Editor’s note: The following article is provided as a supplement to the April 2010 CDI Journal.

The Coding Clinic for ICD-9-CM, First Quarter, 2010, effective for discharges on or after April 8, 2010, has something for everyone.

Physicians (and the clinical documentation specialists and coders who must query them) will enjoy that they no longer have to document what consequences of a stroke were present at the time of discharge in order to capture them in ICD-9-CM administrative databases. Documented sequela of stroke can now be coded even if they resolve prior to discharge.

Those who like to complain (such as myself, sometimes) will fuss that documented compensated respiratory acidosis as a consequence of chronic obstructive pulmonary disease (COPD) cannot be coded, even though this indicates a greater severity of COPD than those without it.

ICD-9-CM purists will see a novel approach to coding a clinical syndrome that can never be a principal diagnosis, the systemic inflammatory response syndrome (SIRS), when it is caused by a properly administered medication.

Others who understood the coding rules for H1N1 influenza published October 1, 2009, will be gratified that Coding Clinic’s clarifications logically follow the ICD-9-CM coding conventions and ICD-9-CM Official Guidelines.

Coding of complications takes an interesting twist in this issue as Coding Clinic differentiates varying severities of intestinal laceration and introduces some intriguing concepts regarding complications of transplanted kidneys.

Finally, for the first time that I can remember, Coding Clinic answers some present-on-admission (POA) questions since its introduction about two to three years ago. So let’s go and learn what Coding Clinic had to say.

H1N1 influenza (p. 3)
Those who read the coding rules for H1N1 influenza in fall 2009 will be gratified that Coding Clinic stuck to its guns and the ICD-9-CM coding conventions and guidelines as it clarified some fairly straightforward situations surrounding this illness. The point in creating a code for H1N1 influenza was to differentiate it from the regular seasonal influenza and facilitate epidemiological surveillance. Coding H1N1 influenza (and its related avian influenza) follows different rules than those for regular seasonal influenza.
These include:

- **Uncertain diagnoses.** As we know, uncertain diagnoses (e.g., those classified as “possible,” “probable,” “likely,” “suspected,” and “rule out”) cannot be coded unless they are documented at the time of discharge. There are three exceptions to this rule whereby, even if they are documented as uncertain at the time of discharge, they cannot be coded. In other words, they must be firmly established to be coded. These are:
  - HIV infections: Codes 042, AIDS, or V08, asymptomatic human immunodeficiency syndrome
  - 488.0 (influenza due to identified avian influenza virus)
  - 488.1 (influenza due to novel H1N1 influenza virus [H1N1 or swine flu])

In this issue, *Coding Clinic* emphasized that a final diagnosis of “possible H1N1 influenza” cannot be coded as 488.1 (influenza due to novel H1N1 influenza virus) for a patient with cough, sore throat, and fever; it must be coded as regular seasonal influenza, 487.1 (influenza with other respiratory manifestations).

Don’t forget that if the provider documents “evidence of” a particular condition, *Coding Clinic*, Third Quarter, 2009 (p. 7) does not designate this as an uncertain diagnosis; thus it may be coded as if it were established.

- **Pneumonia with H1N1 pneumonia.** If a patient with regular seasonal influenza presents with coexisting pneumonia, ICD-9-CM code 487.0 (influenza with pneumonia) is the principal diagnosis which, if there is no significant surgical procedure, groups to MS-DRGs 193–195 (simple pneumonia and pleurisy). This is because ICD-9-CM automatically links coexisting pneumonia and regular seasonal influenza with each other unless the physician explicitly delinks them. Therefore, it does not matter whether the physician documented that the pneumonia was due to *Staphylococcus aureus*, Gram-negative rods, or other organisms related to MS-DRGs 177–179 (respiratory infections and inflammation); 487.0 must be assigned as the principal diagnosis resulting in a simple pneumonia and pleurisy MS-DRG assignment unless the physician explicitly delinks the two conditions.

This is not the case with confirmed H1N1 or avian influenza with pneumonia, given that ICD-9-CM does not automatically link these conditions with pneumonia if they coexist. Should a patient present with confirmed H1N1 or avian influenza with pneumonia, either the applicable influenza code or documented pneumonia code can be the principal diagnosis. Code 487.0 (influenza with pneumonia) is not to be coded since this is reserved for pneumonia with regular seasonal influenza, not H1N1 or avian influenza.

Therefore, if a patient with confirmed H1N1 pneumonia presents with pneumonia documented at the time of discharge to be probable due to MRSA, if there is no significant surgical procedure, and 482.42 (pneumonia due to
MRSA) is coded and sequenced as the principal diagnosis, then MS-DRGs 177–179 (respiratory infections and inflammation) would be the final DRG. If 488.1 (influenza due to novel H1N1 influenza virus [H1N1 or swine flu]) is sequenced as the principal diagnosis, then MS-DRGs 152–153 (otitis media and URI) is the final assigned DRG.

Consequences of stroke (p. 5)
One of the more difficult predicaments in coding strokes has been that Coding Clinic, Second Quarter, 1989, required that consequences of strokes had to be present at the time of discharge in order to be coded. CDI specialists and coders had their jobs cut out for them, given that many physicians do not write extensive discharge notes, fail to dictate their discharge summaries on the day of discharge, and do not know that they have to perform and report a final neurological examination to demonstrate what stroke sequela were present at the time of discharge. Coding Clinic, First Quarter, 2010, amends this previous advice as follows:

- On p. 5, Coding Clinic states that if a patient admitted with a stroke with resultant hemiplegia and that hemiplegia resolves prior to discharge, then the hemiplegia can be coded. Coding Clinic also states that any neurological defect caused by a stroke can be coded, even if it resolves prior to discharge. This advice supersedes the previous Coding Clinic advice that had required documentation that consequences of stroke had to be present at the time of discharge. In MS-DRGs, hemiplegia due to a stroke, coded as 342.90 (hemiplegia, unspecified) is a CC. Code 342.90 also adds weight in 3M’s All-Payer Refined DRGs system (APR-DRGs).

- On p. 8, Coding Clinic opined that if a patient admitted with an intracerebral hemorrhage develops vasogenic (intracerebral) edema, it is appropriate to code the vasogenic (intracerebral) edema, since it is not inherent in cerebral hemorrhage. Often, these patients receive dexamethasone, mannitol, or forced hyperventilation as to reduce the vasogenic (intracerebral) edema. Code 348.5 (cerebral edema) can be added as an additional diagnosis. In MS-DRGs, code 348.5 (cerebral edema) is a MCC and also adds weight in APR-DRGs.

Compensated respiratory acidosis in COPD (p. 5)
In one of the more perplexing opinions offered in this issue, Coding Clinic states that documented “compensated” respiratory acidosis cannot be coded as an additional diagnosis if linked to COPD, even though previous issues of Coding Clinic (e.g., Third Quarter, 2007, pp. 13–14; Second Quarter, 2000, pp. 20–21; Second Quarter, 1992, pp. 16–17) have allowed for chronic conditions to be coded even if they do not have any documented treatments or other qualifications as additional diagnoses. Coding Clinic emphasized that in compensated respiratory acidosis, the body’s pH level is within normal limits due to renal retention of bicarbonate. It left open the question of whether uncompensated respiratory acidosis, respiratory acidosis leading
to an abnormal pH (less than 7.35), or respiratory acidosis not otherwise specified, can be coded. The code for uncompensated respiratory acidosis is 267.2 (acidosis), which is a CC in MS-DRGs. It also adds significant weight in APR-DRGs.

Unless Coding Clinic states otherwise in a future issue, there does not appear to be a prohibition of coding respiratory acidosis when it is documented as uncompensated or when it is not specified as compensated. Although Coding Clinic did not require the following, if a physician documents unspecified respiratory acidosis in a patient with COPD and the pH is normal or no arterial blood gases have been performed, a CDI specialist should query to determine whether it is compensated or uncompensated.

In the POA section of this Coding Clinic, the publication emphasizes that COPD and acute respiratory failure should be coded separately if documented. CDI specialists and coders should remember that patients with chronic hypercapnia (i.e., pCO2 over 45–50 mm Hg) leading to compensated respiratory acidosis likely have hypercapnic chronic respiratory failure which, if documented, can be coded. Acute hypercapnia leading to uncompensated respiratory acidosis is usually manifested with a pH less than 7.33–7.35 and usually indicates acute or acute on chronic respiratory failure. Note that code 518.83 (chronic respiratory failure) is a CC under the MS-DRG system, whereas 518.81 (acute respiratory failure) and 518.84 (acute on chronic respiratory failure) are MCCs.

Cryptogenic organizing pneumonia (p. 6)
Although not in the ICD-9-CM index or table, Coding Clinic, First Quarter, 2010, equates the term “cryptogenic organizing pneumonia” (COP) as “bronchiolitis obliterans organizing pneumonia” (BOOP), which codes to 516.8 (other specified alveolar and parietoalveolar pneumonopathies). COP and BOOP occur in patients with chronic inflammatory conditions, such as rheumatoid arthritis, or may develop as a side effect of medications, such as amiodarone. Unlike infectious pneumonias, COP and BOOP respond to corticosteroids. COP and BOOP group to MS-DRGs 196–198 (interstitial lung disease) instead of the typical pneumonia DRGs.

There is an interesting clinical article in a 2003 issue of the New England Journal of Medicine which, upon free registration, will help familiarize CDI specialists and coders of this condition and its differentiation from other types of pneumonia. You can access the article (with free registration) at http://content.nejm.org/cgi/content/extract/348/19/1902.

Complications
A number of questions concerning complications were raised in Coding Clinic, First Quarter, 2010. CDI specialists need to be aware of these, given that if the circumstance of inpatient admission is due to a complication of care, that complication code is sequenced as the principal diagnosis. The Official ICD-9-CM Guidelines state the following:
When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the 996–999 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

Circumstances addressed in this Coding Clinic include:

- A patient had a failed latissimus dorsi free flap graft due to failure of the arterial and venous anastomosis. Coding Clinic deemed the failure of the graft to be a mechanical complication, not a vascular complication, recommending code 996.49 (other mechanical complication of other internal orthopedic device, implant, and graft).

- A patient underwent a laparoscopy and was discovered to have an inadvertent suture of the bladder that was discovered as the surgical team was closing the patient up. A repeat laparoscopy was performed to remove the suture; the surgeon noted “intravesicular suture” as a complication. Coding Clinic recommended code 998.2 (accidental puncture or laceration during a procedure) for this circumstance.

- A patient with a transplanted kidney was admitted for an obstruction of the ureteropelvic junction on the same side as the transplanted kidney along with a pseudomonas urinary tract infection. Although Coding Clinic did not go into detail of the clinical circumstances prompting the inpatient admission (e.g., whether there was oliguria or an elevated of the serum creatinine), apparently this ureteral obstruction affected the function of the transplanted kidney. In this circumstance, Coding Clinic recommended that code 996.81 (complications of transplanted organ, kidney) be assigned first, rather than the pseudomonas urinary tract infection or the obstruction of the ureteropelvic junction. Coding Clinic opined that the ureteropelvic junction obstruction affected the function of the transplanted kidney. Although Coding Clinic did not overtly state this, it would appear that if any illness affects the function of a transplanted organ, a coder must report a complication code for that transplanted organ and sequence it according to the guidance in the ICD-9-CM Official Guidelines.

- A patient had an extensive lysis of adhesions for small bowel obstruction. Multiple full-thickness enterotomies occurred. Coding Clinic recommended that code 998.2 (accidental puncture or laceration during a procedure) be assigned since an enterotomy is more serious than a serosal tear. This advice must be interpreted in light of Coding Clinic, Second Quarter, 2007 (pp. 11–12), which states that a physician query is required to determine whether intestinal serosal tears requiring operative repair are to be coded as complications.

SIRS due to medications (pp. 10–11)

In an interesting case, a question was asked as to how to code an inpatient admission prompted by the systemic inflammatory response syndrome (SIRS)
due to a medication that is not an accidental overdose or poisoning. To fully understand the problem Coding Clinic faced, the clinical scenario presented is summarized as follows:

The question stated that a patient was admitted with a three day history of fever and that upon admission the patient had tachycardia, tachypnea, and a low white blood count. Note that the question used the words “admitted” and “had”, neither of which mean that these terms were documented by the provider; it just means they existed. What was stated to be documented by the provider was that the patient clinically fulfilled the criteria for SIRS, that it was not due to an infectious origin, and that it was due to Zyprexa (an antipsychotic medication).

The code for SIRS due to noninfectious causes without documented (and linked) organ dysfunction is 995.93 (systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction). Furthermore, adverse effects of medications are coded as to what the physician documented (e.g., nausea, vomiting, etc.) followed by an “external cause of injury and poisoning” code (E-code). Coding Clinic recognized that an E-code assignment was appropriate, given that this was an adverse effect of a properly administered medication.

The problem Coding Clinic faced is that the ICD-9-CM Official Guidelines do not allow an external cause code or a SIRS code to be sequenced as a principal diagnosis. The guidelines further state that a coder should not sequence codes for symptoms, signs, and ill-defined conditions from ICD-9-CM, Chapter 16, as a principal diagnosis when a physician has established a related definitive diagnosis. Coding Clinic had to come up with something that could be sequenced as principal diagnosis and still comply with ICD-9-CM conventions and the Official Guidelines.

In solving this, Coding Clinic appears to have looked at the Official Guidelines, which state that “whereby in the coding of syndromes, if the Index (Volume 1) does not provide guidance, codes for the documented manifestations of the syndrome are to be assigned.” The Official Guidelines further state that SIRS generally refers to the systemic response to infection, trauma/burns, or other insult (such as cancer) with symptoms including fever, tachycardia, tachypnea, and leukocytosis. Based on this, Coding Clinic recommended that codes for the presenting symptoms of SIRS (tachycardia, tachypnea, fever, etc.) be assigned first. In addition, code 995.93 (SIRS due to noninfectious process without acute organ dysfunction) and code E939.9 (psychotropic agents, other antipsychotics, neuroleptics, and major tranquilizers, to identify the external cause) were allowed as additional diagnoses. MS-DRG options for the differing principal diagnoses with 995.93 as a secondary diagnosis include the following:
I strongly encourage coders and CDI specialists to read and discuss this issue of *Coding Clinic* to interpret its advice in the context of ICD-9-CM conventions, the Official Guidelines, and previous *Coding Clinic* advice. Potential issues include:

- *Coding Clinic* allowed the coder to code the symptoms of the SIRS, even though the question does not overtly state that these symptoms were explicitly documented by the provider. The scenario stated only that the patient was admitted with fever and that the patient had tachycardia, tachypnea, and low white-cell count. CDI specialists and coders must remember that code assignment is based only on explicit documentation of diagnoses by a provider legally responsible for assigning them, and that CDI specialists and coders cannot assume that they can be coded simply because a patient presented with them. If no diagnosis has been documented for presenting symptoms, physician query is necessary to properly document and code them.

- Even though the code for low white count, 288.50 (leukopenia, unspecified) is not assigned to ICD-9-CM, Chapter 16, “Symptoms, Signs, and Ill-Defined Conditions,” the Official Guidelines state that “Chapter 16 of ICD-9-CM … contain many, but not all codes for symptoms.” Furthermore, the Guidelines state that an abnormal white count (leukocytosis) is a symptom of SIRS. It is therefore perfectly legal to use other codes than those in Chapter 16 as a symptom code where applicable and appropriate.

- CDI specialists and coders cannot extend this advice of coding symptoms for SIRS first to other syndromes listed in ICD-9-CM, such as acute coronary syndrome, Felty’s syndrome, and syndrome of inappropriate secretion of antidiuretic hormone (SIADH), even if a physician documents symptoms of these diseases. For example, *Coding Clinic* stated in its 5th issue in 1993 that symptoms of SIADH, such as hyponatremia, water intoxication, and confusion, cannot be coded because they are integral to the syndrome. There are many other syndromes whereby documented symptoms are integral.

- CDI specialists and coders must remember that SIRS is not a constellation of symptoms; it is the systemic activation of the innate

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immune system of which a myriad of symptoms are manifested. Many of these “SIRS criteria” are nonspecific and can be explained by other illnesses. For example, tachycardia can occur from hypovolemia, leukocytosis can occur in leukemia, and tachypnea can occur with anxiety. Just because a patient has a number of the SIRS criteria (e.g., two out of four) it does not mean that they have SIRS. There must be some clinical gestalt that the patient is systemically ill as to support a SIRS or sepsis diagnosis.

_Coding Clinic_'s advice appears to apply only for this circumstance, and thus does not necessarily apply to similar circumstances. This guidance will certainly generate spirited discussion, so I recommend that you check with your coding supervisor, compliance officer, or corporate attorney to ensure that your query and coding processes adhere to a compliant standard of practice.

**SIRS due to other noninfectious causes (p. 10)**
_Coding Clinic_ stated that other conditions than those listed in the Official Guidelines, such as burns, pancreatitis, trauma, and malignancy, can be an underlying cause of SIRS of noninfectious etiology. Remember that when ICD-9-CM uses terms like “such as,” the listed conditions are nonexclusive to what’s being described.

**Hypermagnesemia in a newborn (pp. 14–15)**
_Coding Clinic_ presented a situation in which a newborn was diagnosed with hypermagnesemia after his or her mother was treated with magnesium sulfate for eclampsia. This is almost the same scenario offered in _Coding Clinic_, Third Quarter, 2009, p. 21, with slightly different wording. The lesson to learn here is that a CDI specialist should query for all unspecified hypermagnesemia in newborns in order to determine whether it is an inherent metabolism disorder or a transient elevation resulting from the mother’s treatment.

**Specificity in describing chemical dependency (p. 20)**
CDI specialists and coders are integral to fraud and abuse prevention. In doing so, they must know the definitions of compliance-related terminology. Some of these include:

- **Upcoding:** Billing for a code that provides a higher reimbursement rate than the code that actually reflects the service furnished to the patient.
- **Assumption coding:** Assuming (and coding) certain conditions or treatments in the absence of the physician’s explicit documentation of that diagnosis or treatment.
- **DRG creep:** A variety of upcoding scenarios that essentially results in the facility or provider billing for an inaccurate or inappropriate DRG due to its associative higher reimbursement.

When coding the nature of chemical dependency to drugs and alcohol, many coders relied upon _Coding Clinic_, Second Quarter, 1991 (p. 11) for...
synonyms to words that physicians rarely if ever use, such as “episodic,” “continuous,” or “in remission.” For example, this past issue of Coding Clinic seemed to allow for a situation in which, if a chemically dependent patient had a daily intake of large amounts of alcohol or drugs, the coder could assume that the chemical dependency was continuous. In another example, if a patient was in a period during which a decrease toward cessation was taking place, the coder could specify that the chemical dependency was in remission. Furthermore, Coding Clinic seemed to allow documentation of technical and professional personnel other than the attending physician to guide the specificity of these codes. Let’s be honest: When was the last time a physician wrote: “episodic alcoholism,” “continuous chemical dependency to cocaine,” or “methamphetamine addiction, in remission”? 

Unfortunately, Coding Clinic reversed its position on this issue, citing Official ICD-9-CM Guidelines requirements. Now the provider with legal responsibility to assign the diagnosis must document these terms if these conditions are to be coded with higher specificity. Documentation from technical and professional personnel, such as rehabilitation counselors, cannot be relied upon. If these personnel do document these terms, however, and the treating provider is silent, they may serve as a foundation for provider query.

Fortunately, Coding Clinic did not appear to remove the synonyms for “continuous,” “episodic,” and “remitted chemical dependency” that it outlined in its 1991 article.

In MS-DRGs, continuous chemical dependency to narcotics, amphetamines, and cocaine serve as CCs, whereas continuous chemical dependency to alcohol and marijuana do not. Episodic, remitted, and unspecified chemical dependency are not CCs under any circumstance.

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