Alert on Blood Transfusion Procedure Coding

Recommendation

Hospital coding personnel should apply ICD-10-PCS transfusion procedure codes to all **maternity** cases that receive a transfusion given its importance for measuring severe maternal morbidity.

Rationale

- Coding of transfusion procedures is necessary for tracking *Severe Maternal Morbidity (SMM)* — a national public health measure developed by the Centers for Disease Control (CDC) and the basis for the *Maternal Complications* measure being developed by national performance reporting and accreditation organizations.

- Although ICD-10-PCS transfusion procedure codes are not required for billing purposes, they are **necessary** for accurate calculation of the *SMM* rate. Per the *Standards of Ethical Coding* published by the *American Health Information Management Association (AHIMA)*, coders should, "Gather and report all data required for internal and **external reporting**, in accordance with applicable requirements and data set definitions."

Background

U.S. maternal mortality and maternal morbidity rates have doubled in the last 15 years. The rate of *Severe Maternal Morbidity (SMM)* has become a key indicator of maternal health outcomes and decreasing the *SMM/Maternal Complications* rate has become a national priority with several public health and quality improvement organizations initiating projects to address the high rates. These organizations include The Joint Commission and the Agency for Healthcare Research and Quality (AHRQ), among others.

As blood transfusions now account for over half of instances of SMM, tracking blood transfusions during the delivery hospitalization is central to understanding the drivers of SMM. Because blood bank data are not available in data sets used by national and state agencies, new public health and safety initiatives, such as those led by The Joint Commission, AHRQ, and others, rely on widely available administrative data sets (i.e. ICD-10-PCS diagnosis and procedure codes) to easily identify national, statewide and local SMM rates.

What impact did the ICD-9 to ICD-10-PCS transition have on transfusion procedure coding?

Prior to October 2015, most hospitals utilized ICD-9 procedure codes to document transfusions. However, under ICD-10-PCS transfusion procedure coding decreased for a number of reasons:

- ICD-10 transfusion procedure codes are not required for hospital reimbursement.
- The number of transfusion codes increased substantially, and correct utilization of the codes requires greater specificity in documentation (e.g. documenting the vein or artery

and the approach used to administer the transfusion). Coding departments were concerned that often this exact data is not easily available in the medical record.

▪ Hospitals assumed they could access transfusion data from internal blood bank systems, as needed.

As such, some hospitals stopped using ICD-10 PCS codes for blood transfusions. However, now that *SMM/Maternal Complications* is being adopted as a national performance measure it is critical that hospitals utilize ICD-10-PCS procedure codes for blood transfusions in <u>maternity</u> patients.

How can we work with Coding Staff to ensure ICD-10-PCS transfusion procedure codes are used consistently and appropriately?

AHIMA standards and Coding Clinic allow for the development of facility-specific coding guidelines that establish a *default* code based on common practice (*see references on Page 4 below*). In the case of maternity patients, most blood transfusions are administered via a peripheral vein using a percutaneous approach. This type of default internal policy can be developed and applied without significantly impacting coder productivity.

Suggested steps to improve blood transfusions coding:

- Meet with clinical staff to identify common clinical practices for blood transfusions in maternity patients. The most common route of administration will be the *peripheral vein using a percutaneous approach,* although the *central vein* may be used for high-acuity patients.
- If internal clinical staff agree that *peripheral vein transfusions* represent common practice within the facility, the coding department can create a written internal policy stating that would become the default code used.
- The important data element that can change in coding transfusions is for the type of blood product (e.g., red blood cells, platelets, etc.), rather than the body part and approach. The type of blood product should be well documented within the electronic medical record (EMR), and the correct ICD-10-PCS code referencing that blood product type can be applied.

Potential ICD-10-PCS Blood Transfusion Codes for Maternity Patients

The potential codes for use in coding transfusions in maternity patients are listed below, **with the two most common routes highlighted in purple**. When documenting transfusions in the EMR, it is also important to distinguish the type of blood product: *frozen plasma, fresh plasma, plasma cryoprecipitate, red blood cells, frozen red blood cells, platelets,* and *fibrinogen.*

Typical ICD-10-PCS Codes used for Obstetric Blood Transfusions	ICD-10 PCS Code
Transfusions into a Peripheral vein (*usual approach*)	
Transfusion of Nonautologous **Frozen Plasma** into Peripheral Vein, Percutaneous Approach	30233K1
Transfusion of Nonautologous **Fresh Plasma** into Peripheral Vein, Percutaneous Approach	30233L1
Transfusion of Nonautologous **Plasma Cryoprecipitate** into Peripheral Vein, Percutaneous Approach	30233M1
Transfusion of Nonautologous **Red Blood Cells** into Peripheral Vein, Percutaneous Approach	30233N1
Transfusion of Nonautologous **Frozen Red Cells** into Peripheral Vein, Percutaneous Approach	30233P1
Transfusion of Nonautologous **Platelets** into Peripheral Vein, Percutaneous Approach	30233R1
Transfusion of Nonautologous **Fibrinogen** into Peripheral Vein, Percutaneous Approach	30233T1
Transfusions into a Central Line (*typically only used in massive hemorrhages*)	
Transfusion of Nonautologous **Frozen Plasma** into Central Vein, Percutaneous Approach	30243K1
Transfusion of Nonautologous **Fresh Plasma** into Central Vein, Percutaneous Approach	30243L1
Transfusion of Nonautologous **Plasma Cryoprecipitate** into Central Vein, Percutaneous Approach	30243M1
Transfusion of Nonautologous **Red Blood Cells** into Central Vein, Percutaneous Approach	30243N1
Transfusion of Nonautologous **Frozen Red Cells** into Central Vein, Percutaneous Approach	30243P1
Transfusion of Nonautologous **Platelets** into Central Vein, Percutaneous Approach	30243R1
Transfusion of Nonautologous **Fibrinogen** into Central Vein, Percutaneous Approach	30243T1
Autologous Red Blood Cells (previously self-donated blood)	
Transfusion of **Autologous Red Blood Cells** into Peripheral Vein, Percutaneous Approach	30233N0
Transfusion of **Autologous Red Blood Cells** into Central Vein, Percutaneous Approach	30243N0

AHIMA and Coding Clinic References to Support Use of ICD-10-PCS for Transfusions

Coding Clinic Supporting Development of Default Codes based on Common Practice

Excision of Saphenous Vein for Coronary Artery Bypass Graft
[Coding Clinic, Third Quarter 2014: Page 8](#)
Coding advice or code assignments contained in this issue effective with discharges September 15, 2014.

"Question:
Please provide clarification for coding the harvest of the saphenous vein for coronary artery bypass grafting (CABG). In the operative note, the physician documents harvest of left saphenous vein from the leg with no further specificity. Is there any guidance when the documentation does not state upper/greater, or lower/ lesser saphenous vein?

Answer:
ICD-10-PCS does not have an "unspecified" or "not otherwise specified" designation for procedures performed on the saphenous vein. If the documentation does not specify which saphenous vein was harvested, query the physician for clarification so that the appropriate body part may be reported. <u>Facilities may also work with providers to develop facility-specific coding guidelines, which will establish a default code based on common practice."</u>

AHIMA Standard Supporting Development of Internal Coding Policies
1. Apply accurate, complete, and consistent coding practices that yield quality data.
> 1.2. Develop and comply with comprehensive internal coding policies and procedures that are consistent with requirements.

AHIMA Standard Supporting Use of ICD-10-PCS Codes for Performance Reporting
2. Gather and report all data required for internal and external reporting, in accordance with applicable requirements and data set definitions.

AHIMA Standard Supporting Use of Codes to Present a Complete Clinical Picture
Coding professionals **shall not:**
5.3. Misrepresent the patient's clinical picture through intentional incorrect coding or omission of diagnosis or procedure codes, or the addition of diagnosis or procedure codes unsupported by health record documentation, to inappropriately increase reimbursement, justify medical necessity, improve publicly reported data, or qualify for insurance policy coverage benefits.

AHIMA Standard Supporting Collaboration with Providers to Ensure Complete Coding
6. Facilitate, advocate, and collaborate with healthcare professionals in the pursuit of accurate, complete and reliable coded data and in situations that support ethical coding practices.

AHIMA Standard Supporting Use of Provider Queries to Ensure Complete Coding
4. Query and/or consult as needed with the provider for clarification and additional documentation prior to final code assignment in accordance with acceptable healthcare industry practices.