

INGENIX[®]

Risk Adjustment Documentation & Coding Tools

2010



Chart Mechanics for Risk Adjustment Data Validation

Proper chart documentation helps ensure risk adjustment payment integrity and accuracy. *Risk adjustment data validation is the process of verifying that diagnosis codes submitted for payment by the Medicare Advantage (MA) organization are supported by medical record documentation for an enrollee.¹*

In order to help meet the Centers for Medicare and Medicaid Services' (CMS) documentation and validation requirements on risk adjustment data submission, we are recommending the specific documentation tips below. This is not an all-inclusive listing of CMS requirements and is only a reminder of certain chart mechanics and documentation guidelines.

Chart Mechanics and Documentation Considerations¹

- **Identify patient (name) and date on each page of the record.**
- Reported diagnoses must be supported with medical record documentation.
- Acceptable documentation should be clear, concise, consistent, complete and legible.
- Document and report co-existing diagnoses — any that require or affect the care and treatment of the patient that day.²
- Use only standard abbreviations (acronyms and symbols).
 - It is NOT appropriate to **code** a condition that is represented only by an up or down arrow in combination with a chemical symbol or lab abbreviation such as "↑chol" for "hypercholesterolemia."
- CMS requires that the documentation show evaluation, monitoring or treatment of the conditions documented.

Authentication by the Provider¹

All dates of service must be signed (with credentials) and dated by the physician (provider) or an appropriate physician extender (e.g., nurse practitioner). Stamps of the provider's signature are not acceptable per CMS.

The credentials for the provider of services must be somewhere on the medical record:

- next to the provider's signature, or
- pre-printed with the provider's name on the group practice's stationery.

The physician (provider) must authenticate each note for which services were provided with:

- handwritten signatures, or
- electronic signature.

Types of Acceptable Physician (Provider) Signatures and Credentials¹

- Hand-written signature or initials, including credentials (e.g., Mary C. Smith, MD; or MCS, MD)
- Electronic signature, including credentials
 - Requires authentication by the responsible provider (for example, but not limited to, "Approved by," "Signed by," "Electronically signed by")
 - Must be password protected and used exclusively by the individual physician (provider)

Signature Logs

Medicare documentation requirements state each patient encounter should include the date and legible identity of the provider.

- Type or print the provider's name in the first column.
- Type or print the provider's credential.
- The provider should sign his/her legal signature (full name, including credential).
- Under Actual Chart Signature, the provider should indicate all possible ways that he/she would sign the medical record (initials, first initial/last name, etc.).
- The date of implementation of the Signature Log must be on the Signature Log.

Example: Date of Implementation: _____

Provider Name	Credential	Legal Signature	Actual Chart Signature
John Smith	MD		

Ingenix Clinical Assessment Solutions will be happy to supply upon request:

- **signature logs (to be completed by the provider/practice)**
- **stamps with the provider's typed name and credentials (not signature)**

¹CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.

²World Health Organization, "International Classification of Diseases, Ninth Revision, Clinical Modification, 6th Ed." National Center for Health Statistics 2009 1-112. Web. 2 Dec 2009. http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

Update to CMS Model Diagnoses for 2010

There are several revisions to the CMS Risk Adjustment Model Diagnosis codes for 2009 / 2010. The following ICD-9 codes have been added to the CMS Risk Adjustment Model Diagnosis codes for 2010. Deleted codes for 2010 can be found at the bottom of this page. Should you have any questions regarding these changes, please contact your local Ingenix Market Consultant.

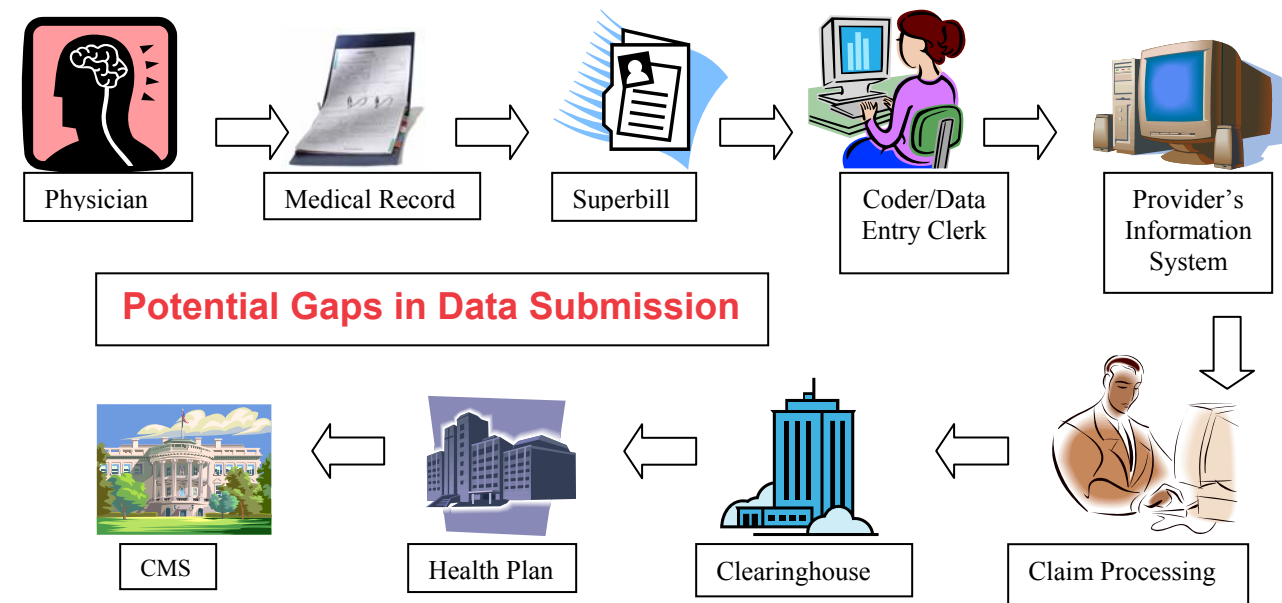
New Codes for 2010

ICD-9 Code	ICD-9 Description	HCC
209.31	Merkel cell carcinoma of the face	10
209.32	Merkel cell carcinoma of the scalp and neck	10
209.33	Merkel cell carcinoma of the upper limb	10
209.34	Merkel cell carcinoma of the lower limb	10
209.35	Merkel cell carcinoma of the trunk	10
209.36	Merkel cell carcinoma of other sites / NOS	10
209.70	Secondary neuroendocrine tumor, unspecified site	7
209.71	Secondary neuroendocrine tumor of distant lymph nodes	7
209.72	Secondary neuroendocrine tumor of liver	7
209.73	Secondary neuroendocrine tumor of bone	7
209.74	Secondary neuroendocrine tumor of peritoneum	7
209.75	Secondary Merkel cell carcinoma	7
209.79	Secondary neuroendocrine tumor of other sites	7
279.41	Autoimmune lymphoproliferative syndrome (ALPS)	45
279.49	Autoimmune disease, NEC	45
359.71	Inclusion body myositis (IBM)	71
359.79	Other inflammatory and immune myopathies, NEC	71
416.2	Chronic pulmonary embolism	104
453.50	Chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity	105
453.51	Chronic venous embolism and thrombosis of deep vessels of proximal lower extremity	105
453.52	Chronic venous embolism and thrombosis of deep vessels of distal lower extremity	105
453.72	Chronic venous embolism and thrombosis of deep veins of upper extremity	105
453.74	Chronic venous embolism and thrombosis of axillary veins	105
453.75	Chronic venous embolism and thrombosis of subclavian veins	105
453.76	Chronic venous embolism and thrombosis of internal jugular veins	105
453.77	Chronic venous embolism and thrombosis of other thoracic veins	105
453.82	Acute venous embolism and thrombosis of deep veins of upper extremity	105
453.84	Acute venous embolism and thrombosis of axillary veins	105
453.85	Acute venous embolism and thrombosis of subclavian veins	105
453.86	Acute venous embolism and thrombosis of internal jugular veins	105
453.87	Acute venous embolism and thrombosis of other thoracic veins	105
569.71	Pouchitis	176
569.79	Other complications of intestinal pouch	176

Discontinued Codes for 2010

ICD-9 Code	HCC
337.0 (now 337.00, 337.09)	71
V45.1 (now V45.11, V45.12)	130
997.3 (now 997.31, 997.39)	164

This information is for informational purposes only and does not replace the professional judgment and expertise of the individual performing coding based on numerous factors including, but not limited to, documentation in the medical record and other industry recognized coding guidance. Because codes, coding requirements and standards can and do change, the individual assigning codes is reminded to verify the accuracy, specificity, currency and acceptability of such codes and coding methods used.



The data path from the patient visit all the way to CMS for Risk Adjustment reporting can be treacherous.

Physicians and provider offices must remember to:

- 1. See Each Patient At Least Once Each Year**
The health status of a Medicare Advantage patient is re-determined each year. Diagnoses from a prior year do not "carry over" for CMS.
- 2. Evaluate and Document All Chronic Conditions**
All conditions that constitute the "composite health picture" of the senior patient should be evaluated and documented clearly and legibly in the progress note of the medical record. This is not limited to what brought the patient to the doctor today. What other conditions is the patient dealing with every day?
- 3. Code All Diagnoses**
The coder must be careful to capture all diagnoses from the documentation. Does the coder have access to the latest ICD-9 codes? Does the coder code to the highest level of specificity to accurately report the level of disease severity?
- 4. Use an Accurate, Up-to-date Superbill**
Is a superbill used? Does it contain a wide variety of ICD-9 codes to allow the specificity of the disease to be coded accurately? Is it up-to-date? Are coders trained to write in additional codes if they apply or do coders use the closest match on the Superbill instead? Is the superbill evaluated each year to ensure it meets the needs of the practice?
- 5. Make Sure the Data Is Captured**
The provider must be aware of the limitations of their medical record or practice management system. How many diagnosis codes can it hold? Is there potential for any codes to be lost?
- 6. The Claim or Encounter Format or Form Must Contain All the Data**
When the data is extracted for claims or encounter reporting, are all diagnosis codes extracted to be sent to the health plan? Does the claim process limit the number of diagnoses that can be submitted? Does the provider practice only call for sending one or two diagnosis codes to support the CPT code on the claim?
- 7. Verify That Clearinghouse or Submission Vendor Can Send and Receive All Recorded Codes**
How many codes can the vendor support for data submission? Are valid codes being dropped because the provider has not updated the number of codes that can be submitted? Many claims systems and practice management systems are being enhanced to capture more data due to HIPAA data requirements. Has the vendor's submission been expanded to accept additional data as well?
- 8. Verify That Health Plan Can Send and Receive All Recorded Codes**
Not all health plans have expanded their systems to accept large numbers of diagnosis codes. How many codes can your payer accept? What happens to any codes submitted beyond the accepted number?

Major Depressive Disorder Algorithm

- **First determine if ALL of the following apply**
 - Not a mixed episode (e.g. bipolar disorder)
 - Symptoms cause clinically significant distress or impairment in social, occupational or other important areas of concern
 - Not due to direct effect of a substance
 - Not accounted for by bereavement unless continuous for over 2 months or severe functional impairment, morbid preoccupation with worthlessness, psychotic symptoms or psychomotor retardation
 - Present for the same 2 week period

If all the above is true move to next box

- **Must have one or both of these symptoms:**
 - Depressed mood most of the day and nearly every day, self reported or observed by others
 - OR**
 - Markedly diminished interest or pleasure in all, or almost all, activities on most days, self reported or reported by others

If either of the above is true move to the next box

- **Must have either one or both of the above symptoms plus 3 or 4 of these to make a total of 5 or more symptoms.**
 - Significant weight loss (not due to dieting) or gain (e.g. 5% change in one month); or decrease or increase in appetite nearly every day
 - Insomnia or hypersomnia nearly every day
 - Psychomotor agitation or retardation nearly every day, observable by others
 - Fatigue or loss of energy nearly every day
 - Feelings of worthlessness or excessive or inappropriate guilt nearly every day:
 - May be delusional
 - Not merely self-reproach or guilt about being sick
 - Diminished ability to think or concentrate, or indecisiveness, nearly every day (self reported or observed by others)
 - Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

If you now have a minimum of 5 symptoms total, your patient meets the requirement for the diagnosis of Major Depressive Disorder per DSM-IV.¹

ICD-9 Diagnosis:

- **296.2x** Major Depressive Disorder, Single Episode
- **296.3x** Major Depressive Disorder, Recurrent.

Fifth Digits:

- 0** = Unspecified **1** = Mild **2** = Moderate
- 3** = Severe w/o psychotic behavior
- 4** = Severe w/ psychotic behavior
- 5** = In partial or unspecified remission
- 6** = In full remission

Patient: "Name"

Date of Service: 10/30/09

MODEL PROGRESS NOTE

Reason for visit: Follow-up for diabetes

S: States she is able to get around, including bathroom and kitchen with aid of her walker. Denies any pain or shortness of breath. No change in bowel or bladder habits. She states she takes her glyburide regularly. She tries to follow her diet but does not check her fingerstick blood sugars.

O: Patient alert, oriented to person, place and time. No acute distress.

Cardiac: RRR no rubs, gallops or murmurs noted

Lungs: Clear to auscultation.

Abd: Soft non-tender to palpitation with colostomy intact, skin dry and intact surrounding pink-red stoma, liquid brown feces.

Feet: Peripheral pulses barely palpable, unchanged from prior exam. Left great toe amputation with healed incision. Monofilament testing shows loss of sensation bilaterally with absent ankle reflexes.

A: Diabetic polyneuropathy (250.60 and 357.2)

PVD due to diabetes (250.70 and 443.81)

Functioning colostomy (V44.3)

Status post lt great toe amputation (V49.71)

P: Continue current diet and medication regime. Refer for dilated eye exam and for diabetes education. Lab for fasting CMP and A1c. RTC 1 month.

Authenticated by: Joseph A. Williams MD, 10/30/09

¹American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

INGENIX Primary Diabetes Mellitus and Associated Manifestations

THE FOLLOWING FIFTH-DIGIT SUBCLASSIFICATIONS ARE FOR USE WITH ALL SUBCATEGORY 250.X DM CODES:

- 0 Type II or Unspecified Type, Not Stated as Uncontrolled** (Fifth-digit 0 is for the use of Type II patients, even if the patient requires insulin.)
 - 2 Type II or Unspecified Type, Uncontrolled** (Fifth-digit 2 is for the use of Type II patients, even if the patient requires insulin.)
 - 1 Type I [Juvenile Type], Not Stated as Uncontrolled**
 - 3 Type I [Juvenile Type], Uncontrolled**
- Use additional code, if applicable, for associated long-term (current) use of insulin (V58.67) for Type II patients only.

Notation (A): All diabetic manifestations are dependent on chart documentation. Assign as many codes from category 250 as necessary to identify all the associated diabetic conditions. Multiple coding is required for this type of complication, with multiple codes for "Diabetes with Complications" as necessary, followed by a code(s) for the associated manifestation(s) indicating the complication(s).

Notation (B): Ulcers are not automatically assumed to be a manifestation of diabetes. However, ulcers may result from Diabetic Neuropathy (250.6x), or Diabetic Peripheral Vascular Disease (250.7x). If there is no indication as to whether the ulcer condition is due to neuropathy or PVD, then it is appropriate to use 250.8x. The patient record must reveal appropriate linkage or a causal relationship of the diabetes to the specific ulcer manifestation of 250.6x and 250.7x, or 250.8x code categories.

Notation (C): Although arteriosclerosis occurs earlier and more extensively in diabetic patients, CAD, cardiomyopathy and CVD are not complications of diabetes and are not included in code 249.7x or 250.7x. These conditions are coded separately unless the physician documents a causal relationship. Brown, F. (2009). ICD-9-CM Coding Handbook with Answers, Chicago, IL/AHA Press, p. 125.

250.0 **Diabetes Mellitus w/o Mention of Complication**
Refer to the pink section above for the fifth-digit subclassifications.
Diabetes (mellitus), NOS
Diabetes mellitus without mention of complication or manifestation classifiable to 250.1–250.9

250.1–250.3 "Acute Diabetes Codes"
(250.4–250.8) For Diabetes with Manifestations: Refer to the pink section above for the fifth-digit subclassifications for the following 250.X DM codes. Also document causal relationship (i.e. "due to," or "Diabetic").

250.4 **Diabetes w/ Renal Manifestations**
Use additional code to identify manifestation as:
 585.1 CKD (Stage I) GFR ≥ 90 ml/min Filtration
 585.2 CKD (Stage II) GFR 60–89 ml/min Filtration
 585.3 CKD (Stage III) GFR 30–59 ml/min Filtration
 585.4 CKD (Stage IV) GFR 15–29 ml/min Filtration
 585.5 CKD (Stage V) GFR < 15 ml/min Filtration
 585.6 CKD (ESRD) requiring chronic dialysis / transplantation
 585.9 CKD, Unspecified
 V45.11 Dialysis Status
 V45.12 Noncompliance with Renal Dialysis

"Diabetic:"
 581.81 Glomerulosclerosis, intercapillary
 583.81 Nephritis and Nephropathy, NOS
 403.90 Nephropathy w/ HTN and CKD, Stage I – IV, or Unspecified (code also, if applicable.)
 585.1–585.4, 585.9 Chronic Kidney Disease (see above)
 V45.11 Dialysis Status
 403.91 Nephropathy w/ HTN and CKD Stage V or ESRD (code also, if applicable.)
 585.5 CKD (Stage V) GFR < 15 ml/min Filtration
 585.6 CKD (ESRD) requiring chronic dialysis / transplantation
 V45.11 Dialysis Status
 581.81 Nephrosis / Nephrotic Syndrome
 791.0 Proteinuria, Albuminuria, Microalbuminuria

250.5 **Diabetes w/ Ophthalmic Manifestations**
"Diabetic:"
 366.41 Cataract (Snowflake), Type I only
 365.44 Glaucoma
 364.42 Iritis
 362.07 Macular / Retinal Edema
Note: This code must be used with a code for diabetic retinopathy (362.01–362.06)
 362.01 Retinitis
 362.01 Retinopathy, Background / NOS
 362.03 Retinopathy, Nonproliferative
 362.02 Retinopathy, Proliferative

***The following fifth-digit subclassifications are for use with all 707.1X (Ulcer of Lower Limbs, Except Pressure Ulcer) codes:**
X = 0 = unspecified 1 = thigh 2 = calf 3 = ankle 4 = heel and midfoot 5 = other part of foot 9 = other part of lower limb

250.6 **Diabetes w/ Neurological Manifestations**
"Diabetic:"
 353.5 Amyotrophy
 355.71 Causalgia of Lower Limb (burning pain)
 355.9 Mononeuropathy, NEC
 355.8 Mononeuropathy, Unspecified, Lower Limb
 354.9 Mononeuropathy, Unspecified, Upper Limb
 713.5 Neurogenic / Neuropathic Arthritis / Arthropathy
 337.1 Peripheral Autonomic Neuropathy (code also, if applicable.)
 536.3 Gastroparesis / Gastroparesis
 596.54 Neurogenic Bladder, NOS
 564.81 Neurogenic Bowel, NOS
 357.2 Polyneuropathy / Neuralgia / Neuritis / Neuropathy in Diabetes
 707.1X* Any Associated Ulcer of Lower Limbs, Except Pressure

250.7 **Diabetes w/ Peripheral Circulatory Disorders**
"Diabetic:"
 440.20 Atherosclerosis, Extremities, NOS
 440.21 Atherosclerosis, Extremities, with Intermittent Claudication
 440.22 Atherosclerosis, Extremities, with Rest Pain
Note: Includes any condition classifiable to 440.21
 440.23 Atherosclerosis, Extremities, with Ulceration
Note: Includes any condition classifiable to 440.21 and 440.22
 707.1X* Any Associated Ulcer of Lower Limbs, Except Pressure
 440.24 Atherosclerosis, Extremities, with Gangrene
Note: Includes any condition classifiable to 440.21, 440.22 and 440.23 with the following:
 785.4 Gangrene
 707.1X* Any Associated Ulcer of Lower Limbs, Except Pressure
 440.29 Atherosclerosis, Extremities, Other
 443.81 Peripheral Angiopathy / Microangiopathy (PVD)

250.8 **Diabetes w/ Other Specified Manifestations**
(i.e. Dermatitis, Complication NEC, Hypoglycemia, Hypoglycemic Shock)
"Diabetic:"
 731.8 Bone Changes
Note: Use additional code to specify bone condition such as: Osteomyelitis, Periostitis and Other Infections Involving Bone (730.00–730.09)
 259.8 Glycogenosis, Secondary
 261 Lancereaux's
 272.7 Lipoidosis
 709.3 Oppenheim-Urbach Dis./Synd. (necrobiosis lipidica diabetorum)
 707.1X* Ulcer of Lower Limbs, Except Pressure
 707.8 Ulcer of Lower Limbs, Other Specified Sites
Note: Assign 250.8X when Ulcers are not due to Neuropathy or PVD
 272.2 Xanthoma

250.9 **Diabetes w/ Unspecified Complication**
Note: Known diabetic manifestations should be coded to the highest specificity using code categories 250.4–250.8. See pink section above for fifth digits.
Codes valid 10/01/2009 to 9/30/2010 • © 2010 Ingenix. All Rights Reserved • Revised 12/15/09 • IN076
These codes are to be used for easy reference; however, the ICD-9-CM code book is the authoritative reference for correct coding guidelines.

INGENIX®

Protein-Calorie Malnutrition

In order to improve the reporting of malnutrition among the elderly, it is important for physicians to document the condition in the medical record and for coders to be aware of malnutrition as a potential diagnosis (ICD-9 Code Categories 262 and 263).

The most severe malnutrition problems are associated with Protein-Calorie Malnutrition (PCM), also known as Protein-Energy Malnutrition (PEM), which occurs in both chronic and acute forms.

Subjective Global Assessment (SGA) for PEM includes 6 clinical parameters, followed by a personal judgment as to whether the patient has (A) no malnutrition, (B) possible or mild malnutrition, or (C) significant malnutrition.

1. Unremitting, involuntary weight loss that is greater than 10% in the previous 6 months, and especially in the last few weeks
2. Food intake is severely curtailed
3. Muscle wasting and fat loss, with attention to the presence of edema, or ascites present on physical examination
4. Persistent, essentially daily gastrointestinal symptoms such as anorexia, nausea, vomiting, or diarrhea in the previous 2 weeks
5. Marked reduction in physical capacity
6. Presence of metabolic stress due to trauma, inflammation or infection

Any combination of these conditions (especially the first 3) indicates that the patient has significant PEM.

Other standards are used and accepted as indicators of PCM:

Body Weight as a value relative to the established norms in the general population;
Body Mass Index (BMI) between 18–18.9 for mild under nutrition (Note that in the elderly, BMI < 21

may increase mortality risk), which can define PCM as a general weight loss standard.¹ Protein calorie malnutrition can also occur in obesity.

Suggested parameters for evaluating significance of unplanned and undesired weight loss are:²

Interval	Significant Loss	Severe Loss
1 month	5%	> 5%
3 months	7.5%	> 7.5%
6 months	10%	> 10%

Protein-calorie malnutrition may accompany illnesses such as:³

- Cancer
- Alcohol Abuse and / or Dependence
- Liver Disease
- Chronic Kidney Disease (CKD)
- Pancreatitis
- Drug Abuse and / or Dependence
- Anemia
- End Stage Renal Disease (ESRD)

ICD-9 Codes	Code Description	Diagnostic Criteria
263.0	Malnutrition of Moderate Degree	"Second Degree" Characterized by superimposed biochemical changes in electrolytes, lipids, blood plasma ^{4,5}
263.1	Malnutrition of Mild degree	"First Degree" Characterized by tissue wasting in an adult, but few or no biochemical changes ⁴
263.8	Other Protein Calorie Malnutrition	Not elsewhere specified ⁴
263.9	Unspecified Protein Calorie Malnutrition	Dystrophy due to malnutrition Malnutrition (calorie) NOS ⁵
799.4	Cachexia	Wasting disease; general ill health and poor nutrition. ⁴ Code first for underlying condition if known. ⁵

1 Merck Manual Professional Edition. (2007). Protein-energy malnutrition definition. (Prepared by TMF Health Quality Institute, under contract with the Centers for Medicare & Medicaid Services). Retrieved from http://nursinghomes.tmf.org/Portals/16/Documents/NH/Tools/PU/ProteinEnergyMalnutrition.pdf
2 Department of Health & Human Services & Centers for Medicare & Medicaid Services. (2008, August). Intent & definitions: §483.25(i) nutritional status. CMS Manual System: Pub. 100-07 State Operations, Provider Certification, Transmittal 36. Retrieved from http://www.health.state.nm.us/divs/rpcoww/R36SOMA.pdf
3 CMAJ, Nov 13, 2001 "Clinical nutrition: 1. Protein-energy malnutrition in the inpatient"
4 Ingenix 2010 Coders' Desk Reference for Diagnoses. USA: Ingenix. 2009. Print., pp. 264, 648.
5 Ingenix 2010 ICD-9-CM Professional for Physicians. 6th ed. 2 vols. USA: Ingenix, 2009. Print.

Correctly Reporting Cancer Diagnoses: Current Cancer vs. History of Cancer

To correctly report a diagnosis of cancer, one must determine whether the patient's cancer has been eradicated or is currently being treated. The neoplasm table in the ICD-9-CM code book establishes three categories of malignancy: primary, secondary and in-situ. These neoplasms should be coded as such and unknown sites must also be coded.

Current Cancer

Patients with cancer who are receiving active treatment for the condition should be reported with the malignant neoplasm code corresponding to the affected site. This applies even when a patient has had cancer surgery, but is still receiving active treatment for the disease.

Example: Malignant neoplasm of kidney, 189.0

Primary Site with Unknown Secondary Site

Example: Metastatic carcinoma from lung 162.9 (Primary site – lung) + 199.1 (secondary site – unknown)

Secondary Site with Active Primary Site

A patient is admitted with metastatic bone cancer. The patient had a mastectomy 2 months ago and is having radiation treatments for the breast cancer. The neoplasm was located in the upper outer quadrant.

Example: Code 198.5 Neoplasm, bone, secondary
Code 174.4 Neoplasm, breast, upper outer quadrant

History of Cancer

Patients with a history of cancer and no evidence of current cancer should be reported as "Personal history of malignant neoplasm" using a code from the V10 series. These codes require additional digits to identify the type of cancer and should be reported only when there is no evidence of current cancer and a patient's presenting problem, signs, or symptoms may be related to the cancer history or impact the plan of care. These codes should not be reported routinely.

Example: Personal history of malignant neoplasm, kidney, V10.52

Faye Brown's ICD-9-CM Coding Handbook, 2010

Aftercare Following Surgery for Neoplasm

Visits to determine the effectiveness of cancer surgery that fall within the global post-operative period should be reported as "Aftercare following surgery for neoplasm", code V58.42 and a second aftercare code to fully identify the reason for the encounter.

Example: Aftercare following surgery for malignant neoplasm, kidney, V58.42;
Aftercare following surgery of the digestive system, V58.75

Follow-up for Patients with History of Cancer

Follow up exams to determine if there is any evidence of recurring or metastasizing cancers that result in no evidence of malignancy should be reported as "Follow-up exam" using a code from the V67 category to identify the most recent therapy carried out.

Example: Follow-up exam following chemotherapy, V67.2

Cancer Drugs prescribed for reason other than Malignancy

Patients with no history of cancer who take prophylactic cancer drugs should not be reported with an active cancer diagnosis or a personal history of malignant neoplasm. Instead, code the reason for the prescription.

Example: Family history of malignant neoplasm, breast, V16.3;
Prophylactic use of selective estrogen receptor modulators (SERMs), V07.51

References:

AHA Coding Clinic, July-August 1985
AHA Coding Clinic, 4th Q 2002
Part B News, published 2/28/2005

INGENIX® Secondary Diabetes Mellitus and Associated Manifestations

THE FOLLOWING FIFTH-DIGIT SUBCLASSIFICATIONS ARE FOR USE WITH ALL "SECONDARY DM" CODES (SUBCATEGORY 249.X):

(Secondary), Not Stated as Uncontrolled or Unspecified

(Secondary), Uncontrolled

Note: Use additional code, if applicable, for associated long-term (current) use of insulin (V58.67)

Notation (A): All secondary diabetic manifestations are dependent on chart documentation. Assign as many codes from category 249 as necessary to identify all the associated diabetic conditions. Multiple coding is required for this type of complication, with multiple codes for "Diabetes with Complications" as necessary, followed by a code(s) for the associated manifestation(s) indicating the complication(s).

Notation (B): Ulcers are not automatically assumed to be a manifestation of diabetes. However, ulcers may result from Secondary Diabetic Neuropathy (249.6x), or Secondary Diabetic Peripheral Vascular Disease (249.7x). If there is no indication as to whether the ulcer condition is due to neuropathy or PVD, then it is appropriate to use 249.8x. The patient record must reveal appropriate linkage or a causal relationship of the diabetes to the specific ulcer manifestation of 249.6x and 249.7x, or 249.8x code categories.

Notation (C): Although arteriosclerosis occurs earlier and more extensively in diabetic patients, CAD, cardiomyopathy and CVD are not complications of diabetes and are not included in code 249.7x or 250.7x. These conditions are coded separately unless the physician documents a causal relationship. Brown, F. (2009). ICD-9-CM Coding Handbook with Answers, Chicago, IL/AHA Press, p. 125.

Notation (D): Although the estimates vary slightly, the incidence of Secondary Diabetes is significantly lower than that of Primary Diabetes — 1 to 5% and 1 to 2% of total diabetes cases, according to the National Diabetes Education Program and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) respectively. To document Secondary Diabetes, use phrases such as: "diabetes due to" or "diabetes secondary to" followed by the causal condition of the diabetes.

249.0 **Secondary DM w/o Mention of Complication**
Refer to the pink section above for the fifth-digit subclassifications.
Secondary diabetes (mellitus), NOS
Secondary diabetes mellitus without mention of complication or manifestation classifiable to 249.1–249.9

249.1-249.3 "Acute Secondary Diabetes Codes"
(249.4–249.8) For Secondary Diabetes with Manifestations:
Refer to the pink section above for the fifth-digit subclassifications for the following 249.X DM codes. Also document causal relationship (i.e. "due to," or "Diabetic").

249.4 **Secondary DM w/ Renal Manifestations**
Use additional code to identify manifestation as:

- 585.1 CKD (Stage I)** GFR ≥ 90 ml/min Filtration
- 585.2 CKD (Stage II)** GFR 60–89 ml/min Filtration
- 585.3 CKD (Stage III)** GFR 30–59 ml/min Filtration
- 585.4 CKD (Stage IV)** GFR 15–29 ml/min Filtration
- 585.5 CKD (Stage V)** GFR < 15 ml/min Filtration
- 585.6 CKD (ESRD)** requiring chronic dialysis / transplantation
- 585.9 CKD, Unspecified**
- V45.11 Dialysis Status**
- V45.12 Noncompliance with Renal Dialysis**

"Secondary Diabetic:"

- 581.81 Glomerulosclerosis, intercapillary**
- 583.81 Nephritis and Nephropathy, NOS**
- 403.90 Nephropathy w/ HTN and CKD, Stage I – IV, or Unspecified *(code also, if applicable)*
- 585.1–585.4, 585.9 Chronic Kidney Disease** *(see above)*
- V45.11 Dialysis Status**
- 403.91 Nephropathy w/ HTN and CKD Stage V or ESRD** *(code also, if applicable)*
- 585.5 CKD (Stage V)** GFR < 15 ml/min Filtration
- 585.6 CKD (ESRD)** requiring chronic dialysis / transplantation
- V45.11 Dialysis Status**
- 581.81 Nephrosis / Nephrotic Syndrome**
- 791.0 Proteinuria, Albuminuria, Microalbuminuria

249.5 **Secondary DM w/ Ophthalmic Manifestations**

"Secondary Diabetic:"

- 366.41 Cataract (Snowflake), Type I only
- 365.44 Glaucoma
- 364.42 Iritis
- 362.07 Macular / Retinal Edema
Note: this code must be used with a code for diabetic retinopathy (362.01–362.06)
- 362.01 Retinitis
- 362.01 Retinopathy, Background / NOS
- 362.03 Retinopathy, Nonproliferative
- 362.02 Retinopathy, Proliferative**

***The following fifth-digit subclassifications are for use with all 707.1X (Ulcer of Lower Limbs, Except Pressure Ulcer) codes:**

**X = 0 = unspecified 1 = thigh 2 = calf 3 = ankle
4 = heel and midfoot 5 = other part of foot
9 = other part of lower limb**

249.6 **Secondary DM w/ Neurological Manifestations "Secondary Diabetic:"**

- 353.5 Amyotrophy
- 355.71 Causalgia of Lower Limb (burning pain)
- 355.9 Mononeuropathy, NEC
- 355.8 Mononeuropathy, Unspecified, Lower Limb
- 354.9 Mononeuropathy, Unspecified, Upper Limb
- 713.5 Neurogenic / Neuropathic Arthritis / Arthropathy
- 337.1 Peripheral Autonomic Neuropathy** *(code also, if applicable)*
- 536.3 Gastroparesis / Gastroparesis
- 596.54 Neurogenic Bladder, NOS
- 564.81 Neurogenic Bowel, NOS
- 357.2 Polyneuropathy / Neuralgia / Neuritis / Neuropathy in Diabetes**
- 707.1X* Any Associated Ulcer of Lower Limbs, Except Pressure**

249.7 **Secondary DM w/ Peripheral Circulatory Disorders "Secondary Diabetic:"**

- 440.20 Atherosclerosis, Extremities, NOS**
- 440.21 Atherosclerosis, Extremities, with Intermittent Claudication**
- 440.22 Atherosclerosis, Extremities, with Rest Pain**
Note: Includes any condition classifiable to 440.21
- 440.23 Atherosclerosis, Extremities, with Ulceration**
Includes any condition classifiable to 440.21 and 440.22
- 707.1X* Any Associated Ulcer of Lower Limbs, Except Pressure**
- 440.24 Atherosclerosis, Extremities, with Gangrene**
Note: Includes any condition classifiable to 440.21, 440.22 and 440.23 with the following:
- 785.4 Gangrene**
- 707.1X* Any Associated Ulcer of Lower Limbs, Except Pressure**
- 440.29 Atherosclerosis, Extremities, Other**
- 443.81 Peripheral Angiopathy / Microangiopathy (PVD)**

249.8 **Secondary DM w/ Other Specified Manifestations (i.e. Dermatitis, Complication NEC, Hypoglycemia, Hypoglycemic Shock) "Secondary Diabetic:"**

- 731.8 Bone Changes
Note: Use additional code to specify bone condition such as: Osteomyelitis, Periostitis and Other Infections Involving Bone (730.00-730.09)
- 259.8 Glycogenosis, Secondary
- 261 Lancereaux's**
- 272.7 Lipoidosis
- 709.3 Oppenheim-Urbach Dis./Synd. (necrobiosis lipoidica diabetorum)
- 707.1X* Ulcer of Lower Limbs, Except Pressure**
- 707.8 Ulcer of Lower Limbs, Other Specified Sites**
Note: Assign 250.8X when Ulcers are not due to Neuropathy or PVD
- 272.2 Xanthoma

249.9 **Secondary DM w/ Unspecified Complication**

Note: Known diabetic manifestations should be coded to the highest specificity using code categories 250.4–250.8. See pink section above for fifth digits.

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These codes are to be used for easy reference; however, the ICD-9-CM code book is the authoritative reference for correct coding guidelines.

Chronic Kidney Disease Reporting

ICD-9-CM coding for Chronic Renal Failure, Category 585, changed in 2006.¹ The Renal Physicians Association along with the National Kidney Foundation promoted code Category 585 being renamed and expanded to reflect the new clinical practice standards for treating Chronic Kidney Disease (CKD).

Chronic Kidney Disease is defined as either kidney damage* or GFR < 60 mL/min/1.73 m² for ≥ 3 months.²

**Kidney damage is defined as pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests or imaging studies.²*

Staging Chronic Kidney Disease³

Note: All stages need to be chronic, not a one time event.

Stage	Severity	GFR Value	ICD-9 Codes
Stage I		GFR ≥ 90 mL/min/1.73 m ² with kidney damage	585.1
Stage II	Mild	GFR 60-89 mL/min/1.73 m ² with kidney damage	585.2
Stage III	Moderate	GFR 30-59 mL/min/1.73 m ²	585.3
Stage IV	Severe	GFR 15-29 mL/min/1.73 m ²	585.4
Stage V	Kidney Failure	GFR < 15 mL/min/1.73 m ²	585.5
	ESRD	Requiring chronic dialysis or transplantation	585.6
CKD Unsp.		Chronic Kidney Disease, unspecified	585.9

ICD-9-CM instructs the coder to use an additional code to identify kidney transplant status if applicable (V42.0). A kidney transplant may not fully restore kidney function, therefore, patients who have undergone a kidney transplant may still have some form of Chronic Kidney Disease.³ Code V42.0, Kidney replaced by transplant, may be assigned with the appropriate CKD code, based on the patient's post-transplant stage.

If a patient is on renal dialysis or if an arterial-venous shunt is present, code also V45.11.⁴

Patients that have had a kidney transplant where documentation indicates the presence of failure or rejection, assign code 996.81 Complication of kidney transplant followed by a code to identify the nature of the complication.⁴

¹ <http://kidneynotes.blogspot.com/2005/10/chronic-renal-failure-is-no-more-new.html>

² National Kidney Foundation, "KDOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification and Stratification." American Journal of Kidney Disease 39: 2002 supplement 1.

³ Ingenix, Coders' Desk Reference For Diagnoses. 2010. Alexandria, VA: Ingenix, 2009.

⁴ World Health Organization, Professional: ICD-9-CM for Physicians-Volumes 1&2. 2010. Alexandria, VA: Ingenix, 2009.

Stroke and Late Effects of Prior Stroke

One of the most common coding errors seen in chart reviews is the assignment of a stroke code in the present tense when the coder is actually trying to code for the residual conditions left behind by a prior stroke. Acute stroke is only coded during the initial episode of care.

Cerebrovascular Accidents (CVA/Stroke)

In a CVA, there is a decreased supply of blood to the brain that can result in an area of infarction (necrotic cerebral tissue). CVA occurs because of thrombosis, embolism, occlusion (code categories 433 or 434) or hemorrhage (Category 430 to 432). There are codes for each type of CVA. The fourth and fifth digits of these codes indicate either "with" or "without" infarction.

Unless otherwise stated, CVA/stroke is considered an assumed ischemic infarction and is coded **434.91**. The fifth digit of 1 indicates "infarction".

After the Initial Acute Care Episode of Stroke

After an initial stroke incident has occurred, generally one of two scenarios will exist. Either the patient will have deficits from the stroke (conditions left behind such as paralysis) or will make a recovery without any long lasting effects.

If the patient recovers without any lingering problems related to the stroke, the code would be V12.54 Stroke NOS without residual deficits.

If the patient has deficits present after the discharge from the initial acute care episode, all deficits are coded to Late Effects (Category 438).

Prior to October 2004, CVA not otherwise specified was coded to Category 436. In the current 2010 ICD-9-CM there is an exclusionary note specifically stating not to use this code for a cerebrovascular accident.

Post-Operative Cerebrovascular Hemorrhage or Infarction

A post-operative cerebrovascular hemorrhage or infarction that occurs as a result of medical intervention is coded 997.02 – Complications affecting specified body systems: Iatrogenic cerebrovascular infarction or hemorrhage. In addition, the specific type of infarction must be coded.

The Time Line is Significant

Example 1:

Stroke initial incident
Acute embolic CVA with infarction
434.11

Example 2:

Stroke initial incident; prior stroke with no deficits
Acute embolic CVA, prior stroke with no deficits
434.11
V12.54

Example 3:

Stroke initial incident with deficits from prior stroke
Acute embolic CVA with infarction; previous CVA with residual dysphagia
434.11
438.82

Example 4:

Follow-up for evaluation of dysphagia. The dysphagia was due to a stroke.
Office visit to evaluate dysphagia from a stroke one month ago
438.82

Example 5:

The patient suffered a post-operative stroke; acute embolic CVA with infarction
997.02
434.11