CPAs & BUSINESS ADVISORS

CODING FOR SEPSIS, AFTERCARE AND BEHAVIORAL HEALTH CONDITIONS AND SERVICES

AGENDA

- Coding Guidance Hierarchy
- Medical Record Documentation
- Sepsis Coding Guidance and Documentation Requirements
- Aftercare Coding and Documentation Requirements
- Overview of Behavioral Health Services and Documentation Requirements

GUIDANCE HIERARCHY

Classification

- ICD-10-CM
- ICD-10-PCS
- Index, Tabular, Instructional Notes

ICD-10-CM Official Guidelines for Coding & Reporting

- FY 2018 with FY 2019 Guidance to be published shortly
- Set of rules to accompany & complement ICD-10

Approved by Cooperating Parties – 4 organizations: AHA, AHIMA, CMS, NCHS

Coding Clinic

- Quarterly Newsletter published by AHA Central Office on ICD-10
- Provides official interpretation, clarification, application of classification and guidelines
- Case Specific
- Approved by Cooperating Parties in addition to CDC

MEDICAL RECORD DOCUMENTATION

Medical Record

Coding Clinic Advice regarding Provider Documentation
Code assignment may be based on other physician (i.e., consultants, residents, anesthesiologist, etc.) documentation as long as there is no conflicting information from the attending physician.

Medical record documentation from any physician involved in the care and treatment of the patient, including documentation by consulting physicians, is appropriate for the basis of code assignment. The issue of whether a resident's documentation needs to be confirmed by the attending physician is best addressed by the hospital's internal policies, medical staff bylaws, and/or any other applicable local/state/ federal regulations.

It would be appropriate to use the health record documentation of other providers, such as nurse practitioners and physician assistants as the basis for code assignment to report new diagnoses, if they are considered legally accountable for establishing a diagnosis within the regulations governing the provider and the facility. The Official Guidelines for Coding and Reporting define a provider as the individual legally accountable for establishing a diagnosis.

It is appropriate to assign a procedure code based on documentation by a nonphysician professional when that professional provides the service. This may be the only evidence that the service was provided. For example, infusions may be carried out by a nurse, mechanical ventilation may be provided by a respiratory therapist, or a drug may be ordered by the physician and administered by a nurse. Please note this only applies to procedure coding where there is documentation to substantiate the code. This advice does not apply to diagnosis coding.

SEPSIS - CHAPTER SPECIFIC CODING GUIDELINES

Infectious and Parasitic Diseases

Sepsis

- If type of infection or causal organism is not specified, A41.9 Sepsis, unspecified organism
- If Sepsis is linked to organism assign appropriate code, Sepsis due to Staphylococcus, A41.2
- Assign a code for underlying infection (pneumonia, cellulitis). If sepsis present on admission, sepsis sequenced first
- Severe sepsis R65.20 should not be assigned unless documentation of severe sepsis or with organ dysfunction
    - An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code
- Sequencing - Underlying systemic infection, sepsis A41.X, severe sepsis R65.20 or R65.21 if shock present, and additional codes for acute organ dysfunction, and underlying local infection.

SEPSIS - CHAPTER SPECIFIC CODING GUIDELINES

Infectious and Parasitic Diseases

Sepsis

- Severe Sepsis
  - If severe sepsis is present on admission and meets UHDDS (Uniform Hospital Discharge Data Set) definition of principal diagnosis (condition after study that necessitated admission – assign first the code for the underlying systemic infection (i.e. A41.9) followed by the appropriate code from subcategory R65.2 as required by the sequencing rules in the Tabular List.
  - A code from subcategory R65.2 can never be assigned as a principal diagnosis.
  - Severe sepsis may be present on admission, but the diagnosis may not be confirmed until sometime after admission.
  - When documentation is not clear as to whether severe sepsis was present on admission the provider must be queried for clarification.
  - Patient admitted with pneumonia, sepsis, and septic shock
    - A41.9
    - J18.9
    - R65.21
  - Patient admitted with pneumonia, develops sepsis after admission
    - J18.9
    - A41.9

SEPSIS - CHAPTER SPECIFIC CODING GUIDELINES

Infectious and Parasitic Diseases

Sepsis

- Sepsis associated with noninfectious condition
  - Trauma with resulting sepsis – i.e. burn
  - Sequencing depends on circumstances of admission
  - If sepsis or severe sepsis is documented as associated with a noninfectious condition, such as a burn, and this condition meets the definition for principal, the noninfectious diagnosis should be sequenced first, followed by code for infection.
  - If both the associated noninfectious condition and the infection meet the definition of principal diagnosis, either condition may be assigned as principal diagnosis.
  - Only one code from category R65, Symptoms and signs specifically associated with systemic inflammation and infection, should be assigned. When a noninfectious condition leads to an infection resulting in severe sepsis, assign the appropriate code from subcategory R65.2, Severe sepsis.
    - Do not additionally assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin.
- SIRS due to non-infectious process – SIRS due to heatstroke
  T670XXA – Heatstroke
  R6510 - SIRS

SEPSIS - CHAPTER SPECIFIC CODING GUIDELINES

Infectious and Parasitic Diseases

Sepsis

- SIRS due to pneumonia, but patient is not septic
  - Systemic inflammatory response syndrome (SIRS) due to an infectious process without presence of sepsis is coded to the infectious process only. No other code is required. AHA Coding Clinic 3rd Quarter 2014.
  - Only assign J18.9

- Sepsis due to postprocedural infection
  - As with all post procedure/postoperative complications, code assignment is based on the provider's documentation of the relationship between the infection and the procedure.
  - Assign:
    - T80.2 – Infections following infusion, transfusion, and therapeutic injection
    - T81.4 – Infection following a procedure
    - T88.0 – Infection following immunization
    - O86.0 – Infection of obstetric surgical wound
  - Followed by the code for the specific infection
  - If severe sepsis present, code from subcategory R65.2 should be assigned along with the code(s) for any acute organ dysfunction.
- If septic shock is present post procedurally:
  - T81.12 Postprocedural septic shock

SEPSIS - CHAPTER SPECIFIC CODING GUIDELINES

Infectious and Parasitic Diseases

Sepsis

- Viral Sepsis
  - Per AHA Central Office on ICD-10CM/PCS
  - Viral sepsis is a systemic infection caused by presence of a virus in the blood.
  - Although sepsis is most commonly caused by bacterial infection, it may also be caused by virus, fungi, and/or parasites.
  - Assign code A41.89 – Other specified sepsis for a diagnosis of viral sepsis.
  - Although codes in categories A30-A49 classify bacterial illnesses, ICD-10 does not provide a specific viral sepsis code. A41.89 is the best available option.
  - Code B97.89 should also be assigned as an additional code to provide further specificity and convey that the sepsis is due to a viral infection, when the specific type of viral infection is not documented.

SEPSIS - CHAPTER SPECIFIC CODING GUIDELINES

Infectious and Parasitic Diseases

Sepsis

- Coding Clinic Third Quarter 2016
  - Question – How do you code a patient who is admitted with sepsis from influenza with pneumonia?
  - Answer – Assign code A41.89 Other specified sepsis, for a diagnosis of sepsis due to influenza. Although codes A30-A49 classify bacterial illnesses, there is not specific code for viral sepsis. In addition, assign code J11.00 Influenza due to unidentified influenza virus with unspecified type of pneumonia, for the influenza with pneumonia.

SEPSIS - CHAPTER SPECIFIC CODING GUIDELINES

Infectious and Parasitic Diseases

Sepsis

- Urosepsis – nonspecific term – no default code in index
  - Provider must be queried

- Bacteremia
  - Assign code R78.81

SEPSIS - CHAPTER SPECIFIC CODING GUIDELINES

Infectious and Parasitic Diseases

- Selection/sequencing of MRSA (methicillin resistant Staphylococcus aureus) codes – Infection due to MRSA

  - Combination codes
    - Assign combination code if exists when infection due to MRSA
      - A41.02 – Sepsis due to MRSA
      - J15.212 – Pneumonia due to MRSA
      - No reason to assign additional organism code of B95.62 MRSA as cause of disease classified elsewhere or Z16.11 Resistance to penicillins

  - No combination code exists
    - Assign code for condition and B95.62 MRSA as cause of disease classified elsewhere

SEPSIS - CHAPTER SPECIFIC CODING GUIDELINES

Infectious and Parasitic Diseases

Sepsis Definition

- Definition of Sepsis
  - Coding Clinic 3rd Quarter 2016
    - Question – We have seen recently issued consensus definitions for sepsis and septic shock. How will this affect the coding? Will coding guidelines be updated?
    - Answer – Coding guidelines are based on ICD-10 as it exists today. Continue to code sepsis, severe sepsis and septic shock using the most current version of ICD-10 and ICD-10 guidelines. Code assignment is based on provider documentation (regardless of clinical criteria the provider used to arrive at the diagnosis)
- Per AHA Central Office on ICD-10-CM/PCS:
  - New clinical consensus definitions for sepsis and septic shock were included in the 2016 sepsis diagnostic guidelines developed by a joint task force of the Society of Critical Care Medicine and European Society of Intensive Care Medicine and published in the Journal of the American Medical Association (JAMA). Coders are questioning whether ICD-10-CM codes for sepsis may be assigned based on the new clinical criteria. Coders should never assign a code for sepsis based on clinical definition or criteria or clinical signs alone. Code assignment should be based strictly on physician documentation (regardless of the clinical criteria the physician used to arrive at that diagnosis). Refer to the Official Guidelines for Coding and Reporting when assigning codes for sepsis, severe sepsis, and septic shock. The coding guidelines are based on the classification as it exists today. Therefore, continue to code sepsis, severe sepsis and septic shock using the most current version of the ICD-10-CM classification and the ICD-10-CM Official Guidelines for Coding and Reporting, not clinical criteria.

BEHAVIORAL HEALTH

BEHAVIORAL HEALTH - CHAPTER SPECIFIC CODING GUIDELINES

Mental Health

- Pain disorders related to psychological factors
  - F45.41 – pain exclusively related to psychological disorders
    - Excludes 1 under G89 should not be assigned with this code
  - F45.42 – pain disorder with related psychological factors
    - Code also associated acute or chronic pain G89-

Substance use, abuse, dependence

- Documentation of use, abuse, and dependence of same substance
  - Only one code should be assigned
  - Use and abuse documented – assign only abuse
  - Abuse and dependence documented – assign only dependence
  - Use, abuse, dependence documented – assign only dependence
- In Remission
  - Requires providers clinical judgement
  - In remission only assigned based on provider documentation
  - Early or sustained remission – coded to in remission

BEHAVIORAL HEALTH CHAPTER SPECIFIC CODING GUIDELINES

Psychoactive Substance Use Disorders

- Assigned based on provider documentation
- Codes used when psychoactive substance use is associated with a physical, mental or behavioral disorder
  - F10.980 – Alcohol use, unspecified with alcohol induced anxiety disorder
    - Anxiety due to daily alcohol use
  - F10.24 – Alcohol dependence with alcohol induced mood disorder
    - Alcohol induced depression with alcohol dependence

'In Remission'

- Assignment is based on provider's clinical judgement and only assigned when documented as such
- Codes used when psychoactive substance use is in remission are assigned from categories F10 to F19

BEHAVIORAL HEALTH CHAPTER SPECIFIC CODING GUIDELINES

2019 ICD-10-CM Code Update

- New codes for:
  - Cannabis Dependence and withdrawal
    - F12.23 Cannabis Dependence with withdrawal
    - F12.93 Cannabis Use with withdrawal
  - Depression and Psychosis following childbirth
    - Additional codes were added to distinguish postpartum depression
    - Current code F53 – used to report diagnosis of either postpartum or puerperal psychosis will be replaced with codes:
      - F53.0 – Postpartum depression
      - F53.1 – Puerperal Psychosis
  - Factitious Disorder
    - F68.A – Factitious disorder imposed on another
    - F68.10 –F68.13 – existing codes describe manifestations of factitious disorder imposed on the self

PSYCHOTHERAPY CODES

Code	Description
90791	**Psychiatric/psychological diagnostic interview without medical services (intake interview)**
90792	Psychiatric diagnostic interview (for prescribers / medical services)
90832	Individual psychotherapy, 30 minutes (when performed with an evaluation & management service: 90833) Non-facility: 64.84 / Facility: 64.12
90834	**Individual psychotherapy, 45 minutes** (when performed with an evaluation & management service: 90836) Non-facility: 85.97 / Facility: 85.62
90837	Individual psychotherapy, 60 minutes (when performed with an evaluation & management service: 90838) Non-facility: 128.6 / Facility: 127.89
90847	**Family Psychotherapy with patient present** (without patient present: 90846; multiple-family group psychotherapy: 90849) Non-facility: 107.47 / Facility: 106.75 (without patient: 104.24 / 103.53; multiple-family group: 34.39 / 30.81)
90853	Group psychotherapy Non-facility: 26.51 / Facility: 25.79

PSYCHOTHERAPY EXAMPLES

CPT Assistant, December 2013 Page: 18

Medicine: Psychiatry

Question:

The coding guidelines for Psychiatric Diagnostic Procedures indicate the following: "Codes 90791, 90792 are used for the diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapeutic services. Psychotherapy services, including for crisis, may not be reported on the same day." Does this mean that a patient's family psychotherapy session reported with code 90846, Family psychotherapy (without the patient present), or code 90847, Family psychotherapy (conjoint psychotherapy) (with patient present), could not be billed on the same day as a psychiatric diagnostic evaluation (90791, 90792), even if the family psychotherapy was a separate session?

Answer:

Family psychotherapy codes 90486 and 90487 cannot be billed on the same day as diagnostic evaluation codes 90791 and 90792. The rationale for this is that the purpose of a diagnostic evaluation is to determine diagnoses and treatment for a patient presenting for the first time (or being seen for a re-evaluation). Family therapy is an identified form of psychotherapy aimed at improving the patient's functioning by working with the patient within the context of the patient's family. Family therapy may be a recommended treatment modality based on the evaluation done in the diagnostic evaluation. The two would not occur on the same day. If a patient's family is interviewed as part of an initial diagnostic evaluation, that is not the same as family therapy, therefore it would be considered a part of the diagnostic evaluation and is not separately reportable.

TESTING

Code	Description
96101	Psychological testing, interpretation and reporting per hour by a psychologist (per hour) Non-facility: 80.96 / Facility: 80.24
96102	Psychological testing per hour by a technician (per hour)
96103	Psychological testing by a computer, including time for the psychologist's interpretation and reporting (per hour)
96105	Assessment of Aphasia
96111	Developmental Testing, Extended
96116	Neurobehavioral Status Exam (per hour) Non-facility: 94.93 / Facility: 88.84
96118	Neuropsychological testing, interpretation and reporting by a psychologist (per hour) Non-facility: 99.23 / Facility: 79.88
96119	Neuropsychological testing per hour by a technician

HEALTH & BEHAVIORAL ASSESSMENTS

Code	Description
96150	Health & Behavioral Assessment – Initial (each 15 mins) Non-facility: 21.49 / Facility: 21.14
96151	Reassessment (each 15 mins) Non-facility: 20.78 / Facility: 20.42
96152	Health & Behavior Intervention – Individual (each 15 mins)
96153	Health & Behavior Intervention – Group (each 15 mins)
96154	Health & Behavior Intervention – Family with Patient (each 15 mins)
96155	Health & Behavior Intervention – Family without Patient (each 15 mins)

CODING EXAMPLE

CPT Assistant, September 2014 Page: 15

Health and Behavior Assessment/Intervention

Question:

Can codes 96150-96155 be reported when a health and behavior intervention is performed by a physician in a clinic or hospital setting?

Answer:

No. The health and behavior assessment codes 96150-96155 should only be reported by qualified non physician health care professionals to identify assessment and treatment for biopsychosocial factors affecting a patient's physical health problems. The health and behavior assessment/intervention guidelines direct that physicians performing health and behavior assessments and/or interventions should report the appropriate E/M or preventive medicine service codes.

CARE PLANNING SERVICES

99483 Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.

99484 Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.

CARE PLANNING DEFINED

Clinical Example (99483)

An 83-year-old female with hypertension, diabetes, arthritis, and coronary artery disease presents with confusion, weight loss, and failure to maintain her house, where she lives alone.

Description of Service (99483)

A complete history, including a focus on the patient's decline, is obtained from the patient, family, and/or caregiver to include identification of potential symptoms that may indicate confounding underlying disease. A pertinent physical examination and assessment of affect, cognition, and functional status (basic activities of daily living and instrumental activities of daily living) are performed, including decision-making capacity, mobility, balance, vision, hearing, psychosocial function, and safety (ie, at home and/or driving). The patient is evaluated for neuropsychiatric and behavioral symptoms, including depression, mood instability, psychotic symptoms, aggression, apathy, and other behavioral disturbance. The stage of dementia is assessed using standardized instruments. A medication reconciliation is completed, and a review for high-risk medications that may affect cognition (separate from rating scales noted in preservice) is performed. The values and preferences of the patient and caregiver for care and goals of care (eg, quality of life, advance care planning) are discussed. The caregiver's relationship to the patient, availability, knowledge, general capability (eg, any physical limitation), and ability and willingness to implement a care plan are evaluated and discussed. Relevant data, options, and risks are considered. A diagnosis is formulated, and a care plan (moderate to high-complexity medical decision making) is developed. A meeting with the clinical care team is held to review findings and develop a care plan. Based on medication reconciliation, a prescription(s) is written, and arrangements for diagnostic testing or referral are made, as necessary. The written care plan is created, and a copy is provided to the patient and/or family or caregiver. Findings and the care plan are reviewed with the patient and/or family or caregiver, to include the etiology and severity of the cognitive impairment, goals of treatment, changes in medication, and recommendations for physical and/or occupational therapy. Safety issues are addressed, caregiving issues are discussed, and recommendations for appropriate community services (eg, rehabilitation services, adult day programs, support groups) are made.

AFTERCARE

AFTER CARE CHAPTER SPECIFIC CODING GUIDELINES

Injury, Poisoning, and Other consequences of External Causes (S00-T88)

- Chapter 19 – most categories have a 7th character requirement
- Most categories have three 7th character values (exception of fractures)
  - A – Initial Encounter – receiving active treatment for condition
  - D – Subsequent Encounter – completed active treatment of condition and is receiving routine care for condition during healing or recovery phase
  - S – Sequela - for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. Scars are sequelae of burn
    - Assign injury code that precipitated the sequela and code the sequela itself. The S is added only to the injury code. The specific sequela (i.e. scar) is sequenced first, followed by injury code
- While patient may be seen by a new or different provider over the course of treatment for an injury, assignment of 7th character is based on whether patient is undergoing active treatment and not whether provider is seeing patient for the first time

AFTER CARE CHAPTER SPECIFIC CODING GUIDELINES

Injury, Poisoning, and Other consequences of External Causes (S00-T88)

- Traumatic fractures have additional 7th character values; for example closed fractures:
  - A – Initial encounter for closed fracture
    - Use for each encounter where patient is receiving active treatment
    - Use for a patient who delayed seeking treatment for fracture or malunion/ nonunion
  - D – Subsequent encounter for fracture with routine healing
    - Completed active treatment & is receiving routine care
  - G –Subsequent encounter for fracture with delayed healing
  - K – Subsequent encounter for fracture with nonunion
  - P – Subsequent encounter for fracture with malunion
  - S – Sequela
- Care for complications of surgical treatment for fractures during healing or recovery phase – code the appropriate complication code
- Care for complications of malunion or nonunion – report fracture with appropriate 7th character

AFTER CARE CHAPTER SPECIFIC CODING GUIDELINES

- Factors Influencing Health Status and Contact with Health Services (Z00-Z99)
- Aftercare
  - Cover situations when initial treatment of a disease has been performed and patient requires continued care during healing or recovery phase or long term consequences

  - **Do not use for aftercare for injuries, for aftercare of an injury, assign acute injury code with appropriate 7th character**

    - Physical Therapy claims – Do not use Z51.89

  - Do not use if treatment for current, acute disease

  - Two exceptions to above:
    - Z51.0 – Encounter for radiation
    - Z51.1 – Encounter for chemotherapy and immunotherapy
      - Sequence these codes dependent on admission circumstances

CHAPTER SPECIFIC CODING GUIDELINES

Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

- Aftercare
  - Status Z codes may be used to indicate nature of aftercare
    - Z95.1 Presence of aortocoronary bypass graft
    - Z43.0 Encounter for attention to tracheostomy
      - Do not use in addition a status code when title indicates status, i.e. do not add Z93.0 Tracheostomy status
- Follow up
  - Used to explain continuing surveillance following completed treatment of a disease, condition or injury
  - Implies condition has been treated and no longer exists
  - Do not confuse with aftercare or injury codes with 7th character for subsequent tx, that explain ongoing care of a healing condition or sequelae
  - May be used to explain multiple visits
    - Z08 – Follow up after completed tx for malignant neoplasm
    - Z09 – Follow up after completed tx for other than malignant neoplasm
    - Z39 – Encounter for maternal postpartum care and examination

CODING EXAMPLE

Coding Clinic, First Quarter ICD-10 2015 Page: 14

Question:

A patient was treated for a fracture and placed in a cast. Two weeks later, the cast was wedged to obtain better position. Would this intervention be considered active treatment? Would any intervention or evaluation done before the fracture is stable be considered active treatment? In this scenario, would the visit for the cast adjustment be considered "initial encounter" or "subsequent encounter"?

Answer:

No, this scenario does not represent active treatment and should be reported with the appropriate 7th character for subsequent encounter. As stated in the guidelines, fractures are coded using the appropriate 7th character for subsequent encounter after the patient has completed active treatment of the fracture and is receiving routine care during the healing or recovery phase. Examples of fracture aftercare are cast change or removal, removal of external or internal fixation device, medication adjustment, and follow up visits following fracture treatment.

CODING EXAMPLE

Coding Clinic, First Quarter ICD-10 2015 Page: 10

Question:

The patient in the presents to a new orthopedist three weeks after moving to a new location. The orthopedist orders x-rays and determines that the right tibia shaft fracture is almost completely healed. He instructs the patient to return in one week for cast removal. Even though active treatment for this fracture had previously been completed, this is an initial encounter with a new physician. Is the 7th character "A" appropriate? How should this encounter be coded?

Answer:

Assign code S82.234D, Nondisplaced oblique fracture of shaft of right tibia, subsequent encounter, as the first-listed code for this visit. Whether the subsequent visit is with the original orthopedist or a new orthopedist does not affect assignment of the 7th character "D." The fact that the injury is receiving routine care during the healing phase is the determining factor.

Assignment of the 7th character "A" is from the perspective of the patient receiving active treatment, and is not based on the patient being "new" to the physician.

SEQUELA (LATE EFFECTS)

A sequela is the residual effect (condition produced) after the acute phase of an illness or injury is terminated.

- There is no time limit on when a sequela code can be used. The residual may be apparent early or it may occur months or years later.

Examples:

- Scar formation resulting from a burn
- Deviated septum due to a nasal fracture
- Infertility due to a tubal occlusion from old tuberculosis

Coding for sequela generally requires 2 codes sequenced in the following order:

- The condition or nature of the sequela is sequenced 1st
- The sequela code is sequenced 2nd

Exceptions to the above sequencing guidance:

- When code for the sequela is followed by a manifestation code identified in the Tabular List and title
- Sequela code has been expanded (at the 4th, 5th or 6th character levels) to include the manifestation(s)

The code for the acute phase of an illness or injury that led to the sequela is NEVER used with a code for the late effect.

CODING EXAMPLE

Coding Clinic, Fourth Quarter 2012 Pages: 90-98

Question:

A nursing home resident is transferred to the hospital for treatment of pneumonia. She returns to the nursing home and is still receiving antibiotics for the pneumonia. However, the main reason she is returning to the nursing home is because this has been her residence since developing a CVA with residuals several years ago. Which diagnosis should be listed first at the nursing home, the pneumonia or late effects of the CVA? Would it make any difference if the pneumonia was no longer receiving any treatment upon the resident's return to the nursing home?

Answer:

Assign the appropriate code from subcategory I69.3, Sequelae of cerebral infarction, as the principal diagnosis to identify the neurologic deficits, which resulted from the acute CVA. Assign the appropriate code for the pneumonia as a secondary diagnosis, for as long as the patient receives treatment for the condition.

QUESTIONS?

THANK YOU

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