Taking a closer look at excisional debridements in ICD-10-PCS

When someone decides to enter the world of medical coding, he or she usually starts off coding for obstetric and newborn charts. After coding for a month or two, the newbie coder is transitioned to low-dollar queues, usually encompassing charts $10,000 and less. Gradually, he or she works toward the medium-dollar and moderate-procedure queues between $20,000 and $39,000.

When the coder has attained a thorough understanding of coding guidelines, rules, and regulations and acquired months of coding experience, he or she is able to code the high-dollar and complex medical charts. Cerebrovascular (embolization, coiling, and spinal fusions), cardiovascular (bypass and heart catheterizations), gastrointestinal (laparotomies, bypass, and anastomosis), and excisional debridement surgeries top the list of these complex and advanced medical coding charts.

Even after getting training on these complicated and advanced charts, coders often find themselves a bit lost and uneasy reporting these
surgery. Since these surgical procedures result in surgical DRGs, it is pivotal that coders have thorough and in-depth understanding of the surgeries, along with comprehensive knowledge of relevant Coding Clinics and guidelines.

**Excisional debridement**

According to Coding Clinic, Third Quarter 2015, p. 3, “Debridement of the skin and subcutaneous tissue is a procedure by which foreign material and devitalized or contaminated tissue are removed from a traumatic or infected lesion until the surrounding healthy tissue is exposed. Debridement can be categorized as excisional or non-excisional.”

An excisional debridement of the skin or subcutaneous tissue is the surgical removal or cutting away of such tissue, necrosis, or slough and is classified to the root operation Excision. Excisional debridement involves the use of a scalpel to remove devitalized tissue.

The same Coding Clinic further directs the coder to code excisional debridement when either “the provider documents ‘excisional debridement’ in the body of the operative report, and/or the documentation meets the root operation definition of ‘Excision.'”

ICD-10-PCS defines an Excision as “cutting out or off, without replacement, a portion of a body part.” However, since both excisional and non-excisional debridement procedures require some kind of “cutting out or off, without replacement” of a tissue, how can a coder differentiate between the two excisions and decide which is excisional and which is non-excisional?

**Explanation**

Let’s review Coding Clinic, Third Quarter 2015, pp. 6–7, which describes the following operative report: “Using a sharp scalpel, I first connected the abscess sites and excised down through the subcutaneous tissue with electrocautery. The tissue was in the process of liquefying and was nonviable. The wound measured 8 cm wide by 4 cm long and 2.5 cm deep, and was extensively excised.”

The physician didn’t document the word “excisional debridement” in the body of the operative report, but Coding Clinic advised the coder to code this procedure as an excisional debridement based on the fact that the...
documentation clearly described an operation that meets the definition of an Excision. The operative report defined five components of the excision that helped it qualify as an excisional debridement. These components are:

<table>
<thead>
<tr>
<th>Components</th>
<th>Example from operative report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Type of instrument used</td>
<td>Sharp scalpel</td>
</tr>
<tr>
<td>2 Nature of tissue excised</td>
<td>Liquefying and nonviable</td>
</tr>
<tr>
<td>3 Depth of tissue excised</td>
<td>Subcutaneous tissue</td>
</tr>
<tr>
<td>4 Wound measurement</td>
<td>8 cm wide by 4 cm long and 2.5 cm deep</td>
</tr>
<tr>
<td>5 Technique used by surgeon</td>
<td>Extensively excised</td>
</tr>
</tbody>
</table>

2017 ICD-10-PCS Official Guidelines for Coding and Reporting convention A11 further states that:

Many of the terms used to construct PCS codes are defined within the system. It is the coder’s responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear.

Recovery Auditors

There are no Coding Clinics or coding guidelines that explicitly describe or endorse the five components described above. However, intense scrutiny on excisional debridement procedures and DRGs by Recovery Auditors (RA) and other external auditors have made it evident that having these five components documented in the body of the operative report is crucial in minimizing the risk of claims being denied.

The Medicare Quarterly Provider Compliance Newsletters for February 2011, October 2011, January 2012, and July 2012 all describe RA findings where an excisional debridement code is replaced with another excision code, resulting in a DRG shift and Medicare recovering overpayments from healthcare facilities.

Volume 1, issue 2, of the February 2011 newsletter clearly summarizes RA findings where an excisional debridement code is replaced with another excision code, resulting in a DRG shift and Medicare recovering overpayments from healthcare facilities.

Incision and drainage

Coders need to be aware that if an incision and drainage procedure is performed, it gets coded as “incision and drainage,” NOT incision and debridement. If there’s any confusion regarding the nature of autolytic, enzymatic, or mechanical [whirlpool] debridement, Hospitals should assign ... non-excisional debridement of wound, infection, or burn for these non-excisional debridement.”

Non-excisional debridement

Going back to Coding Clinic, Third Quarter 2015, p. 3, it states that “the use of a sharp instrument does not always indicate that an excisional debridement was performed. Minor removal of loose fragments with scissors or using a sharp instrument to scrape away tissue is not an excisional debridement.

“A non-excisional debridement of the skin is the non-operative brushing, irrigating, scrubbing, or washing of devitalized tissue, necrosis, slough, or foreign material. Most non-excisional debridement procedures are classified to the root operation ‘Extraction’ (pulling or stripping out or off all or a portion of a body part by the use of force).”

For the coder’s convenience, the following table has been constructed to summarize the findings listed in this Coding Clinic. The table breaks down when a procedure should be coded as an excisional debridement and when it should be coded as an Extraction (non-excisional).

<table>
<thead>
<tr>
<th>Breakdown of Coding Clinic, Third Quarter 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excisional Debridement</strong></td>
</tr>
<tr>
<td>&quot;Excision&quot; as defined in Coding Clinic, Third</td>
</tr>
<tr>
<td>Quarter 2015, pp.6-7</td>
</tr>
<tr>
<td>and/or</td>
</tr>
<tr>
<td>Documentation of &quot;excisional debridement&quot;</td>
</tr>
<tr>
<td>within the body of operative report</td>
</tr>
<tr>
<td>Use of scalpel to remove devitalized tissue</td>
</tr>
<tr>
<td>Removal of loose fragments/tissue with</td>
</tr>
<tr>
<td>scissors</td>
</tr>
<tr>
<td>Autolytic/Enzymatic/Whirlpool according to</td>
</tr>
<tr>
<td>RAs</td>
</tr>
</tbody>
</table>

Incision and drainage

Coders need to be aware that if an incision and drainage procedure is performed, it gets coded as “incision and drainage,” NOT incision and debridement. If there’s any confusion regarding the nature of...
the procedure performed, the coder needs to query the physician for clarification.

Often, surgeons will perform an excisional debridement of a hematoma and document the following:

*Sharply dissected large necrotic hematoma from living viable tissue. Hematoma was evacuated and further debrided. The area was pulse lavaged of all necrotic material until bleeding tissue can be seen. A wound vacuum-assisted closure was then placed; patient awake and taken to recovery room in stable condition.*

Looking at the above table, the use of a pulse lavage does not mean that an excisional debridement is performed. Also, *Coding Clinic* states that the use of sharp dissection is not enough to code excisional debridement. So how would this be coded? According to the ICD-10-PCS coding guidelines, hematomas are coded to the root operation Extirpation since an organized, solid mass is evacuated.

It also is necessary to remember that a debridement is often performed in order to clean, mobilize, and prepare a site for the actual procedure. For example, a surgeon might have debrided scar tissue to mobilize the knee cap and hence prepared the site for knee replacement surgery. In such a case, the debridement of scar tissue is integral to the knee replacement procedure, and only the knee replacement is coded.

**Other excisional debridement questions**

*Coding Clinic*, Third Quarter 2015, p. 4, describes a debridement using knife dissection that is not coded as excisional debridement. *Coding Clinic* explained that “knife dissection is not sufficient language to be able to code the root operation ‘Excision.’ Knife dissection may only be referring to the means used to reach the procedure site, and doesn’t necessarily say what was done at the site.”

*Coding Clinic*, Third Quarter 2015, p. 5, advises to code a procedure as an Extraction when VersaJet is utilized for skin and subcutaneous debridement.

*Coding Clinic*, Third Quarter 2015, pp. 5–6, states that if a patient undergoes debridement with pulse lavage, it should be coded as an Extraction. Pulse lavage is considered a nonsurgical mechanical debridement, and is also known as pulsatile lavage, mechanical irrigation, and high-pressure irrigation.

*Coding Clinic*, Third Quarter 2015, pp. 7–8, states that if a physician only documents “debridement of bone, fascia or muscle,” a coder cannot assume that the debridement performed is excisional. “ICD-10-PCS does not provide a default if the debridement is not specified as ‘excisional’ or ‘non-excisional.’ ”

Here *Coding Clinic* recommends that hospitals work with their providers to ensure the documentation used to support excisional debridement clearly describes the procedure. Clinical documentation improvement (CDI) specialists can play a vital role in getting the most complete documentation by the physicians to help coders with accurate code assignment.

*Coding Clinic*, Third Quarter 2014, pp. 14–15, states that according to the *ICD-10-PCS Official Guidelines for Coding and Reporting* convention B3.5, “If the root operations Excision, Repair, or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded.” For example, excisional debridement that includes skin, subcutaneous tissue, and muscle is coded to the muscle body part.

**Conclusion**

RAs were expected to start auditing in February of this year, and they will be auditing claims submitted over the last three years. In times when reimbursement is drying up for healthcare facilities, and when focus is shifting away from volume to value, coders need to understand that every code reported matters.

With excisional debridement, it is ideal to have physicians documenting the necessary details required for accurate coding. However, we do not live in an ideal world. Consequently, our CDI specialists can play a pivotal role in getting the necessary documentation for coders while the patient is still in the hospital. This will not only eliminate a retrospective query burden, but will expedite the coding process as well.
Tables presented in this article are aimed at easing the challenges associated with excisional debridement coding. Use them as a cheat sheet, print them out, and keep them handy. The next time you are working on an excisional debridement procedure/operative report, compare the operative note with the tables to help you guide to the correct root operation, and hence, the accurate procedure code.

**Analyzer**

**Coding Clinic Second Quarter Perspectives**

**Coding Clinic,** Second Quarter 2017, which became effective May 17, did not disappoint in addressing clinical issues affecting us in coding compliance and instructing us in how to properly use the ICD-10-CM Index and Table. Let’s review several of Coding Clinic’s changes.

**Encephalopathy remains in the forefront**

One of the most vexing challenges we have with physicians and Recovery Auditors is with the term “encephalopathy” and its applications in ICD-10-CM. This Coding Clinic resolved one issue while creating a new one.

Of major significance, Coding Clinic clarified the proper use of ICD-10-CM code G94 (other disorders of brain in diseases classified elsewhere), a code that has a “code first underlying disease” instruction and is listed with an Excludes1 note for the subcategory G93.4- (other and unspecified encephalopathy), impacting metabolic, other specified, and unspecified encephalopathies.

A lot of us have had denials for G93.40 (encephalopathy, unspecified), G93.41 (metabolic encephalopathy), and G93.49 (other encephalopathy), all of which are MCCs in MS-DRGs, based on this Excludes1 note. These denials tend to occur when a physician explicitly documents that a metabolic, septic, or encephalopathy (specified or unspecified) is linked to, or associated with, another condition (such as a urinary tract infection). These recovery auditors claim that G94 (not an MCC) should be used based on the Excludes1 note, impacting thousands of dollars of reimbursement with each denial.

In what I believe will be a major disappointment to Recovery Auditors (RA), Coding Clinic states that G94 should be used only when it is explicitly cited in the ICD-10-CM Index to Diseases. This means that if a physician links an encephalopathy to a condition that is not in the ICD-10-CM Index, or that does not have a G94 instruction, the coder must use G93.49, not G94.

This advice is consistent with the ICD-10-CM etiology/manifestation conventions since the Index lists G94 with brackets, meaning that they are manifestation codes. These codes are listed alongside only certain underlying conditions, such as certain parasitic brain diseases, encephalopathies due to (nondiabetic) hyperinsulinism, and cerebral malaria. Coding Clinic went on to state that if a physician cites a specific cause of encephalopathy that is in the Index, such as a septic encephalopathy due to another condition (e.g., infection), then the Index listing for the septic encephalopathy rules.

Since this ruling does not change or amend the ICD-10-CM Index, Tables, guidelines, or previous Coding Clinic advice, I believe that coding compliance professionals are in a great position to appeal an RA’s
decision due to faulty G94 logic. These auditors might have misapplied or misinterpreted the Excludes1 instruction for G93.4 by assuming that it applied even though the G94 code was not in the Index.

**Encephalopathy clinical coding concepts**

We all know that the *ICD-10-CM Official Guidelines for Coding and Reporting* state “signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification,” and that “additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.”

Note that this guideline applies to “signs and symptoms” which, as we all know, are primarily but not exclusively found in Chapter 18 of ICD-10-CM: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (codes R00–R99). The guidelines emphasize that signs and symptoms that point to a specific diagnosis have been assigned to a category in other chapters of the classification.

Keep in mind that there is no specific ICD-10-CM guideline addressing diagnoses or conditions (as opposed to signs or symptoms) that are “associated routinely” with another diagnoses, conditions, or disease processes. As such, we must refer to the ICD-10-CM Index to Diseases (such as unspecified pancytopenia with myelodysplastic syndrome), Excludes1 notes (which have their own problems, given that the guidelines allow a coder to ignore Excludes1 instructions if the two conditions are “not related” to each other), or a hodgepodge of Coding Clinic advice concerning the subject (such as hypoxia with chronic obstructive pulmonary disease).

We also all know from Office of Inspector General reviews that RAs determine on their own what conditions are integral to others, such as severe malnutrition with HIV disease and malignancies, as to disallow a code even when there is no medical literature, ICD-10-CM Index listing, official guideline, or Coding Clinic advice that verifies their decision. Read my review of this in one of my previous BCCS columns.

Well, *Coding Clinic* has declared that if a patient presents with an acute lacunar infarct, and the provider documents that an encephalopathy is secondary to the lacunar infarction, then the encephalopathy is not inherent to the lacunar infarction, and therefore is coded separately with G93.49. Also note that previous advice in *Coding Clinic*, Fourth Quarter 2013, p. 89, stated that an encephalopathy due to postictal state is not coded separately since it is integral to the condition. I am not aware of any other advice discussing if the term “encephalopathy” is inherent to any other documented condition.

Coders that I have talked to are relieved to see this advice since it supports their coding of G93.40 or G93.49 based on provider documentation. On the other hand, I believe that this will be problematic in assuring the clinical validity of the encephalopathy, given that a lacunar stroke is a localized cerebral infarction due to an occlusion of a small penetrating artery into the brain, whereas the term “encephalopathy” implies a diffuse brain disease or dysfunction.

Does this mean that if a physician documents “encephalopathy” due to any named focal brain disease, such as a brain tumor, temporal sclerosis, or the late effect of any stroke, that we can code it as G93.49, which is an MCC in MS-DRGs?

Seen in another light, if a physician documents that a patient has an encephalopathy due to a named diffuse brain disease, such as Alzheimer’s, Parkinson’s, or another that is not in the ICD-10-CM Index under the term “encephalopathy,” can I code G93.49?

I would exercise caution, given *Coding Clinic’s* admonition that “a basic rule of coding is that further research is done if the title of the code suggested by the Index does not identify the condition correctly,” cited in *Coding Clinic*, First Quarter 2013, pp. 13–14.

I personally believe that the term encephalopathy, defined by the National Institutes of Health as “any diffuse disease of the brain that alters brain function or structure,” is inherent to any named disease that is primarily isolated to the brain, such as most neurodegenerative disorders (e.g., Lewy-body dementia,
normal pressure hydrocephalus, cerebral edema, encephalitis, encephalomalacia, cerebral palsy, Parkinson’s disease, and the like). This also applies to “nephropathy,” which is integral to Kimmelstiel-Wilson disease and “neuropathy,” which is inherent to Charcot-Marie-Tooth disease.

Because of this, I believe that the term “encephalopathy” should be reserved for diffuse diseases not explained by primary brain illness, and that the documentation of these diffuse-disease processes must be clear. Therefore, if a physician links the term “encephalopathy” to a named diffuse-brain disease, we must query the physician as to whether a different disease process other than the named brain disease is present and what that different diffuse-disease process is (such as a toxic encephalopathy due to ciprofloxacin or a metabolic encephalopathy due to hypoglycemia in diabetes).

**Bowel obstruction due to a malignancy**

In coding, we must remember that there is a hierarchy to be followed, which is:

1. Index to Diseases
2. Table to Diseases
3. The Official Guidelines for Coding and Reporting
4. Coding Clinic for ICD-10-CM/PCS
5. Payer policy

If the Index and Table tells me to assign a code one way but the guidelines direct me to assign a code another way, the Index and the Table prevail. Coding Clinic interprets these interactions, much like the Supreme Court interprets the United States Constitution, and thus is binding unless the Index, Table, or guidelines is subsequently amended.

We know that the ICD-10-CM Official Guidelines for Coding and Reporting state that in an encounter for management of a complication associated with a neoplasm, such as dehydration, if the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm. The only exception is anemia due to the malignancy and not another cause (such as gastrointestinal bleeding, an adverse effect of neoplasm treatment).

**Coding Clinic**, Second Quarter 2017, p. 12 discusses the code assignment for bowel obstruction due to peritoneal carcinomatosis. If I look in the Index for bowel obstruction due to a specified cause not in the Index, I’m directed to K56.69 (other intestinal obstruction), which, along with K56.60 (unspecified intestinal obstruction), has an Excludes1 note that states “intestinal obstruction due to specified condition-code to condition.” As such, only C78.6 (secondary malignant neoplasm of retroperitoneum and peritoneum) can be assigned; K56.69 (or K56.60) cannot be assigned, trumping the instruction in the ICD-10-CM official guidelines.

**Summary**

Why does that Excludes1 note affect code assignment but the Excludes1 note in G93.40 for G94 does not? I can only surmise that the Excludes1 to use G94 does not apply due to its unique status in the ICD-10-CM manifestation/etiology architecture in the Index to Diseases, whereas C78.6 and K56.69 or K56.60 do not have this architecture. Note that these “code to condition” Excludes1 notes are not common in ICD-10-CM; however, while they are rare, they are still there.

**EDITOR’S NOTE:**

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Questions? Comments? Ideas?

Contact Amanda Norris, associate editor, Briefings on Coding Compliance Strategies, anorris@hcpro.com.
Cardiovascular code updates on the horizon

by Laura Legg, RHIT, CCS, CDIP, AHIMA-approved ICD-10-CM/PCS trainer

Starting October 1, the new and revised ICD-10-CM and ICD-10-PCS codes go into effect along with proposed DRG changes. Coders will benefit from digging deeper into the meanings of the new cardiovascular code descriptions to be able to fully understand and use them.

Myocardial infarctions

Many coders think of myocardial infarctions (MI) in terms of anatomic location or ST and non-ST elevation. These new codes will further describe MI types often used in physician documentation.

• I21.A-, other type of myocardial infarction
  – I21.A1, myocardial infarction type 2
    » Myocardial infarction due to demand ischemia
    » Myocardial infarction secondary to ischemic imbalance
  – I21.A9, other myocardial infarction type
    » Myocardial infarction associated with revascularization procedure
    » Myocardial infarction type 3
    » Myocardial infarction type 4a
    » Myocardial infarction type 4b
    » Myocardial infarction type 4c
    » Myocardial infarction type 5

The American Heart Association (AHA) describes an MI as an acute ischemia condition that ordinarily appears following prolonged myocardial ischemia. This occurs when the blood supply to the cardiac muscle is diminished or limited. The decreased blood supply leads to ischemia, which progresses to an oxygen shortage, irreversible damage, and/or death to the cardiac muscle tissue.

The 2018 ICD-10 CM code updates include adding types 1 through 5 to MIs. MIs are classified into these types depending on pathologic and clinical differences as well as different treatments. The types of myocardial infarctions are based on the American College of Cardiology categorizations and are as follows:

• **Type 1**: Indicates that the patient has evidence of spontaneous plaque rupture or erosion in an epicardial coronary vessel
• **Type 2**: Indicates that the MI is due to either increased oxygen demand or decreased supply (e.g., coronary artery spasm, coronary embolism, anemia, arrhythmia, hypertension, hypotension, etc.)
• **Type 3**: Indicates that the MI resulted in sudden death
• **Type 4a**: Indicates that the MI is associated with percutaneous coronary intervention (PCI) within 48 hours of the procedure
• **Type 4b**: Indicates that the MI is associated with in-stent thrombosis
• **Type 4c**: Indicates that the MI is associated with restenosis of a PCI
• **Type 5**: An MI associated with a coronary artery bypass graft within 48 hours of the procedure

Type 1 is referred to as a spontaneous MI caused by atherosclerotic plaque rupture, which leads to decreased myocardial blood flow. Type 2 is an MI secondary to ischemic imbalance as stated in the code description above. In type 2, another condition other than oxygen supply imbalance leads to myocardial injury with necrosis such as coronary vasospasm or endothelial dysfunction. When patients suffer cardiac death due to MI, they fall into the type 3 category. Myocardial injury or infarction during instrumentation of the heart during mechanical revascularization procedures describes types 4 and 5.

Heart failure code additions

According to the AHA, heart failure is an abnormality of cardiac function with inability of the heart to pump blood at a rate that keeps up with the body’s needs. Most coders think of heart failure types as acute and chronic, diastolic, or systolic. The new codes will allow code choices that describe heart failure stages.
The new proposed codes for heart failure stages A, B, C, and D are based on the American College of Cardiology and AHA stages of heart failure:

- **Stage A**: The patient has a presence of risk factors but is asymptomatic. The code assigned should be Z91.89 (other specified personal risk factors, not elsewhere classified).
- **Stage B**: Heart disease is present, but there are no symptoms. There are structural changes to the heart present.
- **Stage C**: Structural heart disease is present with symptoms.
- **Stage D**: The patient is in end-stage heart failure with advanced structural heart disease and pronounced symptoms of heart failure at rest or upon minimal exertion.

**Cardiac measurement codes**

Another addition to the 2018 ICD-10-PCS code set is cardiac measurement codes. The newly added codes include:

- 4A0274Z, measurement of cardiac electrical activity, via natural or artificial opening
- 4A0279Z, measurement of cardiac output, via natural or artificial opening
- 4A027CZ, measurement of cardiac rate, via natural or artificial opening
- 4A027FZ, measurement of cardiac rhythm, via natural or artificial opening
- 4A027HZ, measurement of cardiac sound, via natural or artificial opening
- 4A027N6, measurement of cardiac sampling and pressure, right heart, via natural or artificial opening

Expanding documentation specificity

Accurate clinical documentation will be key for coders to assign the new myocardial infarction and heart failure codes because the specificity to match the new codes must be there. CDI staff and coders will need to make sure providers are aware of the new codes and the elements that must be documented to use them.

Coding and sequencing for both MI and heart failure are dependent on the physician documentation in the medical record and application of the 2018 ICD-10-PCS Official Guidelines for Coding and Reporting. Also, use specific AHA Coding Clinic for ICD-10-CM/PCS references to ensure complete and accurate coding.

The final addendum for the 2018 ICD-10-CM and ICD-10-PCS codes can now be found on the CMS website and will be implemented October 1.

**EDITOR'S NOTE:**
Legg is the director of HIM optimization at Healthcare Resource Group in Spokane Valley, Washington. Opinions expressed are that of the author and do not represent HCPro or ACDIS.
Reviewing hepatitis diagnosis coding for the inpatient
by Adrienne Commeree, CPC, CPMA, CCS, CEMC, CPIP

Many national organizations, such as the Centers for Disease Control and Prevention, the American Liver Foundation, the Department of Health and Human Services, and the Food and Drug Administration have information and resources available to provide education and promote testing for viral hepatitis.

Their goal is to improve outcomes for the estimated 3.4 to 5.3 million people living with viral hepatitis in the United States. Understanding the different forms of viral hepatitis and alcoholic hepatitis, as well as their effects on the liver, helps clarify coding assignment. These conditions have combination codes, instructional notes, and other guidelines to be aware of when reviewing medical records and assigning codes.

**Hepatitis background**

The most common types of viral hepatitis are hepatitis A, B, and C. Hepatitis A is highly contagious and is usually spread when a person ingests the virus from contact with objects, food, or drinks contaminated by feces from an infected person. The symptoms of hepatitis A infection can range from a mild illness lasting a few weeks to a severe illness lasting several months. However, hepatitis A can be easily prevented with a safe and effective vaccine as well as preventative measures such as hand washing and safe food preparation techniques.

Hepatitis B can lead to a chronic, lifelong illness for those who have been infected. The virus is spread primarily through contact with body fluids such as blood or semen. Luckily, a vaccine is available for hepatitis B.

Hepatitis C is usually spread when blood from a person infected enters the body of someone who is not infected; therefore, the most common spread of the virus is by sharing needles for intravenous injection of drugs. Organ transplants and blood transfusions administered before 1990 were also a source of infection until widespread testing of donated blood eliminated hepatitis C from the blood supply.

Other forms of viral hepatitis are D and E. Hepatitis D is considered to be a subviral satellite because it can propagate only in the presence of the hepatitis B virus. Hepatitis E is transmitted by drinking water or eating food that’s been contaminated by feces from someone infected with hepatitis E, but the virus usually doesn’t lead to long-term illness or serious liver damage.

Unlike viral hepatitis, alcoholic hepatitis occurs when liver cells are damaged or destroyed by excessive alcohol consumption. Normally, the liver breaks down alcohol so it can be eliminated from the body, but if a person drinks too much on a regular basis, it can have a lasting effect on the liver with fat deposition in liver cells, inflammation, and scarring.

Alcoholic hepatitis can be mild or severe. Mild alcoholic hepatitis might be reversed with complete cessation of alcohol intake. Severe alcoholic hepatitis could lead to serious complications, including liver failure and death.

Autoimmune hepatitis is a type of liver disease that occurs when a patient’s immune system attacks the liver cells. It is a chronic condition and can result in cirrhosis, or scarring, of the liver and ultimately liver failure.

**Coding for inpatient hepatitis**

Coding for viral hepatitis can be found in Chapter 1, Certain Infectious and Parasitic Diseases, in the ICD-10-CM coding manual. For a patient admitted as an inpatient for an acute hepatitis B infection, the Alphabetic Index guides the coder to B16.9 (acute hepatitis B without delta-agent and without hepatic coma). However, other factors can influence the code selection, such as the inclusion of delta-agent or hepatitis D.

Sequencing of these codes is important, as the combination code B16.0 (acute hepatitis B with delta-agent with hepatic coma) is considered an MCC. Note that in Chapter 1 there are other codes for chronic viral
hepatitis (in category B18) and also for unspecified chronic viral hepatitis (B18.9). As always, refer to the Alphabetic Index first for correct coding.

Alcoholic hepatitis in the Alphabetic Index refers coders to K70.10 (alcoholic hepatitis without ascites). Note the non-essential modifiers in parentheses for either “acute” or “chronic.” This means these terms used in the medical record do not affect the code assignment.

The codes for alcoholic hepatitis reside in Chapter 11, Diseases of the Digestive System. There are essentially two codes for alcoholic hepatitis depending on the presence or absence of ascites, an accumulation of excessive fluid in the abdominal cavity. Autoimmune hepatitis can be found under the category K75, other inflammatory liver diseases, at code K75.4.

Hepatic encephalopathy
A serious medical complication that arises with these patients is hepatic encephalopathy. Hepatic encephalopathy is a decline in brain function that occurs as a result of severe liver disease. The damaged liver cannot adequately remove toxins that accumulate in the blood, which can build up and cause brain damage.

Hepatic encephalopathy can progress in stages from mild to severe, with the last stage being hepatic coma. The listing of “encephalopathy, hepatic” in the Alphabetic Index instructs coders to see “failure, hepatic” in the Index. From there, note the subentries for coma, acute, subacute, alcoholic, and chronic hepatic failure. If the term “hepatic encephalopathy” without any further specification is documented in a patient’s record, assign code K72.90 (hepatic failure, unspecified without coma).

From a coding perspective, it is important to understand that a patient can have hepatic encephalopathy but not hepatic coma. The most recent Coding Clinic, First Quarter 2017, addresses the issue regarding coding for these conditions.

For example, if a patient is admitted with chronic hepatitis C and hepatic encephalopathy, Coding Clinic instructs coders to assign B18.2 (chronic viral hepatitis C) and K72.10 (chronic hepatic failure without coma). Sequencing of these conditions would depend on the circumstances of the admission.

Summary
Hepatitis can be a potentially life-threatening disease. Prevention is on the forefront in the month of May, with a concerted effort by multiple agencies to raise awareness and offer testing and vaccination services. Treatments for hepatitis C infection has evolved in recent years with the availability of new hepatitis C protease inhibitor therapies. The potential of a cure to more patients than previously possible is an exciting outcome of these developments in the understanding of the virus and treatment of the disease.

Coding for these conditions has been a challenge, but better understanding of hepatitis and its progression, as well as staying cognizant of coding guidance, should alleviate some of the problems inherent to coding this disease.

EDITOR’S NOTE:
Comeree is a coding regulatory specialist for HCPro, an H3.Group division of Simplify Compliance, LLC, in Middleton, Massachusetts. She has many years of experience in the healthcare industry involving coding, auditing, training, and compliance expertise. She was previously a coding auditor/medical assistance program specialist at the Washington State Healthcare Authority’s clinical review unit within the state’s Medicaid program. Opinions expressed are that of the author and do not represent HCPro or ACDIS.
We want your coding and compliance questions!
The mission of “Coding Q&A” is to help you find answers to your urgent coding/compliance questions.
To submit your questions, contact Briefings on Coding Compliance Strategies Editor Amanda Norris at anorris@hcpro.com.

Q One of my coworkers thought we needed the phrase “unable to clinically determine” as an option on every multiple-choice query we send. My take on it is that if we have “other” with an option for free text, that would cover us for compliance.

Further, I thought it was inappropriate to include this option in some cases as it might offer an option that is preventing me from obtaining the detail and specificity I need. What are your thoughts?

A More than likely, the instruction to include “unable to determine” came from a vendor or consultant, or a publication somewhere down the line. The rationale stems from the possibility that it could be considered leading if every option provided translates into a CC/MCC without any way to pick another option.

I do believe the “other” option satisfies this requirement by giving the physician the opportunity to just write in or list his or her other diagnosis. Many best practice publications advise to give both “other” and “unable to determine,” or even include something like “clinically insignificant” or “disagree” as options.

I usually try to give three or four clinically relevant options. Not all have to be CCs or MCCs, as long as they are clinically relevant or possible given the indicators. I often also include the language of “evidence of” or “possible” in parentheses right in my multiple-choice query, like non-essential modifiers, and then include an “other.”

EDITOR’S NOTE:
Allen Frady, RN, BSN, CCDS, CCS, CDI education specialist for HCPro, an H3.Group division of Simplify Compliance, LLC, in Middleton, Massachusetts, answered this question in CDI Strategies.

Q Can a claim that is edited for a noncovered procedure be appealed?

A If a claim is edited for a noncovered procedure, the claim cannot be submitted to CMS for appeal. Therefore, once the coding of the noncovered procedure is validated, the process to split the noncovered procedure onto a separate claim must be followed so that at least one claim can be submitted and processed. Then an appeal can be filed if the provider actually believes the procedure should be or is covered. With version 33 of the Medicare Code Editor (MCE), the first version of the MCE using the ICD-10 codes, CMS acknowledged errors in this list of noncovered procedures and provided instructions to Medicare Administrative Contractors to process claims having the errors as described in the IPPS.

EDITOR’S NOTE:
For more information, see The Chargemaster Essentials Toolkit.

Q I am having difficulty understanding “late effects.” The statement of a “condition or nature of the late effect is sequenced first,” but the code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect. This seems contradictory. Can you provide some additional context for me?

A “Late effects” can be a confusing concept, especially for new CDI specialists and coders. Basically, instructions governing this coding direction tell us that the acute phase of a condition must be over before we can assign codes for the late effects caused by that acute condition.

An example sometimes helps us better understand the Official Guidelines for Coding and Reporting for ICD-10-CM.
If a patient presents to the ED suffering from a cerebral vascular accident (CVA) or stroke (this would be considered the acute phase of the condition), coders would choose a code from the circulatory system I63 (cerebral infarction). With greater specificity, the code could change to reflect details such as the type of stroke and the location. An example would be I63.9 (cerebral infarction, unspecified). Now, let's say our patient has hemiplegia related to the CVA, and the provider appropriately links the conditions in the chart as related. Then we would also assign a code for the hemiplegia (G81) and, with the appropriate documentation, such as type and dominance, the code could change.

The *Official Guidelines for Coding and Reporting* tells us that a code for the CVA (acute phase) and the code for late effect of the hemiplegia cannot be coded together on the same encounter. After the “acute phase” of a condition has ended, there are combination codes that represent both the late effect and the condition that caused the late effect, but only after the cessation of the acute phase. The codes under I69 (sequelae of cerebrovascular disease) would be used and with greater specificity such as type of CVA and type of late effect; coders can assign the appropriate code. An example would be I69.159 (hemiplegia and hemiparesis following non-traumatic intracerebral hemorrhage affecting unspecified side).

These codes highlight the importance of an accurate past medical history. We need to know when a late effect is caused by a current CVA or by a past episode. As CDI specialists, we need to focus on these details, making sure the coder has the requisite information to accurately code a record.

CDI specialists should also know how conditions are coded and sequenced. In this case, we need two codes. They are sequenced with the condition that caused the late effect first, then a code for the late effect condition. When a CDI specialist knows the rules governing code assignment, they can query effectively to provide the coders with what information they need to accurately code a medical record.

**EDITOR’S NOTE:**
Sharme Brodie, RN, CCDS, CDI education specialist and CDI Boot Camp instructor for HCPro, an H3.Group division of Simplify Compliance, LLC, in Middleton, Massachusetts, answered this question in CDI Strategies. For information, contact her at sbrodie@hcpro.com.