

## September 2014 ICD-10-CM Coordination and Maintenance Committee

by Girolamo “Jerome” Ingrande, RHIT, CCS, CHC

The subject of ICD-10 has been on the minds of health information management (HIM) professionals in recent months. Many of us, no doubt, lobbied hard to make sure that there were no further delays to the new classification system, and saw our efforts pay off, as language to delay I-10 was not included in the omnibus spending bill that Congress passed on December 11, 2014. While the fight continues to ensure that ICD-10 moves forward on the scheduled compliance date of October 2015, the Coordination and Maintenance Committee continues to meet twice a year and allows the public to comment on whether or not changes need to be made to the diagnosis and procedure coding systems, in order to capture new technology or diseases. The following represents a high level summary of the topics discussed at the September 2014 meeting.

### Castleman disease

Specific codes for Castleman disease were proposed by the Scientific Advisory Board of the Castleman Disease Collaborative Network. Castleman disease can be described as a rare disorder that involves an overgrowth of cells in your body’s lymphatic system. The proposal included a number of tabular modifications to include a new subcategory for the disease (D47.Z2).

### National Institutes of Health Stroke Scale

A large number of organizations requested the creation of ICD-10-CM codes that would allow for the capture of what is known as the National Institutes of Health Stroke Scale (NIHSS) score. The NIHSS is an assessment tool used to evaluate and document neurological status and stroke severity. A new subcategory (R29.7, National Institutes of Health Stroke Scale (NIHSS) Score) has been proposed with a large number of codes that would provide specific detail for each score.

### Cryopyrin-Associated Periodic Syndromes and other auto-inflammatory syndromes

A biopharmaceutical company known as “Sobi” requested the creation of new ICD-10-CM codes for Cryopyrin-Associated Periodic Syndromes (CAPS), including familial cold auto-inflammatory syndrome, Muckle-Wells syndrome and Neonatal Onset Multisystemic Inflammatory Disorder (NOMID). This would include the addition of a new category (M04, Autoinflammatory syndromes) in addition to the development of four new codes:

- M04.1 Periodic fever syndromes;
- M04.2 Cryopyrin-associated periodic syndromes;
- M04.8 Other autoinflammatory syndromes; and,
- M04.9 Autoinflammatory syndrome, unspecified

### Dental terms

The Harvard School of Dental Medicine previously submitted a proposal to add a number of dental terms to ICD-10-CM, which were also considered in September 2013. Those proposals included:

- Adding an inclusion term for narrow gingival width (of periodontal soft tissue), at code K05.5, Other periodontal diseases;
- Adding a new code K06.3, Horizontal alveolar bone loss; and,
- Expanding K08.8, creating new codes K08.81, Primary occlusal trauma, and K08.82, Secondary occlusal trauma, along with new code K08.89, Other specified disorders of teeth and supporting structures

#### **Mastocytosis and certain other mast cell disorders**

The American Academy of Allergy, Asthma, and Immunology, together with The Mastocytosis Society, Inc., requested that the code hierarchy for mastocytosis be updated and revised to include:

- Retitling current ICD-10 code Q82.2, Mastocytosis, to read “Pediatric cutaneous mastocytosis of newborn onset” and have it expanded so that patients with an onset of the condition in the newborn or neonatal period can be classified there.

#### **Dyspareunia/incontinence/difficulties with micturition**

The American Urological Association requested the following new codes to identify the types of dyspareunia, incontinence, and voiding dysfunctions, that are not currently represented in ICD-10-CM, to include:

- N94.10 Unspecified dyspareunia;
- N94.11 Superficial (introital) dyspareunia;
- N94.12 Deep dyspareunia;
- N94.19 Other specified dyspareunia;
- N39.491 Coital incontinence;
- N39.492 Postural (urinary) incontinence;
- R39.191 Need to immediately re-void;
- R39.192 Position dependent micturition; and,
- R39.198 Other difficulties with micturition

#### **Irritable Bowel Syndrome with Constipation**

Forest Laboratories, LLC requested new codes to identify and distinguish across subtypes of functional gastrointestinal disorders to include:

- K58.1 Irritable bowel syndrome with constipation;
- K58.8 Other irritable bowel syndrome; and,
- K59.04 Chronic idiopathic constipation

#### **Observation and evaluation of newborns for suspected conditions ruled out**

The American Academy of Pediatrics (AAP) originally submitted a proposal in September 2013 for a unique set of codes to be added to ICD-10-CM that would mimic the existing codes found in ICD-9-CM (V29) used to capture an observation and/or evaluation of newborns for suspected conditions. The proposal was revised and resubmitted for consideration in September 2014 to include a brand new subcategory (Z05 Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out) with a series of codes providing specificity as to the condition(s) being ruled out.

### **Gestational carrier**

The American Congress of Obstetricians and Gynecologists (ACOG) made a number of proposals during the September meeting. The first had to do with new codes for a gestational carrier since ICD-10-CM does not have a unique code for this. ICD-10 codes Z31.7 (Encounter for procreative management and counseling for gestational carrier), and Z33.3 (Pregnant state, gestational carrier) were the two options proposed.

### **Surgical procedures converted to open**

ACOG also requested the addition of codes to indicate when a minimally invasive surgical procedure is converted to an open procedure that would essentially mimic the ICD-9 V-codes currently available to capture those scenarios. This would include either the addition of an inclusion term (and related indexing) to the existing diagnosis code Z53.09, Procedure and treatment not carried out because of other contraindication, or the development of new codes to include:

- Z53.30 Unspecified minimally invasive surgical procedure converted to open procedure;
- Z53.31 Laparoscopic surgical procedure converted to open procedure;
- Z53.32 Thoracoscopic surgical procedure converted to open procedure;
- Z53.33 Arthroscopic surgical procedure converted to open procedure; and,
- Z53.39 Other specified minimally invasive surgical procedure converted to open procedure

A third option would be to add new codes to each related body system chapter.

### **3rd degree laceration**

ACOG, along with collaboration from the Women's Health Registry Alliance, (reVITALize) initiative worked on the current classification of 3rd and 4th degree perineal lacerations and proposed defining 3rd degree OB lacerations to match the definitions of the Royal College of Obstetricians and Gynaecologists to include the following new codes:

- O70.20 Third degree perineal laceration during delivery, unspecified;
- O70.21 Third degree perineal laceration during delivery, IIIa;
- O70.22 Third degree perineal laceration during delivery, IIIb; and,
- O70.23 Third degree perineal laceration during delivery, IIIc

The equivalent diagnosis codes in today's environment are O70.2, Third degree perineal laceration during delivery, and O70.3, Fourth degree perineal laceration during delivery with equivalent inclusion terms.

### **Ectopic pregnancy**

A request was also made to develop ICD-10 codes in order to mirror the existing ICD-9 codes used to capture multiple gestation pregnancy with co-existing ectopic and intrauterine pregnancies. The proposal included the expansion and addition of ten new codes to current category O00, Ectopic pregnancy, which would provide additional specificity regarding the abdominal, tubal, ovarian, or other ectopic pregnancy.

### **Contraceptive initial encounter and surveillance codes**

A request for new codes for initial encounter and surveillance codes for vaginal ring hormonal contraceptive device and transdermal patch hormonal contraceptive device contraceptive methods was also made by ACOG. The proposal included adding inclusion terms for barrier contraception (diaphragm) at the existing subcategories Z30.01, Encounter for initial prescription of contraceptives and Z30.4, Encounter for surveillance of contraceptives, as well as the development of four new codes:

- Z30.015 Encounter for initial prescription of vaginal ring hormonal contraceptive;
- Z30.016 Encounter for initial prescription of transdermal patch hormonal contraceptive device;
- Z30.44 Encounter for surveillance of vaginal ring hormonal contraceptive device; and,
- Z30.45 Encounter for surveillance of transdermal patch hormonal contraceptive device

### **Ovarian cyst laterality**

Lastly ACOG proposed new codes to capture laterality for ovarian cyst-related codes since laterality is not included for ovarian cysts (category N83, Noninflammatory disorders of ovary, fallopian tube and broad ligament).

### **Sarcopenia**

A proposal was made by the Alliance for Aging Research to create a new code for Sarcopenia (M62.84), which would allow for identification and specific intervention for treating the disease.

Keep in mind that the aforementioned information only speaks to the proposals made to the diagnosis classification system. A completely separate list of proposals was made with regard to PCS codes to include, but not limited to, hip and knee replacements, cardiac valve surgeries, and angioplasty procedures in the peripheral vessels. Therefore, I would encourage each of you to read through the entire summary that can be located at [http://www.cdc.gov/nchs/icd/icd9cm\\_maintenance.htm](http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm).

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#### *Reference*

*ICD-10 Coordination and Maintenance Committee Meeting Final Agenda, September 2014; [www.hhs.gov/icd9providerdiagnosticcodes/03\)meetings.asp](http://www.hhs.gov/icd9providerdiagnosticcodes/03)meetings.asp)*

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## Documentation and coding compliance for malnutrition

by Nancy J. Andersen, MS, RHIA, CCS

Compliant coding of malnutrition is dependent upon accurate documentation by the physician and other health care team members. It is important for coding professionals to be familiar with the various forms and severity of malnutrition, as well as the Official Guidelines for Coding and Reporting for appropriate code assignment to help ensure health information data integrity and appropriate capture of diagnoses.

Malnutrition is a significant worldwide problem, especially among children. Poverty, natural disasters, political problems, and war all contribute to malnutrition and starvation. According to the United Nation's Standing Committee on Nutrition (SCN), malnutrition is the largest single contributor to disease in the world.

Malnutrition is defined as a condition that occurs when the body does not receive or is unable to metabolize enough nutrients [Medline Plus, 2013]. It may result from a variety of causes including an inadequate or unbalanced diet; vitamin deficiency; digestion or absorption issues; and certain medical conditions, such as, AIDS and specific types of cancer. Malnutrition can also range in severity from very mild with no symptoms to so severe that it causes permanent body damage. A malnourished person has difficulty doing normal things, such as, growing and resisting disease. Physical work becomes difficult and learning abilities in children can be diminished. For women, pregnancy becomes risky, and malnourished women may have difficulty producing breast milk.

Malnutrition occurs in 30-55 percent of hospitalized patients; however it is not always well-documented or coded, according to a study sponsored by Johns Hopkins and published in the *March Journal of Parenteral and Enteral Nutrition*, even though The Joint Commission requires nutritional screening of patients within 24 hours of admission. Nutritional assessments are generally performed by licensed dietitians, and are particularly important for the reporting of malnutrition among elderly patients.

Symptoms of malnutrition may vary depending on the cause; however, some general symptoms include fatigue, dizziness, and weight loss. Symptoms, such as these, may be noted in a patient's physical examination. Clinical indicators such as body mass index (BMI) values could also be an indication of malnutrition. BMI values do not always have to be coded based on medical record documentation from clinicians, including nurses and dietitians. As stated in the Official Guidelines for Coding and Reporting, BMI code assignment may be based on medical record documentation from clinicians who are not the patient's provider, including nurses and dietitians, since this information is typically documented by other clinicians involved in the care of the patient. However, diagnoses associated with clinical criteria, such as BMI value, documented by clinicians who are not the patient's provider, cannot be assigned by the coder. The associated diagnosis (such as malnutrition) must be documented by the provider.

The ICD-9-CM diagnosis codes for malnutrition were expanded on October 1, 2011 to include degree of severity. The degree of severity of malnutrition must be documented by the physician.

The diagnosis of Kwashiorkor, code 260, is a form of malnutrition caused by severe protein deficiency that is usually seen in some underdeveloped areas in Africa and Central America;

however, it is extremely rare in the United States. The Office of Inspector General (OIG) has made the coding of Kwashiorkor a focus of investigations in 2015. According to the OIG 2015 Work Plan:

*“We will review Medicare payments made to hospitals for claims that include a diagnosis of Kwashiorkor to determine whether the diagnosis is adequately supported by documentation in the medical record. To be processed correctly and promptly, a bill must be completed accurately (CMS’s Medicare Claims Processing Manual, Pub. No. 100-04, ch. 1, §80.3.2.2.). A diagnosis of Kwashiorkor on a claim substantially increases the hospitals’ reimbursement from Medicare. Kwashiorkor is a form of severe protein malnutrition that generally affects children living in tropical and subtropical parts of the world during periods of famine or insufficient food supply. It is typically not found in the United States. Prior OIG reviews have identified inappropriate payments to hospitals for claims with a Kwashiorkor diagnosis (OAS; W-00-13-35715; W-00-14-35715; various reviews; expected issue date: FY 2015).”*

Coders continue to have many questions pertaining to the accurate coding of malnutrition. Clinical terms such as “emaciation,” “cachexia,” or “wasting syndrome,” are not synonyms for malnutrition. The correct diagnosis code for emaciated/emaciation, cachexia, or wasting syndrome is 799.4, Cachexia. The provider must specifically document malnutrition for the condition to be coded.

Here are some common questions that come up when coding malnutrition:

**Are dietitians allowed to establish a diagnosis of malnutrition and document it in the active problem list?**

- Dietitians can document BMI values, but cannot establish a diagnosis (AHA Coding Clinic Second Quarter 2010, page 15). The diagnosis associated with the BMI value, e.g., overweight, obesity, or underweight, must be documented by the provider.

**Are dietitians allowed to establish a diagnosis of malnutrition and document it in the problem list if the physician pulls that documentation into the discharge summary through an automated process?**

- Dietitians may not establish a diagnosis; however, they may follow their scope of practice in documenting their clinical impression. If the physician agrees with that impression, the physician may establish the diagnosis by pulling that documentation into the progress notes and/or discharge summary through an automated process, and adding it to the active problem list.

**Is it appropriate to have physicians counter-sign the dietitian note as a means of establishing the diagnosis by the physician?**

- No, it is not appropriate to have physicians counter-sign the dietitian note as a means of establishing the diagnosis by the physician. Per the CMS 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide:

*“The collection of physician data for risk adjustment is associated with the physician’s specialty. That is, all ICD-9-CM diagnoses that are required for the risk adjustment models and rendered as a result of a physician face-to-face visit must be collected by the MA organization. This includes data collected from non-network as well as network physicians. There must be medical record documentation to support the diagnosis as having been documented as a result of a hospital inpatient stay, a hospital outpatient visit, or a physician face-to-face visit during the data collection period . . . The medical record needs to document a clinician’s diagnosis of malnutrition during the data collection period.”*

When documentation is unclear or there are clinical indications of malnutrition without documentation of an actual diagnosis, query the physician. Below is an example of a physician query for clinical indications related to a patient’s nutritional status.

### **Example Physician Query**

Dear Dr. \_\_\_\_\_;

Clarification of medical record documentation is required to reflect the severity of illness and the risk of mortality of your patient. Clinical indicators in this patient’s record note the following albumin and/or pre-albumin levels and additional indicator(s) (Note: dietician to specify conditions with increased protein needs e.g. dialysis; at least two criteria are needed to query physician).

Please document any corresponding diagnoses that relate to these findings in your progress note and/ or discharge summary, and add or update diagnoses on patient’s problem list. Examples of potential diagnoses are listed below. If you disagree with the clinical significance of the above indications, please indicate in your progress note the reason(s) for lack of clinical significance of findings.

Mild malnutrition

Moderate malnutrition - Malnutrition characterized by biochemical changes in electrolytes, lipids, and blood plasma.

Nutritional marasmus - Protein-calorie malabsorption or malnutrition of children; characterized by tissue wasting, dehydration, and subcutaneous fat depletion (also called infantile atrophy).

Other protein-calorie malnutrition

Other severe protein-calorie malnutrition – Nutritional edema without mention of dyspigmentation of skin and hair.

Unspecified malnutrition

Diagnoses other than malnutrition (please specify)

No Clinical Significance

Below is a table of ICD-9-CM and ICD-10-CM diagnosis codes for malnutrition. ICD-10-CM includes the new clinical term, Marasmic Kwashiorkor, which is an intermediate form of severe protein-calorie malnutrition and includes signs of both Kwashiorkor and marasmus. The clinical term “other protein-calorie malnutrition” has been eliminated in ICD-10-CM.

### ICD-9-CM and ICD-10-CM Malnutrition Diagnosis Codes

ICD-9-CM Diagnosis Code	ICD-10 Diagnosis Code	Description	Definition	Guidelines
260	E40	Kwashiorkor	Nutritional edema with dyspigmentation of skin and hair	Syndrome, particularly of children; excessive carbohydrate with inadequate protein intake; inhibited growth potential; anomalies in skin and hair pigmentation; edema; and liver disease. Kwashiorkor is a rare severe protein deficiency.
261	E41	Nutritional Marasmus	Nutritional atrophy Severe calorie deficiency; Severe malnutrition, NOS	Protein-calorie malabsorption or malnutrition in children; characterized by tissue wasting, dehydration, and subcutaneous fat depletion; may occur with infections disease; also called infantile atrophy.
	E42	Marasmic Kwashiorkor	Intermediate form severe protein-calorie malnutrition; Severe protein-calorie malnutrition with signs of both Kwashiorkor and Marasmus.	
262	E43	Other Severe, Protein-Calories Malnutrition	Nutritional edema without mention of dyspigmentation of skin and hair.	
263.0	E4.0	Malnutrition of moderate degree	Malnutrition characterized by biochemical changes in electrolytes, lipids, blood plasma	
263.1	E44.1	Malnutrition of mild degree		
263.2	E45	Arrested development following protein-calorie malnutrition	Nutritional dwarfism; Physical retardation due to malnutrition.	
263.8		Other protein-calorie malnutrition		
263.9	E46	Unspecified protein-calorie malnutrition	Dystrophy due to malnutrition; malnutrition (calorie); and NOS.	



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