reported for the most severe stage of pre-eclampsia. Since pre-eclampsia was present on admission, "Y" is the appropriate POA indicator**.

Present on Admission Reporting Guidelines for obstetrical conditions state, "The determining factor for POA assignment is whether the pregnancy complication or obstetric condition described by the code was present on admission or not."

Pyelonephritis with Calculus

Q: A patient with a history of kidney stones and appendectomy presents to the emergency department due to LLQ pain. A CT scan revealed pyelonephritis and bilateral nonconstructive renal calculi….



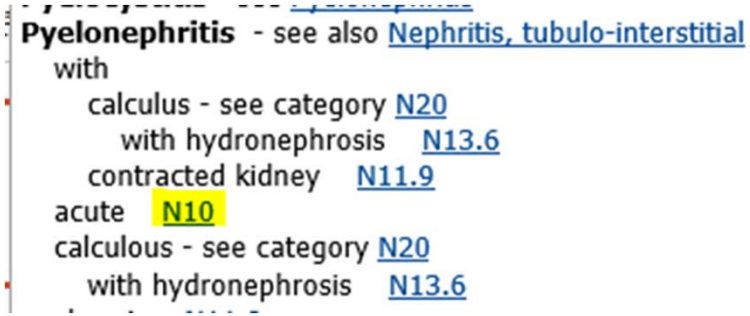
"The patient was admitted because of the pyelonephritis, not kidney stones. The focus of treatment was for the infection, and minimal resources were used for the stone. What is the appropriate code assignment for this patient?"

A: "Assign code N20 Calculus of kidney, for this patient."

Acute Pyelonephritis with Calculus

Q: "…At discharge the provider documents "Acute pyelonephritis and nephrolithiasis"… What is the appropriate code assignment for acute pyelonephritis with calculus?"

A: "Assign codes N10 *Acute pyelonephritis* and N20.0 *Calculus of Kidney*… this case differs from the previous question above, because the provider specifically documents "Acute pyelonephritis" …"



"…there is no Excludes1 note prohibiting the assignment of codes for acute pyelonephritis and renal calculus together."

Hematogenous Infection of Joint Prosthesis

Q: "A patient who is status post left TKA, and recent wisdom tooth extraction, is diagnosed with hematogenous left knew prosthetic joint infection… Does the term "hematogenous" mean the prosthetic joint infection is due to the presence of the prosthesis, or instead is seeded from concurrent infection elsewhere in the body? Is it appropriate to assign code T84.54X1 *Infection and inflammatory reaction due to internal left knee prosthesis, initial encounter…*?"

A: "No. In this case the infection of the knee is not due to the prosthetic joint ,but occurred secondary to another source. **Hematogenous infection by definition means the infection originated in the blood and spread by way of the bloodstream.** Assign code M00.862 *Arthritis due to other bacteria, left knee*, for the hematogenous infection cause by dental infection. Assign also code Z6.652 *Presence of left artificial knee joint….*"

Sepsis d/t CAUTI & Aspiration PNA

Q: "A patient presents to the ED in severe respiratory distress due to possible aspiration. The patient was also noted to be septic on arrival due to pneumonia and Citrobactor UTI associated with an indwelling suprapubic catheter. The patient was subsequently admitted, intubated, and placed on ventilator. The provider diagnosed sepsis due to CAUTI, as well as due to "community acquired pneumonia due to aspiration." **Should sepsis due to post procedural infection be sequenced first or should sepsis due to a localized infection be sequenced as principal diagnosis, or is aspiration pneumonia the principal diagnosis**?"

Sepsis d/t CAUTI & Aspiration PNA

A: "When determining the principal diagnosis for a patient with multifactorial sepsis, the principal diagnosis is the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction, any one of the diagnoses may be sequenced first."

Sepsis d/t CAUTI & Aspiration PNA

CAUTI T83.511A

Sepsis A41.9

Aspiration PNA J69.0

MS-DRG 698 RW 1.6186 GLOS 4.8

Sepsis A41.9

Aspiration PNA J69.0

CAUTI T83.511A

MS-DRG 871 RW 1.8663 GLOS 4.8

Sepsis d/t CAUTI & Aspiration PNA

***Coding Clinic* IQ 2017 pg 24**

"the instructional note at code J44.0, Chronic obstructive pulmonary disease, with acute lower respiratory infection, stating "Use additional code to identify the infection," does not apply to aspiration pneumonia. The ICD-10-CM code for **aspiration pneumonia does not fall in the "respiratory infection" codes**. Code J69.0, Pneumonitis due to inhalation of food and vomit, is under the section titled "Lung diseases due to external agents." **Aspiration pneumonia is an inflammation of the lungs caused by the inhalation of solid and/or liquid matter."**

Correction: Lobar Pneumonia

"*Coding Clinic* 3Q 2018, pages 24-25, advised to assign code J18.1 *Lobar Pneumonia, unspecified organism*, when the provider documents pneumonia of the "right upper lobe" and the causal organism is not documented…"

"…**Lobar pneumonia should only be coded when the provider specifically documents "lobar pneumonia" and a cause organism is not specified**. Lobar pneumonia is a clinical diagnosis and typically involves consolidation of one or more lobes of the lung, meaning there is consolidation of an entire lobe rather than the presence of infiltrates in a lobe."

References and Further Reading

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page.html
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
- https://www.ahd.com/AcutePaymtSysfctsht_JAN09.pdf
- *ICD-10-CM Official guidelines for Coding and Reporting FY 2020*
- *AHA Coding Clinic* for ICD-10CM/PCS