

Coding, Reimbursement,
and Billing Issues for the
Coding Professional

Inpatient Coding News

ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE MEETING

The ICD-9-CM Coordination and Maintenance Committee meeting in March discussed some interesting proposed changes for FY 2011. A summary of the committee agenda can be found on the CDC website: <http://www.cdc.gov/nchs/icd.htm> . Discussions of the changes in FY 2011 can be reviewed here.

We expect to see changes in classification of heart failure down the road. One alternative discussed is to expand 428.0, congestive heart failure for identification of acute, chronic, and acute on chronic CHF. The second alternative is to expand the systolic, diastolic, and combined heart failure codes to capture cases that are congestive in nature.

FISCAL YEAR 2010 ICD-9-CM ADDENDA

Effective October 1st, 2009, the ICD-9-CM addenda are also available, posted on June 3, 2009 on the above website. Some of the

more interesting observations so far include new codes for acute and chronic gouty arthropathy, acute and chronic pulmonary embolism, and acute and chronic venous embolism. There are SWEEPING changes to the E code section. Data captured will now include the patient's activity contributing to a patient's health condition. There are new E codes for never events and for military operations.

NEW PATIENT DISCHARGE STATUS CODE

The National Uniform Billing Committee created a new patient discharge status code. Code 21 now defines discharges or transfers to court /law enforcement. This code includes transfers to jail, prison, and other detention facilities. The Post-acute transfer payment policy does not apply to discharge status code 21.

OFFICIAL GUIDELINES

Updated official guidelines were effective October 1. Changes are minor. One interesting item refers to coding only confirmed cases of Avian influenza (bird

flu) and H1N1 influenza (swine flu). This has been added to the exceptions to the uncertain diagnosis rule. Other changes noted address E code hierarchy when systems allow a limited number, discussion of the new activity E codes, and removal of POA examples. The website above contains the official guidelines and the addenda.

FY 2010 CHANGES

Here is the link to the website that contains tables that you might find useful. <http://www.cms.hhs.gov/AcuteInpatientPPS>. On the left, click on “FY 2010 final rule home page.” If you want to check the tables for revised and invalid codes, CC and MCC lists, additions and deletions to exclusions lists, etc. you can get them here. Table 5 is the MS-DRG weight table, and also contains helpful GMLOS and post acute DRG information.

MALIGNANT CARCINOID TUMOR

The new codes for carcinoid /neuroendocrine tumors were created effective October 1st, 2008. They are discussed in Coding Clinic 4Q08. This reference confirms that if the neuroendocrine tumor is due to multiple endocrine neoplasia (MEN) syndrome, the code for MEN syndrome should be assigned

first. For codes in the 209 section, the tabular note states, “Code first any associate multiple endocrine neoplasia syndrome (258.01-258.03).”

In FY 2009, the MCE edit for codes in this section stated the diagnosis was not acceptable as PDX. So how would malignant carcinoid tumor be coded without the presence of MEN syndrome?

We sent this question to Coding Clinic in June for clarification. The example sent was a case where malignant carcinoid tumor of the lung was documented, and there was no MEN syndrome. Their answer confirmed that 209.21 would be listed as the PDX, and 258.01 would not be used unless the neuroendocrine tumor is associated with MEN syndrome.

“The CMS has advised the FIs that the code edit that prohibits the sequencing of codes from category 209, neuroendocrine tumors, as PDX should be removed. The codes for neuroendocrine tumor are acceptable as PDX.”

It is noted that for FY 2010, codes 209.00 – 209.69 have been removed from the MCE for unacceptable PDX. It was recognized that the tabular note was misinterpreted.