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Medical Peer Review

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PRO GENERAL MEMORANDUM NO. 93/96-2

**FOR IMMEDIATE DISTRIBUTION TO YOUR MEDICAL STAFF
AND UTILIZATION REVIEW - QUALITY ASSURANCE DEPARTMENTS**

**TO: ADMINISTRATORS AND CHIEFS OF STAFF - ALL ALABAMA HOSPITALS;
AMBULATORY SURGERY CENTERS; HOSPITAL OUTPATIENT FACILITIES**

**FROM: H. TERRELL LINDSEY
PRESIDENT AND CHIEF EXECUTIVE OFFICER**

DATE: OCTOBER 20, 1993

SUBJECT: ICD-9CM CODING CLARIFICATIONS

- I.** This General Memorandum is to inform physicians and hospitals on ICD-9-CM coding clarifications from the Health Care Financing Administration (HCFA). As the Peer Review Organization for the State of Alabama, we are to follow official coding advice received from HCFA regional offices. Approved final coding policies sent as instructions to the Foundation supercedes any previously printed coding advice. These coding clarifications are **effective with discharges occurring on or after October 20, 1993**. The information presented in this General Memorandum will also be printed in Coding Clinic for ICD-9 CM.
- II. ICD-9-CM CODING CLARIFICATIONS ADDRESSED IN THIS MEMORANDUM INCLUDE:**
- A. Coding of Secondary Diagnoses - Histoplasmosis
 - B. Diabetes and Peripheral Vascular Disease
 - C. Newborn Detained Because Of Maternal Complications
 - D. Malignant Hypertension Due to a Procedure
 - E. Uncontrolled Diabetes
 - F. Pneumonia Due to Two or More Organisms
 - G. Unstable Angina Due to Myocardial Infarction
 - H. Myocardial infarction vs. Mechanical Complication of Cardiac Device, Implant, and Graft due to Coronary By-pass Graft
 - I. "Two or More Diagnoses of Equal Importance"
 - J. Acute Renal Failure
 - K. Unstable Angina vs. CAD

- L. Admission for Chemotherapy
- M. Thrombosis of a Dialysis Graft
- N. Anemia Due to Blood Loss
- O. Reduction of Fracture with Internal Fixation
- P. Intestinal Lymphoma
- Q. Admission for Chemotherapy & Radiotherapy

III. A. CODING OF SECONDARY DIAGNOSIS - HISTOPLASMOSIS

Question:

Please provide additional clarification on the coding of secondary diagnoses. Specifically, a patient is admitted for gastritis without hemorrhage and underwent a closed biopsy. The patient has a 10-year history of histoplasmosis for which he currently exhibits no symptoms and receives no treatment. Would the histoplasmosis be coded?

Answer:

Without the medical record, it is not possible to provide a definitive answer. Histoplasmosis is a common finding on x-ray in the southeastern United States, and is asymptomatic in most cases. If the condition is merely an x-ray finding, it should not be reported. If, on the other hand, the physician mentions the condition in the history and physical examination, it should be coded since its presence was documented and was taken into consideration by the physician when treating the patient.

DIABETES AND PERIPHERAL VASCULAR DISEASE

Question:

Is a cause-and-effect relationship always assumed in patients who have diabetes and peripheral vascular disease?

Answer:

No. Do not assume a cause-and-effect relationship between diabetes and peripheral vascular disease if one is not stated by the physician. Therefore, category 250.7x, Diabetes~with Peripheral Circulata~ Disorders, would not be used unless the physician so stated that the peripheral vascular disease was diabetic or due to diabetes. If the conditions would be coded separately. If the documentation is not clear, the coder should query the physician. More specific coding advice on this subject is provided in **Coding Clinic**, Third Quarter 1991, page 10.

C. NEWBORN DETAINED BECAUSE OF MATERNAL COMPLICATIONS

Question:

What diagnosis code(s) would be used to describe an infant born by cesarean section who was kept in the hospital for twelve (12) days because of maternal complications? These complications had no direct effect on the newborn. In addition to V30.01 Single Liveborn, Born in the Hospital, Delivered by Cesarean Delivery, would one or both of the following codes be appropriate?

V65.0 Healthy Person Accompanying Sick Person

V20.1 Other Healthy Infant or Child Receiving Care

Answer:

Assign code V30.01 Single Liveborn, Born in Hospital, Delivered by Cesarean Delivery, as the principal diagnosis for this admission. Code also V20.1 Other Healthy Infant or child receiving care, as an additional code. The inclusion note for this code, "Medical or nursing care supervision of healthy infant in cases of maternal illness, physical or psychiatric" is applicable.

D. MALIGNANT HYPERTENSION DUE TO A PROCEDURE

Question:

If a malignant hypertension developed during a procedure and was stated as being a complication of the procedure, should a code for complications of surgical and medical care be assigned in addition to the code for hypertension?

Answer:

Assign code 997.1 Complications Affecting Specified Body Systems, NEC, Cardiac Complications, if the hypertension was stated to be a complication of the surgery. Some coders have expressed concern that this code may not be the best choice since hypertension is a vascular problem, not a cardiac complication. However, the National Center for Health Statistics advised the use of this code as the closest descriptor. There is not a code for vascular complications of surgery, and the unspecified codes are not descriptive enough. Also code 401.0 Malignant Essential Hypertension, to further specify the nature of the complication.

E. UNCONTROLLED DIABETES

Question:

We are concerned about coding a complication of diabetes mellitus present in

a patient admitted with uncontrolled diabetes. For instance, if a patient is admitted with uncontrolled diabetes and has diabetic retinopathy, we are to use category 250.5x, Diabetes With Ophthalmic Manifestations. It seems that information is being lost as "uncontrolled diabetes" cannot be captured.

Answer:

The National Center for Health Statistics (NCHS) has fully evaluated this issue and will be revising the ICD-9-CM codes effective October 1, 1993 so that all categories of diabetes will have fifth digits to indicate whether the diabetes is controlled or uncontrolled. In the meantime, you should continue to follow the current guidelines and not use category

250.9x, Diabetes With Other Unspecified Manifestations when the patient has a specified manifestation.

F. PNEUMONIA DUE TO TWO OR MORE ORGANISMS

Question:

When coding pneumonia and a sputum culture- confirms the responsible organism, the pneumonia is coded with the specific organism type. When two or more organisms are identified, is code 482.89 assigned? Coding Clinic Third Quarter, 1988, page 11 would seem to suggest this is the correct code. For the patient in question the sputum culture revealed 3+ Hemophilus Influenza and "few" Enterobacter Cloacae. Would it be appropriate to code only the HInfluenza Pneumonia since there were only "few" Enterobacter Cloacae, or should this be coded with 482.89 to indicate both organisms were present?

Answer:

It is always inappropriate for a coder to assign codes based on lab results only. In cases as this, the physician should be queried to determine the responsible pathogen. If the physician states that the pneumonia is due to both Hemophilus pneumoniae (482.2) and Enterobacter cloacae (482.83), both types of pneumonia should be coded.

G. UNSTABLE ANGINA DUE TO MYOCARDIAL INFARCTION

Question:

According to Coding Clinic, Third Quarter 1990, pages 6 and 9, and First Quarter 1991, page 14, when a patient is admitted with unstable angina and is found after study to have a myocardial infarction, the myocardial infarction is the principal diagnosis. Time limits are not given in the examples in Coding Clinic. Is this applicable when the patient is admitted

with unstable angina and experiences an infarction six days after the admission?

Another example would be a patient who was admitted with unstable angina who developed an infarction during a cardiac catheterization. Would the myocardial infarction be reported as the principal diagnosis in these cases?

Answer:

In the first case, the coder would assign the appropriate code from the 410.xx series to document the myocardial infarction as principal diagnosis. Angina, a symptom, would not be coded additionally, as it represents an integral part of the disease process.

In the second example, the physician must be queried to determine whether the myocardial infarction was caused by the cardiac catheterization. If the physician documents that the infarction has been caused by (is due to) the cardiac catheterization, then the principal diagnosis would be listed as 411.1, Intermediate Coronary Syndrome, with additional codes to describe the complication, i.e., 997.1, Cardiac Complications, and the appropriate code from the 410.xx series. Otherwise, only the infarction would be coded from the 410 category; no additional code would be necessary.

H. MYOCARDIAL INFARCTION vs. MECHANICAL COMPLICATION OF CARDIAC DEVICE, IMPLANT, AND GRAFT DUE TO CORONARY BY-PASS GRAFT

Question:

A patient with a history of coronary artery by-pass graft is admitted to Hospital A with a myocardial infarction. A cardiac catheterization during this stay reveals progression of his coronary artery disease with occlusion in native vessels as well as re-occlusion of two vein grafts. He is transferred to Hospital B where coronary artery by-pass graft is performed. Would the principal diagnosis at both hospitals be the myocardial infarction or the complication of the by-pass graft?

Answer:

The answer to this question is complex, and depends on the physician's documentation of the diagnosis. There are three possible answers, and the physician should be queried to obtain the most accurate information.

- (1) If the physician documents that the infarction was a result of the occluded grafts, 996.03, Mechanical Complication of Cardiac Device, Implant, and Graft Due To Coronary By-pass Graft, would be principal diagnosis for both admissions. An additional code from category 410 should also be used to identify the myocardial infarction.

- (2) If the physician documents that the infarction was a result of a result of atherosclerosis of a native coronary vessel(s), 410.xx, Acute Myocardial Infarction, with site and episode of care specified, should be used as the Principal diagnosis. An additional code 996.03, Mechanical Complication of Cardiac Device, Implant, and Graft Due To Coronary By-pass Graft, would be used to capture the re-occlusion of the two vein grafts.
- (3) If the physician documents that the infarction is a result of occlusions in Both the native vessels and the grafts, and if the physician is unwilling or unable to specify the cause of the infection, either 410.xx or 996.03 may be selected

1. "TWO OR MORE DIAGNOSES OF EQUAL IMPORTANCE"

Question:

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In a book published in 1984 titled Coding for Prospective Payment, a chapter called "Guidelines for Sequencing and Designating Principal Diagnosis and Procedure Codes" contains the statement: "Two or more diagnoses of equal importance - If medical record documentation does not indicate otherwise, the principal diagnosis is the one for which a definitive surgical or non-surgical procedure was performed." I have never seen this statement in Coding Clinic nor in the official Health Care Financing Administration responses to Peer Review Organization coding questions. Is this a true statement?

Answer:

"In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic work-up 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".

This guideline can be found in Coding Clinic for ICD-9-CM, Second Quarter

1990, page 4. It is unclear what constitutes a "definitive" procedure, and the publication cited should not be considered to be official coding advice.

J. ACUTE RENAL FAILURE

Question:

A patient was admitted to hospital "A" with acute renal failure. After study, it was determined that the patient would require hemodialysis. Hospital "A" does not provide hemodialysis. Therefore, when stabilized, the patient was transferred to Hospital "B" and admitted for renal dialysis. What is the principal diagnosis for Hospital "A"? What is the principal diagnosis for Hospital "B"?

Answer:

The principal diagnosis for hospital "A" is acute renal failure. Code 584.9, Acute Renal Failure, unspecified should be assigned. The principal diagnosis for Hospital "B" is admission for renal dialysis. Code V45.0, Extracorporeal Dialysis should be assigned. In addition, code 584.9, Acute Renal Failure should be assigned as the secondary diagnosis.

K. UNSTABLE ANGINA VS CAD

Question:

There has been some concern expressed regarding the assignment of the principal diagnosis for a patient admitted with unstable angina. Following diagnostic work-up with cardiac catheterization, the patient was diagnosed with coronary atherosclerosis. The principal diagnosis is coronary atherosclerosis. Some suggest the principal diagnosis should be unstable angina. They feel that coding coronary atherosclerosis as the principal diagnosis does not accurately reflect the condition of the patient at the time of the admission and the treatment rendered to stabilize the patient prior to the cardiac catheterization. Should the coding guidelines be re-evaluated?

Answer:

We have shared your concerns with the National Center for Health Statistics (NCHS). Although some PROs have expressed opposition to the assignment, others at least feel that there is at least a definitive coding rule on this subject. There are no plans to modify this policy at the present time.

L. ADMISSION FOR CHEMOTHERAPY

Question:

A newly diagnosed leukemia patient is admitted for chemotherapy. What is the principal diagnosis?

Answer:

The principal diagnosis is V58.1, Encounter or Admission For Chemotherapy. There is no difference in sequencing for patients admitted for consolidation chemotherapy for acute myeloid leukemia versus newly diagnosed patients admitted for induction chemotherapy. If the patient is admitted solely for chemotherapy, V58.1 should be assigned. The code for the leukemia should be listed as secondary diagnosis.

M. THROMBOSIS OF A DIALYSIS GRAFT

Question:

What is the correct ICD-9-CM procedural code for removal of a thrombosis during the revision of an arteriovenous shunt? The patient had a recurrent thrombosis of a dialysis graft. Would both 39.49, Other Revision of Vascular Procedure and 39.42, Revision of Arteriovenous Shunt for

Renal Dialysis be needed?

Answer:

No, assign only code 39.42, Revision of Arteriovenous Shunt for Renal Dialysis since the thrombosis was removed as part of the revision of the graft.

N. ANEMIA DUE TO BLOOD LOSS

Question:

What is the appropriate ICD-9-CM coding of anemia due to blood loss? Would the appropriate codes be either 280.0 or 285.1 depending on whether the anemia is documented as acute or chronic?

Answer:

The physician clearly documents the anemia is due to acute blood loss, code 285.1, Acute Post-Hemorrhagic Anemia should be assigned. Anemia due to chronic blood loss is coded to 280.0, Secondary to Blood Loss (chronic). The physician should always be queried if there is lack of sufficient documentation. Never assume cause and effect relationship.

O. REDUCTION OF FRACTURE WITH INTERNAL FIXATION

Question:

What is the appropriate ICD-9-CM procedural coding for reduction of fracture with internal fixation when the reduction is performed prior to making an incision for the internal fixation? Is this an open or closed reduction of the fracture?

Answer:

This procedure is a closed reduction with internal fixation, and Code 79.1x, Closed Reduction of Fracture With Internal Fixation should be assigned.

P. INTESTINAL LYMPHOMA

Question:

A patient with intestinal lymphoma was admitted with acute abdominal pain and hypotension. The patient was diagnosed with lymphoma one to two months ago and had been started with induction chemotherapy. The abdomen was distended, firm in the left lower quadrant where the lymphomatous mass was present. Abdominal films showed air-fluid levels suggestive of small-bowel obstructive pattern. On admission, the patient was in hypovolemic shock, quite cachectic and granulocytopenic from the aggressive chemotherapy. Blood pressure was averaging 80/50. The patient later developed left-leg embolus. Unfortunately, despite aggressive fluid therapy, the patient developed acute renal failure and subsequently expired with multi-organ failure. What is the principal diagnosis?

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Answer:

The principal diagnosis is intestinal lymphoma. Code 202.83 Other Lymphomas of the Intra-abdominal Lymph Nodes should be assigned.

Q. ADMISSION FOR CHEMOTHERAPY & RADIOTHERAPY

Question:

A patient with small-cell carcinoma of the lung is admitted for combined chemotherapy/radiotherapy. What is the principal diagnosis?

Answer:

The principal diagnosis is admission for chemotherapy/radiotherapy. Codes V58.1 Encounter or Admission For Chemotherapy and V58.0 Encounter or Admission for Radiotherapy should be assigned. Sequencing of these codes should be determined by the individual hospitals based on documentation in the medical record. Code 162.9, Malignant Neoplasm of Bronchus and Lung, Unspecified, should be assigned as a secondary diagnosis to identify the small-cell carcinoma of the lung.

- IV. If you have any questions regarding this information, please contact Ms. Pam Baber, RRA, CCS, Director of DRG Validation/Coding/Medical Records at (205) 970-1600, Extension 3204 or 1-(800)-7604550, Extension 3204.

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