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THE CODE

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CA Modifier

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Effective January 1, 2016, if an *inpatient-only* service is done but the patient dies before the inpatient admission or the patient is transferred to another hospital; then the inpatient-only service modifier CA should be applied to any service that is designated with a status indicator "C" (found in the OPPS Addendum B and also listed together in Addendum E of each year's OPPS/ASC final rule).

Guidelines

Modifier CA is allowed when ALL of the following conditions are met:

- The status of the patient is outpatient.
- The patient has an emergent, life-threatening condition.
- A procedure on the inpatient-only list is performed on an emergency basis (either in the emergency room or the operating room) to resuscitate or stabilize the patient).
- The patient dies or is transferred without being admitted as an inpatient.

CMS will then make a single payment for all of the services reported on the claim (including the inpatient-only procedure) through one unit of ambulatory payment classification (APC) 5881 (ancillary outpatient services when the patient dies). If the patient has more than one inpatient-only procedure done, the CA modifier need only be reported on one procedure. The facility would need to report the appropriate HCPCS/CPT code for the inpatient-only procedure with modifier CA.

Payment is made under the APC for all services on the claim that have the same date of service as the HCPCS/CPT code billed with modifier CA. The PPS (Prospective Payment System) hospital would bill the claim as outpatient (type of bill 013X) with patient status code 20 (patient expired). The claim will deny if Edits 18 (inpatient procedure) and 49 (service on the same day as an inpatient procedure) are triggered in the Outpatient Code Editor (OCE).

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If you have an article or idea to share for *The Code*, please submit to:
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Never chase happiness, love, passion or success. Those things will find you when you start chasing opportunities to make a difference in people's lives.

Alexander Den Heijer

CA Modifier *(Continued from page 1)*

Payment is only allowed for ONE procedure with modifier CA. If multiple inpatient-only procedures are submitted with modifier CA, the claim will be returned to the provider (RTP). CMS has updated (Rev. 3425, Issued: 12-18-15, Effective: 01-01-16, Implementation: 01-04-16) the Medicare Claims Processing Manual, Chapter 4, Section 180.7 to reflect the revised payment policy.

If an inpatient-only procedure is performed on an outpatient basis, for the most part there will be no reimbursement not only for the procedure done but also the other services that were performed (i.e., ED visit, X-rays etc.) in the facility for the same date of service. However, it is interesting to point out that the surgeon can still bill and she/he will be reimbursed.

For more information on the most current Addendum B and for Addendum E published with the OPPS notices and regulations, see http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/index.html

For additional information on the CA modifier refer to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf

It is courage which makes you fight through your fears and help you become more self-confident.
Confidence provides necessary impetus to your effort and you achieve the success which you deserve most.
A positive state of mind makes it easier to avoid worries and negative thinking.

Dr. Anil Kumar Sinha

Leveling and Billing An E&M Service

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Some physician/patient outpatient Evaluation and Management (E&M) encounters involve lengthy discussions of test results and continuing treatment options and sometimes an exam never occurs as the patient is only coming in for a follow up for results of labs, x-rays or other results of test performed.

There is an alternative to using the three key components of history (HX), examination and medical decision making (MDM).

If the physician spends more than half of the face-to-face time with the patient and/or the patient's family in counseling or in coordination of care, the CPT E&M code may be selected based on the total time of the face-to-face time of the encounter.

What is Needed to be Documented

The medical record must show the total time (face-to-face) and the phrase "more than 50 percent of time was spent counseling and or coordination of care." Plus, the medical record must include a concise description on the content of the counseling and what was done for the coordination of care. Just one or two lines, naming the individuals counseled, and brief description of the subject matter is sufficient. It can be included in the dictation.

Be careful that the concise description in the medical record is essential. Also remember that the time requirements for new and established outpatient E&M levels are not the same.

New Patient E&M Levels	Time/Code	Established Patient E&M Levels	Time/Code
99201	10 minutes	99211	5 minutes
99202	20 minutes	99212	10 minutes
99203	30 minutes	99213	15 minutes
99204	45 minutes	99214	25 minutes
99205	60 minutes	99215	40 minutes

More Details

Face-to-face time for these services is defined as only the time that the physician spends face-to-face with the patient/and family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination and counseling the patient.

Counseling is a discussion with a patient and the family concerning one or more of following areas: diagnostic results, impressions, recommended diagnostic studies, risk and benefits of treatment, follow-up; importance of compliance with chosen management (treatment) options, risk factor reduction, and patient and family education.

Anxiety and Depression: Understanding the Differences and its Coding Approach

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Anxiety and depression are the most common form of mental health issues in our society. These mental health issues are often triggered by a variety of stimuli such as psychological, emotional, physical, nutritional, social, spiritual, etc.… Many people are unclear on the difference of; anxiety and depression. They are not the same but it is common to people who experience anxiety will also experience depression. But how does one differ from the other?

Anxiety

Anxious individuals often fear that the future will be bad. Being anxious to a certain situation is a normal reaction of an individual. However, when this becomes excessive, it could lead to a disorder. Anxiety disorder is characterized by several symptoms which involve worrying, fear and other self-protective behaviors. An individual will be likely to experience physical symptoms such as headache, fatigue, irritability and sweating.

Depression

A depressed individual is often characterized with low self-esteem, a feeling of sadness or hopelessness, loss of interest and enjoyment in an activity, loss of appetite, and likely to have thoughts of death and suicide.

Treatment Management

More likely, people suffering from anxiety or depression will have psychosocial therapies and counseling, promoting lifestyle modifications and other integrative therapies and healing practices; which could cover physical, mental, emotional and spiritual health aspects. Physicians often prescribe an anti-depressant medication; particularly the group of anti-depressant medications known as the Selective Serotonin Reuptake Inhibitors (SSRI) which demonstrate its efficacy in alleviating anxiety to people suffering from anxiety disorder.

Coding Perspective

Question: What is the code assignment for depression and anxiety?

Answer: Assign codes 311, Depressive disorder NEC, and 300.00, Anxiety state, unspecified, for a diagnostic statement of depression and anxiety. Code 300.4, Dysthymic disorder, is not appropriate since the provider has not established a linkage between the two conditions. When there is no association between the two conditions, assign separate codes.

If, however, the provider documents depression with anxiety, assign code 300.4, Dysthymic disorder.

As far as previously published advice on documentation is concerned, documentation issues would generally not be unique to ICD-9-CM and, so long as there is nothing new published in coding clinic for ICD-10-CM and ICD-10-PCS to replace it, the advice would stand.

References:
AHA Coding Clinic for ICD-9-CM, 2001, third quarter, page 6
AHA Coding Clinic, Fourth Quarter 2015, page 20.

Are You a Good Auditor?

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Direction: All medical coding staff 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.

DISCHARGE DIAGNOSES

- Coronary artery disease (CAD)
- S/P Percutaneous transluminal coronary angioplasty (PTCA)
- Dyslipidemia

DISCHARGE PROCEDURES: PTCA

BRIEF HISTORY: Patient is a 77-year-old gentleman, with known coronary artery disease and a prior PTCA and stent x3, is being admitted today for crescendo angina. He underwent a cardiac catheterization two weeks ago, which showed restenosis of his stents.

HOSPITAL COURSE

Patient's catheterization two weeks ago shows significant CAD with stent restenosis. After careful and extensive review of the catheterization studies by Cardiology and discussion with the patient and family, the decision was made to proceed with PTCA. He had a successful angioplasty of his mid-left anterior descending artery (LAD) focal in-stent restenosis, distal LAD and mid right coronary artery (RCA) focal in-stent restenosis. His heart rate decreased to 53 with a drop in blood pressure to 70/55. Pulse and pressure responded to IV atropine. He tolerated the remainder of the procedure well and was stable overnight, with no recurrent chest pain. The patient was noted to have elevated blood pressures in the 150s over 90s during his hospitalization. We did start metoprolol for his hypertension with good control of his blood pressure at the time of discharge.

	ICD-10-CM
Principal Diagnosis	T82.858A
Secondary Diagnosis	I25.10
Secondary Diagnosis	R03.0
Secondary Diagnosis	I20.0
Secondary Diagnosis	E78.5
Secondary Diagnosis	Z95.5
	ICD-10-PCS
Principal Procedure	02723DZ

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Are You a Good Auditor? *(Continued from page 5)*

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Audit Remark
Principal Diagnosis	I44.2	Report code I44.2, Atrioventricular block, complete as the principal diagnosis. Although the patient presented to the emergency department for swelling in the hands and legs, he was admitted to the cardiac unit for the heart block found after the EKG exam. Also, the focus of treatment/surgery was for the heart block.
Secondary Diagnosis	I50.9	Resequencing code I50.9, Heart failure, unspecified as additional diagnosis.
Secondary Diagnosis	I10	No change.
Secondary Diagnosis	K21.9	GERD treated during the hospital stay.
	ICD-10-PCS	**Audit Remark**
Principal Procedure	0JH606Z	Revise 6th character for pacemaker insertion. As per operative report, pacemaker leads were inserted in two heart chambers thus, 6th character "6" is appropriate. The first lead was placed in the right ventricle and the second in the right atrium.
Secondary Procedure	02HK3JZ	Revise 5th character for the pacemaker lead insertion. As per the operative note, the surgeon used a french-8 catheter and guidewire to place the leads in the heart via the subclavian vein. This is an example of a "transvenous" approach and is reported with the 5th character "3" for percutaneous.
Secondary Procedure	02H63JZ	Revise 5th character for the pacemaker lead insertion. As per the operative note, the surgeon used a french-8 catheter and guidewire to place the leads in the heart via the subclavian vein. This is an example of a "transvenous" approach and is reported with the 5th character "3" for percutaneous.

Coding Case Scenario

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

HPI: This is a pleasant 63-year-old female with a right colon mass and is presenting for a right colectomy.

DESCRIPTION OF PROCEDURE: The patient was placed in supine position, given general endotracheal anesthesia, prepped and draped in sterile fashion to start laparoscopically. We cannot proceed with laparoscopic procedure so we then went to open, and mobilized the right colon, identifying the area in question. We excised the entire right colon. Sent it off for pathologic analysis, did an end-to-end anastomosis. We irrigated copiously with excellent hemostasis. We then closed the fascia with Biosyn and re-approximated skin with staples. The patient tolerated the procedure well.

HOSPITAL COURSE: This is a 63-year-old female with a right colon mass who was admitted for right colectomy. Her past history is most notable for hypertension and osteoporosis. Procedure was performed and pathology studies revealed that the patient has adenocarcinoma of the cecum. The patient recovered well after surgery. On postop day two, she was hyponatremic and IV fluids were given. The patient was also given extra care for her anemia. Her home medications for asthma were also continued during this admission. The patient recovered well and was discharged home in good condition. She was instructed to present to the nearest emergency department should her symptoms worsen.

DISCHARGE DIAGNOSES:

- Right colon mass, status post right colectomy
- Adenocarcinoma of cecum
- Dyslipidemia
- Hyponatremia

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Coding Remark
Principal Diagnosis	D57.01	The patient came in for diffuse pain with shortness of breath typical of sickle cell disease. After study, the cause of the patient's initial symptoms was determined to be sickle cell crisis and acute chest syndrome.
Secondary Diagnosis	L97.319	Non-pressure chronic ulcer of right ankle with unspecified severity
Secondary Diagnosis	J45.909	Unspecified asthma, uncomplicated