Issue No. 6 Volume No. 1 September 2014

THE CODE

The Official Medical Coding Newsletter of MiraMed, A Global Services Company

When to Apply Modifiers

Denise M. Nash, MD, CCS, CIM
Vice President of Compliance and Education
MiraMed Global Services

Part 5

In part 4 of this article we discussed modifiers that may be applied when billing for split or shared work of a surgical procedure between providers requiring modifier 62 (two different specialty co-surgeons) or modifier 66 (surgical team).

Below are situations that you might encounter when patients have another surgery during a global period and, therefore, it might be necessary to append modifier 58 (staged or related procedure), modifier 78 (return to the operating room for a related procedure during the postoperative period) or modifier 79 (unrelated procedure or service by the same physician during the postoperative period).

<u>Modifier 58 – Staged or Related Procedure</u>

Modifier 58 is utilized for an *anticipated (planned)* return to the operating room for a procedure during the postoperative period. Modifier 58 is not utilized for a post-operative **unanticipated (unplanned)** complication related to the original surgery which requires a return to the operating room.

When modifier 58 is used, the staged relationship to the original surgery must be documented in the medical record. This does not necessarily mean that the final decision to perform the subsequent surgery or the date it will be performed is known at the time of the original surgery. "Decisions to perform subsequent procedure(s) may depend on the outcome of the surgery and the patient's postoperative status. The term 'anticipated" was added [to the description for modifier 58] because physicians can anticipate the potential for subsequent procedure(s) but cannot always predict it." ("Coding Clarification: Modifiers 58 and 78," CPT Assistant, February 2008, page 3).

(Continued on page 2)

If you have an article or idea to share for *The Code*, please submit to:
Dr. Denise Nash
denise.nash@miramedgs.com

Life is one percent what happens to you, and ninety-nine percent how you respond to it.
Shubhra Krishnan

When to Apply Modifiers *(continued from page 1)*

Append

Physician may need to indicate that the performance of a procedure or service during a post-operative period was either:

- Planned or anticipated at the same time as the original procedure (staged);
- More extensive than the original procedure; or
- For therapy following a diagnostic surgical procedure.

Do Not Use When

- The procedure(s) definition includes the description "one or more sessions."
- When treatment of a *problem* requires a return to the OR (append modifier 78).

Example

- A 32 year old female undergoes a mastectomy for breast cancer. One week later, the patient is scheduled for breast implants.
- **19342-58** Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction.

Note

- Without modifier 58, the carrier could reject the claim because the surgery occurred during the post-op period.

Modifier 78 – Return to the Operating Room for a Related Procedure during the Postoperative Period

Usage of modifier 78 only applies to services done by the *same* Provider during the global period for the original procedure.

Append

- When a patient returns to the Operating Room for an *unplanned* related procedure during the postoperative period (global).
- One or more additional procedures.
- When a second operative session is used and occurs during the postoperative period.
- Second procedure is related to the first procedure usually due to complication or other problems related to initial surgery.
- When the unplanned surgery involves a separate operative session than the original surgery.

Do Not Use When

- Subsequent treatment (even if for a complication of initial surgery) occurred in the patient's hospital room, and not in the operating room, modifier 78 may not be used with place of service 11 (office). Modifier 78 requires a return to the operating room or procedure room (e.g. Cath Lab, Interventional Radiology Procedure Room, Endoscopy Room) ("Coding Clarification: Modifiers 58 and 78," CPT Assistant, February 2008, page 3. "Coding Communication: More on Modifiers," CPT Assistant, September 1997, page 4. CMS Manual System, Medicare Claims Processing Manual (Pub. 100-4), Chapter 12, § 40.1, B, "Services Not Included in the Global Surgical Package.")

(Continued on page 3)

When to Apply Modifiers *(continued from page 2)*

When to Use

- Excessive bleeding or infection requiring a return trip to the operating room.

Example

- Patient brought to recovery room S/P abdominal surgery. Dressings became saturated and vital signs were unstable. Patient was brought back to the OR for exploration for post-op hemorrhage.
- **35840-78** Explore abdominal vessels.

Note

- The unplanned surgery does **not** restart or begin a new global period.
- If modifier 78 is reported with assistant surgeon modifiers (80, 81, 82, and AS), list the assistant surgeon modifier first.
- Modifier 78 is a payment modifier. Procedures are reimbursed for the intraoperative portion of the procedure (70 or 80 percent of the physician fee schedule for the surgical procedure).

The Differences Between Modifiers 58 and 78

Criteria	Modifier 58	Modifier 78
Planned Surgery	The subsequent surgery is either planned or anticipated (staged).	The subsequent surgery is unplanned.
Return to OR	Does not necessarily require a return to the operating room.	Should be done in an operating/procedure room.
Complication	Is not done because of complication of the initial surgery.	Is done because of complication of the initial surgery.
Term "Related"	"Related" refers to the patient's underlying problem (illness, injury or condition) which necessitated the surgery.	"Related" refers to the initial surgery.
Global Period	Breaks a global period and starts a new global period.	Does not break a global period and does not start a new global period, i.e., the global period of the initial surgery will continue.
Reimbursement	Surgery with modifier 58 is paid at its full fee schedule, i.e., there is no reduction in payment.	Surgery with modifier 78 is paid at the intra-operative percentage in the Fee Schedule of the payor.

https://www.codeitrightonline.com/ciri/uncomplicating-the-complicated-cpt-modifiers-58-78.html

Modifier 79 – Unrelated Procedure or Service by Same Physician During the Postoperative Period

Modifier 79 applies to surgical procedures performed on patients while they are in a postoperative period for a different, unrelated surgery. The new surgical procedure is performed to treat a new problem or injury. Modifier 79 is required when reporting identical procedures that are performed on the same day, but are not repeats of the same procedure on the same anatomical site.

(Continued on page 4)

When to Apply Modifiers *(continued from page 3)*

Append

- To report an unplanned, *unrelated* procedure performed during postoperative period that is unrelated and not a result of the first surgery.
- To explain surgery/procedure.

Note

- Carrier may deny if modifier 79 is not included on the submitted claim.
- Claim should be submitted with a different diagnosis and documentation should support the medical necessity.
- The unrelated procedure starts a new global period.
- For repeat procedures on the same day, see modifier 76.
- Do **not** report modifier 79 with modifiers 58 or 78.
- Modifier 79 is an information modifier (not subject to payment reduction).

Example

- January 22 – Patient is seen for an injury to the right index finger. The patient's finger is amputated at the DIP joint.
- **26951** Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure.
- March 15 – Same patient has an amputation of the right leg at femur.
- **27590 – 79** Amputation, thigh, through femur, any level.

To be continued in the next issue.

ANSWER TO PREVIOUS PUZZLE

D	U	S	I	S	Y	L	A	I	D	U	I	H	J	A
J	R	V	C	O	D	E	I	M	R	D	E	M	N	M
M	K	G	B	K	P	H	J	I	A	N	Z	E	W	O
I	L	C	C	F	E	M	O	R	A	L	S	A	P	B
T	Z	O	I	P	J	D	S	A	G	T	H	S	O	S
O	N	D	G	M	L	Q	I	M	H	G	T	L	S	H
S	B	I	P	R	Q	R	K	E	A	A	R	E	O	N
I	E	N	F	Y	X	C	S	D	M	S	R	S	L	E
S	N	G	L	I	P	I	D	S	N	T	E	C	D	A
M	I	G	V	R	A	W	V	C	H	R	O	N	I	C
X	G	T	C	E	B	R	D	N	T	I	L	Z	A	N
Z	N	R	L	M	M	B	A	R	U	C	B	R	B	S
M	P	W	Q	B	L	A	N	E	R	D	A	C	E	R
U	H	V	T	R	N	M	W	N	C	D	S	Y	T	K
S	M	N	O	Y	Y	E	R	A	C	X	I	D	E	F
C	Q	B	L	O	O	D	G	L	H	I	L	J	S	K
L	W	S	Z	B	K	L	M	P	O	N	A	Q	R	S
E	P	S	U	O	R	B	I	F	A	B	R	D	E	Z

VCODE
MIRAMED
ANESTHESIA
ADRENAL
BASILAR
BENIGN
BLOOD
CODING
CHRONIC
DIABETES
DIALYSIS
EMBRYO
FEMORAL
FIBROUS
GASTRIC
DRG
MEASLES
LIPIDS
MUSCLE
MITOSIS
RENAL

Deadline for ICD-10-CM/PCS – October 1, 2015

Sharon Hughes, MBA, RHIA, CCS
Vice President of Coding and Auditing, AHIMA- Approved ICD-10-CM/PCS Trainer
MiraMed Global Services

According to the Federal Register, Volume 79, No. 149, the U.S. Department of Health and Human Services (HHS) issued a rule finalizing October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to the International Classification of Diseases, 10th Revision (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets. Extension of the date from this year allows additional time for the industry to be prepared and to help minimize disruptions—although polls show that most are ready to begin ICD-10, there still seems to be uncertainty. This new 2015 deadline will allow all an opportunity for compliance without jeopardizing ICD-10 from becoming obsolete if the extension of goes any longer than another year. The Centers for Medicare and Medicaid Services (CMS) has implemented a comprehensive testing approach, including end-to-end testing in 2015 to help ensure providers are ready. "ICD-10 codes will provide better support for patient care, and improve disease management, quality measurement and analytics," said Marilyn Tavenner, Administrator of CMS. "For patients under the care of multiple providers, ICD-10 can help promote care coordination."

Not only does ICD-10 allow better and more concise information regarding a patient's health because of the expanded level of detail this system allows, researchers and public health officials can keep an improved handle on diseases and health issues. ICD-10 also provides improved diagnosis of chronic illness and communicates concisely the degree of and the stages of illnesses such as diabetes, heart disease, cancer etc.; which significantly impacts the entire health care community. Whether coding in ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Level II; accurate coding always demands coding with data integrity. Coding is not just about reimbursement, but has many other uses that need to be considered. "Coders should focus on coding completely and accurately so that it can be used for various purposes," notes Sue Bowman, AHIMA's senior director of coding policy and compliance. The demand for trustworthy data has never been more apparent than it is today, and the coding process plays a critical role in meeting the need for complete, accurate, and reliable healthcare data.

CMS.gov
Centers for Medicare & Medicaid Services

PLEASE TAKE A MOMENT …

This issue marks six months that *The Code* has been in publication. It is our mission to grow and improve this newsletter with each issue. In order to accomplish this goal we need your help! Your input is extremely valuable. Please take a moment to answer the following:

- Tell us what you would like to see in future publications.
- What types of articles would be most beneficial?
- Has this newsletter been of value to you?
- Would you be interested in submitting an article for publication?

You may send your responses via e-mail to kim.capello@miramedgs.com.

Distinguishing Diagnostic Testing Reviews from Reports Are Your TEE Reports Compliant?

Joette Derricks, CPC, CHC, CMPE, CSSGB
Vice President of Regulatory Affairs and Research
Anesthesia Business Consultants, LLC

The American Medical Association (AMA) Current Procedure Terminology (CPT) Manual Introduction Section has the definitions and instructions related to Results, Testing, Interpretation and Reports.

> "Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of test results. Certain procedures or services described in the CPT codebook involve a technical component (e.g., tests), which produce results (e.g., data, images, slides). For clinical use, some of these results require interpretation. Some CPT descriptors specifically require interpretation and reporting to report that code."[1]

The Introduction to Radiology Guidelines also states that, "A written report, signed by the interpreting physician, should be considered an integral part of a radiology procedure or interpretation."[2]

Throughout the CPT Manual the requirement for a separately documented written report is noted. For example, the Introduction to the Diagnostic Ultrasound section states that the:

> "Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation and final, written report, is not separately reportable."[3] Even more exacting is the Introduction to the Cardiology section that states, "Codes 93040-93042 are appropriate when an order for the test is triggered by an event, the rhythm strip is used to help diagnose the presence or absence of an arrhythmia, and a report is generated. There must be a specific order for an electrocardiogram or rhythm strip followed by a separate, signed, written, and retrievable report. It is not appropriate to use these codes for reviewing the telemetry monitor strips taken from a monitoring system. The need for an electrocardiogram or rhythm strip should be supported by the documentation in the patient medical record."[4]

According to Medicare's Claims Processing Manual the professional component of a diagnostic procedure furnished to a beneficiary in a hospital includes an interpretation and written report for inclusion in the beneficiary's medical record maintained by the hospital.[5]

Payers generally distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure.

> "A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service. This is because the review is already included in the E/M payment. For example, a notation in the medical records saying "fx-tibia" or EKG-

[1] AMA CPT, Professional Edition, 2014, page xv.
[2] AMA CPT, Professional Edition, 2014, page 393
[3] AMA CPT, Professional Edition, 2014, page 412
[4] AMA, CPT, Professional Edition, 2014, page 548
[5] See 42 CFR 415.120(a)

> normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available)."[6]

The CPT Evaluation and Management (E/M) documentation guidelines also address the need for a separate written report if the physician is reporting the professional interpretation of diagnostic tests, as follows:

> "The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code with modifier 26 appended."[7]

Written Interpretation and Report Documentation

The report should include a description of the studies and/or procedures performed and any contrast media and/or radiopharmaceuticals (including specific administered activities, concentration, volume, and route of administration when applicable), medications, catheters, or devices used, if not recorded elsewhere. Any known significant patient reaction or complication should be recorded. The report should use appropriate anatomic, pathologic, and radiologic terminology to describe the findings. The report should, when appropriate, identify factors that may compromise the sensitivity and specificity of the examination. Clinical issues should be addressed. If there are factors that prevent answering of the clinical question, this should be stated explicitly. Comparison with relevant examinations and reports should be part of the radiologic consultation and report when appropriate and available. The interpreting physician's impression (conclusion or diagnosis) should be included in an "impression" section and a specific diagnosis should be given when possible. A differential diagnosis should be rendered when appropriate. Follow-up or additional diagnostic studies to clarify or confirm the impression should be suggested when appropriate.[8]

Echocardiography Studies

The AMA Coding Book requires that echocardiographic studies, whether complete or limited, include an interpretation of all obtained information, documentation of all clinically relevant findings, including quantitative measurements obtained, plus a description of any recognized abnormalities. Pertinent images, videotape, and/or digital data are archived for permanent storage and are available for subsequent review. Use of echocardiography not meeting these criteria is not separately reportable.[9]

A final written interpretation of all echocardiography studies, including TEE, must be produced and maintained in the patient's record. The rationale for performing the study must be clearly documented in the medical record. Similar to all diagnostic testing requirements a printout of the test results does not meet the requirements for a separate written interpretation.

[6] http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf, Section 100.1
[7] AMA CPT Professional Manual, 2014, page 6
[8] http://www.acr.org/~/media/C5D1443C9EA4424AA12477D1AD1D927D.pdf
[9] AMA CPT Manual, Professional 2014 page 555

Intraoperative TEE for monitoring purposes (CPT code 93318) is a noncovered service by the majority of Medicare Carriers. A few carriers provide coverage of this service for a small group of high-risk patients. Providers are advised to check their individual carrier's website. Medical necessity should be documented in the patient's record. Diagnostic intraoperative TEE is covered under certain circumstances. Most Medicare Carriers consider diagnostic intraoperative TEE to be medically necessary if it is required for the optimal performance of a cardiac surgical procedure such as proper valve placement, placement of a septation device, or evaluation of mitral balloon valvuloplasty. Routine use of intraoperative TEE, even in patients undergoing bypass or valvular vary and providers should contact their carriers to learn the applicable details.

The entire duration of an intraoperative examination may total several hours, as repeated sequential examinations are conducted to assess acute hemodynamic changes or the adequacy of surgical repair. Echocardiographic data that will influence the surgical plan should be interpreted and reported to the surgeon in an ongoing and timely manner. A verbal report must be provided throughout and, in particular, at the completion of the initial examination to both the surgical and anesthesia care teams.

A written or electronic description of the findings should be left in an obvious location within the operating room on completion, so that it is available for immediate reference. Furthermore, a written or electronic report (preliminary or final) outlining key findings should be included in the medical record by the end of the procedure. Official reports of all the intraoperative data may be generated after completion of the surgical procedure, and should be consistent with the real-time interpretation provided to the surgeon. Such a report should be legible, placed in the patient's medical record within 24 hours of operation, and include: (1) a description of the echocardiographic procedure; (2) indications for the procedure; and (3) important findings. An electronic printout of data with no input from the physician on what the numbers mean constitutes the results rather than the interpretative report.[10] This information may be sufficient if the TEE was used for just for intraoperative monitoring which is included in the anesthesia care. If the TEE was specifically used for diagnostic purposes the results of the test should be needed and used in making the management decisions on the patient's intraoperative treatment.

Physicians and coders need to familiarize themselves with the documentation requirements needed to turn the test results into reports. Otherwise, "worthless" services may be submitted as the results were never reviewed and interpreted in a written report.

[10] http://files.asecho.org/files/CQIPeriOp.pdf

ICD-10-CM/PCS Myths and Facts

Sharon Hughes, MBA, RHIA, CCS
Vice President of Coding and Auditing, AHIMA- Approved ICD-10-CM/PCS Trainer
MiraMed Global Services

The following are just a few of the myths and facts published by: CMS.gov Centers for Medicare & Medicaid Services

MYTH: ICD-10-CM/PCS was developed without clinical input.

FACT: The development of ICD-10-CM/PCS involved significant clinical input. A number of medical specialty societies contributed to the development of the coding systems.

MYTH: ICD-10-CM/PCS was developed a number of years ago, so it is probably already out of date.

FACT: Prior to the implementation of the partial code freeze, ICD-10-CM/PCS codes had been updated annually since their original development to keep pace with advances in medicine and technology and changes in the health care environment. The ICD-9-CM Coordination and Maintenance Committee implemented a partial freeze where only codes capturing new technologies and new diseases would be added to ICD-9-CM and ICD-10. The code freeze resulted in the following updates:

- On October 1, 2011, the last regular, annual updates were made to both code sets.
- On October 1, 2012 and October 1, 2013, only limited code updates for new technologies and new diseases will be made to both code sets as required by Section 503(a) of Public Law 108-173.
- On October 1, 2014, only limited code updates for new technologies and new diseases will be made to the ICD-10 code sets to capture new technologies and diseases. No further updates will be made to ICD-9-CM on or after October 1, 2014, as it will no longer be used for reporting.
- On October 1, 2015, regular updates to ICD-10 will resume.

MYTH: Unnecessarily detailed medical record documentation will be required when ICD-10-CM/PCS is implemented.

FACT: As with ICD-9-CM, ICD-10-CM/PCS codes should be based on medical record documentation. While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation doesn't support a higher level of specificity. As demonstrated by the American Hospital Association/American Health Information Management Association field testing study, much of the detail contained in ICD-10-CM is already in medical record documentation, but is not currently needed for ICD-9-CM coding.

MYTH: Current Procedural Terminology (CPT) will be replaced by ICD-10-PCS.

FACT: ICD-10-PCS will only be used for facility reporting of hospital inpatient procedures and will **not** affect the use of CPT.

Coding Case Scenario

Denise M. Nash, MD, CCS, CIM
Vice President of Compliance and Education
MiraMed Global Services

Each month will offer a coding question for our staff to solve. If you'd like to quiz yourself, feel free. We will gladly let you know the results of your answer. The first coder from each Team (Philippines and India) who correctly answers will be given a prize and recognition in the next issue of our newsletter. Read the case scenario below and code for appropriate ICD-10 codes.

CODING CASE SCENARIO:

Mr. Winer accidentally cut his upper thigh while trying to prune a tree with a chainsaw in his backyard. He presented to the Emergency Department where he was diagnosed with a laceration of the femoral artery. He was transferred to the Operating Room where Dr. Bolus did a direct repair of the femoral artery. Dr. Bolus then turned his attention to performing a removal of a piece of wood imbedded in the thigh and a 7.5 cm complex repair of his leg.

Please code all diagnosis and surgical procedures done by Dr. Bolus.

Correct Answer from Previous Case Scenario:

L89.614 - Pressure Ulcer of Right Heel, Stage 4
I73.9 - Peripheral Vascular Disease, Unspecified

Rationale for Diagnosis Codes:

The provider has specified that this is a pressure ulcer. The inclusion term guidance provided by ICD-10-CM assists to describe the stage of the ulcer if the provider has not documented a specific stage. In this scenario, the muscle and fascia were affected. The guidance for stage 4 specifies, "Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone." Rubric L89 is used to report the condition pressure ulcers. The 4th character, 6, is used to identify the ulcer site as heel; the 5th character indicates the laterality or, in this case, the 1 identifies the right; and the 6th character, 4, identifies the stage of the ulcer.

The severity of the pressure ulcer is reported using the National Pressure Ulcer Advisory Panel (NPUAP) staging stages 1–4 and unstageable. ICD-10-CM also includes the unspecified coding option.

The peripheral vascular disease is also reported as I73.9 (Peripheral Vascular Disease, Unspecified) because the documentation is insufficient to assign a more specific code.

CONGRATULATIONS!

Last Month's Winner from India:

Thenmozhi Ayyasamy

Degree: Bachelor of Physiotherapy
Coding Experience: 3.4 Years
Certification: CPC
Designation: Officer - Medical Coding
Specialties Worked: Emergency Department

Last Month's Winner from Philippines:

Margaret Anne Bunyi

Degree: B.S. in Nursing
Coding Experience: 1 Year and 1 Month
Certification: CCS-P
Designation: Internal Lead Auditor
Specialties Worked: Emergency Department, Ancillary

Destiny is no matter of chance. It is a matter of choice. It is not a thing to be waiting for, it is a thing to be achieved.
William Jennings Bryan