Issue No. 5 Volume No. 3 May 2016

THE CODE

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

ICD-10 Rough Spots

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As ICD-10 approaches the six month mark of implementation, many problems have been encountered from system issues to reporting issues to LCD/NCD mapping issues. Also, the coding staff has encountered issues with interpretation of coding guidelines and coding guidance. This needs to be rectified either with upcoming ICD-10 new code updates for Fiscal Year 2017 or through American Hospital Association (AHA) Coding Clinic guidance. I'm not sure if anyone out there has encountered the sequencing problem of Chronic Obstructive Pulmonary Disorder (COPD) and pneumonia or the coding problem of sepsis secondary to a viral infection? For those of you facing the dilemma, rest assured that the Editorial Advisory Board (EAB) of Coding Clinic will be coming to the rescue soon as the problem of COPD with pneumonia is on their docket for discussion later this month. However, I will be waiting with bated breath on the advice. Why do I say this? Because being a physician sometimes it is very hard to understand the coding advice given by AHA as I never agreed with the advice on coding seizures in ICD-9. What are the two scenarios for those of you who have not encountered them yet?

COPD prevents adequate air exchange in the lungs whereas pneumonia is caused by a lung infection. Patients with COPD are at a higher risk of developing pneumonia and, when they do, the two disease processes work in tandem, as one impacts the other where symptomatology increases the severity for the patient. However, COPD includes two main conditions emphysema, whereby the walls of the air sacs are damaged, and chronic bronchitis whereby the lining of the airway is constantly irritated and inflamed. It can be hard to tell the difference between the symptoms of worsening COPD or an exacerbation and pneumonia because they are often quite similar but they are both very distinct clinical processes. In such cases that the patient comes in

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Information is powerful. But it is how we use it that will define us.

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with pneumonia and is treated aggressively for the condition then, clinically, pneumonia should be the principal diagnosis and not COPD. Why am I stating this? Because currently coders are being advised to code the J44.0, chronic obstructive pulmonary disease with lower respiratory tract infection, as the principal diagnosis and then the pneumonia code? This is being based on the ICD-10 instruction note that says to use additional code to identify infection. The interpretation is that the pneumonia is an add-on code (infection). Although clinically it makes sense to code the J44.0 and acute bronchitis, the same definition should not apply to pneumonia. It would make more sense that either should be allowed to be selected as principal diagnosis based on the circumstance of admission and the patient's hospital stay. Also, from a DRG standpoint, coding J44.0 as a principal diagnosis groups to 190, 191 or 192 whereas coding the pneumonia first can range from 177-179 to 193-195 impacts both reimbursement and length of stay (LOS) statistics.

DRG	Description	Weight	GLOS	ALOS
190	Chronic Obstructive Pulmonary Disease with MCC	1.1578	4	4.9
191	Chronic Obstructive Pulmonary Disease with CC	0.9321	3.3	4
192	Chronic Obstructive Pulmonary Disease without CC/MCC	0.7313	2.7	3.3
193	Simple Pneumonia and Pleurisy with MCC	1.4261	4.8	5.8
194	Simple Pneumonia and Pleurisy with CC	0.9695	3.7	4.4
195	Simple Pneumonia and Pleurisy with CC	0.7111	2.8	3.3
177	Respiratory Infections and Inflammations with MCC	1.9033	6	7.4
178	Respiratory Infections and Inflammations with CC	1.3575	4.8	5.8
179	Respiratory Infections and Inflammations without CC/MCC	0.9659	3.6	4.3

*Medicare severity diagnosis-related groups (MS-DRGs) FY2016

The second scenario is sepsis secondary to, for example, corona virus infection. Per Coding Clinic, Second Quarter 2005, pg. 18-19 the advice is to assign 038.9 for sepsis. "According to the official coding guidelines Chapter related to Sepsis; "Sepsis with any infection would code to 038.X with the infectious site secondary (in this case 079.99) with a code from 995.9X to indicate organ damage." Following the guidance from AHA, the coding would be A41.9 with B34.2 for the corona virus and R65.20. However, coders are being guided to code B34.9 viral infection, unspecified as the principal diagnosis and this guidance is based on AHA.

Coding Clinic, Fourth Quarter, ICD-10 2014 Page 46, Effective with Discharges, December 31, 2014.

Question:

We are requesting that the Coding Clinic Editorial Advisory Board revisit advice published about non-Candida albicans sepsis. The Alphabetic Index under the term "Sepsis, candida," directs to code B37.7, Candida sepsis, as the code assignment is not Candida species specific. There are multiple species of Candida other than albicans, such as tropicalis, glabrata, etc. Please explain why code B48.8, Other specified mycoses, was assigned instead of B37.7.

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Answer:

Coding Clinic, Second Quarter 2014, page 13, advised the assignment of code B48.8, Other specified mycoses, for sepsis due to non-Candida albicans. This code assignment was based on the health record documentation which was unclear as to the causal organism. Since the documentation is unclear, the physician should be queried for clarification. Non-candida albicans sepsis may refer to either sepsis of Candida, but not Albicans type or it may refer to an organism that is not of the Candida type at all. If Candida sepsis of any type is present, assign code B37.7, Candida sepsis. If the causal organism is not Candida at all, assign code B48.8, Other specified mycoses.

So, based on the above, there are conflicting opinions on how to code either or both scenarios. We will just have to wait and see what the advice will be later this month when the Coding Clinic Editorial Advisory Board convenes.

Confront your path with courage, and don't be afraid of the criticism of others. And, above all, don't allow yourself to become paralyzed by self-criticism.

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Modifier 25 in Correct Coding

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Modifier 25 indicates on the day of a procedure or other service the patient's condition required a significant, separately identifiable Evaluation and Management (E&M) service above and beyond the other service provided or beyond the usual preoperative care associated with the procedure that was performed. This modifier should only be used if an E&M is being billed on the same day as a procedure.

Every time a provider does a procedure, minor or major, the provider has to perform an exam on a patient before they perform the procedure. Modifier 25 would be used to indicate that an E&M service is performed on the same day as a minor surgery (000 or 010 global days) and is significant and separately identifiable from the usual work associated with the surgery as all procedures have an evaluation incorporated in the procedure that would normally bundle under the National Correct Coding Initiative (NCCI).

Example:

An established patient presents to the office complaining of knee pain. The provider does an exam of the knee and makes a medical decision to give the patient an injection of pain medication Euflexxa, a corticosteroid for the pain. Because the patient presented with the pain of the knee, and this appointment was not scheduled for the procedure, charging for the E&M service and adding the modifier 25 to the E&M would be correct. Coding would be 99212-25, 20610, J7323.

Take the same patient, but this time the patient was scheduled for the knee injection after the provider saw the patient for an evaluation the day before, we would not charge for the E&M or add the modifier 25; the coder would only code for the procedure and the medication with 20610, J7323.

When the Modifier 25 is used the documentation in the patient's medical record must support the use of this modifier. In the documentation the provider must indicate that separate E&M service is essential to determine the need for any same-day procedure with the new or worsening condition. Providers can help to substantiate a separate E&M service by physically separating the documentation for the E&M service from general documentation for any other same-day procedure.

A different ICD-10 code from the one submitted with the minor surgery is not required with the E&M code. The diagnosis for the E&M service and the other procedure may be the same or different.

As seen with the above example both the E&M and the procedure would have the same diagnosis. The reasoning is that the provider had to do an evaluation of the knee in order to treat the patient.

Correct coding is knowing when and how to use Modifier 25 in order to capture all services that the provider performed.

References:
Medicare MLN Matters Number: MM5025 updated on November 1, 2012
Medicare CR1725, Transmittal A-01-80, June 29, 2001
Use of Modifier -25 and Modifier -27 in the Hospital Outpatient Prospective Payment System (OPPS)

Cataracts: An Education

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Cataracts are the most common cause of vision loss in people over age 40 and it is the principal cause of blindness in the world. A cataract is an eye disorder where there is a progressive opacity or clouding of lens. One factor that contributes to the disorder is when protein becomes less soluble in the lens and clumps together. The changes may result from either degeneration related to aging or any metabolic abnormality such as diabetes or obesity. Other risk factors include lifestyle or behavioral factors such as smoking or alcohol use and environmental factors such as prolonged exposure to sunlight. Also, contributing to cataract formation is statin medication utilized to control cholesterol, prolonged used of corticosteroids and hormone replacement therapy. There is also new evidence to suggest that many cataracts are caused by oxidative changes in the human lens. This is supported by nutrition studies that show fruits and vegetables high in antioxidants may help prevent certain types of cataracts.

People suffering from cataracts may at first only experience cloudy vision but other symptoms may also occur such as halo around lights, poor night vision and multiple images in one eye. It is recommended that a cataract must be removed through cataract surgery. There are two types of cataract surgery; 1) Phacoemulsification and 2) Extracapsular surgery.

A cataract can occur in either or both eyes. This condition is not contagious and cannot spread from one eye to another.

CODING PERSPECTIVE:

Bilateral Cataracts
Coding Clinic, First Quarter 2016: Page 32

Question:

A patient comes into a physician practice for a cataract evaluation. The physician determines that the patient has bilateral age-related nuclear cataracts and schedules the patient for surgery at an outpatient facility. The plan is to operate on one eye at a time with the right eye being operated on first. How should the physician practice and the outpatient facility code this case, since only one eye will be treated? Should the condition be reported as bilateral or do we "break apart" the code based on the eye that is to be operated on first?

Answer:

For the encounter for the cataract evaluation as well as the first surgery, both the physician practice and the outpatient facility should assign code H25.13, Age-related nuclear cataract, bilateral, as the patient has a bilateral condition. The specific eye that is treated during the surgical encounter would be reflected using the appropriate CPT code with a modifier appended to reflect which eye was treated. For the second surgery, after the right eye has been previously treated, assign code H25.12, Age-related nuclear cataract, left eye, as the patient no longer has a cataract on the right eye. The appropriate CPT code with a modifier to identify the left eye should be reported for the second procedure.

Senile vs Unspecified Cataract in Elderly Patients

Coding Clinic, September - October 1985 Page: 10

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Cataracts: An Education *(Continued from page 5)*

Question:

Can the code for senile cataract be used if the physician has not indicated the term senile, but the patient is over 70 years of age?

Answer:

No. Cataract, unspecified, is coded 366.9. Inform the physician that the type of cataract should be documented so that the hospital can maintain quality control of data for use within and outside of the hospital.

Applying Past Issues of AHA Coding Clinic for ICD-9-CM to ICD-10
AHA Coding Clinic, Fourth Quarter 2015, page 20

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.

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 is a follow-up visit for this 29-year-old female who was seen two months ago for her hip fracture. She presents today for removal of her external fixation device that was placed two months ago. The hip fracture was secondary to an underlying malignant process. She did have further evaluation study with complete malignant workup performed, which included findings of a left breast carcinoma with metastases to the hilum of the left lung.

She also had some elevated blood pressure initially, which has now been relatively controlled on antihypertensive agents of Lopressor and Procardia XL. She also has blood loss anemia, which she initially received two bags of PRBC and has been stable for the last few days in the 10.0 range.

The external fixation device was removed from the right femoral shaft and upper femur without any problems.

FINAL DIAGNOSES:

1. Fracture of right femur secondary to metastatic disease
2. Lung mass
3. Left breast mass
4. Metastatic disease to the bone from breast with metastases to lung
5. Hypertension

	ICD-10-CM
Principal Diagnosis	S72.001A
Secondary Diagnosis	R91.8
Secondary Diagnosis	N63
Secondary Diagnosis	C50.919
Secondary Diagnosis	C78.02
Secondary Diagnosis	C79.89
Secondary Diagnosis	D64.9
Secondary Diagnosis	I10
	ICD-10-PCS
Principal Procedure	0Q2YXYZ

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Are You a Good Auditor? *(Continued from page 6)*

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Audit Remark
Principal Diagnosis	T82.857A	Assign as principal diagnosis since the patient is coming in because of angina that is associated with the restenosis of his stents. As per alpha index, Complication > cardiac > device, graft or implant > stenosis
Secondary Diagnosis	I25.110	Assign coronary artery disease (CAD) with unstable angina. As per documentation, the patient has CAD and he has crescendo angina. This is a combination code and there is no need to code CAD and angina separately. According to ICD-10-CM guideline, Chapter 9, letter b, ICD-10-CM has combination codes for atherosclerotic heart disease (ASHD) with angina pectoris. When using one of these combination codes, it is not necessary to use and additional code for angina pectoris. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris. Crescendo angina is unstable angina. As per Alpha Index, Angina > crescendo > see Angina, unstable.
Secondary Diagnosis	I10	Assigned as secondary code since the patient has hypertension
Secondary Diagnosis	E78.5	Assigned as secondary code since there is diagnosis of dyslipidemia on discharge.
	Z95.5	Assigned as secondary code since the patient has undergone a previous percutaneous transluminal coronary angioplasty (PTCA).
	ICD-10-PCS	**Audit Remark**
Principal Procedure	02713ZZ	Assign code for PTCA of left anterior descending (LAD) and right coronary artery (RCA). The patient did undergo another PTCA for dilation of the restenosis of his stents. The patient had PTCA of LAD and RCA. Although the patient had PTCA of mid LAD, distal LAD, and RCA, this would still be counted as two coronary arteries, thus, the two sites will be coded as body part. Code no device since there was no stents that was implanted or inserted in this PTCA procedure.

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.

This is a 20-year-old male who was assaulted by being run over by a car in a homicide attempt. Because of this incident, he sustained intracerebral hemorrhage of the left cerebrum. The EMTs describe a 36-minute loss of consciousness. Glasgow Coma Scale (GCS) taken and documented by the EMTs is seven, with eyes open to pain, verbal response is incomprehensible, and motor response is abnormal.

Past medical history states that the patient has a left hand scar from a 2nd-degree burn that he suffered three years ago.

The patient was given immediate attention by the EMTs and was sent to our hospital where he was treated and continued to recover. GCS on day three is 13, with eyes opening spontaneously and obeys command on motor response. He was discharged home on continued recovery is stable and on good disposition.

Final diagnosis: Head injury with loss of consciousness for 36 minutes.

	ICD-10-CM	Coding Remark
Principal Diagnosis	C18.0	Assign code as principal diagnosis. Patient came in for right colectomy because of the right colon mass. Studies showed that the mass was an adenocarcinoma and the site is specified as the cecum.
Secondary Diagnosis	I10	Assigned as secondary code since the patient has hypertension.
Secondary Diagnosis	M81.0	Assigned as secondary code since the patient has osteoporosis.
Secondary Diagnosis	E87.1	Assigned as secondary code since the patient has hyponatremia on postop day two and was treated with IV fluids.
Secondary Diagnosis	D64.9	Assigned as secondary code since the patient was given extra care for her anemia.
Secondary Diagnosis	J45.909	Assigned as secondary code since the patient's medications for asthma were continued during the hospital stay.
Secondary Diagnosis	E78.5	Assigned as secondary code since the patient has a diagnosis of dyslipidemia on discharge.

Coding Case Scenario

	ICD-10-PCS	Coding Remark
Principal Procedure	0DTF0ZZ	Report code for resection of right colon, open approach. As per ICD-10-PCS, the root operation resection is defined as cutting out or off, without replacement, all of a body part. In this case, although it was documented as excision, the report clearly states that the entire right colon was removed; and since there is a separate body part value for right large intestine, it will be coded as resection. Approach is open. Although the procedure started laparoscopically, the report states that the procedure was converted to open. End-to-end anastomosis is not coded separately.
Secondary Procedure	0DJD4ZZ	Assign code for inspection of lower intestinal tract, percutaneous endoscopic approach. As per ICD-10-PCS guideline B3.2d, if the intended root operation is attempted using one approach, but is converted to a different approach, a laparoscopic approach is converted to open approach, code percutaneous endoscopic inspection and open procedure. Since there is no specific body part value for large intestine, we can code it under lower intestinal tract. As per ICD-10-PCS guideline B4.1a, if a procedure performed on a portion of a body part that does not have a separate body part value, code the body part value corresponding to the whole body part.