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THE CODE

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Getting Proper Reimbursement for Work Done

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We all know how important clinical documentation is to patient care and from a compliance standpoint it is crucial to auditing; but for those dealing with the financial side, the importance may translate into reimbursement losses. Let us look at a clinical scenario.

An 80-year old male patient with a history of myeloepithelial carcinoma of the left parotid presented with a new left neck mass which through fine needle aspiration (FNA) showed carcinoma. The patient underwent a radical resection of the left neck tumor with resection of the overlying skin (5 cm x 2 cm) and deep muscle along with an adjacent tissue transfer advancement flap closure (flap dimensions 5 cm x 2 cm) of neck defect. Per the pertinent sections of the operative note, "We deepened our incision circumferentially along the ellipse down to the sternocleidomastoid muscle. We then encompassed a small cuff sternocleidomastoid muscle deep to the mass to ensure adequate deep margin and removed the specimen en bloc. We then created adjacent flaps on either side of the 5 cm x 2 cm defect in subcutaneous plane with flap dements 5 cm x 2 cm in aggregate. These flaps were advanced over the defect, and then we performed a multilayered closure."

What I think may have happened is that the coding staff either didn't have access to the operative note at the time of coding or in a rush to meet their daily quota didn't fully read the operative note and therefore coded this case as 11620 (EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS) and 12041 (LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 2.5 CM OR LESS). This case was then pulled for an audit by the payer and you may have already guessed the reason. The reason this claim was flagged by the payer's system for an audit was because of an NCCI edit. The primary code would be 11620 and the component code would be

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If you have an article or idea to share for *The Code*, please submit to:
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The easiest way to make employees do their best work is to appreciate them.

Alexander Den Heijer

Getting Proper Reimbursement for Work Done *(Continued from page 1)*

12041. For those of you who don't live, breathe and die NCCI edits, this means that 12041 cannot be billed with 11620 (see table below). Per Centers for Medicare and Medicaid Services (CMS), the purpose of the National Council on Compensation Insurance (NCCI) Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains one table of edits for physicians/practitioners and one table of edits for outpatient hospital services. So, what this means is that there are tables out there that have one code in column 1 and one or many codes in column 2. The payer software is set up so that if the system sees a claim with two codes identified as a pair it will either flag the chart for review or deny the claim.

Primary Code	Component Code	Rationale
11620	10140 12031 12032 12034 12035 12036 12037 12041 12042 12044 12045	NCCI Policy Manual
	12046 12047 12051 12052 12053 12054 12055 12056 12057 96405 96406	Chapter IC6 Chapter III G
		Chapter III E

This chart was appealed to the payer with the billed codes 11620 and 12041. The payer denied the claim stating that it did not meet NCCI standards. An appeal was submitted a second time and after a second level review it was determined that the chart was incorrectly coded and should have been coded as 21558 (RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF NECK OR ANTERIOR THORAX; 5CM OR GREATER) and 14040 (ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; DEFECT 10SQ CM OR LESS). The explanation given was when lesion excision is of such an extent that closure cannot be accomplished by simple, intermediate or complex closure, other methodology must be employed. Frequently adjacent tissue transfer or tissue rearrangement is employed (Z-plasty, W-plasty, flaps, etc.). This family of codes (Current Procedural Terminology® [CPT] codes 14000-14350) involves excision with adjacent tissue transfer and correlates to excision codes. Excision CPT codes (11400-11646) and repair CPT codes (12001 – 13160) are not to be separately reported when CPT codes 14000-14350 are reported. Skin grafting performed in conjunction with these codes may be separately reported if it is not included in the specific code definition. In the case of closure of traumatic wounds, these codes are appropriate only when the closure requires the surgeon to develop a specific adjacent tissue transfer; lacerations that coincidentally are approximated using a tissue transfer technique (e.g., Z-plasty, W-plasty) should be reported with the more simple closure code.

In conclusion, there are several messages in this case scenario:

1. Make sure you have the necessary documentation to code a chart. If there is documentation missing such as an operative report or a pathology report pend the chart until the documentation is available to correctly process.
2. Make sure you have a scrubber in your billing system that will catch the NCCI edits the first time, thus avoiding the time consuming appeals process.
3. Make sure that the appeals staff either understands coding or routes the case to the coding department so that they can investigate the codes utilized.
4. Never leave money on the table as would have been the case in the above scenario had it bypassed the NCCI edits. I understand that most facilities/practices have a very short turnaround time for billing, some as little as 48 hours, but if the case above had not hit the payer edits it would have reimbursed at a much lower dollar value than the 2nd level appeal recoding of the case. Always try to optimize your reimbursement by having the right staff, the right protocols and a claims scrubber to catch edits before the claims go out the door.

Hierarchical Condition Category Coding Pearls

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Target Progress Note Contents and Coding

As stated by the Centers for Medicare & Medicaid Services, the format of choice is the SOAP (Subjective, Objective, Assessment, Plan) note. An explanation of each section follows:

SUBJECTIVE:

- The chief complaint of the patient belongs in this section and reports additionally any subjective information of clinical significance.

OBJECTIVE:

- Report measurable/observable information obtained during the visit. Review of Systems (ROS), physical examination, test results and communication with specialists should all be noted in this section.

ASSESSMENT:

- Indicate ALL current diagnoses for ALL active and historical conditions assessed during the visit; such as in the following example.
    - Assessment:
        - Hypertension I10
        - Type 2 diabetes mellitus with renal manifestations E11.29
        - Right shoulder osteoarthritis M19.011
        - Left ventricular failure I50.1
        - Chronic kidney disease stage 3 N18.3

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Hierarchical Condition Category Coding Pearls *(Continued from page 3)*

PLAN:

- The final section of your SOAP notes is where you outline the course of treatment, after considering the information you gathered during the visit. Indicate the prescriptions given and why, etc., testing to be done/ordered and referrals to other providers. See the following example.
    - Plan: Continue on current blood pressure medications and recheck in four weeks at the office. Tramadol 50mg, one to two tablets every six hours was refilled for arthritic shoulder pain. Blood sugar in the office was 117. Patient will continue with present treatment with metformin. Congestive heart failure is being monitored by her cardiologist, Dr. Heart, and is presently controlled. Recent kidney testing from 3/3/09 showed a creatinine of 1.10, with an estimated GFR 54 and a BUN of 16. Will follow-up and recheck next month.

ASSURE PROGRESS NOTE COMPLIANCE:

- A compliant handwritten signature that is legible and includes the clinicians' credentials.
- If the signature is illegible, then it can be made compliant by having the clinicians name and credential pre-printed on the form. This may be in the letterhead or in the form of a signature block on the form checked off.
- Electronic Medical Records must be authenticated; digitally signed or electronically signed by the provider.
- The patient's name, date of birth and date of service must be on each page of the patient's progress note/chart.
- The medical record must be legible and complete.
- Only standard medical abbreviations should be used.
- Late entries/addendums can be made to clarify confirmed diagnoses. The date and time of the late entry must be included.

References:

https://www.rpndocs.com/rehr/documents/CodingTips/progressnote.pdf

Don't let your disappointments destroy you. They're meant to give you moral strength and resilience to carry on and do the best you can.

Mufti Ismail Menk

Endotracheal Intubation

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INTRODUCTION:

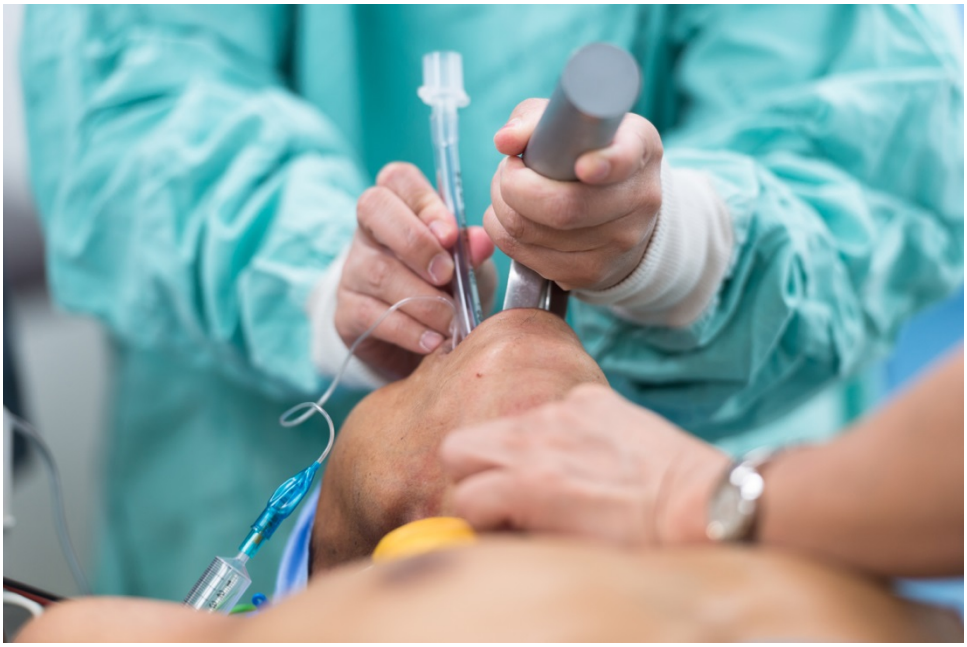
Endotracheal intubation for the purpose of providing anesthesia was first described by William MacEwan in 1878 when he passed a tube from the mouth into the trachea, using fingers as a guide in the conscious patient. Edgar Rowbotham and Ivan Magill gained wide experience of endotracheal intubation during World War I and popularized it subsequently.

Orotracheal intubation is the introduction of a tube through the mouth, through the larynx and into the trachea. Intubation assists in keeping the airway patent, permits suctioning of airway secretions, it provides an artificial conduit between the atmosphere and the patient's trachea for the purpose of alveolar gas and promotes oxygenation, also provides an alternative route for medication delivery.

INDICATIONS:

The clinical situations where endotracheal intubation is indicated are listed below:

- Routine
  - To provide anesthesia
- Emergency
  - Airway obstruction
  - Respiratory distress
  - Oxygenation failure (hypoxia)
  - Ventilation failure (hypercarbia)
  - Mental status alteration (GCS<8/15)
  - Flail chest/Pulmonary contusion
  - Cardio pulmonary resuscitation



CONTRAINDICATIONS:

- Total upper airway obstruction
- Loss of facial landmarks
- Unstable cervical spine injury or an anticipated difficult airway
- The patient is unable to open the oral cavity more than two finger breadths
- Distance from the thyroid notch to the mandible is less than three finger breadths
- High arched palate or the normal range of flexion-extension of the neck is less than 80 degrees

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Endotracheal Intubation *(Continued from page 5)*

RISKS AND COMPLICATIONS:

- A buildup of too much water in the tissues
- A collapsed lung (Pneumothorax)
- Aspiration (oral or stomach contents may enter into the airway)
- Dental and soft tissue trauma
- Esophageal intubation (insertion of tube in to the esophagus by mistake)
- Perforation or laceration of upper esophagus, vocal cords and Larynx
- Dysrhythmias
- Hypertension/hypotension

CODING GUIDELINES:

CPT provides a single code to report endotracheal intubation – **31500.**

Per CPT and National Correct Coding Initiative (NCCI) guidelines, 31500 describes an emergency endotracheal intubation and should not be reported for elective endotracheal intubation.

Code 31500 "should be reported for a stand-alone emergent or semi-emergent endotracheal intubation, such as rapid sequence intubation either using a rigid or flexible type of endoscope (i.e., laryngoscope, bronchoscope)." There is no CPT code for elective endotracheal intubation.

Additional points to keep in mind when considering 31500 include:

- Do not separately report 31500 with any anesthesia procedure. NCCI guidelines confirm, "Airway access is necessary for general anesthesia and is not separately reportable."
- Endotracheal intubation is bundled in (included in) pediatric and neonatal critical care service codes (99293-99296).
- Per CPT, "Visualization of the airway is a component part of an endotracheal intubation, and CPT codes describing procedures that visualize the airway (e.g., nasal endoscopy, laryngoscopy, and bronchoscopy) should not be reported with an endotracheal intubation. It is a misuse of diagnostic and therapeutic endoscopy codes to report visualization of the airway for endotracheal intubation."
- If a critically-ill patient is intubated with a bronchoscope, and the airway is then examined to exclude, for example obstruction, infection or other processes contributing to the respiratory failure, Code 31622 bronchoscopy rigid or flexible with or without fluoroscopic guidance; diagnostic, with or without washing (separate procedure) should be reported in addition to the endotracheal intubation.
- Moderate sedation may be reported in addition to the endotracheal intubation procedure, provided the criteria for reporting the Codes 99143-99150 are met.
- Chest x-ray used to confirm endotracheal tube placement is included in the procedure.

References:

www.rchsd.org
www.aapc.com
CPT 2016 Professional Addition
www.healthline.com
www.ispub.com
https://en.wikipedia.org/wiki/Tracheal_tube

Thoracic Paravertebral Nerve Blocks: An Education

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Paravertebral block was first performed by Hugo Sellheim in 1905. However, it was Arthur Lawen who coined this technique as paravertebral conduction anesthesia in 1911. The popularity of this procedure faded in the 1950's and 1960's, but started to reappear in the late 1970's.

Paravertebral nerve blocks involve injection of local anesthesia where its analgesic effect works by blocking the nerve impulses that are carried by various spinal nerves as they come out unilaterally from the spinal column to the paravertebral spaces. The said procedure is performed for breast procedures such as mastectomy and cosmetic breast surgeries and also thoracic surgery such as thoracotomy or surgeries involving the ribs. Paravertebral blocks are noted to be safer and easier to perform than thoracic epidurals, and also reduce the need for further opioid treatment.

Coding Perspective:

In 2016, CPT has created new codes for thoracic paravertebral nerve blocks:

- 64461 – Paravertebral block (PVB), thoracic; single injection site (includes imaging guidance, when performed)
- +64462 – Second and any additional injection site(s) (includes imaging guidance, when performed) (list separately in addition to code for primary procedure)
- 64463 – Continuous infusion by catheter (includes imaging guidance, when performed)

CPT 64461 is to be used when a single injection is performed.

CPT add-on code 64462 should be reported only once per day.

CPT code 64463 is to be used when the block uses catheter placement for continuous infusion.

These codes are unilateral services, if performed bilaterally, modifier 50 or RT/LT would be applicable per payer guidelines.

The best day for doing your best is the
one that comes seven times a week.

Vikrant Parsai

Are You a Good Auditor?

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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 35-year-old patient has Type 1 diabetes and is being admitted today for a right heel ulcer that had failed a number of therapies. A non-excisional debridement of the right heel was performed. The skin was debrided. Also, because the patient was hypoxic on admission because of decompensation of his long-standing history of COPD, he was given supplemental oxygen. He coughed up sputum and a chest x-ray showed a mild increase in interstitial markings. Consequently, he was treated for acute bronchitis with erythromycin, which provided good results. Gradually, the ulcer has resolved. But the hypoxia persisted, he subsequently developed respiratory failure and intubation and mechanical ventilation was initiated. Continuous ventilation was helpful and patient was completely weaned off on day five of hospital stay. He was to be followed upon by home health services.

Discharge diagnosis:

- Diabetic skin ulcer, right heel
- COPD
- Acute bronchitis
- Diabetes mellitus

	ICD-10-CM
Principal Diagnosis	E10.622
Secondary Diagnosis	J44.1
Secondary Diagnosis	J20.9
Secondary Diagnosis	J96.00
	ICD-10-PCS
Principal Procedure	5A1945Z

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Audit Remark
Principal Diagnosis	E84.9	Assigned as PDX since the patient has DM that was due to a condition and would fall under the category E08. E08 has a convention to code first underlying condition, which was cystic fibrosis.
Secondary Diagnosis	E08.65	Assigned as secondary code for diabetic hyperglycemia.
Secondary Diagnosis	E08.22	Assigned as secondary code for diabetic CKD. As per Coding Clinic, CKD is automatically related to DM.
Secondary Diagnosis	N18.3	Assigned as secondary code for CKD stage 3.
Secondary Diagnosis	K26.0	Assigned as secondary code for acute duodenal ulcer with hemorrhage.
Secondary Diagnosis	D50.0	Assigned as secondary code for chronic blood loss anemia.
	ICD-10-PCS	**Audit Remark**
Principal Procedure	3E033VG	Assigned as PPX since the patient was put on insulin drip via IV for his diabetes with hyperglycemia.
Secondary Procedure	5A1D00Z	Assigned as secondary procedure code for hemodialysis.

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.

The patient, an elderly Hispanic man, was admitted through the emergency department for severe urinary retention. In the emergency department, it was also determined that his hypertension was accelerated at 210/105. He had been hospitalized three months ago for similar problems, and he said he had not taken any of his antihypertensive medications since the last hospitalization because he could not afford the cost of these medicines. This was the cause for the patient's high blood pressure now. The urinary retention was relieved by placement of a Foley Catheter. Medications were started, and the hypertension improved very rapidly. The patient was evaluated for the extent of benign prostatic hypertrophy, and a transurethral resection of the prostate was recommended. The patient underwent the procedure with no complications.

Discharge Diagnoses:

1. Hypertension
2. Benign hypertrophy of the prostate

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Coding Remark
Principal Diagnosis	S13.4XXA	Assign code as principal diagnosis. Patient came in because of multiple injuries (superficial injury of eye and whiplash injury). As per ICD-10 guidelines, the injury which is more severe will be sequenced first, thus, making the whiplash injury as PDX. As per Alpha Index: Injury → whiplash (S13.4-).
Secondary Diagnosis	S05.91XA	Assigned as secondary code for superficial injury of right eye.
Secondary Diagnosis	A41.52	Assigned as secondary code for sepsis due to pseudomonas. The patient developed sepsis during the stay and blood cultures revealed pseudomonas as the organism.
Secondary Diagnosis	R65.20	Assigned as secondary code for severe sepsis. The patient had an acute organ dysfunction (AOD) which was the encephalopathy. As per ICD-10 guidelines, if an AOD was caused by sepsis, it will be coded as severe sepsis.
Secondary Diagnosis	G93.41	Assigned as secondary code for septic encephalopathy. Convention from R65.2- states to use an additional code for any AOD. In this case, the encephalopathy.
Secondary Diagnosis	N39.0	Assigned as secondary code for UTI.
Secondary Diagnosis	V47.52XA	Assigned as secondary code for external cause of MVA. The patient was the driver of the car that collided with a vehicle that was at a stop (stationary object). And since the accident occurred in a highway, it is considered as a traffic accident. As per Alpha Index: Accident → transport → car occupant → driver → collision with → stationary object (V47.52-).
Secondary Diagnosis	W22.11XA	Assigned as secondary code for external cause of airbag deployment.
Secondary Diagnosis	Y92.415	Assigned as secondary code for place of occurrence, which was in the interstate entrance ramp.
Secondary Diagnosis	Y93.C2	Assigned as secondary code for activity, which was using the cellphone.