On Call Consulting Is Now
MiraMed On Call

Tony Mira
President and CEO
MiraMed Global Services

We are pleased to announce that On Call Consulting has become MiraMed On Call, in an effort to better serve clients.

On Call Consulting has long been a leader in health information management (HIM) consulting, offering services in medical records coding and oncology data management. Parent company, MiraMed Global Services, is a full service healthcare business process outsourcing (BPO) provider which provides a broad portfolio of customizable solutions, to uncover and capitalize on hidden financial opportunities, improve productivity and ultimately increase value for our clients.

In these challenging times of decreased financial and staffing resources, the increased need for healthcare providers to collect and submit accurate data to ensure they receive total and correct reimbursement is more vital than ever.

We invite you to take a look at MiraMed On Call’s website to find out more about what we offer: www.miramedoncall.com.

Many thanks! 🎉

Contact Us Today (877) 641-9913

If you have an article or idea to share for The Code, please submit to:
Dr. Denise Nash
denise.nash@miramedgs.com
Advance Care Planning Coding/Billing

Joette Derricks, CPC, CHC, CMPE, CSSGB
Vice President of Regulatory Affairs & Research
MiraMed Global Services

The two new CPT advanced care planning codes (99497 and 99498) are used to report the face-to-face service between a physician or other qualified healthcare professional (QHP) and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. The use of these codes requires a face-to-face visit, however, the patient may not be present.

The CPT manual defines an advanced directive as, “A document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.”

Some examples of advance directives include:

- Health Care Proxy,
- Durable power of attorney for healthcare,
- Living will, and
- Medical Orders for Life-Sustaining Treatment (MOLST).

These are time-based codes, with 99497 to be billed for the first 30 minutes, and 99498 for each additional 30 minutes. Because the purpose of the visit is the discussion, no active management of the patient’s problem(s) is performed during the time of these visits. If during the encounter the physician or QHP does address the patient’s problem(s) a separate Evaluation and Management (E/M) code may be reported with the exception of critical care codes, inpatient neonatal and pediatric critical care codes or initial and continuing intensive care services.

Currently Medicare has indicated that it will NOT pay for codes 99497 or 99498 in 2015. Check with your commercial payers to see if they are reimbursing for these codes. Prior to 2015 and the two new CPT codes, some payers were recognizing and reimbursing the HCPCS code S0257. This code was used for “counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate E/M service).” Although some commercial payers reimbursed the service, the S0257 was not payable by Medicare. When reimbursed, the payer may consider the advance care planning as a preventive health service. In such cases, the service may not be subject to copays, deductibles or coinsurance. Also, some payers have incorporated advance care planning services into various primary care incentive measures.

Minimum documentation requirements for advance care planning discussions may include all of the following points with the first three as required:

1. A person designated to make decisions for the patient if the patient cannot speak for him or herself
2. The types of medical care preferred
3. The comfort level that is preferred
4. How the patient prefers to be treated by others
5. What the patient wishes others to know

Adequate documentation also requires an indication of whether or not an advance directive or physician orders for life-sustaining treatment (POLST) document has been completed.
Using General Equivalence Mappings as a Coding Tool

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

The General Equivalence Mappings (GEMs) were designed by Centers for Medicare and Medicaid Services (CMS) and Center for Disease Control (CDC) with input from the American Health Information Management Association (AHIMA) and the American Heart Association (AHA) as a general purpose translation tool as a means of converting large data sets. The intended purpose of the GEMs was to give a general idea of the approximate code conversion. It was meant to be utilized to give a knowledge to payers, large providers and others on how historical data would look once the ICD-10 was implemented. The data would not only give the ICD-10 equivalent but, most importantly, would show a snapshot of what the reimbursement would look like once implementation were to take place; hence, why the GEMs were utilized as a starting point by CMS to convert Medicare Severity-Diagnosis Related Groups (MS-DRGs) from an ICD-9-CM-based application to an ICD-10-CM/PCS-based application. The GEMs were developed to serve a specific limited short-term need—to allow the industry to migrate systems, applications, and data from ICD-9-CM to ICD-10-CM/PCS.


Because the GEMs are content and not software, they present a network of relationship between two code sets (ICD-9 and ICD-10). Mapping involves either forward mapping from ICD-9 to ICD-10 or backward mapping from ICD-10 to ICD-9. Although many refer to the GEMs as a crosswalk, this is not entirely true. A crosswalk implies a one-to-one relationship. The GEMs are not a crosswalk because although there are codes that have a one-to-one relationship (exact match), many codes have a one-to-many relationship and others have no relationship at all.

The following is from CMS’ publication General Equivalence Mappings Frequently Asked Questions:

Is there a one-to-one match between ICD-9-CM and ICD-10?

No, there is not a one-to-one match between ICD-9-CM and ICD-10, and the reasons for such include:

- There are new concepts in ICD-10 that are not present in ICD-9-CM™;
- For a small number of codes, there is no matching code in the GEMs™;
- There may be multiple ICD-9-CM codes for a single ICD-10 code; and
- There may be multiple ICD-10 codes for a single ICD-9-CM code.


Below are different examples of ICD-9 to ICD-10 mapping:

**Example of One-to-One Mapping:** The example below shows that ICD-9 code 251.0, hypoglycemic coma, is an exact match to ICD-10 code E15 because none of the attributes (flags) are turned “on.”

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Definition</th>
<th>ICD-10 Code</th>
<th>Definition 2</th>
<th>GEM Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>251.0</td>
<td>Hypoglycemic coma</td>
<td>E15</td>
<td>Nondiabetic hypoglycemic coma</td>
<td>00000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approximate</th>
<th>No Map</th>
<th>Combination</th>
<th>Scenario</th>
<th>Choice List</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(Continued on page 4)
Using General Equivalence Mappings as a Coding Tool (continued from page 3)

Example of One to Many Relationship: Notice in position three of the attributes that two codes are required to cover the concept and the attributes combination flag has been turned “on” by the first designation under GEM Attributes.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Definition</th>
<th>ICD-10 Code</th>
<th>Definition 2</th>
<th>GEM Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>249.21</td>
<td>Secondary diabetes mellitus with hyperosmolarity, uncontrolled</td>
<td>E08.01</td>
<td>Diabetes mellitus due to underlying condition with hyperosmolarity with coma</td>
<td>10111</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E08.65</td>
<td>Diabetes mellitus due to underlying condition with hyperglycemia</td>
<td>10112</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E09.01</td>
<td>Drug or chemical induced diabetes mellitus with hyperosmolarity with coma</td>
<td>10111</td>
</tr>
</tbody>
</table>

Example of an Approximate Match: Where code 782.0 can be mapped to six possible codes in ICD-10 and also notice that position one (approximate) of the GEM attributes/flags has been turned “on.”

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Definition</th>
<th>ICD-10 Code</th>
<th>Definition 2</th>
<th>GEM Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>782.00</td>
<td>Disturbance of skin sensation</td>
<td>R20.0</td>
<td>Anesthesia of skin</td>
<td>10000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R20.1</td>
<td>Hypoesthesia of skin</td>
<td>10000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R20.2</td>
<td>Paresthesia of skin</td>
<td>10000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R20.3</td>
<td>Hyperesthesia</td>
<td>10000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R20.8</td>
<td>Other disturbances of skin sensation</td>
<td>10000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R20.9</td>
<td>Unspecified disturbances of skin sensation</td>
<td>10000</td>
</tr>
</tbody>
</table>

Code 707.20, Pressure ulcer, unspecified stage is an example of an ICD-9 code that does not have an equivalent in ICD-10. The reason for this is because ICD-10-CM provides inclusion terms within L89 (Pressure Ulcer) to describe the stage identified by the code title. Unlike ICD-9, ICD-10 codes from category L89 are combination codes that identify the site of the pressure ulcer as well as the stage of the ulcer (Coding Guidelines Section I.C.12.a. 1-6).

The following represent the description of the stages:

- **Stage 1**: Pressure pre-ulcer skin changes limited to persistent focal edema.
- **Stage 2**: Pressure ulcer with abrasion, blister and partial thickness skin loss involving epidermis and/or dermis.
- **Stage 3**: Pressure ulcer with full thickness skin loss involving damage or necrosis if subcutaneous tissue.
- **Stage 4**: Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon or bone.
- **Unstageable**: Based on clinical documentation pressure ulcers are those “whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma.”
- **Unspecified**: The ICD-10-CM unspecified coding option is not considered a part of the National Pressure Ulcer Advisory Panel (NPUAP) staging but is provided for reporting when the documentation is insufficient to assign a more specific code.

In conclusion, although the GEMs are being utilized to assist in the ICD-10 conversion, the GEMs were never meant to be utilized as a coding solution. Just as CMS publishes the specifications for MS-DRGs and companies develop groupers from them, CMS publishes the GEMs from which private industry creates software. These private software vendors utilize coding guidelines and many other resources which can be utilized to create products that greatly improve the accuracy and completeness of automated translation and code assignment.
Are You a Good Auditor?

John Christian Sayo, RN, COC-A
Inpatient Trainer, Training Department
MiraMed Philippines Group, LLC—Philippines Branch

Direction: All medical coding staff is encouraged to send their answers for the case provided below. 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.

INPATIENT: A 64-year old patient who had stroke five months ago was admitted to the hospital for a surgical tendon transfer on his right hand. The patient acquired a contracture of the right hand as a result of the stroke. The patient had recovered well from the stroke. During the hospital stay, the orthopedic surgeon performed an open hand tendon transfer with no complications and the patient was discharged from the hospital on the day after surgery. The patient was also noted to have benign hypertension and COPD.

<table>
<thead>
<tr>
<th>Principal Diagnosis</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>438.21 I69.391</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>718.43</td>
<td>M62.442</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>401.1</td>
<td>I10</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>496</td>
<td>J44.9</td>
</tr>
</tbody>
</table>

Answers to this auditing scenario will be published in our next issue.

Are You a Good Auditor – Answers from March 2015 Scenario

Audit Remarks:

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Audit Remark</th>
<th>ICD-10-CM</th>
<th>Audit Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>162.9</td>
<td>Change 162.9 to 162.2, as per documentation, specific site is documented to main bronchus of the lung.</td>
<td>C34.00</td>
<td>No change.</td>
</tr>
<tr>
<td>198.5</td>
<td>No change.</td>
<td>C79.51</td>
<td>No change.</td>
</tr>
<tr>
<td>492.8</td>
<td>No change.</td>
<td>J43.8</td>
<td>Revise J43.8 to J43.9, as per documentation, it was only emphysema.</td>
</tr>
<tr>
<td>496</td>
<td>Delete 496, as per the note this code is not to be used with any other categories from 491 to 493.</td>
<td>Z87.891</td>
<td>No change.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Audit Remark</th>
<th>ICD-10-PCS</th>
<th>Audit Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>33.25</td>
<td>Revise 33.25 to 33.24, procedure was closed endoscopic biopsy of the bronchus.</td>
<td>0BB47ZX</td>
<td>Needs further clarification as to which part of the main bronchus was being biopsied, right or left.</td>
</tr>
</tbody>
</table>
Stars of MiraMed

Each month we will highlight an executive of MiraMed Global Services, LLC. This month’s star is Phil C. Solomon, Vice President of Global Services for MiraMed Global Services.

Phil has 25 years of experience as a healthcare industry thought leader, strategist, solution provider, author and featured speaker. He has designed and implemented leading practice business processing outsourcing (BPO), health information management (HIM), information technology (IT) and revenue cycle optimization strategies for some of the largest and most-respected health systems and large physician groups in the industry. Phil is experienced in all facets of BPO outsourcing, revenue cycle management, HIM, and IT enterprise sales, sales leadership, partnership development, business strategy and customer relationship management.

Mr. Solomon currently serves as Vice President of Global Services and oversees expanding business partner relationships, developing new markets that optimize prospect and customer engagement and improve return on investment performance. His responsibilities include leveraging his knowledge and expertise to create and design advanced marketing strategies that focus on driving demand and building successful revenue streams that support MiraMed’s global expansion.

Phil is the publisher of Revenue Cycle News, a healthcare industry blog, and is an active member of HFMA, AHIMA, HIMSS and MGMA. He holds a B.A. from San Diego State University and currently resides in Atlanta, Georgia. 🏙️
Medical Coding Comes of Age in the Philippines

Evelyn S. Abat  
Country Head  
MiraMed Philippines Group, LLC—Philippines Branch

The Philippines’ medical coding Industry is coming of age. As part of the broader milieu of the revenue cycle management process, medical coding was unheard of in the Philippines five years ago. The “in” thing during the 2000s was medical transcription. With more than 2,000 nursing schools turning out around 100,000 nurses annually, the Philippines was then burdened with about 400,000 out-of-job nurses who easily turned to medical transcription as their second career. This was an easy transition being equipped with the medical background and backed by the Philippines’ strong American English culture.

Medical transcription grew to its height in 2012 with hundreds of companies set up offering these services up until the entry of voice recognition technology. The demand for transcriptionists dwindled into a select group of highly-experienced medical editors who were auditing and editing the transcripts from the voice recognition software.

Toward the middle of 2014, we have seen hundreds, if not thousands, of medical transcriptionists trained in listening and preparing medical reports for many US hospitals. This pool of medical transcriptionists will add to the Philippines’ projected pool of the growing medical coding industry.

Medical coding premiered in the Philippines in 2011. These pioneering Philippine medical coders became the core team of our MiraMed Philippines Group, LLC – Philippine Branch’s (MMP) coding department.

MMP officially started commercial operations November 5, 2012. From a core team of ten certified coders in 2012, MMP has grown to the current 500 full time employees (FTEs) medical coders and continues to grow where nearly 50 percent are AHIMA/AAPC certified.

This year, the Philippines, has seen the phenomenal growth of the business processing outsourcing (BPO) sector where the number of medical coding companies and the number of medical coders in the country have more than quadrupled in the last two years. We have seen the entry of many US- and India-based medical coding companies setting up facilities in metropolitan Manila. We are seeing several US- and India-based BPO companies adding medical coding in their slew of outsourced services.

We are projecting continued growth of the health information management solutions and services (HIMSS) industry sector in the Philippines considering the strength of the Philippines’ manpower pool in the medical and allied medical sciences as well as the strong influence of American culture in the Philippines and the experience of many with call center projects.

MMP has found that along with expansion in the BPO sector, comes the challenges associated with that growth. Staff poaching and competition for the best salaries, benefits, etc. are some of the usual burdens associated with an expanding industry such as medical coding. MMP is proud of its steady growth and having retained the best staff in the industry. MMP can and will continue to lead the industry as one of the best places to work in the Philippines.

MMP will remain steadfast, firm and robust in the pursuit of its corporate mission, which is to be one of the top three healthcare information management solutions and services in the Philippines in the next two to three years, if not before. It will continue its mission of being able to provide quality, timely and efficient HIMSS to its clients, support and contribute to the global goals and objectives of MiraMed Global Services and be able to provide its staff with the best working conditions and environment in the country.
Percutaneous Vertebroplasty and Vertebral Augmentation

Angelie Fajardo, RN, CCA
Outpatient Trainer, Training Department
MiraMed Philippines Group, LLC—Philippines Branch

What is the difference between percutaneous vertebroplasty (CPT code 22510-22512) and vertebral augmentation (CPT code 22513-22515)? First, let us briefly look at the history of the two procedures. Percutaneous vertebroplasty was developed in France in 1984 to treat painful vertebral hemangioma. Later, on subsequent adaptations were made to further improve the procedure.

What is the difference between vertebroplasty and augmentation? Both are vertebroplasties and both procedures use bone cement to treat fractures, as well as vertebral pathology such as myeloma and metastasis. In vertebral augmentation supplemental techniques are used such as the use of a balloon to create a cavity in the vertebral body as an attempt to restore the height of the vertebral body. With the advancement of the technology, both procedures have proven very safe and are highly-effective in the treatment of back pain related to vertebral body compression and bony pathology.

As per Coder’s Desk Reference for CPT Procedures:

22510-22512: Percutaneous vertebroplasty is performed by a one- or two-sided injection of a vertebral body. A local anesthetic is administered. Sterile biomaterial such as methyl methacrylate is injected from one or both sides into the damaged vertebral body and acts as a bone cement to reinforce the fracture or collapsed vertebra. The procedure does not restore the original shape to the vertebra, but it does stabilize the bone, preventing further fracture or collapse. Following the procedure, the patient may experience significant, almost immediate, pain relief. These codes include a vertebral bone biopsy, if performed, during the same operative session.

22513-22515: The physician performs a percutaneous kyphoplasty, a modification of the percutaneous vertebroplasty, to reduce pain the pain associated with osteoporotic vertebral compression fractures. This procedure has the added advantage of restoring vertebral body. The patient is placed in a prone, slightly flexed position. A five mm to seven mm incision is made and small cannulae are inserted into the vertebral body from one or both sides. Balloon catheters, called “tamps,” are inserted into the vertebra and inflated. Tamps create a void in the soft trabecular bone and restore vertebral alignment. The balloon is removed and bone cement is injected into the cavity.

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.
How Well Do You Know LADA: Diabetes Type 1.5?

Evan Lendle Ramos, RN, CCS
Senior Manager, Training Department
MiraMed Philippines Group, LLC—Philippines Branch

Most of us know little about the existence of Diabetes Mellitus (DM) Type 1.5, also known as Latent Autoimmune Diabetes in Adult (LADA). The first concept of LADA was introduced in 1993. In 2003, an editorial in Diabetes Care discussed the topic an essay entitled: “What’s in a Name: Latent autoimmune diabetes of adults, type 1.5, adult-onset, and type 1 diabetes.” The authors emphasized that patients with LADA have also been named as type 1.5 diabetes.

LADA is a form of type 1 DM that occurs in adults with a slower course of onset. These patients gradually lose their insulin-producing capability, requiring insulin within five to ten years of diagnosis. Patients with LADA may manifest symptoms similar to those found in other forms of diabetes: excessive thirst, excessive drinking, excessive urination and often blurry vision.

<table>
<thead>
<tr>
<th></th>
<th>Type 1</th>
<th>Type 1.5 (LADA)</th>
<th>Type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age of onset</strong></td>
<td>Children and young adults</td>
<td>Adult</td>
<td>Older, but also younger adults</td>
</tr>
<tr>
<td><strong>Progression to insulin dependence</strong></td>
<td>Rapid</td>
<td>Latent</td>
<td>Slow</td>
</tr>
<tr>
<td><strong>Presence of autoantibodies</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Insulin dependence</strong></td>
<td>At the time of diagnosis</td>
<td>Within six years</td>
<td>Over time, if at all</td>
</tr>
<tr>
<td><strong>Insulin resistance</strong></td>
<td>No</td>
<td>Some</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Coding Classification:** As per Coding Clinic, Third Quarter 2013, Pages 13-14, Effective with discharges - September 10, 2013

**Question:** A patient was admitted with ketoacidosis and the attending physician documented that he was unable to determine whether the patient had type 1 or type 1.5 diabetes. We have received advice that if the physician does not indicate whether the diabetes is type 1 or type 2, it should be classified to 250.00, DM without mention of complication, type 2 or unspecified type, not stated as uncontrolled, for diabetes type 1.5.

The endocrinologists at our facility believe that, lacking a specific diagnostic code for type 1.5, it is more appropriate to code type 1.5 as type 1, because the patient “clearly is not type 2, and the patient does not have an autoimmune component to their diabetes.” What is the appropriate code assignment for type 1.5 diabetes?

**Answer:** ICD-9-CM does not currently recognize DM type 1.5. Query the provider so the most appropriate code can be assigned. If the physician does not indicate type 1, assign code 250.00, DM type 2 or unspecified type, not stated as uncontrolled, for diabetes type 1.5. Code 250.00 is the default.
Meet the Team

Each month we will highlight a team of coders that exemplify the qualities MiraMed Global Services is known for. This month’s team is MedData.

MedData is one of the earliest teams to start medical coding at Ajuba International, LLC in 2002. The team started with around ten members coding for emergency department (ED) facilities. Currently, the team consists of 150 members and codes for ED pro-fee, ED Facility, Hospitalists, Skilled Nursing and Observation coding for 48 hospitals.

The team consists of a very strong group of 20 auditors who act as the client QA team also auditing for other offshore vendors of MedData. The team not only consistently scores very high marks in client audits, it also maintains a high consistency record of turn-around time.

Over the years, many of the coders who have moved from the MedData team to newer projects have applied their skills to build a solid foundation for those new projects which later on excel for the client. As a testimony to the continued excellence in performance by the team, Ajuba was awarded a big subcontract by MedData, which proved to the biggest transition to any one vendor. Apart from coding, the team has also been honored at all of the MiraMed awards ceremonies in the last 12 years including events such as: Cultural Day and Annual Sports Day. The team has also fastidiously maintained its annual team outing during Thanksgiving, which shows the spirit that has been maintained and nurtured within the team. 🎃
Coding Case Scenario

Each month we 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 (United States, Philippines and India) who correctly answers will be given a prize and recognition in the next issue of our newsletter.

**DIRECTION:** Code for ICD-9-CM Diagnosis and Procedure and its corresponding ICD-10-CM and PCS

**INPATIENT:** A 45-year old female patient was admitted for biopsy of an enlarged lymph node located on her right axilla. The patient has a past medical history of breast cancer with a mastectomy of the right breast one year ago. The patient is no longer receiving any therapy for her cancer. A needle biopsy was performed. The pathology report showed normal lymphatic tissue with no evidence of metastasis. The patient was also noted to have Asthma, COPD and Diabetes Mellitus. She is currently taking insulin medication for maintenance.

Final diagnosis: Lymphadenopathy right axilla; ruled out metastasis

Procedure: Needle biopsy axillary lymph node

**Correct Answer from Previous Case Scenario:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Condition</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Diagnosis</td>
<td>Acute blood loss anemia, AMS</td>
<td>285.1</td>
<td>D62</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>Stage 3 sacral pressure ulcer</td>
<td>707.11, 707.23</td>
<td>L89.212</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>Stage 2 hip pressure ulcer</td>
<td>707.04, 707.22</td>
<td>L89.153</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>IDDM</td>
<td>250.00</td>
<td>E11.9</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>Lumbar spondylosis</td>
<td>721.3</td>
<td>M47.26</td>
</tr>
<tr>
<td>Procedure</td>
<td>Non-autologous RBC transfusion</td>
<td>99.04</td>
<td>30233N1</td>
</tr>
</tbody>
</table>

**Principal Diagnosis:** Principal diagnosis as defined by the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

In this case, 285.1/D62 is assigned as the principal diagnosis as the patient was admitted for anemia.

**Secondary Diagnoses:** As per the Coding guideline of Pressure Ulcer, "Multiple pressure ulcers of different sites and stages," when a patient has multiple pressure ulcers at different sites and each pressure ulcer is documented as being at different stages, assign the appropriate codes for each different site and a code for each different pressure ulcer stage.

- 707.03, 707.23/L89.212 – pressure ulcer sacral, stage 3
- 707.04, 707.22/L89.153 – pressure ulcer hip, stage 2

250.00/E11.9 is to be coded for Insulin Dependent Diabetes Mellitus (DM). IDDM was coded as an additional diagnosis as DM is classified as a chronic systemic disorder. These conditions are routinely reported even in the absence of documented active intervention. As per coding clinic, second quarter 1990.

As per Coding Clinic, Fourth Quarter 2004, Pages 53-56: **DM Type 1 and Type 2:**

Effective October 1, 2004 changes have been made to the fifth digits applicable to category 250, DM.
Correct Answer from Previous Case Scenario (continued from page 11)

This change has been made to make the classification consistent with current terminology used to describe DM. The two main types of diabetes are no longer properly referred to as "insulin-dependent" and "non-insulin dependent." The current distinction is now based on the functioning of the pancreatic beta cells.

In type 1 diabetic patients, pancreatic beta cells are absent following destruction by an autoimmune process. These patients must use insulin. In type 2 diabetic patients, pancreatic beta cells are present and produce insulin. However, there is insulin resistance, so the insulin levels are not high enough to keep glucose levels normal. Type 2 diabetic patients may or may not use insulin, depending on the severity of their condition and other health issues. Pregnant women who develop gestational diabetes may also require insulin to maintain proper blood sugar levels. The use of insulin is not a determining factor in the type of diabetes a patient has.

721.90 - spinal osteoarthritis is to be coded as it would affect the care management of the patient. Spinal osteoarthritis was coded as an additional diagnosis due to documentation that patient is experiencing chronic lumbar pain due to the osteoarthritis. Chronic lumbar pain is not coded in this case as its underlying cause was identified. As per coding guidelines, a code from subcategories 338.1 and 338.2 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain.

Procedures: 99.04/30233N1, the patient received one non-autologous red blood cell transfusion.

<table>
<thead>
<tr>
<th>Character</th>
<th>Meaning</th>
<th>Case Code</th>
<th>Case Code Description</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Section</td>
<td>3 Administration</td>
<td>The main procedure is to administer blood products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Body system</td>
<td>0 Circulatory</td>
<td>The body system affected is the circulatory system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Root operation</td>
<td>2 Transfusion</td>
<td>Transfusion is defined as putting blood or blood products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Body part</td>
<td>3 Peripheral vein</td>
<td>As per documentation &quot;Through a peripheral vein&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Approach</td>
<td>3 Percutaneous</td>
<td>As per documentation &quot;Transfusion percutaneously&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Device</td>
<td>N Red blood cells</td>
<td>As per documentation &quot;The patient received one non-autologous red blood cell&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Qualifier</td>
<td>1 Non-autologous</td>
<td>As per documentation &quot;The patient received one non-autologous red blood cell&quot;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Last Month’s Winner from the Philippines:

May-Anne Villaret, RN, USRN, CCS
Degree: B.S. Nursing
Coding Experience: 1 Year and 11 Months

Last Month’s Winner from India:

Priyadharsini Marudhupandian, MCC
Degree: M.Sc (Microbiology)
Coding Experience: 3 Years & 7 Months
Certification: MCC
Specialty: Emergency Department (Professional & Facility)