ICD 10 Coding Alert

Training: Top 4 ICD-10 Coding Mistakes You Cannot Afford To Make

Don't just correct, perfect your respiratory failure and seventh character coding.

You have now entered the era of hard-core ICD-10 coding. No more grace period luxuries you need to tighten your seatbelt and focus let specificity guide your path. Take a lesson from last year's most common coding mistakes to chart your way to a denial-free 2017.

Learn from Other's Mistakes

The most common challenge when tackling ICD-10-CM coding lies in not factoring in all of the available information before you make your code choice, says **Carol Pohlig, BSN, RN, CPC, ACS,** senior coding and education specialist at the Hospital of the University of Pennsylvania. You'll need to consider all the details and the associated complications in order to choose the correct code.

1. Fight Respiratory Failure Coding Blues with CMS's 2017 Coding Guidelines

One common mistake coders made in 2017 was inappropriately reporting respiratory failure as a principal diagnosis, according to an AHIMA Body of Knowledge article. Fortunately, the new 2017 ICD-10-CM coding guidelines offer some clarity on how and when to report respiratory failure.

According to the ICD-10 guidelines, if Acute Respiratory failure (ARF) is the primary reason for the patient's visit to the provider, then you may choose an appropriate code from subcategory J96.0- (Acute respiratory failure...), or subcategory J96.2-, (Acute and chronic respiratory failure...) as the primary diagnosis.

But, if the ARF occurs after admission, or even if it exists at the time of admission, but doesn't meet the definition of principal diagnosis above, you will report it as the secondary diagnosis.

When ARF is coexistent with another acute condition, (such as myocardial infarction [I21.-, I22.-], cerebral infarction [I63.-], aspiration pneumonia J69.- [Pneumonitis due to solids and liquids...], the selection of principal diagnosis will be different according to the situation.

In this situation, selecting the correct code can be a little tricky, depending on whether the other existing pathology is respiratory or non-respiratory in nature, and also on the circumstances of admission. Here's how to make your decision, according to the ICD-10 guidelines:

- If both ARF and the other acute condition are equally responsible for patient's admission, check for any chapter specific sequencing rules, or any chapter specific guidelines that lead you to zero in on the primary diagnosis.
- If the documentation does not make it clear whether ARF and the other condition were equally instrumental in effecting the patient's admission, you may have to ask the provider for further clarification.

2. Solve Seventh Character Conundrums in Reporting Trauma Cases

Coding up to the seventh character in the acute hospital setting, especially in trauma and fracture cases, has been amongst top five recurrent mistakes in coding, according to the AHIMA article.

Example: Suppose a patient has an accident, and faces blunt trauma to the right front wall of thorax. He also has a fracture of shaft of right humerus with a single break line that runs transversely through the central portion of the upper arm bone, separating the humerus into upper and lower portions with these fracture fragments remaining in their original alignment, due to sudden or blunt trauma. Based on the provider's documentation, you will code S20.211A

(Contusion of right front wall of thorax, initial encounter), as well as S42.324A (Nondisplaced transverse fracture of shaft of humerus, right arm, initial encounter for closed fracture), as the patient is seeing the provider for the first time.

3. Be Sure To Code It Right For Fluoroscopy with Dyes

Another recurrent mistake coders make is in coding whether or not the provider used a dye during the fluoroscopy or ultrasound procedure. "This can be done on an [outpatient] basis," says **Sarah Goodman, MBA, CHCAF, CPC-H, CCP, FCS**, president of the consulting firm SLG, Inc., in Raleigh, N.C.

Example: Consider the EBUs CPT® code 31654 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound [EBUS] during bronchoscopic diagnostic or therapeutic intervention[s] for peripheral lesion[s] [List separately in addition to code for primary procedure[s]]). There tend to be mistakes around the use of guidance tools, such as fluoroscopy and ultrasound, and whether dye was used. Facilities should address their requirements in the coding policy so the application of codes for these services is consistent the AHIMA article suggested.

4. Don't Forget To Report Precise HCPCS Codes for Devices and Components

If hope to avoid denials, make sure you capture the device and the details of its components as impeccably as you code for the diagnoses and the procedure. Documentation should include components and grafting material details, according to the AHIMA article.

The bottom line: If you hope to avoid a negative payment impact, take time to identify and proactively work on your ICD-10 coding pain points. Contact your payers if you are not sure about any specific documentation or coding requirements the payer may have for on accepting a claim.

To know more, go to http://bok.ahima.org/doc?oid=301549#.WAnkdPkrLIU.