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

At first glance, the 2nd Quarter, 2010 Coding Clinic for ICD-9-CM, effective for discharges on or after July 7, 2010, appears light on content relevant to CDI specialists and inpatient coders. But closer inspection reveals some entries that offer new guidance as well as controversial advice that may require further clarification from the AHA.

For example, Coding Clinic, 2nd Quarter 2010, rendered an opinion that permits ICD-9-CM coding of pathological diagnoses documented by attending physicians on cancer staging forms, a potential solution for admissions when the pathology report is not available at the time of discharge. Coding Clinic also issued clear, definitive guidance that allows coders to report body mass index (BMI) from the documentation of nurses and other clinicians who are not the patient’s provider, with the caveat that an associated diagnosis is documented by a treating provider.

But there were a couple entries that may be deemed controversial. For example, Coding Clinic recommends assigning an active herpes simplex infection code (054.10) rather than a history of herpes simplex infection code (V12.09, History of infectious and parasitic disease, other) in the case of an asymptomatic patient with a history of herpes simplex. The patient was treated with antibiotics to suppress herpes simplex exacerbations. Some coders or CDI specialists may be uncomfortable with this notion.

Let’s investigate what this issue of Coding Clinic has to say.

Gross hematuria due to prostate cancer (p. 3)
In this scenario, a patient receiving treatment for prostate cancer was admitted for gross hematuria with a drop in hemoglobin. There is no indication what this treatment includes (e.g., radiation via external beam or brachy-therapy, or chemotherapy). The patient cannot pass urine, passing only frank blood and clots, which suggests urinary retention or bladder outlet obstruction, which is not mentioned. Inpatient treatment includes bladder irrigation and transfusion of 12 units of blood (a rather large amount, given that one unit of blood increases the hematocrit by an average of two to three points). One would assume that a foley catheter was placed as to perform the bladder irrigation, relieving the urinary retention or bladder outlet obstruction. There is no documentation as to why the patient developed hematuria and...
urinary obstruction, any documented diagnosis to support the transfusion of 12 units of blood, or any description of any procedures performed other than bladder irrigation or blood transfusion.

Given that Coding Clinic stated that gross hematuria was the documented reason for admission (it did not state whether this was on the history and physical or in the discharge summary), the publication advised to code the gross hematuria (code 599.71, Gross hematuria) as the principal diagnosis and the prostate cancer (code 185, Malignant neoplasm of prostate) as a secondary diagnosis. Coding Clinic did not mention if the drop in hemoglobin (code 790.01, Precipitous drop in hematocrit) should be added as an additional diagnosis.

Provided that no other diagnoses are present, following are the DRG assignments for this inpatient admission:

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>APR-DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG number</td>
<td>696</td>
</tr>
<tr>
<td>DRG title</td>
<td>Kidney &amp; Urinary Tract Signs and Symptoms without MCC</td>
</tr>
<tr>
<td>Relative weight</td>
<td>0.6453</td>
</tr>
<tr>
<td>APR-DRG SOI</td>
<td>1</td>
</tr>
<tr>
<td>APR-DRG ROM</td>
<td>1</td>
</tr>
</tbody>
</table>

This scenario brings a number of coding and CDI issues into play. Improved physician documentation would have better characterized the attending physician’s likely intent in designating this encounter as an inpatient admission and captured the patient’s true severity of illness based on the underlying etiology and consequences of this patient’s hematuria and the medical necessity for receiving such a large amount of blood. These include the following:

- **Principal diagnosis assignment:** This Coding Clinic admits what many previous issues have emphasized; principal diagnosis assignment is difficult. Coders and CDI specialists are strongly encouraged to read the instructions in the 2010 Official ICD-9-CM Guidelines for Coding and Reporting for principal diagnosis assignment, especially in the setting of malignancy, available on pp. 23–26 and pp. 91–93. The guidelines are available at the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/nchs/data/icd9/icdguide09.pdf.

- **Coding of signs and symptoms:** Almost equally important is a thorough understanding of the ICD-9-CM conventions for coding of signs and symptoms, many of which—but not all—are listed in Chapter 16 of ICD-9-CM, “Symptoms, Signs, and Ill-Defined Conditions” (codes 780.0–799.9). Some signs and symptoms serve as CCs or MCCs. You can find these conventions on p. 10 of the 2010 ICD-9-CM Official Guidelines referenced above.

- **The meaning of the word “with”:** Coding Clinic, 2nd Quarter 2009, p. 15, emphasizes that in ICD-9-CM’s Alphabetic Index, the subentry term “with”
means “associated with” or “due to”. Therefore, unless Coding Clinic states otherwise in the future, I personally believe that physician linkage of two conditions with the word “with” can be interpreted as “associated with” or “due to”. This advice may be controversial with some, thus you should consider consulting an ICD-9 expert or compliance officer if you have questions.

Now, let’s investigate the coding of this circumstance based on what Coding Clinic gave us in the scenario.

■ **Patient presentation:** The patient has a known diagnosis of prostate cancer and is receiving some form of treatment, justifying code 185, Malignant neoplasm of prostate. Coding Clinic does not tell us what this treatment is; it could be radiation (external beam or brachytherapy) or chemotherapy. He presents as an outpatient with gross hematuria and a drop in hemoglobin. Although both gross hematuria and drops in hemoglobin are symptoms, gross hematuria (code 599.71, Gross hematuria) is not in Chapter 16, whereas a drop in hemoglobin (code 790.01, Precipitous drop in hematocrit) is. The gross hematuria and significant drop in hematocrit are linked to each other with the word “with”; however, while they are related to each other, a drop in hemoglobin does not always occur with gross hematuria, thus they are not integral. There is no overt linkage between the drop in hemoglobin and the hematuria with the prostate malignancy.

■ **Coding issues:** Both the hematuria and the drop in hemoglobin were treated. The hematuria received bladder irrigations and the drop in hemoglobin received blood transfusion. Since Coding Clinic stated the circumstance of admission was to address the hematuria and not the malignancy directly, the publication opted for hematuria as the principal diagnosis. Unless the physician can demonstrate that the reason for admission is to determine the extent of the malignancy or a procedure directed at the malignancy, a coder cannot report malignancy as the principal diagnosis.

I am perplexed as to why Coding Clinic did not consider the blood transfusions to be a significant treatment, mentioning only the bladder irrigations, given that the patient presented with a drop in hemoglobin. Gross hematuria alone does not result in the medical necessity for inpatient admission using Interqual or Milliman criteria; however, a significant drop in hemoglobin requiring 12 units of blood does qualify. CDI specialists and coders must partner with case management and the attending physician to determine what conditions qualified the patient for inpatient admission, given that retrospective auditors are denying inpatient admissions for conditions they deem can be treated as an outpatient or in an observation setting (such as gross hematuria).

For non-coders reading this supplement, if a patient is admitted for a Chapter 16 symptom linked in the documentation to an underlying cause, a coder must sequence the underlying cause as the principal diagnosis. However, in this instance hematuria is not listed in Chapter 16, therefore Coding Clinic
advises to report 599.71 (Gross hematuria) as the principal diagnosis, especially since the physician did not document an underlying cause.

Another issue is that Coding Clinic refers its readers to Section II, Part B, of the Official Guidelines for Coding and Reporting (“Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis”), for more information. Section II, B, states the following:

When there are two or more interrelated conditions (such as diseases in the same ICD-9-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

Given that Coding Clinic did not provide the entire circumstance of admission for our review, we can only trust that its advice for this particular case is correct. I would be interested if the coding community asks for clarification, given that code 790.01 was not offered as an additional diagnosis or even considered as an option for principal diagnosis selection.

**Query opportunities:** According to the 2008 AHIMA Practice Brief, “Managing an Effective Query Process,” CDI specialists should query the physician for the following reasons:

- Legibility
- Completeness
- Clarity
- Consistency
- Precision


Opportunities for physician query include the following:

- Reasons for the hematuria: Hematuria is a symptom, even though it is not listed in Chapter 16. The lack of physician documentation of its underlying cause qualifies a reason for query under the “clarity” provision of the 2008 AHIMA Practice Brief, given that prostate brachytherapy can result in radiation or hemorrhagic cystitis leading to gross hematuria. Consider the following reference at [www.ncbi.nlm.nih.gov/pubmed/12597957](http://www.ncbi.nlm.nih.gov/pubmed/12597957).

If the gross hematuria is a consequence of radiation treatments, coders should only report the gross hematuria code. Coders should not report code 990, Effects of radiation, unspecified, given that the “excludes note” excludes the use of this code when a physician documents specified adverse effects of radiation. However, since the hematuria was so severe as to require 12 units of blood, it is possible that another etiology, such as radiation or hemorrhagic cystitis, may be present. Consider
the following reference from MD Anderson hospital in Houston at www.goldjournal.net/article/S0090-4295(09)00611-6/abstract.

- **Significance of the severe drop in hemoglobin:** According to the article above, gross hematuria after radiation treatments for prostate cancer does not require blood transfusion. Given the use of 12 units of blood, this patient more than likely had an acute blood loss anemia (code 285.1, Acute posthemorrhagic anemia) that required inpatient admission and treatment. Given that a drop in hemoglobin is only a symptom, lack of documentation of its underlying or associated conditions is incomplete, requiring physician query.

Provided the provider completely documented the following diagnoses, some potential DRG options include:

<table>
<thead>
<tr>
<th>Coding Clinic’s advice</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Diagnosis *</td>
<td>599.71 Gross Hematuria</td>
<td>599.71 Gross Hematuria</td>
<td>595.82 Radiation cystitis</td>
</tr>
<tr>
<td>Secondary #1 *</td>
<td>185 Prostate Cancer</td>
<td>185 Prostate Cancer</td>
<td>599.71 Gross hematuria</td>
</tr>
<tr>
<td>Secondary #2 *</td>
<td>285.1 Acute Blood Loss Anemia</td>
<td>285.1 Acute blood loss anemia</td>
<td>185 Prostate Cancer</td>
</tr>
<tr>
<td>Secondary #3 *</td>
<td>185 Prostate Cancer</td>
<td>Radiation cystitis effects no change</td>
<td></td>
</tr>
<tr>
<td>MS-DRG #</td>
<td>696</td>
<td>696</td>
<td>699</td>
</tr>
<tr>
<td>Description</td>
<td>Kidney &amp; Urinary Tract Signs and Symptoms</td>
<td>Kidney &amp; Urinary Tract Signs and Symptoms</td>
<td>Other kidney and urinary tract diagnoses w/CC</td>
</tr>
<tr>
<td>Relative weight</td>
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<td>0.6453</td>
<td>0.9518</td>
</tr>
<tr>
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<td>468</td>
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<tr>
<td>Description</td>
<td>Other Kidney/Urinary Tract Disorder</td>
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<td>Other Kidney/Urinary Tract Dx</td>
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<tr>
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<td>0.6876</td>
</tr>
<tr>
<td>SOI</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>ROM</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

*Presumes that these were documented by the physician and the principal diagnosis was reasonably tied to the reason for inpatient admission.

Given that a drop in hemoglobin is only a symptom, lack of documentation of its underlying or associated conditions is incomplete, requiring physician query.
Septic shock due to peritonitis (p. 4)
This entry advises coders to report septicemia (0.38.x) as the principal diagnosis when a patient is admitted with septic shock due to bacterial peritonitis. It’s a fairly straightforward answer, explaining that bacterial peritonitis is a localized infection. Coding Clinic also appropriately adds additional codes for severe sepsis (995.92) and septic shock (785.52).

Impending pathological fracture (p. 6)
In this scenario, a patient with multiple myeloma is admitted for management of a pathologic fracture of the proximal shaft of the humerus. He also has impending pathologic fractures in his left femur in two places and one in his ischium. Coding Clinic advised that a coder should only report 733.11 (Pathologic fracture of the humerus) as the principal diagnosis and to not code the impending fracture in the other locations.

To understand why, CDI specialists should familiarize themselves with Section I, Part B, subsection 13 of the Official Guidelines for Coding and Reporting (“Impending or Threatened Condition”), which states the following:

Code any condition described at the time of discharge as “impending” or “threatened” as follows:
- If it did occur, code as confirmed diagnosis.
- If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”
- If the subterms are listed, assign the given code.
- If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

There is no specific code for impending pathological fracture and, in this case, no documented underlying bony pathology that could lead to the impending fracture, thus a coder should assign no additional code.

One interesting note was that Coding Clinic did not recommend that the coder/CDI specialist query for the underlying conditions causing the impending pathologic fractures, given that the Official Guidelines require this measure. Multiple myeloma is known to cause osteolytic bone lesions (code 733.90, Disorder of bone and cartilage, nonspecified) or present as an isolated plasmacytoma (code 238.6, Neoplasms of uncertain behavior of other and unspecified sites and tissue, plasma cell). You can learn more in the following reference from the American Academy of Orthopedic Surgeons at orthoinfo.aaos.org/topic.cfm?topic=A00086.

Note that other malignancies may cause impending fractures as well. You can learn more about this in the The New England Journal of Medicine (keep in mind that you need a subscription to access the full article, but most hospital’s medical libraries should carry it) at www.nejm.org/doi/full/10.1056/NEJMra030831.

Note that other malignancies may cause impending fractures as well.
Physician documentation of the underlying conditions leading to impending conditions creates a more complete dataset. Coders and CDI specialists should never assume what the underlying condition of an impending condition is, even though their clinical knowledge and gestalt may suggest otherwise.

**Elective termination of pregnancies (p. 6)**

This entry states that a coder should report 635.92 (Legally induced abortion) as the principal diagnosis for a mother who presents for an elective termination of pregnancy as a consequence of lethal fetal anomalies and, in the course of the procedure, her fetus is injected with potassium chloride. Do not report code 656.4x (Intrauterine death) in this instance, since this is an elective abortion, *Coding Clinic* advises. Code 655.93, Known or suspected fetal abnormality affecting management of the mother, antepartum condition or complication, should be reported as an additional diagnosis.

This advice has relevance for programs that receive inpatient reimbursement determined by the APR-DRG system. By reporting 656.43, Intrauterine death, as a secondary diagnosis, the APR-DRG would move the case from a severity of illness level one (minor) to two (moderate), but *Coding Clinic* advises against this.

**Use of cancer staging forms (p. 7)**

Documentation and coding of surgical pathology has always been a problem. Frequently, pathology reports are not available at the time of discharge, thus the physician does not document a pathological diagnosis in his or her progress notes or discharge summaries. Coders are stuck because they cannot code from inpatient pathology reports obtained after discharge and have to query the physician to determine whether the pathological diagnosis can be added.

However, in this entry, *Coding Clinic* advises that cancer staging forms are permissible for code assignment, provided they are made a permanent part of the inpatient record and an attending physician signs them. This should ease some of the burden for hospitals.

Note, however, that the *attending* physician must authenticate the cancer staging form, not a consulting or resident physician.

**Pseudoaneurysm of saphenous vein graft (p. 8)**

In this entry, a patient with a history of coronary artery disease and status post coronary artery bypass grafting (CABG) is admitted for non-ST segment elevation myocardial infarction (NSTEMI). A diagnostic left cardiac catheterization reveals a pseudoaneurysm of the saphenous vein graft of the diagonal artery and coronary occlusion (atherosclerosis) of the vein grafts. *Coding Clinic*
advise to report 410.71 for the NSTEMI as the principal diagnosis. Secondary codes include 996.72, Complication due to other cardiac device, implant, and graft; E878.2, Surgical operation with anastomosis, bypass, or graft; and 414.02, Atherosclerosis of an autologous biological bypass graft. Coding Clinic also states that code 414.11 (Aneurysm of coronary vessels) is not appropriate.

What's the difference between an aneurysm and a pseudoaneurysm? An aneurysm is a dilation of a blood vessel due to an intrinsic weakness of the vessel wall. A pseudoaneurysm is a hematoma from a persistent leaking hole in the vessel wall that is usually enclosed by scar tissue. A good reference is the University of California, Davis' website at www.ucdmc.ucdavis.edu/vascular/lab/exams/pseudoaneurysm.html.

While pseudoaneurysm codes to aneurysm in ICD-9-CM, there is no specified code for a pseudoaneurysm of a CABG. It appears that ICD-9-CM equates aneurysms and pseudoaneurysms only when they occur in native arteries, not autologous or artificial grafts. Coding Clinic opted not to use code 411.11, Aneurysm of coronary vessels, as an additional code since it occurred in an autologous bypass graft, not a native artery.

Therefore, a coder should report an appropriate complication code should he or she see a pseudoaneurysm of a CABG (or I would guess any other nonnative autologous or artificial graft). You can find a list of these in the ICD-9-CM Index under Complications, Blood Vessel.

One may ask why Coding Clinic assigned code 414.02 even though total occlusion of a CABG not specified as to its etiology codes to 996.72 (remember that ICD-9-CM diagnosis codes can only be reported once for a given encounter). The reason is the physician documented coronary occlusion (atherosclerosis) of the vein graft, specifying that atherosclerosis played a role. For further clarification look at code 414.02 in your ICD-9-CM Table of Diseases and the “excludes” note above.

One may also ask why Coding Clinic did not recommend 996.72 as the principal diagnosis, even though it was coded and its associated condition was addressed during this admission. The reason is the circumstances of inpatient admission, the NSTEMI, was not linked to the pseudoaneurysm.

You can find case studies that suggest a coronary pseudoaneurysm can cause an acute myocardial infarction, including the following at the Wiley Interscience website at www3.interscience.wiley.com/journal/112135973/abstract. Therefore, a CDI specialist should query for the underlying causes of the patient’s NSTEMI, given that two different pathologies were demonstrated in the cardiac catheterization.

DRG options based on the physician’s response to the query include the following:
## Pregnancy and genital herpes (p. 10)

This entry states that a coder should report genital herpes (code 054.10) as an additional diagnosis for a pregnant patient admitted to the hospital for delivery with a history of genital herpes receiving chronic suppressive medications (e.g., Valtrex), but with no current symptoms or outbreaks. A coder should not code a history code when a patient is receiving suppressive antibiotic treatment, given that the underlying condition is not resolved and requires ongoing therapy.

*Coding Clinic* also recommends code 647.61 (Infectious and parasitic conditions in the mother classifiable elsewhere) be reported as the principal diagnosis, not 650, Normal delivery, given that genital herpes poses a risk to the fetus.

Because the patient is on a chronic medication to suppress the infection, it is as if he or she had an active infectious illness for coding purposes. Other circumstances whereby a patient may receive chronic suppressive antibiotic treatment for chronic infections that may not be clinically apparent includes infected orthopedic or cardiac prostheses (see reference at [www.jstor.org/pss/4481612](http://www.jstor.org/pss/4481612)), pneumocystis jiroveci (Bactrim or pentamidine), or chronic urinary tract infections.

*Coding Clinic* set a precedent for this advice when it advised that active breast cancer can be coded in patients receiving biological adjuvant therapies, such as Herceptin® (see *Coding Clinic*, 3rd Quarter 2009, pp. 3–4). Note that I also discussed this issue in the October 2009 *CDI Journal*, available at [www.hcpro.com/content/240858.pdf](http://www.hcpro.com/content/240858.pdf). But despite this precedent this advice may be controversial.
I recommend that you discuss the applicability of this advice regarding genital herpes to other infections with appropriate ICD-9 or compliance experts.

**Acetylcholine challenge test (p. 11)**

This entry advises coders to report code 89.59 (Other nonoperative cardiac and vascular measurements) for a patient referred for cardiac catheterization to rule out endothelial dysfunction. An acetylcholine (ACh) test was performed and the patient's coronary artery stenosis was reversed with intracoronary injections of nitroglycerin.

I strongly encourage coders and CDI specialists to learn the indications for the ACh challenge test, primarily in the evaluation of angina decubitus or accelerated angina in the setting of “normal” coronary arteries. An excellent article discussing this disease is in the *Journal of the American Medical Association* at [http://jama.ama-assn.org/cgi/content/full/293/4/477](http://jama.ama-assn.org/cgi/content/full/293/4/477). Just because the coronary anatomy looks normal at first glance this does not necessarily mean that the patient’s chest pain is not angina pectoris, especially if there is a suggestive noninvasive coronary artery study.

In this circumstance, given that the patient presented with chest pain and demonstrated reversible coronary stenosis upon an acetylcholine challenge, a CDI specialist should clarify the nature of the patient’s chest pain.

**Arobella Qoustic Wound Therapy System (p. 11)**

In this entry, *Coding Clinic* proscribes the use of 86.28 (non excisional debridement of wound) for the Arobella Qoustic Wound Therapy System, which uses an ultrasonic-assisted curette to debride wounds. However, *Coding Clinic* says if the provider also documents that he or she performed an excisional debridement in addition to the use of this device, a coder may report excisional debridement separately.

Note that excisional versus non-excisional debridements remain a Recovery Audit Contractor (RAC) target. Remember also that skin removal is not skin debridement unless the physician documents it as such. CDI specialists can assist with RAC defense through appropriate documentation of the type of debridement performed.

**Methadone treatment (p. 13)**

In this entry, *Coding Clinic* advises to report code 304.00 (Opioid type dependence, unspecified) for patients who are receiving methadone maintenance because of heroin dependence. Do not report V58.69 (Long-term current use of other medications) since this code should not be used for patients who have addictions to drugs, *Coding Clinic* advises.

The net effect of this guidance is unfortunately a lost CC for CDI specialists, given that 304.01 (Opioid type dependence, continuous) is a CC while 304.00 is not. In the past, coders could report 304.01 (Opioid type dependence,
continuous) for patients who received methadone maintenance (per Coding Clinic, 4th Quarter 1988, p. 8), as the assumption could be made that patients receiving it had a continuous drug dependence. Now, per this Coding Clinic, CDI specialists must query the physician to determine the specific nature of the patient’s chemical dependency if he or she receives chronic methadone treatment.

**BMI and nursing documentation (p. 15)**

In this entry, Coding Clinic clarifies that you can assign a patient’s BMI from nursing documentation. “The BMI may be assigned based on medical record documentation from clinicians, including nurses and dietitians who are not the patient’s provider,” Coding Clinic states. However, the associated diagnosis (such as overweight, obesity, or underweight) must be documented by the provider.

Note this guidance was previously given in the ICD-9-CM Official Guidelines for Coding and Reporting but was not stated in an explicit fashion, leading to some confusion.

A further question is raised: If one can now query a nurse for the clinical significance of a patient’s height and weight to add precision if a treating provider documents a corresponding and related diagnosis (e.g., morbid obesity, moderate malnutrition).

Although there is no Coding Clinic advice that says one cannot query a nurse, there is no explicit advice that says that one can. While probably not illegal to query a nurse, it is always safest to query a treating provider if additional precision is needed to stage the severity of a patient’s morbid obesity or malnutrition using the BMI codes, unless Coding Clinic provides further clarity.

**Multiple pressure ulcers and POA assignment (p. 17)**

Coding Clinic instructs providers to report 707.24 (Pressure ulcer stage IV) with a present on admission (POA) indicator of N (not POA) once only in the instance of a patient admitted with a pressure ulcer of her ankle who later developed another pressure ulcer of the sacrum, both of which progressed to stage IV ulcers.

Coding Clinic admitted that reporting one code for two pressure sores’ stages is less than ideal, but it is the best solution due to the limitations of ICD-9-CM (within which providers cannot report the same diagnosis code twice on the same admission). “There is no ideal answer for this situation; however, due to the constraints of the classification, this is the most appropriate approach,” Coding Clinic states.

Note that when a patient is admitted with a pressure ulcer that worsens during his or her stay, a coder reports a POA indicator of Y (POA), which does not
impact payment. However, in the situation described above, a hospital could suffer the loss of reimbursement since 707.24 is an MCC.

**Transition from ICD-9-CM to ICD-10**

Finally, *Coding Clinic* announced in this issue it has no plans to translate all previous issues of *Coding Clinic for ICD-9-CM* into ICD-10-CM/PCS since many of the questions published arose out of the need for guidance on ICD-9-CM, and would not necessarily apply to ICD-10. *Coding Clinic* plans to begin to accept and process ICD-10 questions at a later, unspecified date.

Until next time, best wishes to all. Thank you for your interest in CDI and for your advocacy in ICD-9 code accuracy and data integrity.

*Kennedy is a managing director at FTI Healthcare. His team supports providers and facilities in their quest for accuracy in ICD-9 and CPT code assignment. He may be reached at james.kennedy@ftihealthcare.com or 615/479-7021.*