ALABAMA QUALITY ASSURANCE FOUNDATION
Medical Peer Review

PRO GENERAL MEMORANDUM NO. 93/96-4

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 OUT-PATIENT FACILITIES**

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

DATE: **NOVEMBER 9, 1993**

SUBJ: **ICD-9-CM CODING CLARIFICATIONS AND REVISION TO III. J., GENERAL MEMORANDUM NO. 93/96-2**

I. PURPOSE:

This General Memorandum is to inform physicians and hospitals of ICD-9-CM coding clarifications received from the Health Care Financing Administration (HCFA). These coding clarifications are effective with discharges occurring on or after November 15, 1993.

II. ICD-9-CM coding clarifications addressed in this memorandum include:

A. Postoperative Premature Ventricular Contractions (PVCs)
B. Postoperative COPD
C. Angina vs Coronary Artery Disease
D. Postoperative Hypertension/Hypotension
E. Acute Bronchitis With Emphysema
F. Uncontrolled Diabetes Mellitus
G. Vaccinations

III. DISCUSSION:

A. POSTOPERATIVE PREMATURE VENTRICULAR CONTRACTIONS

1. PCVs NOT AS A RESULT OF SURGERY

QUESTION:
What code assignment would you use for a patient with a past history of premature ventricular contractions (PVCs) who has an out-patient procedure performed and is admitted postoperatively for continued monitoring of the PVCs? The PVCs were not exacerbated by the surgery. Would the principal diagnosis be PVCs, or a code for complication of surgery?

ANSWER:
Assign code 427.69, Other Premature Beats. A complication code would be assigned if a causal relationship exists between the condition and the care received as an out-patient. The fact that a condition develops following surgery or other care does not necessarily mean that it is a complication of that care.

2. PCVs AS A COMPLICATION OF SURGERY

QUESTION:
What code assignment would be used for a patient with a past history of premature ventricular contractions (PVCs) who has an out-patient procedure performed and is admitted postoperatively due to an increase or exacerbation of the PVCs resulting from the surgery? Would a complication of surgery code be used?

ANSWER:
Assign code 997.1, Cardiac Complications, as principal diagnosis. Assign 427.69, Other Premature Beats, should also be assigned to identify the specific cardiac complication. Advice to assign an additional code for the specific condition can be found in Coding Clinic for ICD-9-CM, first quarter 1992, page 13, third quarter 1992, page 15, and second quarter 1993, page 10, because category 997 covers a variety of complications without specifying the nature of the complication.

B. POSTOPERATIVE COPD

QUESTION:
What code assignment would be used for a patient with a past history of chronic obstructive pulmonary disease (COPD) who has an out-patient procedure performed and who is admitted postoperatively due to an exacerbation of his COPD? Would a complication of surgery code be used?

ANSWER:
The coder should query the physician whether the COPD is a complication of the surgery. If the physician indicates that it is a complication, then assign 997.3, Respiratory Complications, as the principal diagnosis, with an additional diagnosis of 496, Chronic Airway Obstruction, Not Elsewhere Classified.

If there is no complication, assign only 496, Chronic airway Obstruction. NOTE: 496 is a non-specific code which should not be used if further information about the nature of the COPD is available.

C. ANGINA VS CAD

QUESTION:
Some hospitals have expressed concern about the coding advice provided to PROs on unstable angina and coronary atherosclerosis (also known as coronary artery disease, or CAD). The advice given stated that if a patient is admitted with unstable angina and a heart catheterization is done, the coronary atherosclerosis must be used as the principal diagnosis. To code a case like this to a principal diagnosis of coronary atherosclerosis breaks the first rule of coding which specifies the acute condition is always coded over the chronic condition. Could this coding advice be re-evaluated?

ANSWER:
Angina is a symptom occurring when cardiac work and myocardial oxygen demand exceed the ability of the coronary arterial system to supply oxygen to the heart muscle itself. It is always preferable to assign a code for a known diagnosis rather than a symptom.

A patient admitted with angina due to underlying coronary atherosclerosis or CAD must have that relationship so stated by the physician. When the cause of the angina is not established or documented, the angina should be listed as the principal diagnosis. When the cause of the angina is clearly documented, that cause (e.g., CAD) should be listed as the principal diagnosis.

This advice **does not** violate any coding rules. The definition of principal diagnosis, "that condition established after study to by chiefly responsible for occasioning the admission of the patient to the hospital for care," is met by the CAD which caused the symptom of angina.

D. POSTOPERATIVE HYPERTENSION/HYPOTENSION

QUESTION:
Please provide clarification on the correct coding of postoperative hypertension and postoperative hypotension. In a previous response to a PRO coding question you advised using code 997.1, Cardiac Complications, when postoperative hypertension was stated as being a complication of the procedure. We believe these diagnoses are vascular problems and it would be incorrect to use the code for cardiac complications. We suggest the use of code 997.9, Complications Affecting Other Specified Body Systems, Not Elsewhere Classified, with a secondary code for hypertension or hypotension. An alternative would be to list the hypertension and/or hypotension first with a code 998.8, Other Specified Complications of Procedures, Not Elsewhere Classified.

ANSWER:
We discussed your comments with the National Center for Health Statistics which is responsible for Volumes 1 and 2 of the ICD-9-CM. They agreed with your comment that hypertension is not a cardiac complication; however, this code appears to be the closest possible match. Continue to use code 997.1 to describe postoperative hypertension or postoperative hypotension. Sequence the complication code first, followed by the code which specifies the nature of the complication.

E. ACUTE BRONCHITIS WITH EMPHYSEMA

QUESTION:
In a previous response to a PRO question, the National Center for Health Statistics (NCHS) stated if a patient has acute bronchitis and emphysema, codes 466.0, Acute Bronchitis, and 492.8, Other Emphysema, should be assigned. There is an exclusion note under code 492.8 excluding emphysema with bronchitis. This exclusion note does not state "due to" or "caused by" but rather just "with bronchitis". Exclusion notes state 491.2x, Obstructive Chronic Bronchitis, should be used. It should also be noted in the alphabetic index, bronchitis with emphysema states "see bronchitis, with obstruction", leading to the 491.21 code. Can you further clarify this issue?

ANSWER:
The NCHS is making revisions to the index of ICD-9-CM effective October 1, 1993 that should result in consistent coding and provide clearer direction. In the meantime, you should follow the advice previously given. HCFA has been

further advised by NCHS that the excludes note under 492.8, Other Emphysema, is intended to refer to chronic bronchitis.

F. UNCONTROLLED DIABETES MELLITUS

QUESTION:
Can you provide any additional advice on the coding of uncontrolled diabetes when a diabetic complication is present?

ANSWER:
The National Center for Health Statistics is making significant changes to category 250, Diabetes Mellitus, effective October 1, 1993. There will be revisions at the fifth-digit level that will identify whether the diabetes is specified as uncontrolled for all the fourth-digit categories. Look for these revisions as part of the FY-1994 Addendum. In the meantime, continue to follow previous advice.

G. VACCINATIONS:

Effective for services furnished on or after May 1, 1993, Medicare Part B now covers influenza virus vaccine, Hepatitis B, and pneumococcal vaccine and the administration of these vaccinations. The appropriate ICD-9-CM and HCPCS codes are as follows:

a. Hepatitis B

(1) ICD-9-CM:
V05.3*, Need for other prophylactic vaccination and inoculation against viral hepatitis. *NOTE: this is a new code effective October 1, 1993.

(2) HCPCS:
90731, Immunization, active; hepatitis B vaccine. A local code will be assigned by the carrier for the administration of this vaccination.

b. Pneumococcal pneumonia

(1) ICD-9-CM:
V03.8, Need for prophylactic vaccination and inoculation against other specified single bacterial disease.

(2) HCPCS:
90732, Immunization, active; pneumococcal vaccine, polyvalent
Q0124, Administration of vaccine

c. Influenza Virus

(1) ICD-9-CM:
V04.8, Need for prophylactic vaccination and inoculation against influenza virus

(2) HCPCS:
Q0124, Administration of vaccine

IV. REVISION TO PRO GENERAL MEMORANDUM NO. 93/96-2

Answer To: III. J.

The principal diagnosis for Hospital "B" is admission for renal dialysis. Code **V56.0** Extracorporeal Dialysis should be assigned.

V. If you have questions regarding this memorandum, please contact Ms. Pam Baber, RRA, CCS, Director, Review Support; (205) 970-1600, Extension 3204 or 1-(800)-760-4550, Extension 3204.

rf;jd

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