Editor's note: The following article is provided as a supplement to the April 2011 CDI Journal.

Greetings fellow clinical documentation specialists, coders, and physician advisors. It’s time to review Coding Clinic, First Quarter 2011, as we partner with physicians to clarify inconsistent, incomplete, imprecise, conflicting, and illegible clinical documentation in the medical record.

Complications were again on center stage in this issue, so let’s take a look at what the Central Office on ICD-9-CM at the American Hospital Association (AHA) had to say.

Postoperative hemorrhage and postoperative hematoma (pp. 13–14)
Iatrogenic pneumothorax (p. 14)
Postsurgical aspiration pneumonia (p. 16)

What hospital is not struggling with its reporting of surgical complications, especially those impacting the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI) and Medicare’s Value-Based Purchasing Program? Toward that end, CDI specialists, coders, and physician advisors are encouraged to read the PSI technical specifications available on the AHRQ website at http://tinyurl.com/PSIspecifications. Note that iatrogenic pneumothorax is one of AHRQ’s PSIs.

CDI specialists, in concert with their coding staffs, are integral to negotiating ICD-9-CM and Coding Clinic’s definitions of surgical complications with providers, given that many physicians and their quality committees are not aware of these unique requirements. In reading these specifications, CDI specialists and coders should note that many of the complication codes (e.g., those starting with 996, 997, and 998) factor into PSI calculations.

This advice, along with Coding Clinic, Third Quarter 2009, p. 5, and the ICD-9-CM Official Guidelines for Coding and Reporting, sets the standard of what coders need in order to classify an intraoperative or postoperative condition as a complication. These include the following:

- The condition must meet the definition of a secondary or additional diagnosis or be deemed clinically significant. The Official Guidelines state that conditions must require one of the following in order to qualify:
- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and/or monitoring

Therefore, if a perioperative or postoperative condition does not meet any of these criteria, a coder may not report it.

Likewise, if the condition is deemed to be clinically insignificant (i.e., it does not affect the procedural outcomes), as in a dissection of a coronary artery in the course of percutaneous coronary angioplasty described in *Coding Clinic*, First Quarter 2011, pp. 3–4, the condition would not be coded. *Coding Clinic*, Second Quarter 2007, pp. 11–12, applies the same logic for a clinically insignificant serosal tear that occurred to surgery, stating that if these tears are documented to be an incidental occurrence inherent to the procedure (note the need for both terms, incidental and inherent), they would not be coded as complications. If the provider is silent, you must query.

*Coding Clinic*, Third Quarter 2007, pp. 13–14, qualifies this by stating that chronic conditions such as, but not limited to, hypertension, Parkinson’s disease, chronic obstructive pulmonary disease (COPD), and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. *Coding Clinic* emphasizes that since these conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, they therefore should be coded. It is conceivable that if a patient has a chronic long-standing complication, such as an occluded coronary artery bypass graft or a malfunctioning orthopedic implant, it should be coded if it is documented by the provider.

- **The condition must be directly related to the procedure to be coded as a complication of that procedure.** The *Official Guidelines* state, “As with all procedural or postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the condition and the procedure.” This *Coding Clinic* advice reemphasizes the need for this direct correlation.

This is important since perioperative or postoperative conditions, such as postoperative ileus or respiratory failure, may be an adverse effect of a drug (e.g., morphine) or the direct effect of an underlying disease (e.g., an autonomic neuropathy or COPD). If the patient’s circumstances reasonably fit this possibility, clarification from the physician as to the cause of the perioperative or postoperative condition is warranted.
The condition must be more than routinely expected in order to be coded as a complication of the procedure. Let’s face it—procedures have clinically significant known risks that are routinely expected. Radical mastectomies routinely lead to lymphedema of the arm; bowel surgery routinely leads to a perioperative ileus; cardiac surgery and its anesthesia routinely have a period of respiratory failure requiring postoperative mechanical ventilation; lysis of dense adhesions can routinely result in serosal tears; and radical prostatectomy routinely leads to erectile dysfunction. Only a provider can determine whether the perioperative or postoperative condition is routinely expected. If this is the case (and if documented as such), while the condition may be coded if it meets the definition of a secondary diagnosis, it should not be coded as a complication.

There must be an indication in the documentation that the condition is a complication. This is probably the most difficult aspect in reporting complications. Many physicians or facilities do not wish to be labeled as having a high complication rate, and the ICD-9-CM Index to Diseases forces the coding of complication codes for some circumstances (e.g., postoperative ileus, postoperative atelectasis, or iatrogenic pneumothorax) unless explicitly documented by the provider not to be a complication. Most physicians consider the term “postoperative” to mean that an event occurred in the postoperative period, whereas ICD-9-CM automatically classifies this term with some conditions (e.g., lung edema, ileus, atelectasis) as a complication of the procedure.

*Coding Clinic*’s advice on iatrogenic pneumothorax on p. 14 of this issue outlines this dilemma. *Coding Clinic* explicitly states that if the provider documents “iatrogenic pneumothorax” (which has a listing in the ICD-9-CM Index to Diseases) or if he or she documents that the pneumothorax is due to the procedure (without mentioning whether it is clinically significant), code 512.1, Iatrogenic pneumothorax, should be assigned. *Coding Clinic* qualifies this statement by citing the three requirements for a condition to be a complication (other than its qualification as a secondary diagnosis):

- It is more than a routinely expected condition or occurrence
- There is a cause-and-effect relationship between the care provided and the condition
- There is an indication in the documentation that the condition is a complication

Previous advice published in *Coding Clinic*, Third Quarter 2003, p. 19, discusses a circumstance in which a pneumothorax was noted on a postoperative chest x-ray after thoracic spine surgery. *Coding Clinic* advised not to add the 512.1 code based solely on radiology findings (which coders should never do anyway) without physician concurrence.
Coding Clinic’s advice on postsurgical aspiration pneumonia on p. 16 further outlines this dilemma. If a provider documents “postoperative aspiration pneumonia,” Coding Clinic stipulates that code 997.39, Respiratory complications, Other respiratory complications, and code 507.0, Pneumonitis due to solids and liquids, Due to inhalation of food or vomitus, should be coded. Of course, if it is clinically reasonable that the patient’s aspiration pneumonia is not due to the procedure (e.g., it is due to an overdosage of sedatives or opioids), or if it is not the surgeon’s intention that the aspiration pneumonia be classified as a surgical complication, then a query is suggested to clarify the surgeon’s intent.

One final thought: The present-on-admission (POA) indicator factors greatly in AHRQ’s PSI methodology. If a condition is either present at the time of inpatient admission or cannot be clinically determined to be present at the time of inpatient admission, it does not count as a PSI. If the condition was not present at the time of inpatient admission or its status is unknown, more likely than not, it will count. These rules apply only to acute conditions, given that chronic conditions are always present on admission. If the POA status is uncertain or unknown, a CDI specialist should query, even if the condition is not on the official hospital-acquired condition or PSI list.

Dissection of artery during coronary intervention (pp. 3–4)

In this entry, Coding Clinic recommends assigning 997.1, Cardiac complications, instead of 998.2, Accidental puncture or laceration during a procedure, for documentation of dissection deemed to be a complication of a percutaneous coronary intervention (PCI). Code 414.12, Dissection of coronary artery, was added to further describe the complication. Learn more about the classification of coronary artery dissections on the Journal of Invasive Cardiology website at www.invasivecardiology.com/article/3052.

It is clear in the question that the dissection was a complication of the PCI as the physician confirmed it following a query. Given that code 998.2, Accidental puncture or laceration during a procedure, is a PSI impacting Medicare value-based purchasing, some hospitals may breathe a sigh of relief.

In the next PCI-related scenario on p. 4 of Coding Clinic, the AHA recommends a query to the provider regarding the clinical significance of a “small dissection” that occurred during a PCI with a balloon angioplasty and subsequently requiring a stent. Coding Clinic states that the insertion of a stent as a result of the dissection “does not automatically mean that the dissection is clinically significant.”

The important takeaway for clinical documentation specialists is that when they see a coronary dissection in the documentation—even if it’s treated with another stent—the physician must describe its clinical significance and whether it is a complication in order for the dissection itself and/or its status as a complication to be coded.
Broken needle left during surgery (pp. 5–6)
This entry describes a needle lost in tissue during aortic surgery. The chest was reopened after an x-ray confirmed the location of the needle, but the surgeon could not confirm its location and closed the patient after deciding that continuing to look would cause more harm than good. Coding Clinic says to report 998.4, Foreign body accidentally left during a procedure, in this scenario since it was not the intention of the surgeon to leave the foreign body in the patient during the original operation. This is consistent with advice rendered in Coding Clinic, First Quarter 2009, p. 18, whereby a sponge was discovered in the patient after the incision had been closed, even if the patient had not yet left the operating room.

On pp. 5–6, Coding Clinic then describes a similar scenario in which a catheter tip separated during aspiration of the patient’s thrombus to treat a clot. An open thrombectomy was performed to remove the catheter tip. In this instance, Coding Clinic says to report 996.1, Mechanical complication of other vascular device, implant, and graft, for the broken catheter tip instead of 998.4, Foreign body accidentally left during a procedure. What differentiates reporting these two different codes? It appears to be the fact that the foreign body in the first case was not the result of a mechanical complication of a device, whereas the second event was.

Drug-induced pancytopenia (p. 6)
Pancytopenia is defined as a significant reduction of red cell mass (anemia), the absolute neutrophil count, and the platelet count. When documented, it is coded as 284.1, Pancytopenia. Note that it has a significant “excludes” list that includes aplastic anemia, hairy cell leukemia, HIV disease, myelodysplastic syndrome, and others. One exclusion is drug-induced pancytopenia, which, according to the excludes note, must be coded as 284.89, Other specified aplastic anemia.

This entry validates that the ICD-9-CM Index to Diseases instructs us per an instructional “Excludes note” for 284.1, Pancytopenia, to code pancytopenia due to drugs (such as cytotoxic cancer chemotherapy) as 284.89, Other specified aplastic anemia, even if the term “aplastic anemia” is not documented in the medical record. As most CDI professionals know, 284.1, Pancytopenia, is a CC, whereas 284.89 is an MCC within the MS-DRGs system.

This guidance resolves an ongoing source of confusion, especially as this code assignment results from a strict application of ICD-9-CM coding conventions. Some coding or CDI professionals have problems with reporting 284.89 for pancytopenia due to drugs because aplastic anemia is either not present or documented. Many choose either not to code 284.89 or query for aplastic anemia secondary to chemotherapy when it is not clinically present (pancytopenia due to cytotoxic cancer chemotherapy is usually due to bone marrow suppression, not bone marrow aplasia). While the ICD-9-CM
coding conventions support the use of 284.89 when pancytopenia due to
drugs is documented, Coding Clinic makes it explicit that 284.89 is the correct
code to report in this circumstance.

Be aware that new codes for antineoplastic chemotherapy–induced pancyto-
penia (284.11) and other drug-induced pancytopenia (284.12) take effect on
October 1, 2011. I would like to think that comments from ACDIS influenced
CMS to maintain both of these codes as MCCs, sparing them the fate of
285.3, Anemia due to cancer chemotherapy, which was not given any status
as a CC or MCC upon its implementation two years ago.

Read ACDIS’ comment to CMS on the ACDIS website at www.hcpro.com/
acdis/details.cfm?topic=WS_ACD_JNL&content_id=268419.

Also, don’t forget to query the provider if any specific component of the
pancytopenia, such as the neutropenia, anemia, or thrombocytopenia, was
addressed but was not documented. This documentation may impact prin-
cipal diagnosis sequencing or additional diagnosis assignment. Coding Clinic,
Third Quarter 2005, pp. 11–12, is a must-read in order to properly under-
stand this issue.

Superior semicircular canal dehiscence syndrome
(pp. 6–8)
Superior semicircular canal dehiscence syndrome is a rare condition of the
inner ear whereby a thinning or complete absence of the temporal bone
overlying the superior semicircular canal results in the Tullio phenomenon
(sound-induced vertigo), hyperacusis (an oversensitivity to sound in the
affected ear), chronic disequilibrium, and other various symptoms related
to the vestibular system. It is diagnosed by a high-definition CT scan of the
temporal bone and other neuro-otologic diagnostics and is repaired by an
open or burr hole procedure on the temporal bone.

Read the initial description of this syndrome on the Archives of Otolaryngology
website at http://archotol.ama-assn.org/cgi/content/full/124/3/249 and Wikipedia’s

This entry instructs coders to assign 386.8, Other disorders of labyrinth,
along with code 733.99, Other disorders of bone and cartilage, for a patient
who presents with left superior semicircular canal dehiscence syndrome,
or SSCDS. This makes sense since SSCDS is a labyrinthine disorder due to
a defect of the temporal bone. A procedure to treat the condition and the
instructions for its correct coding is described on pp. 7–8.

Acute graft versus host disease (pp. 8–9)
In this entry, Coding Clinic states that a patient presenting with acute graft
versus host disease following a stem cell transplant should be reported
using complication code 996.89, Complications of transplanted organ, other
specified transplanted organ. While Coding Clinic states that code 996.85, Complications of transplanted bone marrow, is not appropriate in this instance, it did acknowledge that stem cells are neither an organ nor bone marrow. This advice will no longer be needed after October 1, given that the National Centers for Health Statistics approved a new code, 996.88, Complications of transplanted organ, stem cell, for use on and after that date.

Both 996.89 and 996.88 group to MS-DRGs 919–921, Complications of treatment, after October 1, whereas 996.85 groups to the relatively higher-weighted MS-DRGs 808–810, Major hematologic and immunologic diagnosis except sickle cell crisis and coagulopathy. Be sure that your CDI and coding teams understand that Coding Clinic does not consider stem cells to be bone marrow and that code 996.85 will likely be denied if retrospectively reviewed.

**Borderline diabetes (pp. 9–10)**

**Other borderline conditions (p. 10)**

In this entry, Coding Clinic states that borderline diabetes should not be coded as diabetes unless the physician explicitly states that the patient has diabetes mellitus. A diagnosis of “borderline diabetes” without further confirmation of the disease should be reported with an appropriate code from the 790.2 series (abnormal glucose), according to Coding Clinic.

On the other hand, Coding Clinic allowed for assignment of code 416.8, Other chronic pulmonary heart disease, for documented pulmonary hypertension, and delegated it to a symptom code such as 796.2, Elevated blood pressure reading without diagnosis of hypertension. Coding Clinic emphasized that the term “borderline” qualifying a diagnosis does not make it an uncertain diagnosis, thus it can be coded if clinically supported and documented during any part of the inpatient or outpatient encounter.

Without trying to be critical, Coding Clinic does not appear to be consistent in its advice on the coding of conditions labeled as “borderline.” What’s the take-home lesson, given that this advice appears to be inconsistent? I would say that if any provider documents a condition as being borderline (other than borderline personality), a query is necessary to ascertain that the condition actually existed, especially if it influences reimbursement.

**Gastric band erosion with infection (p. 10)**

In this entry, a female is diagnosed with gastric band erosion with infection. I suspect that this gastric band was implanted as a treatment for morbid obesity. Coding Clinic instructs coders to report 996.59, Mechanical complication of other specified prosthetic device, implant, and graft, as the principal diagnosis in this scenario and to assign code 996.69, Infection and inflammatory reaction due to internal prosthetic device, implant, and grant, as the secondary diagnosis. This scenario does not leave the coder with the option to choose one code or the other since they both coexisted and impacted the condition found after study to occasion the inpatient admission.
Note that both codes as a principal diagnosis group to MS-DRGs 919–921, Complications of treatment, and are both on the CC exclusion list for each other. Therefore, under MS-DRGs, reimbursement is not affected by this sequencing instruction.

On the other hand, there is a difference in the APR-DRG system. Code 996.59 as a principal diagnosis maps to APR-DRG 813, Other complications of treatment, whereas 996.69 as principal maps to APR-DRG 721, Postoperative, posttraumatic, or device infection, which is weighted slightly higher. Take note if your hospital is paid under the APR-DRG system.

**NMDA receptor antibody encephalitis (p. 12)**
In this entry, Coding Clinic states that a coder should report 323.81, Other causes of encephalitis and encephalomyelitis, for a patient admitted with final NMDA receptor antibody encephalitis presenting as psychosis. Code 293.81, Psychotic disorder with delusions in conditions classified elsewhere, should be reported as a secondary diagnosis. This is per an instructional note in category 293.

The takeaway point for clinical documentation specialists: If documentation exists of an alteration in mental status (e.g., delirium, psychosis, stupor, confusion), try to clarify the suspected underlying physical or neurological condition with the physician. These may include metabolic or hepatic encephalopathies, neurodegenerative disorders, neurovascular disorders (e.g., transient ischemic attacks or strokes), and the like.

Don’t forget that uncertain diagnoses cannot be coded unless documented at the time of discharge. Therefore, should the provider qualify the underlying code as such, it must be documented in the discharge note, summary, or order.

**Methadone maintenance (p. 15)**
Coding Clinic clarified in this entry that coders should report 304.00, Opioid type dependence, unspecified, for patients receiving methadone maintenance because of heroin dependence, not code 304.01, Opioid type dependence, continuous. This appears to be the same advice rendered in Coding Clinic, Second Quarter 2010, p. 13. Note that 304.00 is not a CC in MS-DRG, whereas 304.01 is a CC.

**Neuroendocrine cell hyperplasia of infancy (pp. 16–17)**
Neuroendocrine cell hyperplasia of infancy (NCHI) is a rare nonlethal interstitial lung disease originally described as persistent tachypnea of infancy. While the gold standard for diagnosis is a lung biopsy, it has a characteristic appearance on high-resolution CT scans from which a diagnosis may be made. Some patients have chronic hypoxemic respiratory failure requiring supplemental oxygen, and in these instances physicians may only document it as hypoxia. Learn more about this condition online at [www.ncbi.nlm.nih.gov/pubmed/15965897](http://www.ncbi.nlm.nih.gov/pubmed/15965897) and [www.ajronline.org/content/194/1/238.long](http://www.ajronline.org/content/194/1/238.long).
Coding Clinic described a 13-month-old infant with NCHI who requires nighttime oxygen at 1 liter per minute. Of interest, Coding Clinic says to report code 770.7, Chronic respiratory disease arising in the perinatal period (even though the condition may arise in the postnatal period), code 516.8, Other specified alveolar and parietoalveolar pneumonopathies, and code 786.06, Tachypnea, for a 13-month-old child diagnosed with neuroendocrine hyperplasia of infancy.

I find this advice interesting in that Coding Clinic allows the coder to assume that the condition arose in the prenatal period (defined in the ICD-9-CM Official Guidelines for Coding and Reporting as before birth through the 28th day after birth), even though it was not documented as such. Apparently, Coding Clinic must believe that NCHI occurs in the perinatal period, even though the mean onset of symptoms is 3.8 months of age. A precedent for this was published in Coding Clinic, November-December 1986, pp. 11–12, which states that bronchopulmonary dysplasia originates in the perinatal period, and that the age at which the diagnosis was made does not affect the assignment of code 770.7.

I also find it interesting that the symptom code of tachypnea was coded, even though this was not documented by the provider, is not required of codes 770.7 or 516.8, and, at least in my mind, should be considered integral to the condition, given this condition's former title. The ICD-9-CM Official Guidelines for Coding and Reporting state that signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

These patients would likely not require inpatient admission other than to perform a lung biopsy or to address a complication, such as acute (on chronic) respiratory failure. The good news is that codes 770.7 and 516.8 both group to MDC 4 – Respiratory Diseases, and that 516.8 is not excluded as a CC if code 770.7 is the principal diagnosis, giving us an automatic CC. I would think that code 770.7 would be used as the principal diagnosis only if the inpatient admission was to diagnose NCHI and that other codes would be more appropriate if the reason for inpatient admission was a complication of the disease, such as acute or chronic respiratory failure.

Use of up and down arrows (p. 17)

This entry clarifies the old rule that coders may not code diagnoses if up and down arrows are used to describe the condition. For example, if a physician documents ↑ next to cholesterol, a coder may not assume that a diagnosis of hypercholesterolemia has been made. Coding Clinic notes that arrows have ambiguous meanings—for example, an arrow may simply indicate a change, even improvement, in a patient without implying that the value is abnormal. It’s an old concept everyone preaches, but it’s nice to see it written out in Coding Clinic in full. Share this entry with your medical staff.
Transbronchial biopsy of the lung (p. 18)
This entry indicates that the absence of lung tissue in a pathology report does not preclude a coder from reporting 33.27, Closed endoscopic biopsy of lung, for an explicitly transbronchial lung biopsy. Frame this Coding Clinic and show it to your Recovery Audit Contractor the next time he or she denies the coding of 33.27 just because a pathology report is not in the chart.

Don’t fall into the trap of assuming that the presence of lung tissue after a Wang needle aspiration biopsy or transbronchoscopic fine needle aspiration means that a transbronchial lung biopsy was performed.

Deep vein thrombosis and thrombophlebitis (p. 19)

History of deep venous thrombosis on Coumadin (p. 20)

Chronic deep vein embolism and thrombosis (p. 21)

Coding Clinic addressed deep venous thrombosis and thrombophlebitis in this issue. To better understand its advice, some background information is warranted.

Pathophysiology of deep venous thrombosis. Deep vein or venous thrombosis is the formation of a blood clot in a deep vein, as described by the National Heart, Lung, and Blood Institute at www.nhlbi.nih.gov/health/dci/Diseases/Dvt/DVT_WhatIs.html.

During the 1800s, Rudolph Virchow described three factors contributing to deep venous thrombosis:
   - Venous stasis
   - Vein damage
   - A hypercoagulable state

Physicians commonly describe the clot but may not describe the vein damage or the hypercoagulable state. Read more at http://emedicine.medscape.com/article/1911303-overview#a0104.

Should the deep venous thrombosis break off and move to another part of the body, this is deemed as an embolus. Pulmonary emboli are dreaded complications of deep venous thrombosis.

Deep vein thrombosis vs. deep vein thrombophlebitis. While deep vein thrombosis is a clot within a deep vein, deep vein thrombophlebitis is inflammation of the vein as a result of the clot. Although these conditions are closely related, they are coded as distinct entities and considered differently in AHRQ’s PSI methodologies.
ICD-9-CM treats deep venous thrombosis and deep vein thrombophlebitis in the following manner:
- 451.xy: Phlebitis and thrombophlebitis (xy relates to the location of the phlebitis and thrombophlebitis)
- 452: Portal vein thrombosis
- 453.xy: Other venous embolism and thrombosis

Note that there is no “code also” note with 451, 452, or 453 instructing a coder to code any associated thrombosis or thrombophlebitis in addition. For this reason, physicians must document the clinical circumstances completely, given that thrombophlebitis and hypercoagulable states are likely present when there is a deep venous thrombosis or embolism.

Use of abbreviations
Abbreviations are tricky in ICD-9-CM. The ICD-9-CM Index to Diseases includes some abbreviations, such as HIV meaning human immunodeficiency virus, AAT meaning alpha-1-antitrypsin deficiency, GSS meaning Gertsmann-Sträussler-Scheinker syndrome, and so forth.

On the other hand, some commonly used abbreviations are not in the ICD-9-CM Index to Diseases. Note that Coding Clinic does not offer advice that allows a coder to assume the meaning of an abbreviation that is not in the ICD-9-CM Index to Diseases.

For example, does ARF mean acute renal failure or acute respiratory failure? Does AKI mean acute kidney insufficiency or acute kidney injury? Does CHF mean congestive heart failure or chronic hepatic failure? If you look up these abbreviations in the ICD-9-CM Index to Diseases, you will find that documentation of such cannot be coded unless you make assumptions about their meaning. This is always a dangerous practice. A query is necessary to determine what these abbreviations mean if not otherwise documented or if there is conflicting documentation (e.g., acute kidney injury and acute kidney insufficiency).

This principle comes into play when a physician documents “DVT.” Does “DVT” mean “deep venous thrombosis” or does it mean “deep venous thrombophlebitis”? Unless the physician explicitly states it, a query is required.

In its advice in First Quarter 2011, p. 19, Coding Clinic emphasizes that thrombophlebitis is not an important component of thrombosis, yet if both deep venous thrombosis and deep venous thrombophlebitis are documented in the record, both should be coded.

On the next page, Coding Clinic states that if a patient has “a history of deep venous thrombosis” and is receiving warfarin, a query should be entered to determine whether the warfarin is being given prophylactically to prevent recurrence (for which code V12.51, Personal history of venous thrombosis...
and embolus, would be assigned) or to actively treat a clot (for which the appropriate code from 452 or 453 would be coded).

Note, however, that if a patient has a history of a deep venous thrombosis, is on chronic warfarin therapy, is not in atrial fibrillation, does not have a prosthetic heart valve, and does not currently have a clot, it is likely that a hypercoagulable state exists. Coding Clinic’s opinion is different, based on its advice of Third Quarter 2008, pp. 16–17, which states that the presence of a deep venous thrombosis does not imply the presence of a hypercoagulable state, even though this is part of Virchow’s triad.

If a provider documents a hypercoagulable state as contributory to the clot, it should be coded. Read Coding Clinic’s advice of Fourth Quarter 2003, pp. 56–57, to learn more about its approach to the hypercoagulable state. Read one physician’s opinion of the hypercoagulable state online at http://emedicine.medscape.com/article/211039-overview. Note: While thrombophilia is clinically equivalent to hypercoagulable states, there is no ICD-9-CM code for thrombophilia.

Note that there are different codes for acute and chronic venous thrombosis. Coding Clinic, First Quarter 2011, p. 20, emphasizes that Coding Clinic does not specify the timelines for when a clot becomes chronic; this is based on provider documentation.

Why is this all important? Here’s why:

- Deep venous thrombosis and deep venous thrombophlebitis group to different DRGs.
  - Deep venous thrombosis groups to MS-DRG 299–301, Peripheral vascular disorder
    • This DRG has three levels: without CC/MCC, with CC, and with MCC
  - Deep venous thrombophlebitis groups to MS-DRG 294–295, Deep vein thrombophlebitis
    • This DRG has two levels: without CC/MCC and with CC/MCC
- Deep venous thrombophlebitis and deep venous thrombosis are CCs to each other if they are both documented and coded.
- Both deep venous thrombophlebitis and deep venous thrombosis are PSIs if they are not present on admission. For this reason, the coder must know whether they are chronic, given that chronic conditions are always POA and do not count as a PSI.

SIRS due to pancreatitis (p. 22)
Coding Clinic issued a clarification to advice it published in First Quarter 2010, p. 10, in which coders were instructed to report code 995.93, SIRS due to noninfectious process without acute organ dysfunction, for SIRS due to an inflammatory condition not documented to be infectious. These
conditions include pancreatitis, diverticulitis, orchitis, and any other “itis” (other than cellulitis or pneumonitis, which, according to the ICD-9-CM Official Guidelines for Coding and Reporting, are infections).

In those rare circumstances in which the provider documents SIRS due to infectious pancreatitis, use the infectious SIRS codes (e.g., 995.91 or 995.92) rather than the noninfectious codes (995.93 or 995.94). The majority of cases of pancreatitis are noninfectious, according to Coding Clinic, so this circumstance is rare. If it is not clear what the cause of the pancreatitis is, a query is required.

The takeaway for CDI specialists: Encourage your providers to document the term “sepsis” if they mean “SIRS due to infection” and to reserve the term “SIRS” for noninfectious circumstances.

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