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THE CODE

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Stem Cell Transplants

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Hematopoietic stem cells (HSCs) are produced in bone marrow. These stem cells are responsible for the constant renewal of blood with the production of billions of blood cells every day. What is amazing about an HSC is the fact that it can differentiate itself into a variety of cells. An HSC may differentiate into a myeloid progenitor cell or it may differentiate into a lymphoid progenitor cell. The myeloid progenitor cells may become neutrophils, basophils, eosinophils, monocytes, macrophages, platelets or red blood cells. The lymphoid progenitor cells become B or T lymphocytes.

When patients are found to have certain cancers such as leukemia, multiple myeloma, some types of lymphoma or even blood (severe aplastic anemia) or immune system disorders they may undergo stem cell transplants. In the past, patients underwent a bone marrow transplant (BMT) which was done to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. Patients either underwent autologous (AUTO transplant) (where the donor and recipient are the same person) or allogeneic (ALLO transplant) (where the donor and recipient are different individuals) transplants. This procedure was called a bone marrow transplant because the stem cells were collected from the bone marrow. In the past physicians performed bone marrow transplants by anesthetizing the stem cell donor, puncturing a bone such as a hipbone (iliac crest) or sternum and drawing out the bone marrow cells with a syringe. Physicians now prefer to harvest donor cells from peripheral circulating blood. Apheresis ("a taking away") is another term utilized for the collection of peripheral blood stem cells which are then frozen and given back to the patient after intensive treatment. Since the procedure now collects stem cells from blood the term now utilized is a stem cell transplant. Often the term rescue is used instead of transplant. The donor is injected with a cytokine, such as granulocyte-colony stimulating factor (GCSF) a few days before the

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If you have an article or idea to share for *The Code*, please submit to:
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Courage is being scared to death and saddling up anyway!

John Wayne

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cell harvest. To collect the cells, a physician will insert an intravenous tube (transplant catheter) into the donor's vein and pass his blood through a filtering system collecting the white blood cells (CD34+) and returning the red blood cells back to the donor. With umbilical cord transplants, stem cells are taken from and immediately after delivery of an infant. These stem cells reproduce into mature, functioning blood cells quicker and more effectively than do stem cells taken from the bone marrow of another child or adult. The stem cells are tested, typed, counted and frozen until they are needed for a transplant.

In comparison, a biopsy has the following definitions:

- The removal of a small piece of tissue for laboratory examination
- A sample of tissue taken from the body in order to examine it more closely
- A procedure to remove a piece of tissue or a sample of cells from your body so that it can be analyzed in a laboratory
- The removal of cells or tissues for examination by a pathologist

In the 2016 ICD-10-PCS Official Guidelines for Coding and Reporting, Guideline B3.4a for biopsy procedures says:

Biopsy procedures are coded using the root operations excision, extraction or drainage and the qualifier diagnostic. Examples: Fine needle aspiration biopsy of lung is coded to the root operation drainage with the qualifier diagnostic. Biopsy of bone marrow is coded to the root operation extraction with the qualifier diagnostic. Lymph node sampling for biopsy is coded to the root operation excision with the qualifier diagnostic.

The root operation for bone marrow biopsy procedure is extraction since the main objective is to pull out a portion of the bone marrow. The alphabetic index entry main term extraction, subterm bone marrow refers the coding professional to Table 07D. Biopsy of bone marrow is coded with the qualifier diagnostic. A hollow needle is inserted into the bone. The needle is then twisted and advanced. This motion allows a sample of bone marrow to enter the core of the needle. The qualifier, DIAGNOSTIC, is used to identify drainage procedures that are biopsies per coding guideline B3.4a.The approach is percutaneous because a puncture is made to accommodate insertion of the biopsy needle.

The ICD-10-PCS code for this procedure is 07DR3ZX. The fourth character (R) identifies the body part as bone marrow, iliac.

Section	**O** Medical and Surgical
Body System	**7** Lymphatic and Hemic Systems
Operation	**D** Extraction: Pulling or stripping out or off all or a portion of a body part by the use of force

Body Part	Approach	Device	Qualifier
Q Bone Marrow, Sternum **R** Bone Marrow, Iliac **S** Bone Marrow, Vertebral	**O** Open **3** Percutaneous	**Z** No Device	**X** Diagnostic **Z** No Qualifier

The root operation in ICD10-PCS for therapeutic plasmapheresis is pheresis (extracorporeal separation of blood products). This can be found under extracorporeal therapies root operations character six. If a patient is undergoing a single plasmapheresis the code assigned would be 6A550Z3. The seventh character captures the blood product that is being extracorporeally separated. As you can see the options for the qualifier (seventh character) are: erythrocytes (0), leukocytes (1), platelets (2), plasma (3), stem cells, cord blood (4) or stem cells and hematopoietic (5).

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Stem Cell Transplants *(Continued from page 2)*

Section	**G** Extracorporeal Therapies
Body System	**A** Physiological Systems
Operation	**5** Pheresis: Extracorporeal separation of blood products

Body System	Duration	Qualifier	Qualifier
5 Circulatory	**O** Single **1** Multiple	**Z** No Qualifier	**O** Erythrocytes **1** Leukocutes **2** Platelets **3** Plasma **T** Stem Cells, Cord Blood **V** Stem Cells, Hematopoietic

According to the ICD-10-PCS Guidelines, the putting in of autologous or non-autologous bone marrow, pancreatic islet cells, or stem cells is coded in the administration section. Therefore, in coding a non-autologous bone marrow (BM) transplant via central venous line the code would be 30243G1 where the first character three, identifying the administration section. Character two, body system will be circulatory (0), the operation is transfusion and the CVP line will be placed in the peripheral vein hence the body system/region character three. The approach will always be percutaneous (3) and the substance is bone marrow (G) and the qualifier one for non-autologous.

Section	**3** Administration
Body System	**0** Circulatory
Operation	**2** Transfusion: Putting in blood or blood products

Body System / Region	Approach	Substance	Qualificer
3 Peripheral Vein **4** Central Vein	**O** Open **3** Percutaneous	**A** Stem Cells, Embryonic	**Z** No Qualifier
3 Peripheral Vein **4** Central Vein	**O** Open **3** Percutaneous	**G** Bone Marrow **H** Whole Blood **J** Serum Albumin **K** Frozen Plasma **L** Fresh Plasma **M** Plasma Cryoprecipitate **N** Red Blood Cells **P** Frozen Red Cells **Q** White Cells **R** Platelets **S** Globulin **T** Fibrinogen **V** Antihemophilic Factors **W** Factor IX **X** Stem Cells, Cord Blood **Y** Stem Cells, Hematopoietic	**0** Autologous **1** Non-autologous

Reference:

2016 CMS PCS Code table and Index https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-PCS-and-GEMs.html

Risk Adjustment: How Long Has It Been Around?

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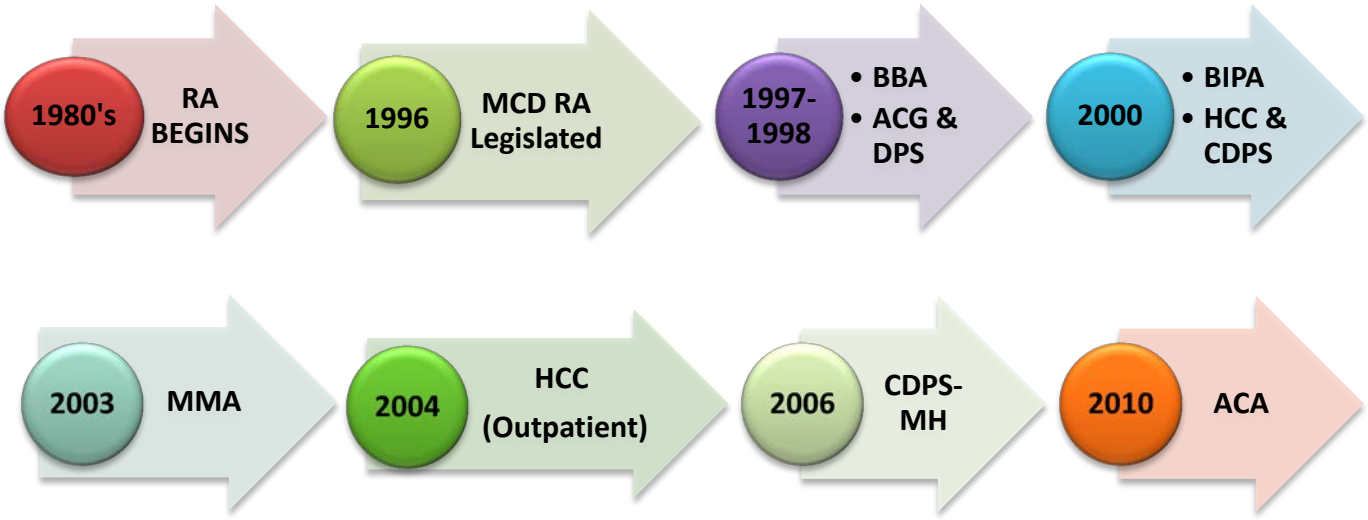
Where Did Risk Adjustment Plans Originate?

Think about your car insurance! We all know that with car insurance not everyone pays the same premium to the insurance carrier for their car insurance. It's going to cost more to insure a 16 year-old boy in a sports car than it is to insure a 40-year-old female in that same sports car. The color of the car as well as the region of the country in which the individual resides is also going to also make a difference which cumulatively factor in the adjustment of the final premium.

As seen above with car insurance, risk adjustment (RA) applies to lots of different arenas and it is becoming more prevalent in how insurance services are reported for healthcare services rendered. Risk adjustment describes methods for determining whether patient characteristics will necessitate higher utilization of medical services. Risk adjustment plans have been around for years, dating back to the 1980s when Medicare initiated the first one. In the 1980s Medicare and Medicaid plans paid based on a RA model which included four factors for the adjustment: the patient's age, the patient's gender, whether or not they were eligible for Medicaid services and whether or not they were a nursing home resident.



Why Do I Need to Understand Risk Adjustment?

The vast majority of states, with the exception of Alaska, have a number of beneficiaries enrolled in a Medicare Advantage Plan. Several states have well above 15, 20 or 25 percent of their Medicare population enrolled in a plan. Now, some of you might say that "25 percent is nothing." However, that's a quarter of the Medicare population, and if the practice or health system is composed predominantly of elderly patients, aged, disabled and those over 65, i.e., those who are eligible for Medicare, this could potentially be a very large subset of the practice population.

This represents just the Medicare Advantage Plans. Data is not yet available on how many patients are enrolled in those Affordable Care Act Marketplace Plans that risk adjusts. A good way of tracking how many patients are enrolled in Medicaid Risk Adjustment Plans is also not yet available. However, if the numbers are comparable to the percentages

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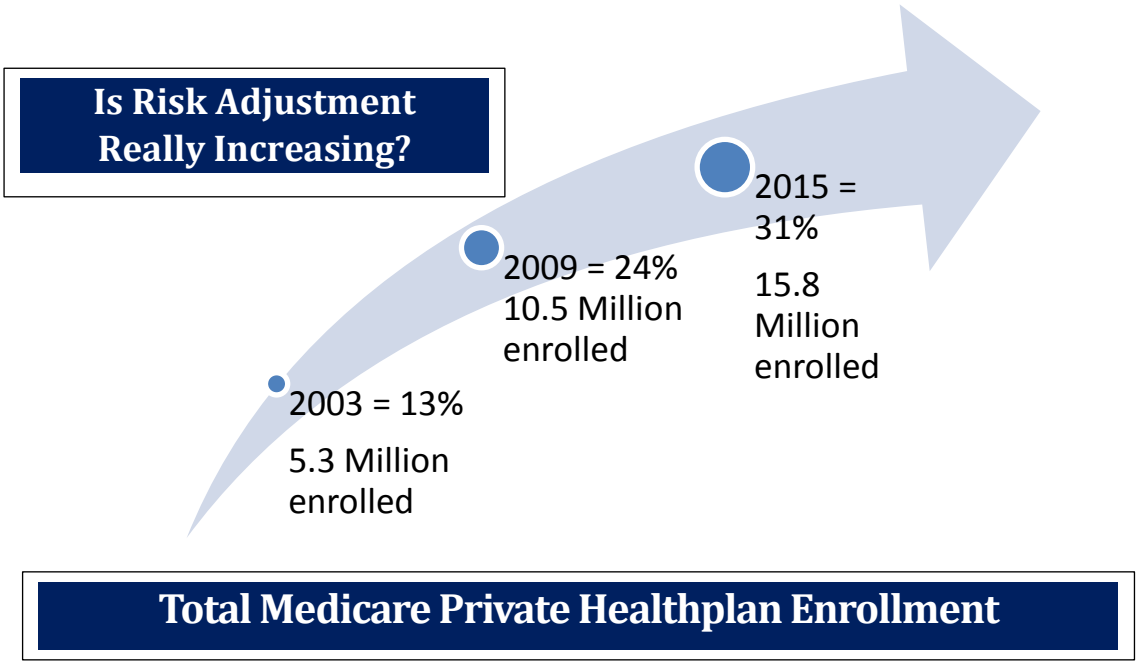
Risk Adjustment: How Long Has It Been Around? *(Continued from page 4)*

cited above, think about the total population depending on each individual state. It could be 25 or even 50 percent of the patient population, or even more than that. This is not only just based on state, it's based on specialty, based on the name, type of insurance plans that the practice or facility accepts if the enrollment is through the healthcare system.



Yes, we are seeing a huge increase in the number of RA plans. It's tripled in the last ten years and these findings only take into account Medicare Advantage Plans, their Special Needs Plans, and all of the different things that factor under Medicare Advantage Plans. This does not address how many patients are enrolled in Medicaid Managed Care Plans or how many patients are enrolled in the ACA Marketplace Managed Care Plans.

What's The Purpose of Risk Adjustment? (Level Payment and Expectations)

The purpose of RA is to provide payments to health insurance issuers that disproportionately attract higher-risk populations, such as individuals with chronic conditions. It also is utilized to transfer funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection.

To illustrate this, there are four patients below that are labeled patients A through D.

Patient A	Patient B	Patient C	Patient D
Healthy	Diabetes	Diabetes	Diabetes
		Retinopathy	Retinopathy
			CKD III

- Patient A is a normal healthy patient. A normal healthy patient may or may not receive healthcare services throughout the course of the year. The expectation is that the patient will at least come in for their annual wellness visits or annual preventative exam, their immunizations, any mammogram or colonoscopy or age appropriate, gender appropriate preventive services. But overall, we do not anticipate this patient population requiring a vast number of services because they are healthy. This patient population does not present with long term chronic comorbidities, or any other presenting problem that necessitates concern and vigilance.

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Risk Adjustment: How Long Has It Been Around? *(Continued from page 5)*

- Patient B on the other hand, is healthy, but suffers from long-term diabetes. In comparison to Patient A, Patient B is likely to receive more healthcare services throughout the course of a year than Patient A, simply because Patient B is a diabetic. This patient population is more prone to complications. It is also probable that it is going to take them longer to heal after illnesses or injuries. They may require medications to control their diabetes depending on the type of diabetes that they have their activity level, their age and a number of other factors. It is also more likely that they're going to visit the provider more frequently on a more routine basis for services than Patient A will in a calendar year.

  So, in the world of RA, the insurance plans would get paid a little bit more for Patient B than they would for Patient A.

- Looking at a third scenario we now look at the difference between Patient B and Patient C. With Patient B there is a higher payment because the patient suffers from a chronic diabetic condition. Patient C is also noted to suffer from diabetes but has also developed retinopathy as a diabetic complication or comorbidity. Retinopathy adds to the level of service and utilization of resources that is going to be necessary to provide quality care for Patient C. Patient C may also need additional services provided by specialty providers. Maybe the patient was seeing either an endocrinologist or a primary care doctor for the diabetic condition and developed retinopathy which requires an ophthalmologist to become involved in the services provided. The ophthalmologist and the primary care doctor will need to collaborate and coordinate services, and that patient is now going to require more diagnostic testing, perhaps more therapeutic treatment. Patient C is going to require higher levels of services over and above that of Patient B.

- Finally, we look at Patient D. The payment has increased because that patient is a diabetic, and has retinopathy which requires involvement of an ophthalmologist performing additional services. However, this patient's disease has progressed and the patient has developed an additional comorbidity, chronic kidney disease (CKD) stage III, which will affect long-term care. Chances are this patient is under the care of a nephrologist. This patient therefore requires additional services to monitor that the CKD does not decompensate and progress to eventually requiring dialysis. In monitoring the kidney functions on a regular basis, there are additional lab tests required and potentially additional diagnostic tests such as either an ultrasound or an MRI. These requirements over the course of the calendar year increase the payment for Patient D.

Comparing the amount received for Patient D, to the amount receive for Patient A, you're going to see a drastic difference in how much money the insurance plan is going to get due to the additional comorbidities found in Patient D. Justifiably so, since it is going to cost them more to cover Patient D's healthcare expenses than it is to cover Patient A.

Documentation for Risk Adjustment

So how does coding affect capture of risk adjustment? As illustrated above, variation in patient disease process can substantially affect payments under a risk arrangement. Any change in the hierarchical condition category (HCC) could mean you are receiving too much or too little revenue. In order to capture HCCs by coding staff documentation must be available in the medical record. Even if the condition is listed in the problem list and has supporting documentation that it is being treated such as the medication list, the condition cannot be pulled out as an HCC. For example, angina is found in the problem list and the medication lists Nitroglycerin; this is now a "suspect" HCC but cannot be coded as such. It is up to the provider to document angina in the assessment and plan in order for the condition to qualify and count. HCC coders can only capture what the provider documents. They can query the provider with the "suspect" HCC, but they cannot capture and code it. The HCC must meet plan of care guidelines: Was it monitored, evaluated, assessed and/or treated (MEAT) and is the diagnosis linked and documented in the A&P (Assessment & Plan) by the physician?

Medicare risk adjustment utilizes HCC grouping logic in its risk adjustment model and therefore capturing the accurate diagnostic information as seen in the examples above will cumulatively have a positive impact on the patient's risk scores and revenue at each member's premium.

Surgical Global:
Make Sure You are Not Losing Revenue in a Physician Practice

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Understanding surgical global rules and when they apply to you or your practice can allow capture of the revenue that is properly the physician's and the practice.

The number one rule to remember is that the surgical global follows the surgeon who performs the procedure and anyone in his/her group practice specialty, i.e., OBGYN, cardiology, etc. If the patient's own primary care provider took out the sutures because the specialist who performed the surgery practice was too far away from the patient's home, the primary care provider can and should bill for the follow up appointment even if the primary care provider is in the same larger group practice with the same tax identification number (TIN). I have seen many coders from the primary care office state, "This is part of the global, we can't bill." That is incorrect thinking and is a cause of lost revenue. Physicians in the same group practice with different specialties may bill and be paid without regard to their membership in the same group.

The number two rule is to know how many days in the surgical global. There can be zero, 10 or 90 global days attached to surgical CPT codes. Not knowing how many global days could lead the physician and medical coder to incorrectly code for a post-op visit (99024 @ $0.00), where these visits could have been a fully charged visit. Many of the transcatheter procedures and gastrointestinal scopes are zero day global, but many times when the patient comes into the office for the "follow-up" visit after the procedure, the physician and medical coders will bill for a "post-op visit 99024" which means that this practice is losing revenue on the unbilled evaluation and management (E&M) for office visit services.

The number three rule is to know the global medical coding modifiers, and when to use the correct modifier. These modifiers break the global period in order to be able to bill for other procedures that were performed during a global period.

The first two are Modifier 25 (significant, separately identifiable E&M—use on global zero to 10 days) and Modifier 57 (decision for surgery—use for 90 global days), both are used on the E&M CPT codes only. Remember that all procedures have an E&M attached to the procedure; the physician always has to do an evaluation on a patient before any procedure. These modifiers are used to explain to the insurance payer that the E&M was necessary beyond the normal evaluation to determine the need for surgery.

The next three modifiers are attached to the surgical CPT codes; Modifiers 58, 78 and 79. All of these modifiers explain to the insurance payer why the patient went back to the operating or procedure room during the global period.

Modifier 58 is used for staged or related during a post-op or global period where the patient went back to the operating room (OR) either because this was a planned or staged procedure; such as in skin grafting where staging is common during the post-op or related procedure. Another example would be a breast biopsy positive for cancer and a mastectomy performed within the global period of the biopsy.

Modifier 78 is used for unplanned return to the OR following initial procedure for a related procedure. You would use this modifier if something went wrong during the post-op period and the patient had to return to the OR for a related surgery to treat a complication.

Modifier 79 is used for unrelated procedure during the post-op period such as a cataract surgery on right eye and two months later the removal of the cataract of the left eye was performed. By adding Modifier 79 to the second cataract extraction, this indicates to the payer that these two procedures were unrelated to each other.

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Surgical Global: Make Sure You are Not Losing Revenue in a Physician Practice *(Continued from page 7)*

With these last three modifiers, there seems to be a lack of understanding on using the modifiers and how the global rules apply. Often it can be found that the physician did not put in a charge for the procedure performed during a global period because he/she thought that the surgical procedure was part of the "global." This presents as a large loss of revenue for both the physician and the practice.

The last modifier is Modifier 24 and is used for unrelated E&M during a post-op visit which can only be used on an E&M CPT code. Usage of this modifier indicates to the insurance payer that the patient came into the office for an unrelated E&M service. For example, the patient was seen in a primary care's office for removal of a wart, which has a ten day global, but two days later comes back to the office for a sore throat. In this case, Modifier 24 would be added to the E&M code for the office visit. This explains to the insurance payer that this was not a post-op visit and this visit should be paid as it was unrelated to the first visit.

Global rules are not difficult to understand, but making sure that the medical coder, the physician and the office staff get training in the global rules will help make sure that the practice does not suffer any loss in revenue.

References:

Global Surgery Fact Sheet, Medicare Learning Network.
"Medicare Claims Processing Manual", Chapter 12, Sections 40 and 40.1, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
Coding for Medical Necessity in the Physician's Office, Deborah Kelly-Farwell and Cecil Favreau authors, Delmar Cengage Learning

Sacral Dimple: An Education

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A sacral dimple is the presence of a small indentation or hole in the skin above the buttock area. It is also called a sacral pit, pilonidal dimple or spinal dimple. Most sacral dimples are harmless and do not require medical intervention. This condition is congenital without a known underlying cause.

A patient found to have a sacral dimple is usually asymptomatic, however, if the dimple is very large or accompanied by tuft of hair around it, or any skin discolorations around it, the physician might order an ultrasound or magnetic resonance imaging (MRI) test to rule out any spinal cord abnormality conditions such as spina bifida.

CODING PERSPECTIVE:

Sacral Dimple

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Question:

What is the appropriate code assignment for a newborn diagnosed with a sacral dimple?

Answer:

Assign Code Q82.8, other specified congenital malformations of skin, for sacral dimple. A sacral dimple is a congenital condition. Sacral dimples may be associated with a serious underlying abnormality of the spine or spinal cord. It is appropriate to code congenital anomalies when identified by the provider, since they can have implications for further evaluation.

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 patient is a 15-year-old teenager who was admitted to the emergency department after a phone call from a residence where she was found trying to jump from the second floor roof deck with evidence of visual hallucinations with the belief she could fly. She suffered a left fibula fracture after she fell because of the visual hallucinations. She had been seen attending a party and consumed a large quantity of alcohol and smoked marijuana. The reason she is being admitted here is because she overdosed on marijuana and alcohol. After workup, the final diagnosis was acute alcohol with marijuana intoxication, with abuse, with both alcohol- and drug-inducing delirium and psychotic hallucinations. X-rays showed that the fracture was at the upper end with a type 1 Salter-Harris.

	ICD-10-CM
Principal Diagnosis	T51.0X2A
Secondary Diagnosis	T40.7X2A
Secondary Diagnosis	F10.221
Secondary Diagnosis	F10.251
Secondary Diagnosis	F12.221
Secondary Diagnosis	F12.251
Secondary Diagnosis	S82.402A

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Audit Remark
Principal Diagnosis	M84.551D	Assign as principal diagnosis since the patient is coming in because of removal of external device from a hip fracture, which is considered as a subsequent encounter.
Secondary Diagnosis	C50.912	Assigned as secondary code for left breast cancer, which is a primary malignancy.
Secondary Diagnosis	C78.02	Assigned as secondary code for left lung cancer since it was documented that the patient has cancer on his left hilum.
Secondary Diagnosis	C79.51	Assigned as secondary code for bone cancer, which is specified as metastatic disease from breast cancer.
Secondary Diagnosis	D50.0	Assigned as secondary code for blood loss anemia.
Secondary Diagnosis	I10	Assigned as secondary code since the patient has hypertension.
	ICD-10-PCS	**Audit Remark**
Principal Procedure	0QP8X5Z	Assign code as principal procedure since the reason for the visit was to remove the external device, and the removal was performed. The external device was installed on the patient's femoral shaft, as stated in the document.
Secondary Procedure	OQP6X5Z	Assign procedure code for removal of external device from the patient's upper femur.

Imagination is the highest kite one can fly!

Lauren Bacall

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.

A 50-year-old female with terminal breast cancer with metastasis is seen today in the hospital because of severe shoulder pain. The pain has worsened over the past several days in spite of oral medications. She is being admitted for pain control and is given morphine 10 mg by mouth every four hours for severe pain when necessary. The oral meds did not alleviate the patient's pain and so was given IV (via peripheral vein) morphine two mg, which relieved her pain. Eventually, her pain subsides and she was taken off morphine gradually. She was about to be discharged when she complained of upper abdominal pain. Findings on CT scan were consistent with acute and chronic pancreatitis and pancreatic duct stones. Extracorporeal shockwave lithotripsy then achieved fragmentation of stone. Her symptoms improved and she was discharged and referred to the outpatient clinic for follow-up care.

Discharge Diagnoses:

1. Severe shoulder pain due to bone metastasis from malignant neoplasm of right breast
2. Pancreatitis
3. Pancreatic duct stones

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Coding Remark
Principal Diagnosis	S06.352A	Assign code as principal diagnosis. Patient came in because of intracerebral hemorrhage. As per Alpha Index: Hemorrhage > intracranial > traumatic > see injury > intracranial > intracerebral hemorrhage > left side = S06.35-.
Secondary Diagnosis	R40.243	Assigned as secondary code for total GCS score of seven.
Secondary Diagnosis	R40.2121	Assigned as secondary code for GCS score of eyes, taken in the field or by EMT.
Secondary Diagnosis	R40.2221	Assigned as secondary code for GCS score of verbal response, taken in the field or by EMT.
Secondary Diagnosis	R40.2331	Assigned as secondary code for GCS score of motor response, taken in the field or by EMT.
Secondary Diagnosis	L90.5	Assigned as secondary code for scar from a previous burn.
Secondary Diagnosis	T23.202S	Assigned as secondary code to report burn as a sequela, second degree, left hand.
Secondary Diagnosis	R40.241	Assigned as secondary code for total GCS score of 13 on day three of admission.
Secondary Diagnosis	Y03.0	Assigned as secondary code to report homicide or assault by being run over by a motor vehicle.