ICD-10-CM coding for Chapter 19 & 20: Injuries, Poisonings, and External Causes of Morbidity

By Stacy Hartstine, RHIT, CCS

Coding for conditions in Chapter 19 and Chapter 20 of ICD-10-CM, requires great detail in specificity and require thorough detailed documentation to accurately code these injuries, poisonings, and external causes. Many codes in Chapter 19 have a 7th character. The 7th character identifies the phase of treatment the patient is receiving, such as active, subsequent, sequelae, etc. Open fracture codes have additional 7th character values that identify the Gustillo Classification. However, when the Gustillo Classification is not documented, the default is Type 1 or 2. Fracture codes are also subdivided into categories that identify the fracture as Traumatic vs Pathologic, Open vs Closed, Displaced vs Non-displaced, and even further very detailed specificity for location. ICD-10-CM has provided us with other defaults as well. When a fracture has not been documented as open or closed, the default is closed. When a fracture is not documented as displaced or non-displaced, the default is displaced. If you are coding multiple fractures, the fractures need to be sequenced in the order of severity, most severe to least severe. Another important reminder is that the Aftercare Z codes are never assigned for an injury, including late effects of old injury. You will assign the initial injury code with the appropriate 7th character to identify the encounter as subsequent care, sequelae, etc.

Codes for Burns and Corrosions are also found in Chapter 19 of ICD-10-CM. Burn coding now requires much more detail. In order to accurately code the burn you will need to know the site, the depth (degree), the extent, and the causative agent. The exception is burns of the eyes or internal organs which are classified only by site, not degree. Burns of various degree that fall in the same 3 digit code category are coded only once, to the highest degree documented. Nonhealing burns are still coded as acute burns. Codes for the extent are based on the basic “rule of nines”.

Classic “rule of nines” -
- head and neck or arm (each) = 9%
- Leg (each) or Anterior trunk or Posterior trunk = 18%
- Genitalia = 1%
- Providers may change percentage to accommodate infants and children who have proportionately larger heads than adults, and patients who have large buttocks, thighs, or abdomen that involve burns.

Codes for Poisoning, Toxic Effects, Adverse Effects, and Underdosing are all found in Chapter 19 as well. Poisoning is defined as a reaction or condition due to improper use of a medication (prescription or over the counter), e.g., overdose, wrong substance given or taken...

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in error, wrong route of administration. Toxic Effects are coded when a harmful substance is ingested or comes in contact with a person. This would be a non-medicinal substance (lead, gas, bleach, etc). Adverse effects occur when the patient has a condition or reaction to a drug that was correctly prescribed and administered, including taking over the counter medications as per label directions. Underdosing is taking less of a medication that what was prescribed by the provider or manufacturer’s instructions.

Chapter 20 contains codes for External Causes of Morbidity. There is no national requirement making these codes mandatory. However providers may have State or Payer based requirements. Providers are encouraged to voluntarily report these codes because they do provide valuable data for injury research assist with developing injury prevention strategies.

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Selection of Principal Diagnosis Part 2
By Marquita Rawlins, RHIA, CCS

The accurate and appropriate selection of principal diagnosis cannot be overstated. As such, we felt it would be important to further delve into the principal diagnosis selection process. One area that coders should also be aware of and not overlook when selecting a principal diagnosis is present on admission (POA) indicators. These present on admission indicators are:

- Y = present at the time of inpatient admission
- N = not present at the time of inpatient admission
- U = documentation is insufficient to determine if condition is present on admission
- W = provider is unable to clinically determine whether condition was present on admission or not

According to the Official Coding Guidelines (OCG), present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission. However, there is no required timeframe as to when a provider must identify or document a condition to be present on admission. In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission. In some cases it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission. Determination of whether the condition was present on admission or not will be based on the applicable POA guideline or on the provider's best clinical judgment.

As such, being present on admission is an important component of the principal diagnosis selection process. It is quite rare that a condition not present on admission will be assigned as the principal diagnosis. Careful consideration must be applied to ensure the condition is present on admission. For example, symptoms of a diagnosis may be present on admission and the diagnosis may not be confirmed and documented until several days into the admission. For instance, in relation to sepsis when reviewing the OCG it tells us that “Severe sepsis may be present on admission, but the diagnosis may not be confirmed until sometime after admission; if the documentation is not clear whether severe sepsis was present on admission, the provider should be queried.” Query opportunities are also necessary to determine if a diagnosis was present on admission or not and should be used in cases where the coder is unable to clearly determine.

Inpatient coders also must be careful when assigning uncertain diagnoses as the principal diagnosis. Per the Official Coding Guidelines, we are directed if the diagnosis documented at the time of discharge is qualified as 'probable', 'suspected', 'likely', 'questionable', 'possible', or 'still be to be ruled out', or other similar terms indicating uncertainty, code the condition as it existed or was established.” As coders we must pay close attention to the phrase “at the time of discharge”. Recently published in Coding Clinic, Fourth Quarter 2017 page 102 advice states that “if a provisional or differential diagnosis on admission is

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determined not to be present, not clinically supported, or ruled out by the time of discharge, it should not be considered as an uncertain diagnosis. Even if the condition has been worked up and initially treated, once the condition is ruled out, it should no longer be coded. "Ruled out" means that the diagnosis has been eliminated as a possibility.” As coders it’s important that we read our documentation carefully for clues to see if the uncertain diagnosis has been ruled out.

Reference:
ICD-10 Official Coding Guidelines FY 2017
AHA Coding Clinic, Fourth Quarter 2017, page 102: Coding Ruled-Out Diagnosis

Flu Vaccine Code Changes 2017-2018 Season

CPT 2018 brings changes to the flu vaccine codes. Three flu vaccine codes (90657, 90661, 90672) have been excluded from the flu vaccine list this year and two new flu codes were added. Both new codes 90756 and 90682 are related to quadrivalent vaccines.

90756 – Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5ml dosage, for intramuscular use

90682 – Influenza virus vaccine, quadrivalent (RIV4) derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use

90682 can start to be reported in 2017 but 90756 (manufactured by Seqirus) cannot! Claims for 90756 for the remainder of 2017 dates of service should be reported with HCPCS code Q2039 (influenza virus vaccine otherwise specified) to your local MAC. For dates of service January 1, 2018 when using the Seqirus vaccine code 90756 should be reported on the claim. CMS reports that any claims submitted after January 1, 2018 with 90756 for dates of service in 2017 will be rejected. Use the table below for guidance.

<table>
<thead>
<tr>
<th>Correct claims submission for new Seqirus vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date of Service</strong></td>
</tr>
<tr>
<td>August 1 to December 31, 2017</td>
</tr>
<tr>
<td>January 1 to July 31, 2018</td>
</tr>
</tbody>
</table>

Source: MLN Matters 10196
Commonly with outpatient coding, in particular ancillary coding, coding professionals have a limited amount of available documentation to code from. With what little we have to work from, the next challenge being, what to code and what to leave out! What is incidental and what is relevant? The ICD-10-CM Official Coding Guidelines can be helpful when sorting through the documentation.

The first listed diagnosis in outpatient coding, is the condition, problem or other reason stated to be chiefly responsible for services provided. This can be challenging when documentation states an uncertain diagnosis such as probable, suspected or “rule-out.” In these cases, code instead the sign, symptom or abnormal test result that prompted the visit. The reasoning for this, is that it may take a few visits before the provider can establish a diagnosis. In the meantime code what we know!

When a patient presents for reasons other than disease or injury, a code from Chapter 21 may be your best option. Chapter 21 codes can also supply additional relevant information about the encounter. Some helpful terms to index include:

<table>
<thead>
<tr>
<th>Admission</th>
<th>Counseling</th>
<th>Lack of</th>
<th>Resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare</td>
<td>Dialysis</td>
<td>Maintenance</td>
<td>Screening</td>
</tr>
<tr>
<td>Attention to</td>
<td>Donor</td>
<td>Maladjustment</td>
<td>Status</td>
</tr>
<tr>
<td>Boarder</td>
<td>Examination</td>
<td>Observation</td>
<td>Supervision of</td>
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<tr>
<td>Care of</td>
<td>Exposure to</td>
<td>Problem with</td>
<td>Test</td>
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<tr>
<td>Carrier</td>
<td>Fitting of</td>
<td>Procedure</td>
<td>Transplant</td>
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<tr>
<td>Checking</td>
<td>Healthy</td>
<td>Prophylactic</td>
<td>Unavailability</td>
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<tr>
<td>Contraception</td>
<td>History</td>
<td>Replacement</td>
<td>Vaccination</td>
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</table>

When coding aftercare and follow-up there are a few things to keep in mind. Follow-up codes are used when a condition has been fully treated and no longer exists. In other words, the condition is now a history and treatment has been completed. A common example of this would be follow-up with a history of cancer. On the other hand, if the patient is receiving care after the initial treatment of a condition, during a healing or recovery phase, an aftercare code may apply. The exception to the rule of course being with our injury and poisoning codes. In these cases you will not code an aftercare code but instead will apply the appropriate 7th character to the injury or poisoning code (i.e. “D”). Check out the Chapter 19 & 21 guidelines for additional information!

Patients presenting for diagnostic/therapeutic services or ambulatory surgery have a common theme regarding selection of the first listed diagnosis. Code first the reason for the service. If however the provider establishes a more specific diagnosis after study, code this instead as it is the most definitive diagnosis documented. For example a patient presents for a chest x-ray due to chest pain and the radiologist diagnoses pneumonia, code the pneumonia. Another example is a patient presenting with an unknown skin lesion which is biopsied and the pathologist diagnoses melanoma, code the melanoma. In the instance where a definitive diagnosis cannot be made after study, code the sign, symptom or other reason initially stated as the reason for the service.

The guidelines give additional information for coding Outpatient Surgery and Observation stays. If a patient presents for a surgery that cannot be performed due to a contraindication, the first listed code will remain the reason for the surgery. Assign additional codes to capture the reason the surgery was cancelled. If a patient develops a complication after surgery and is admitted to Observation status you will also code the reason for the surgery as first listed, followed by codes for the complications(s).

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services is a good place to start if you have a question about code assignment. These guidelines in addition to ICD-10-CM coding conventions, general and disease specific guidelines will hopefully supply any answers you may be looking for. Happy Coding!

Sarah Reed, RHIT, CCS is RMC’s Senior Outpatient Auditor. Sarah joined RMC in 2013, and has nearly 10 years of experience in the Health Information Management Field. She has a love for all Outpatient Coding, ER, Outpatient, Profee and specializes in SDS. Prior to joining RMC, Sarah’s past positions include Surgery Coding Specialist, Senior Coding Compliance Auditor and Revenue Integrity Failed Claims Specialist. She has worked in a variety of acute care hospitals, ranging from a 25-bed critical access hospitals to large multi hospital networks including trauma level 1 teaching hospitals. Sarah is a multi-talented coder, auditor, educator and trainer. Sarah has been actively involved with RMC’s ICD-10 Training and education program. Sarah resides in Oregon and can be reached at sreed@rmcinc.org
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