Medicare’s Foray into Mandatory Bundling: The Comprehensive Care for Joint Replacement Payment Model

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Medicare’s Comprehensive Care for Joint Replacement (CJR) regulation, issued on November 16, 2015, requires bundled payments for joint replacements to the lower extremities over a 90-day "episode of care" in 67 Metropolitan Statistical Areas (MSAs) across the country.

Under the CJR program, nearly 800 hospitals will be financially responsible for all of the inpatient and postoperative care of patients undergoing total knee or hip replacements from admission until 90 days after discharge. CMS estimates that the new bundled-payment test will cover about 23 percent of lower extremity joint replacement (LEJR) procedures for which Medicare pays and save Medicare $343 million over the five years during which performance will be measured and paid—or penalized.

“This model,” according to CMS’ Innovation Center, “tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.”

The episode of care begins with an admission to a CJR hospital of a Medicare patient who is ultimately discharged under MS-DRG 469 (Major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (Major joint replacement or reattachment of lower extremity without major complications or comorbidities). The procedures in these MS-DRGs include elective hip and knee arthroplasty procedures (total or partial) caused by osteoarthritis or similar conditions, and also ankle arthroplasty, as well as arthroplasty for fracture repair such as hip hemiarthroplasty or total hip arthroplasty for hip fracture. The episode ends 90 days post-discharge.

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The episode includes all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries, including clinical laboratory services, skilled nursing care, home health, physical therapy, durable medical equipment and hospice care, with certain exclusions.

Participating hospitals, physicians and other providers will continue to be paid by Medicare under its existing fee-for-service payment policies. Following each performance year, however, CMS will compare actual expenditures for MS-DRGs 469 and 470 to the established target prices individually established for each CJR participating hospital. These target prices will be set by a combination of a hospital’s blended, regional and historical episode spending data, with a discount factor of three percent.

CMS will also use a simple risk stratification methodology to set different target prices for patients with hip fractures within each MS-DRG. If the hospital’s expenditures are lower than CMS’ established target price, the hospital will be eligible for a reconciliation payment, the size of which will depend partly on the quality of its care, subject to the maximum amounts shown in Table 1. If the participating hospital’s expenditures are higher than CMS’ established target price, the hospital will be required to pay CMS a percentage of the difference.

The first performance period will begin on April 1 and end on December 31, 2016. During that period, there will only be upside risk; hospitals that exceed their targets will not have to refund any money to CMS. In the second through fifth years of the program, hospitals will have downside risk, but stop-loss limits will be set, as shown in Table 1.

| Table 1. Maximum Positive and Negative Gains/Losses after Reconciliation |
|--------------------------|-----------------|-----------------|-----------------|-----------------|
|                         | Performance Year 1 | Performance Year 2 | Performance Year 3 | Performance Year 4 | Performance Year 5 |
| Gain Standard Limit     | 5%               | 5%               | 10%              | 20%              | 20%               |
| Stop-Loss Standard Limit| N/A              | 5%               | 10%              | 20%              | 20%               |

Source: American Society of Anesthesiologists CJR Toolkit

Hospitals will have a chance to lower the three percent discount included in their target prices if they meet quality performance metrics. The quality measures can reduce their discount by as much as half, from three percent to 1.5 percent, in years four and five. Minimum quality thresholds must be met before any gain sharing can be earned. The measures are listed in Table 2.

<table>
<thead>
<tr>
<th>Table 2. CJR Model Quality Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
</tr>
<tr>
<td>Hospital-level Risk Standardized Complication Rate following elective primary total hip or total knee arthroplasty (National Quality Forum Measure #1550)</td>
</tr>
<tr>
<td>HCAHPS patient satisfaction survey (National Quality Forum Measure #0166)</td>
</tr>
<tr>
<td>Patient Reported Outcomes (PROs) and limited risk variable voluntary data</td>
</tr>
</tbody>
</table>

Source: Health Loop, Comprehensive Care for Joint Replacement (CJR) Readiness Kit

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These measures are combined into a composite quality score. CMS also provides an additional bonus for voluntary submission of PROs. Based on relative rankings of surgical complication rates and HCAHPS scores, CJR hospitals will earn ‘points’ towards the composite quality score. Hospitals can earn two bonus points for voluntary submission of PROs and up to 1.8 bonus points if they achieve a three percent improvement in HCAHPS and/or surgical complication rates from the prior year.

Based on their composite quality scores, hospitals will be given one of four grades: “Excellent,” “Good,” “Acceptable” or “Below Acceptable.” These grades affect the hospital’s target prices for LEJR procedures.

Upon request, CMS will make three years of baseline data, including spending and utilization data and sharing of best practices, available to the CJR hospitals before the April 1, 2016 start date. On an ongoing basis, aggregate and identifiable data will be available no less than quarterly.

The final rule itself did not include waivers of any fraud and abuse laws, but CMS and the Department of Health and Human Services Office of Inspector General issued a joint statement waiving the anti-kickback, physician self-referral (Stark), and civil monetary penalty laws with respect to certain carefully defined financial relationships between CJR hospitals and collaborating providers involved in the delivery of care to CJR patients. CMS will also permit limited beneficiary incentives that would otherwise implicate the Civil Money Penalty Law or the Anti-kickback statute.

LEJR surgeries are an obvious target for CMS as it moves toward its goal of having 30 percent of all Medicare fee-for-service payments made via alternative payment models by 2016 and 50 percent by 2018. They are the most common inpatient surgery for Medicare beneficiaries and can require lengthy recovery and rehabilitation periods. Medicare spent more than $7 billion on more than 400,000 LEJR procedures in 2013 and again in 2014. There is considerable variation in the costs of episodes of care, both between patients and on a geographic basis. The rate of complications, like infections or implant failures after surgery, can be more than three times higher at some facilities than others, increasing the chances that the patient may be readmitted to the hospital. The average Medicare expenditure for surgery, hospitalization and recovery varies from $16,500 to $33,000 across geographic areas.

The CJR model will extend for five performance years, beginning on April 1st and ending on December 31, 2021. The CMS program out of which it developed, the Bundled Payments for Care Improvement initiative, has yielded data showing increased quality, decreased length of stay and lower post-acute care costs. “When CMS launches its first mandatory bundled-payment program in the spring, CJR appears poised to accelerate the pace of the federal agency’s efforts to link payment to value.”


2To determine whether a given hospital is among the CJR facilities, see the tool in Evans M, How hospitals are prepping for Medicare’s mandatory bundled pay test, Modern Healthcare online, November 18, 2015, http://www.modernhealthcare.com/article/20151118/NEWS/151119898?utm_source=modernhealthcare&utm_medium=email&utm_content=20151118-NEWS-151119898&utm_campaign=dose+-+bundlemap#bundlemap

3CMS Innovation Center, Comprehensive Care for Joint Replacement Model. https://innovation.cms.gov/initiatives/cjr

4https://www.asahq.org/psh/comprehensive%20joint%20replacement/cjr%20tool%20kit


Coding for Queries

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*MiraMed Global Services*

Why are coding queries necessary?

Because when a physician writes down a diagnosis it may not necessarily be the correct diagnosis for that particular patient. Physicians see numerous patients per day either in the hospital, clinic or office setting or sometimes in all locations. They probably don’t have time to take a lunch and if they do and you ask them what they had for lunch seldom will they remember. So, how do you expect them to remember all the patients and all the clinical conditions each patient is exhibiting? Did you ever think that the provider might be mistaking Mrs. Jones’s chart for Mrs. Smith’s and documenting the wrong diagnosis? It probably doesn’t happen often but there is a possibility that it can happen.

For each inpatient visit, the entire length of stay is a story with a beginning either represented as an emergency room visit or an H&P (history and physical examination); a middle with progress notes, and consults and surgical notes (if any); and an end represented by a discharge summary.

In simple terms, if I am reading a book about apple picking then the entire book should reference apples.

If somewhere in the middle of my apple story all of a sudden I see reference to an orange but there is no introduction about the orange, no other mention of the orange throughout the story and the end does not mention the occurrence of the orange or why the orange was important to the story; then I am left pondering what the orange had to do with the story? It is not a mystery and, therefore, not a red herring. For those of you that read mysteries you will understand that a red herring is something thrown in to have the reader arrive at a wrong conclusion or is thrown off track in an Agatha Christie whodunit.

Bringing the concept to healthcare, sometimes you encounter an entry in the chart for acute renal failure (ARF) but in reading the chart you wonder how the provider arrived at that diagnosis. Acute kidney injury or acute renal failure means that the kidneys have suddenly stopped working. The kidneys remove waste products and help balance water and salt and other minerals (electrolytes) in the blood. When kidneys stop working, waste products, fluids and electrolytes build up in the body.

Acute kidney injury has three main causes:

1. A sudden, serious drop in blood flow to the kidneys.
2. Heavy blood loss, an injury or a bad infection (sepsis) can reduce blood flow to the kidneys.
3. Not enough fluid in the body (dehydration) also can harm the kidneys.

If the indication of the renal failure is dehydration, but in reading the chart there is no assessment to indicate a decrease in the patient’s skin turgor, but yet the documentation states moderate to severe dehydration (fluid loss of five percent of the body weight is considered mild dehydration, 10 percent is moderate, and 15 percent or more is severe dehydration), then the next step would be to look at the input and output (I&O) documented in the nurses notes.

The amount of urine produced over a period of hours may also be measured for quantity and quality or the amount of waste being excreted. When kidney tissue is injured, protein (a large molecule with a daily excretion of <30mg) and desirable substances may be inappropriately excreted in the urine. Sometimes there are no symptoms as expressed by the patient but instead of insufficient urine production there may be urinary retention or water electrolyte imbalance or fatigue. In the case of urinary retention, the amount of urine remaining in the bladder after urination will be measured by inserting a Foley catheter to drain the bladder. However, if in reading the documentation in the chart there is no

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Coding for Queries  (Continued from page 4)

indication of decreased urinary output, swelling due to fluid retention, nausea, fatigue and or shortness of breath, shouldn’t the coder stop and question especially if the diagnosis-related group (DRG) is impacted? When coding or auditing, the individual should be thinking what tests were ordered to substantiate the diagnosis or what was the provider thinking in ordering the tests.

From a lab perspective, the levels of urea (blood urea nitrogen [BUN]) and creatinine are high in kidney failure; this is called azotemia. However, a patient with chronic renal failure may exhibit a high BUN and creatinine and this is why it is imperative for the provider to indicate in the clinical documentation the patient’s baseline so that if the patient has acute or chronic renal failure, the acute condition can be coded as well. Electrolyte levels in the blood may be abnormally high or low because of improper filtering. When the duration and severity of kidney failure is severe, the red blood cell count may be low; this is called anemia. One can also look at the lab values for too much acid in blood and tissues. If the diagnosis is not certain after laboratory tests, an ultrasound of the kidneys and bladder may be done to help reveal signs of specific causes of kidney failure. In some cases, tissue samples of the kidneys are taken (biopsy) to find the cause of the renal failure as in the case of suspected acute tubular necrosis (ATN).

There must be clinical evidence along with laboratory evidence (if indicated) to back up all diagnoses in the chart. The reader cannot infer from a single line entry or just from lab values that someone is indeed is exhibiting the condition. Each condition must be verifiable. However, if a coder sees acute renal failure (ARF) as an entry in the chart and the documentation is vague, then the correct next step should be to issue a query to the provider. An outside auditor (non-physician auditor) cannot refute a confirmatory query that is well documented. Per the American Health Information Management Association (AHIMA) Guidelines for Achieving a Compliant Query Practice, generation of a query should be considered when the health record documentation is conflicting, imprecise, incomplete, illegible, ambiguous or inconsistent (AHIMA Guidelines for Achieving a Compliant Query Practice, Journal of AHIMA February 2013), especially when considering diagnoses that are major comorbidities (MCCs) and comorbidities (CCs) (also important on their own as severity measures) which can affect DRG assignment. Also, per AHIMA Guidelines for Achieving a Compliant Query Practice, generation of a query should be considered when the health record documentation describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis. Per the American Heart Association (AHA) Coding Clinic 2008 Q3 pg. 14 and Coding Clinic 2004 pgs. 18-19, the provider is ultimately responsible for the final diagnosis.

When I was in medical school the first lesson I learned was to cover my bases. When in doubt, issue a query for clarification. This may cause a delay and you have to wait before the final bill can be dropped, but this will avoid the appeal process (which could take a year or longer) and you will get the deserved reimbursement the first time the chart is billed.

If your life is a mess, clean it up.
Throw away your excuses, sweep the negative people out of your life, fix the problems that you can fix and pick up the pieces of your life one at a time.

Sonya Parker
HCPCS Modifiers for Selective Identification of Distinct Procedural Services

Aiswarya Govindhan, CPC
Team Leader
Ajuba Solutions India Pvt. Ltd.

**Modifier XS**

**Definition:** Separate structure: a service that is distinct because it was performed on a separate organ/structure

**Appropriate Usage:**
- Coding pairs are part of the National Correct Coding Initiative (NCCI) procedure to procedure edits.
- Documentation indicates the services were provided on different organs/structures.
- Use Modifier XS with the column two procedure code in the NCCI files.
- Use Modifier XS only when there is no other modifier to describe the situation.

**Inappropriate Usage:**
- Code pairs are not part of the NCCI procedure to procedure edits.
- If another valid modifier exists to identify the separate services.
- Submission of E/M Codes.
- Submission of weekly radiation therapy management codes (CPT 77427). Code 77427 means radiation treatment management, five treatments, 77427 also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately.
- The NCCI code files show the modifier application as "0."
- Documentation does not support the services were provided on a separate organ/structure.
- For example, both procedures were performed on the liver during a single encounter.
- Exact same procedure code performed twice on the same day.
- Multiple administrations of injections of the same drug.
- Submitted with Modifier 59.

**Modifier XE**

**Definition:** Separate encounter: a service that is distinct because it occurred during a separate encounter.

**Appropriate Usage:**
- Coding pairs are part of the NCCI procedure to procedure edits.
- Documentation indicates the services were provided during separate patient/provider encounter.
- Use Modifier XE with the column 2 procedure code in the NCCI files.
- Use Modifier XE only when there is no other modifier to describe the situation.

**Inappropriate Usage:**
- Code pairs are not part of the NCCI procedure to procedure edits.
- If another valid modifier exists to identify the separate services.
- Submission of E/M codes.
- Submission of weekly radiation therapy management codes (CPT 77427).
- The NCCI code files show the modifier application as "0."
- Documentation does not support the services were provided during a separate patient/provider encounter.
• The patient did not leave and come back for the secondary service.
• Exact same procedure code performed twice on the same day.
• Multiple administrations of injections of the same drug.
• Submitted with modifier 59.

**Modifier XP**

**Definition:** Separate Practitioner: a service that is distinct because it was performed by a different practitioner.

**Appropriate Usage:**

• Coding pairs are part of the NCCI procedure to procedure edits.
• Documentation indicates the services were provided by different practitioners with the same specialty in the same group practice.
• Use Modifier XP with the column 2 procedure code in the NCCI files.
• Use Modifier XP only when there is no other modifier to describe the situation.

**Inappropriate Usage:**

• Code pairs are not part of the NCCI procedure to procedure edits.
• If another valid modifier exists to identify the performance of the services by different practitioners.
• Submission of E/M codes.
• Submission of weekly radiation therapy management codes (CPT 77427).
• The NCCI code files show the modifier application as "0."
• Documentation does not support the services were provided by different practitioners.
• Exact same procedure code performed twice on the same day.
• Multiple administrations of injections of the same drug.
• Submitted with Modifier 59.

**Modifier XU**

**Definition:** Unusual Non-Overlapping Service: the use of a service that is distinct because it does not overlap usual components of the main service.

**Appropriate Usage:**

• Coding pairs are part of the NCCI procedure to procedure edits.
• Documentation indicates the service was not part of the usual components of the main service.
• Use Modifier XU with the column 2 procedure code in the NCCI files.
• Use Modifier XU only when there is no other modifier to describe the situation.

**Inappropriate Usage:**

• Code pairs are not part of the NCCI procedure to procedure edits.
• If another valid modifier exists to identify the service does not overlap the usual components of the main service - the column 1 procedure code.
• Submission of E/M codes
• Submission of weekly radiation therapy management codes (CPT 77427).
• The NCCI code files show the modifier application as "0."
• Documentation supports the service is a component of the main service.
• Exact same procedure code performed twice on the same day.
• Multiple administrations of injections of the same drug.
• Submitted with Modifier 59.

**References:**
www.wpsmedicare.com
**Health Information Management (HIM) Services**

- Medical Records Coding
- Oncology Data Management Services
- Trauma Registry

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This article will explore the new clinical concept that distinguishes burns and corrosions as conveyed in ICD-10. In ICD-9, burn codes are reported by body site, depth, extent and an additional code to identify the external cause, when applicable. The same will be reported in ICD-10 but with a few additional concepts. The additional concepts are reporting the agent or cause of the corrosion, laterality and encounter. ICD-10 also makes a distinction between burns and corrosions. Burn codes apply to thermal burns (except sunburns) that come from a heat source, such as fire, hot appliance, electricity and radiation. Corrosions are burns due to chemicals.

**ICD-9: Burns and Corrosions Classifications:**
- Body Site
- Depth
  - Erythema: first degree.
  - Blistering: second degree.
  - Full Thickness Involvement: third degree.
- Extent
  - Total Body Surface Area (TBSA).
- External Cause
  - To identify the source, place and intent of the burn/corrosion.

**ICD-10: Burns and Corrosions Classifications:**
- Body Site
- Depth
  - Erythema: first degree.
  - Blistering: second degree.
  - Full Thickness Involvement: third degree.
- Extent
  - Total Body Surface Area (TBSA).
- External Cause/Agent
  - External Cause – To identify the source, place and intent of the burn.
  - Agent – To identify the chemical substance of the corrosion.
- Laterality
  - Right.
  - Left.
  - Unspecified.
- Encounter – For burns and corrosions, the seventh character designates the episode of care as:
  - Initial Encounter – A.
  - Subsequent Encounter – D.
  - Sequela – S.

**NOTE:** Burns of the eye and internal organs are classified by site, not by degree.
ICD-10 Distinction Between Burns and Corrosions (Continued from page 9)

ICD-9: Body Site, Depth, Extent and External cause

The same code is used for burns and corrosions.

<table>
<thead>
<tr>
<th>Body Site, Depth</th>
<th>Extent (TBSA)</th>
<th>External Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn/Corrosion</td>
<td>945.26 Blisters with epidermal loss due to burn (second degree) of thigh (any part).</td>
<td>948.10 Burn (any degree) involving 10% to 19% of body surface with third degree burn of less than 10% or unspecified amount.</td>
</tr>
</tbody>
</table>

ICD-10: Body Site, Depth, Encounter, Laterality, Extent and External Cause/Agent

Distinct codes are used for burns and corrosions.

<table>
<thead>
<tr>
<th>Body Site, Depth, Encounter and Laterality</th>
<th>Extent (TBSA)</th>
<th>External Cause/Agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn</td>
<td>T24.211A Burn of second degree of right thigh, initial encounter.</td>
<td>T31.10 Burns involving 10%-19% of body surface with 0% to 9% third degree burns.</td>
</tr>
<tr>
<td>Corrosion</td>
<td>T24.611A Corrosion of second degree of right thigh, initial encounter.</td>
<td>T32.10 Corrosions involving 10% to 19% of body surface with 0% to 9% third degree corrosions.</td>
</tr>
</tbody>
</table>

ICD-10 makes a distinction between burns and corrosions. In addition to the distinction, there are coding conventions that are essential in attaining the correct code assignment. These conventions include:

Sequencing:
- When more than one burn/corrosion is present, sequence the code that reflects the highest degree first.
- When the reason for the admission or encounter is for treatment of external burns/corrosions, sequence the code that reflects the highest degree first.
- When a patient has both internal and external burns/corrosions, the circumstances of admission govern the selection of the principal diagnosis (i.e., first-listed diagnosis).
- When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal diagnosis.

Rule of Nine:

The 2016 ICD-10-CM Official Guidelines for Coding and Reporting states, “Categories T31 (Burns classified according to extent of body surface involved) and T32 (Corrosions classified according to extent of body surface involved) are based on the classic ‘rule of nines’ in estimating body surface involved.” The rule of nines, for adult patients, assigns 1% of TBSA to the genitalia, and multiples of 9% to other body areas (e.g., 9% head, 9% per arm, 18% per leg, etc.). A modified rule of nines is applied for infants, to account for their relatively larger head (18%) and smaller legs (14%, each). However, the ICD-10-CM guidelines does allow, “Providers may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults, and patients who have large buttocks, thighs or abdomen that involve burns.

References:
https://www.ibx.com/pdfs/providers/claims_and_billing/icd_10/icd_10_spotlight.pdf
https://www.aapc.com/blog/33717-icd-10-continues-to-follow-rule-of-nines-but-allows-wiggle-room/
Zika Virus Infection and Its ICD-10-CM Coding Update

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In 2015, Zika virus disease outbreaks were reported in South America. The condition is caused by Zika virus from the Flavivirus genus, Flaviviridae family, from the Spondweni group. It was first noted in a rhesus monkey in the Zika forest, Uganda in 1947, followed by mosquitoes Aedes africanus in the same forest in 1948 and in humans in Nigeria in 1952. Zika can be transmitted through infected mosquitoes as well as sexual contact with the infected person.

The signs and symptoms of Zika are similar to Dengue and Chikungunya diseases spread by mosquitoes that transmit Zika. People who are infected with Zika virus are most likely to manifest fever, maculopapular rashes, joint pains, muscle pains, headache and non-purulent conjunctivitis. People will likely experience a mild illness which will not necessitate bringing them to the hospital. Symptoms can last from several days to a week.

Diagnostic testing can be done through detection of viral RNA from a specimen in people infected by the disease. The mode of medical treatment is symptomatic such as having plenty of rest, drinking fluids to prevent dehydration, medications for the relief of pain with precaution directed at the risk of developing hemorrhage. A vaccine or prophylactic treatment is not available.

ICD-10-CM Coding Perspective:

On February 5, 2016, the American Health Information Management Association (AHIMA) released an update in coding for Zika virus infection. It was noted that as per Centers for Disease Control and Prevention (CDC), the correct code for confirmed Zika virus infection is A92.8; other specified mosquito-borne viral fevers.

Education is not all the lessons we learn from in our life. We all are witness to our own life and we gain knowledge from our mistakes and that gives us wisdom. We can all speak about our own lessons we learn from living our own life and that they don’t teach in school.

Glen Rambharack
Are You a Good Auditor?

John Christian Sayo, RN, COC-A,
Training Supervisor
MiraMed Philippines Group, LLC - Philippine Branch

Direction: All Medical Coding staffs are encouraged to send their correct codes based from the case provided. They must present their codes along with Coding clinics, coding guidelines or any coding references applicable for any codes that are to be Added, Deleted or Revised. Answers to this scenario will be published in our next issue.

This is a case of a 90-year-old male who presented to the emergency room with swelling in the hands and legs. He has had intermittent problems with swelling on and off. He presented to the emergency room, underwent evaluation with an EKG, which showed third-degree heart block and thus the patient was admitted to the cardiac surgical unit with external pacemaker backup ordered. Upon admission, his heart rate was in the 30s. He does have a history of bradycardia in the past, but really never had any problems being symptomatic to that. The patient denies any chest pain, palpitations or orthopnea. During admission, he was also given medications for his hypertension and gastroesophageal reflux disease. The patient was then seen in the cardiac unit by Dr. S who recommended that the he undergo pacemaker placement secondary to third-degree heart block. The patient agreed with the planned surgery.

Preoperative diagnosis: symptomatic heart block
Postoperative diagnosis: same
Procedure: permanent dual chamber pacemaker implantation

Following informed consent, the patient was brought to the operating room and was prepped and draped in the usual manner. Following local anesthesia, a venogram was obtained. The left subclavian system was noted to be tortuous but patent. Access to the left subclavian vein was obtained. On two occasions, two guidewires were passed via the left subclavian vein into the inferior vena cava. Using a #10 blade, an incision was made in the left infraclavicular region. Using blunt and bovie dissection, a subcutaneous pocket was made. Using a french-8 introducer, the first pacemaker lead was introduced via the left subclavian vein and guided into the right ventricular apex. Another lead was introduced via the subclavian and was threaded into the right atrial wall. Both leads were secured to the pectoral muscle using #0 ethibond sutures in the collar. Leads were then attached to the pacemaker. Normal placing was noted and the device was placed in the pocket. The pocket was irrigated with gentamicin solution and the operative site was closed appropriately with hemostasis.

Final diagnosis:
- Congestive heart failure
- Third degree heart block
- Hypertension
- GERD

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>ICD-10-PCS</th>
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<tbody>
<tr>
<td>Principal Diagnosis</td>
<td>I50.9</td>
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<tr>
<td>Secondary Diagnosis</td>
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<tr>
<td>Secondary Diagnosis</td>
<td>I10</td>
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<td>Secondary Diagnosis</td>
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<td>Principal Procedure</td>
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<td>Secondary Procedures</td>
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Are You a Good Auditor? *(Continued from page 12)*

Correct Answer from Previous Case Scenario:

<table>
<thead>
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<th>ICD-10-CM</th>
<th>Audit Remark</th>
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<tbody>
<tr>
<td><strong>Principal Diagnosis</strong></td>
<td>Revise K43.5 to K43.3, Parastomal hernia with obstruction, without gangrene. The patient’s postoperative diagnosis is incarcerated parastomal hernia. As per ICD-10-CM index pathway, incarcerated is coded as obstructed:</td>
</tr>
<tr>
<td>K43.3</td>
<td>Hernia → incarcerated(see also Hernia, by site, with obstruction) → parastomal → with obstruction = K43.3</td>
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<table>
<thead>
<tr>
<th>Secondary Diagnosis</th>
<th>E78.5</th>
<th>No change.</th>
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<tr>
<td>Secondary Diagnosis</td>
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<thead>
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<tr>
<td>DELETE K66.0</td>
<td>Delete code for adhesions of the omentum and abdominal wall since there was no indication of their clinical significance by the surgeon within the body of the operative report. According to the ICD-10-PCS Official Guidelines for Coding and Reporting, section B3.1b, adhesions and the lysis of the adhesions should not be coded simply because they are mentioned in the body of the operative note: They must be clinically significant. Documentation of clinical significance by the surgeon may include, but is not limited to, the following language: numerous adhesions requiring a long time to lyse, extensive adhesions involving tedious lysis, extensive lysis, etc. If uncertainty exists regarding clinical significance, then query the provider.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Diagnosis</th>
<th>Z93.3</th>
<th>Add code for the colostomy status.</th>
</tr>
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<table>
<thead>
<tr>
<th>ICD-10-PCS</th>
<th>Audit Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principal Procedure</strong></td>
<td>Change 5th character to “0” for open approach. As per ICD-10-PCS, open approach is defined as cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure. In the case provided, an 8 cm infraumbilical midline incision was made on her previous surgical scar which provided direct visualization of the procedure site.</td>
</tr>
<tr>
<td>0WQF0ZZ</td>
<td>Change 5th character to “0” for open approach. As per ICD-10-PCS, open approach is defined as cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure. In the case provided, an 8 cm infraumbilical midline incision was made on her previous surgical scar which provided direct visualization of the procedure site.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Secondary Procedure</th>
<th>DELETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DELETE 0DN80ZZ</td>
<td>Delete code 0DN80ZZ, Release small intestine, open approach. As per coding clinic first quarter ICD-10 2014, adhesions may exist without being organized and without causing any symptoms in the patient or increasing the difficulty of performing the operative procedure. When such minor adhesions exist and are lysed as part of the principal procedure, coding a diagnosis of adhesions and the procedure of lysis of adhesions is inappropriate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Procedure</th>
<th>0WQFXZ2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add code for the takedown of the stoma. As per ICD-10-PCS index, Takedown → stoma → see repair</td>
<td></td>
</tr>
</tbody>
</table>

**THE CODE: The Official Medical Coding Newsletter of MiraMed, A Global Services Company**
Coding Case Scenario

John Christian Sayo, RN, COC-A
Training Supervisor
MiraMed Philippines Group, LLC - Philippine Branch

Direction: Code for ICD-10-CM Diagnosis and Procedure. Answers to this scenario will be published in our next issue.

A 55-year-old female patient presents to the emergency department complaining of acute diffuse pain all over her body associated with shortness of breath typical of sickle cell disease. The patient denies having fever or cough. She was previously admitted at an outside hospital but did not receive transfusion at that time. Her past history is most notable for sickle cell anemia, asthma and right ankle ulcer that is chronic. The patient is chronically anemic with baseline hemoglobin around six gm/dL (grams per deciliter). She also has a slightly elevated AST of 55 and alkaline phosphatase of 142. She is then admitted for pain control with a diagnosis of sickle cell crisis and started on oxygen and intravenous fluids. Hemoglobin and reticulocyte count monitoring were also ordered. Patient was also given extra care for her ankle ulcer and was assessed for any possible ascites. Her home medications for asthma were also continued during this admission. Basically, treatment was focused on administration of folic acid, fluid hydration and narcotic treatment for her pain. The patient recovered well and an abdominal ultrasound performed prior to her discharge showed unremarkable liver and no ascites.

Discharge diagnoses:
- Sickle cell crisis with acute chest syndrome
- Chronic lower extremity ulcer
- Asthma

Correct Answer from Previous Case Scenario:

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Principal Diagnosis</strong></td>
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<tr>
<td><strong>Secondary Diagnosis</strong></td>
<td>D27.1</td>
</tr>
<tr>
<td><strong>Secondary Diagnosis</strong></td>
<td>E11.22</td>
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<tr>
<td><strong>Secondary Diagnosis</strong></td>
<td>N18.5</td>
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<tr>
<td><strong>Secondary Diagnosis</strong></td>
<td>E89.0</td>
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</thead>
<tbody>
<tr>
<td><strong>Principal Procedure</strong></td>
<td>OUT20ZZ</td>
</tr>
<tr>
<td><strong>Secondary Procedure</strong></td>
<td>OUT70ZZ</td>
</tr>
<tr>
<td><strong>Secondary Procedure</strong></td>
<td>OUTC0ZZ</td>
</tr>
<tr>
<td><strong>Secondary Procedure</strong></td>
<td>OUT90ZZ</td>
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