Coding Issues and Tips

Last revised: April 2024

Neuropathy: Neuralgia is not the same as neuropathy.

Use, Abuse and Dependence:[xiii]
When the provider documentation refers to use, abuse and dependence of the same substance (e.g., alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

- If both use and abuse are documented, assign only the code for abuse.
- If both abuse and dependence are documented, assign only the code for dependence.
- If use, abuse, and dependence are all documented, assign only the code.for dependence If both use and dependence are documented, assign only the code for dependence.

Alcoholism: Physician must state alcohol dependence or alcoholism to code F10.20. Alcohol Abuse is coded F10.10 and is not an HCC.

Depression: Physician must specify “recurrent or major” and episode and severity of depression to code. If this is a situational event or the physician has not specified - use the lower specificity codes.

Venous Stasis Ulcers: If a patient has chronic venous insufficiency (I87.2 - not an HCC) you can code the additional code for the ulceration if significant enough. (ie: L97.209 ulceration of calf) Documentation must be very clear that it is not a stasis ulcer.

Osteoporosis / Compression Fractures: If patient has a compression fracture of hip (M84.453A) or spine (M84.48XA) make sure to look for documentation in chart note.

- You may only code compression on the initial fracture –
  - Do not code history of pathological fracture to the active code.
- Compression Fractures can be traumatic or pathologic - it is hard to tell!
  - If non-traumatic then code as pathologic (per the code book index).
- Spontaneous = pathologic. Healing or healed fractures should be coded as hx of not current unless documented as “Chronic” see below.

Chronic Pathologic Fractures: If a patient is on meds ok to code M84.48XA but documentation must state “Chronic Pathological Fracture”.

- Question: When a patient is in a skilled nursing facility (SNF) for multiple problems including a chronic vertebral pathological fracture with orders for pain medication, what is the appropriate code to assign to identify the chronic pathological vertebral fracture?
  - Assign code M84.48XA, Pathologic fracture of vertebrae, for a chronic vertebral fracture for which the patient is receiving medication.[xiv]

Dialysis Status: Codes Z99.2 for patients receiving dialysis treatment or Z91.15 for patients that

are non-compliant with dialysis. These are frequently not coded. Also, codes Z49.01 – Z49.02 and Z49.31

- Z49.32 should be used for dialysis testing and catheter fitting and adjustment.

Pneumonia: For risk adjustment, it is important to determine the etiology of pneumonia.

- ICD-10 code "J18.9 Pneumonia, Organism Unspecified" does not map to an HCC.
- While specified bacterial pneumonia (Ex: J15.8) map to HCC 282.
  - Lower lobe pneumonia is not the same as Lobar Pneumonia. Coders can look at sputum culture (though you cannot code from the sputum) to verify if a bacteria type of pneumonia is present.
- Coding Clinic and Official Coding Guidelines state:[xv]
  - **September 23, 2018 And Before**: For discharges/dates of service and before – Coders could only code Lobar Pneumonia when specified by a provider
  - **September 24, 2018 Discharges – through Sept 30 2021**: Coders MAY code Lobar Pneumonia when RUL Pneumonia is noted, or if it is in multiple lobes.
  - **Effective October 1, 2021**: Coders may only code Lobar Pneumonia when it is specified by the provider.

"Metastatic": Caution in coding "metastatic" – this can mean either primary or secondary site.

- Coders need to investigate in the documentation as to whether it is
  - "Metastatic to the breast -C79.81" (HCC 10) or
  - "Metastatic from the breast" C50.919 (HCC 12).
- This is a particularly challenging area – and coders must use extreme caution – asking for clarification whenever possible.

Urinary Catheter: If the catheter is a suprapubic (inserted through the abdominal wall just above the pubic bone and into the bladder then code Z93.59.

- If having problems, then potentially code to complication code (if documented) T83.9XXA.
- An indwelling catheter is NOT a urethrostomy – this implies cutting which is not done in an indwelling.
- These codes are only used in subsequent visits – NOT on visits or hospitalization in which the catheter is placed.
  - The only instance we would capture an indwelling catheter is when there is an infection or reaction – T83.511A.

Atrial Fibrillation on a pacemaker: Only code Atrial fibrillation if patient is on medication (regardless if pacemaker present or not).

- It is appropriate to code for A-fib when there is evidence of treatment with
  - an anticoagulant (e.g., warfarin or Coumadin) and
  - the treatment cannot be linked to another condition (e.g., Pulmonary Embolism (PE), Deep Vein Thrombosis (DVT) and
  - if the provider documentation clearly indicates that the condition is current/active.
  - If the provider documents "Atrial fibrillation s/p ablation" it may be coded if the patient is on an antiarrhythmic medication that indicate treatment

Ulcer of Breast: Ulcer of the breast codes to N61 (no HCC)

- NOT L98.499 (skin NEC)

Complication Coding: Be incredibly careful with this! Do not assume something is a complication.

Cauda Equina: Do not code G83.4 Cauda Equina Syndrome when only Cauda Equina is documented. The syndrome is very SEVERE.

PEG Tube: Cannot be coded on admission where the tube has been placed. This would be a procedure code. Needs to be found on subsequent documentation to code it.

- Z93.1 – Gastronomy status (HCC)

Collagenous Colitis: Code K52.831 (No HCC) IS NOT the same as M35.9 Collagen (vascular) disease NOS.

Myelodysplasia vs Myelodysplastic Syndrome: These conditions are different and carry different risks. Review the chart note carefully to make sure the documentation supports the code.

- D46.9 Myelodysplastic syndrome, unspecified (HCC 19)
- Q06.1 Myelodysplasia of spinal cord (no HCC)

Liver transplant – Coding transplant status cannot be done from the same encounter the transplant occurred.

- In that case it would be the procedure code. For it to be the status code it would be in subsequent encounters.
- The same goes for any other such status codes (Amputations, other transplants, etc.)

Ostomies - Ostomy coding is dependent upon whether it is current or not.

- If the ostomy is located in the Past Medical History/Problem List, if there is documentation elsewhere within the chart note (i.e. Physical Exam, Surgical Hx, etc.) that shows it was reversed, it would not be reported.
- If there is no documentation showing the ostomy as reversed, it should be reported.

Congenital Conditions – Coding of congenital conditions can be a tricky thing.

- One thing to note if/when you see a congenital condition within a chart note; if the condition has been remedied with surgery and no longer requires care, it would be a history code.
- “If a congenital anomaly has been corrected, a personal history code should be used to identify the history of the anomaly. Codes in subcategory Z87.7 are used for congenital malformations that may still be present but do not require additional care, as well as corrected anomalies that are no longer present.” [xvi]

Auto-transplant – Auto-transplant is when a patient's organ (kidney, liver, etc.) is moved to another part of the patient's body due to illness, injury, or pain. This is not considered a transplant so a transplant status code would not be reported.

Alzheimer's/Dementia –

Code first – Some of the Dementia codes have a "code first the underlying physiological condition" note. Alzheimer's is included in this note. If a patient has Alzheimer's documented in the same DOS as dementia, following the "code first" guideline, you would code the Alzheimer's first.

- **Use additional code** – The Alzheimer's codes have a "use additional code to identify" note. Dementia with/without behavioral disturbance are included in this note.
- **Tip –** Along with the "use additional code to identify" there is also a tip/note that states "A code from subcategory F02.8 should always be assigned with a code from this category, even in the absence of documented Dementia."
  - If the patient has Alzheimer's documented, you would also report either F02.80 (dementia w/o behavioral disturbance or F02.81 (dementia w behavioral disturbance).
  - Both Alzheimer's and Dementia without behavioral disturbance are HCC 52, and generally we would only report an HCC once. But since there are the "code first" and "use additional" guidelines, please note both codes when appropriate.
  - Dementia with behavioral disturbance is HCC 51. In the case Alzheimer's is coded as well, you would report both HCC 51 and HCC 52. There is no outranking on the Hierarchy List for these, so we would report both.

New/Old compression fractures – This is an area that is difficult to confirm. Review the entire note for mention of "Previous Imaging" results, mention of "old" regarding the fracture, or if there is a past date stated.

- If it is OLD, we cannot code it to a Compression Fracture and get an HCC.
- Collapsed vertebra, NEC, lumbar region - M48.56XA – HCC
- Collapsed vertebra, NEC, lumbar region - M48.56XD – Not an HCC

Osteonecrosis - When coding osteonecrosis, it is important to verify if the condition is current.

- Example – documentation states "she is status post multiple debridement's…received six-week course of iv penicillin and is now on oral amoxicillin."
- Although the documentation mentions the diagnosis, the rest of the documentation does not discuss the condition as a current condition.

7th character A "Initial Character"- The use of this 7th character is for active treatment only and is rarely used in the OP/Clinic setting. More often it will be coded in IP or ER settings.

- "7th character "A", initial encounter is used for each encounter where the patient is receiving active treatment for the condition."
- "While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time."[xvii]

Lymphoma – When coding lymphomas, unless the documentation states the condition is healed or wording indicating the condition is gone, it would be coded as an active condition.

- o "Lymphoma patients who are in remission are still considered to have lymphoma and should be assigned the appropriate code from categories C83-C88 (200-202)".[xviii]
- o If the disease is completely cured and documented as "history of","," assign code Z85.72

Spinal Stenosis with cord compression –Not all spinal stenosis cases are so severe that they have cord compression. Also make sure that you are coding to the most specific diagnosis code.

- According to the below Coding Clinic the compression WOULD be coded -
  - o But it would be G99.2 – Myelopathy in diseases classified elsewhere.
- Instead of G95.20 – Unspecified cord compression (HCC 72), which is frequently reported.

Cervical Spinal Stenosis with Spinal Cord and Nerve Root Compression[xix]

Question: The provider's documentation describes cervical stenosis with spinal cord and nerve root compression. What is the proper code assignment for cervical stenosis with C4-C7 spinal cord and nerve root compression?

Answer: In this case, the patient has cervical spinal stenosis (C4-C7) with both radiculopathy (nerve root compression) and myelopathy (spinal cord compression). Assign codes M48.02, Spinal stenosis, cervical region, M54.12, Radiculopathy, cervical region, and G99.2, Myelopathy in diseases classified elsewhere.

Immunodeficiency Status - Previously, if a person was noted as Immunocompromised and it was due to a transplant, RA meds, etc. it was not reported. This has changed.[xxiii]

- o New codes were created to report specific causes for a patient's immunocompromised state. An immunocompromised state refers to the weakened condition of an individual's immune system that makes it less able to fight infections and other diseases. Treating a patient who is immunocompromised poses more risks and challenges; therefore, it is important to identify a patient with this status.
  - o **Code D84.821, Immunodeficiency due to drugs**, was created for immunodeficiency due to medications that interfere with the immune system. These medications include but are not limited to immunosuppressants, corticosteroids and chemotherapy.
  - o **Code D84.822, Immunodeficiency due to external causes**, was created for immunodeficiency caused by external factors such as exposure to radiation therapy or due to bone marrow transplant.
  - o **Code D84.81, Immunodeficiency due to conditions classified elsewhere**, was created for an immunocompromised state due to a specific medical condition such as HIV (Human Immunodeficiency Virus), AIDS, certain cancers, and genetic disorders that are classified elsewhere in ICD-10-CM.
  - o **Code D84.89, Other immunodeficiencies**, is for immunodeficiency due to other causes.

Multiple codes may be assigned to show immunodeficiency due to multiple causes (e.g.,

cancer and antineoplastic medication). In cases where the cause of the immunosuppression is not clearly documented, make a note.

Question: A patient was seen in the emergency department for cellulitis of two fingers on her right hand. She was admitted to start intravenous antibiotics due to having an immunocompromised state caused by immunosuppressant medication that she takes for systemic lupus erythematosus (SLE). What are the appropriate code assignments for the admission?

Answer: Assign code L03.011, Cellulitis of right finger, as the principal diagnosis. Assign codes M32.9, Systemic lupus erythematosus, unspecified, for SLE, D84.821, Immunodeficiency due to drugs, and Z79.899, Other long-term (current) drug therapy, for the patient's immunosuppressed state due to long-term use of immunosuppressants.

In this case, the immunosuppressant medication was prescribed by the provider to suppress the patient's immune system. An adverse effect code is not assigned when the medication has achieved its intended result in lowering the patient's immune response to systemic lupus erythematosus.

Question: A patient with multiple myeloma was seen for ear pain and cold symptoms due to acute otitis media of the left ear and acute viral bronchitis. The provider documented that the patient is immunosuppressed due to current long-term chemotherapy. What are the appropriate code assignments for this encounter?

Answer: Sequence either code J20.8, Acute bronchitis due to other specified organisms, or code H66.92, Otitis media, unspecified, left ear, as the first-listed diagnosis. Assign codes D84.821, Immunodeficiency due to drugs, for the patient's immunosuppressed state as a result of chemotherapy, and T45.1X5A, Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter. In this case, the immune suppression is not part of the intended effect of the antineoplastic drugs and is coded as an adverse effect. Additionally, assign codes C90.00, Multiple myeloma not having achieved remission, for the multiple myeloma and Z79.899, Other long term (current) drug therapy, for the chemotherapy.

Facet Arthropathy/Facet joint arthropathy -This diagnosis equals osteoarthritis of facet joint and does not map to an HCC. See the paths/examples below.

- M46.XX codes, which do code to an HCC, are occasionally incorrectly reported.
  - The path taken is Arthropathy to Arthritis, spine to Spondylopathy, inflammatory.
  - Since facet joint arthropathy equals osteoarthritis, this is the incorrect path.
- M47.XX codes are the correct codes, which do not map to an HCC.
- The path to take is Osteoarthritis, spine to Spondylosis, without myelopathy or radiculopathy.

Hypoparathyroidism/Secondary Hypoparathyroidism – When coding this diagnosis, coders need to make sure they are using the correct MEAT/support. At times, this diagnosis will be reported with Vitamin D as MEAT/support.

- Because Vitamin D is an OTC medication, to use it for this condition it needs to be specifically tied to it in the chart note.
- When looking for other MEAT/support for the diagnosis (labs, other documentation, etc.) we also need to determine if the condition is active.

Dependence on Ventilator – To be able to code this condition, the patient needs to come into the facility already on a vent.

- If a patient comes into a facility, and because of their condition, needs to be intubated/put on a vent, this cannot be coded for use as an HCC.
- We do not code status codes for temporary measures.
  - Ex: Patient comes into hospital after being intubated by EMS or patient is intubated while in the hospital (after a surgery, etc)
  - "Codes from category Z99-. Dependence on enabling machines and devices, not elsewhere classified, should only be reported when physician documentation supports dependence."[xx]

Acute/chronic conditions - Some acute/chronic conditions can only be coded if the provider specifically notes "acute" or "chronic." Coders cannot make assumptions as to the severity.

Amputation status – This should not be captured during the initial surgical phase; it should be captured on subsequent encounters.

- We can only use the Pre and Post Op Diagnosis. The other documentation would be coded in PCS for the procedure.

Ostomy Status – As with Amputation status, this cannot be captured in the surgical phase.

Liver transplant – Coding transplant status cannot be done from the same encounter the transplant occurred. In that case it would be the procedure code. For it to be the status code it would be in subsequent encounters.

Osteonecrosis - When coding osteonecrosis, it is important to verify if the condition is current.

- Example – documentation states "she is status post multiple debridement's…received six-week course of iv penicillin and is now on oral amoxicillin." Although the documentation mentions the diagnosis, the rest of the documentation does not discuss the condition as a current condition.

Bacteremia – When coding this condition, make sure there is not another condition the patient already has that would be coded instead of.

- Example – On DC summary, both Bacteremia and Sepsis are noted. Under Bacteremia in the Index it says, "with Sepsis – see Sepsis." So, you would go to, and code the Sepsis instead of the Bacteremia.

Hemiplegia/Hemiparesis – If weakness is noted due to a stroke/cva/etc, it can be coded to hemiplegia/hemiparesis following a cerebral infarction.

- Residual Right-Sided Weakness Due to Previous Cerebral Infarction[xxi]

Question: *The patient is a 72-year-old male admitted to the hospital, because of gastrointestinal bleeding. The provider documented that the patient had a history of acute cerebral infarction with residual right-sided weakness (dominant side) and ordered an evaluation by physical and occupational therapy. What is the appropriate code assignment for residual right-sided weakness, resulting from an old CVA (cerebrovascular accident) without mention of hemiplegia/hemiparesis?*

Answer: *Assign code I69.351, Hemiplegia and hemiparesis following cerebral infarction, affecting right dominant side, for the residual right-sided weakness due to cerebral infarction. When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia. Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia unless it is associated with some other brain disorder or injury.*

Monoplegia – like above, if weakness of one limb is noted due to a cva/etc you can code it to monoplegia of… following cerebral infarction.

- Upper or Lower Extremity Weakness Following Acute Cerebrovascular Accident[xxii]

Question: *A patient presented with weakness of the right arm due to an old cerebrovascular accident (CVA). The provider documented, "h/o CVA with mild residual right arm weakness." How would weakness of one extremity (upper or lower) be coded in a patient who is post CVA?*

Answer: *Assign the appropriate code from subcategory I69.33-, Monoplegia of upper limb following cerebral infarction, or I69.34-, Monoplegia of lower limb following cerebral infarction, for upper or lower limb weakness that is clearly associated with a CVA.*

- *Previous advice in Coding Clinic, First Quarter 2015, states that, "unilateral weakness that is clearly documented as being associated with a stroke, is considered synonymous with hemiparesis or hemiplegia. Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia unless it is associated with some other brain disorder or injury." This same logic would apply to upper or lower limb weakness that is clearly associated with a stroke.*

Hemiplegia/hemiparesis/weakness due to an acute cva – If weakness/hemiplegia/hemiparesis is noted during a stay with an acute cva, category "g81.x" can be coded.

- Acute Cerebral Infarction with Left-Sided Weakness[xxiii]

Question: *An 88-year-old male patient is admitted secondary to a cerebral infarction. In the final diagnostic statement, the provider documented "acute cerebral infarction involving the right hemisphere with left-sided (nondominant) weakness." How should left-sided weakness due to an acute cerebral infarction be coded when there is no specific mention of hemiplegia/hemiparesis?*

Answer: Assign code I63.9, Cerebral infarction, unspecified, as the principal diagnosis. Assign code G81.94, hemiplegia, unspecified affecting left nondominant side, as an additional diagnosis. When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia. Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia unless it is associated with some other brain disorder or injury.

AAA: If/when an aneurysm is documented along with an endograft procedure, make sure the condition is still currently active. Due to the fact that the endograft procedure is to fix aneurysms.

Code specificity – Always make sure that you are reporting the most specific code. Even if the HCC stays the same, it is important to report the code with the most specificity.

- Ex: E11.40 - Type 2 diabetes mellitus with diabetic neuropathy, unspecified vs. E11.42 - Type 2 diabetes mellitus with diabetic neuropathy, unspecified
- Both map to the same HCC, but the E11.42 is a more specified code.

Multiple codes, same HCC - When there are multiple codes found that map to the same HCC, report the one with the best documentation. Or, if both are documented equally, choose the most severe condition. Because an HCC is only reported once a year, we would only report a finding once.

- Example: BMI (Body Mass Index) 40+ and Morbid obesity. Both map to HCC 22
- Example: DM (Diabetes Mellitus) with diabetic kidney disease and DM with cataract. Both map to HCC 18

Conditions noted as Resolved - For Inpatient facility coding, you can code a condition that occurs during the admit (or ER visit that patient was put into inpatient status from) that resolves prior to discharge.

CareOregon Staff are asked to submit questionable items for further review/second opinion. Educational items are key to improving documentation.

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