Haugen Academy Webinars: Secondary Diagnosis FAQ's

Question
Why do they have an Excludes1 note for volume depletion/dehydration with hypovolemic shock? Not every patient with dehydration is in shock! Shock seems like a significant symptom that should be coded.

Answer
Hypovolemic shock is a life-threatening condition caused by a significant loss in the body's blood or fluid supply. Although not all patients with dehydration/volume depletion have hypovolemic shock, all patients with hypovolemic shock have either dehydration or volume depletion. Hypovolemic shock is assigned to code R57.1 in the signs and symptoms chapter of ICD-10-CM and is listed as a major complication/comorbidity (MCC). Volume depletion/dehydration is assigned to category E86 in the endocrine/nutrition/metabolic chapter and is not a CC/MCC. When a patient presents with both conditions, assign only code R57.1, Hypovolemic shock.

Question
When coding newborn inpatient charts and patient is preemie - how/when do you pick up premature weeks' gestation? Always, only if they have significant prematurity issue(s)?

Answer
Per the *ICD-10-CM Official Guidelines for Coding and Reporting* (Section I.C.16.d.), a diagnosis of prematurity should not be assigned unless it is documented since providers utilize different criteria in determining prematurity. Don't code prematurity based on weeks' gestation without a documented provider diagnosis of prematurity. If the provider documents that the patient is premature, the prematurity code should be reported since this condition impacts patient care.

Question
I recently had an ED chart where the patient had hypertension and diabetes mellitus listed under the past medical history. The patient was not being seen for either of these conditions and was not on any medications for either condition. I did not code these and was told by an auditor that I should have picked them up because they are chronic conditions. What would your advice be? In the past I have gotten dinged for coding these diagnoses as secondary when the patient is not currently being treated for them or not on any medications for them.

Answer
Section IV.I. and IV.J. of the ICD-10-CM Official Guidelines for Coding and Reporting address coding chronic diseases and coexisting conditions in the outpatient setting, respectively. Chronic conditions treated on an ongoing basis or that impact patient care may be coded. If the patient is not on medications for the diabetes and hypertension and there are no other indications in the record that the patient is being treated for them (e.g., placed on a diabetic diet), or that the conditions were monitored or assessed during the current visit I would not recommend coding them.

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Question

In the webinar, there was a question regarding an ER visit with chest pain, had abnormal EKG and was sent for testing. The patient had GERD. You suggested abnormal EKG with GERD which I agree. However, I have found that the Reason For Visit fields (it is now up to 3) can be used to satisfy LCD while still maintaining coding guidelines. It wasn't mentioned and have you come across this?

Answer

Yes, the UB-04 has three fields for reason for visit and those fields can be used to satisfy medical necessity issues. However, we've seen payer inconsistencies with the use of these fields. Some payers recognize them and some do not. Some facilities have those fields set up for use for coders and some do not. The exercise presented in the webinar was to show how medical necessity can sometimes be met without blindly attaching additional signs and symptoms codes.

Question

I have a follow-up question. Specifically related to recurring hospital outpatient accounts. I questioned a client regarding secondary diagnoses on the UB04 that were not documented in the reports corresponding to the date of service on the claim. The client stated "even though there was only one date of service on the claim, the account is recurring and we assign the diagnosis codes documented in the initial date of service documentation, not just the date of service billed." Just wondered if you have had this situation occur before and your response. And if it really matters. Could it impact the accuracy of the data being collected by the payer?

Answer

Recurring account coding is challenging at best. Facilities may choose to bill recurring accounts per date of service or using a series account with admission and discharge dates that span a monthly period. Regardless of the method of billing used, there should be a valid physician order for the services listing the patient's diagnoses as well as the term of the service (e.g., "PT services from October 1 through October 31). While it is not compliant to refer back to previous dates of service for coding diagnoses, the coder may refer back to the initial order that covers the date of service for the current episode. I would not recommend coding diagnoses from other encounters within the recurring account period other than the order. For recurring accounts using series account billing, the documentation from the admission date to the discharge date listed on the claim form can be used for coding purposes.

Question

You recommend comparing the past medical history to the medication list. Would you code a condition like hypertension if they were on meds but weren't given that medication during an outpatient encounter?

Answer

Yes, I would still code hypertension since it's a chronic condition for which the patient is undergoing treatment and it could impact the patient's care, such as the prescription of other medications.

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Question
Should you code Mongolian spots on a newborn record?

Answer
That depends on whether the physician indicated the condition was clinically significant. It is the physician, not the coder, who decides if a condition is clinically significant. If you are unsure if a condition is clinically significant or not, you should query the provider for clarification.

Question
Should the long-term use of insulin code be used for Type 1 diabetics?

Answer
Coding Clinic for ICD-9-CM addressed this question in Fourth Quarter, 2004. Since type 1 diabetics require insulin because their pancreas do not produce insulin naturally, it is not necessary to report an additional code for the long-term use of insulin. The use of this code is optional.

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