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THE CODE

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New and Revised Place of Service Codes for Outpatient Hospital

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Any health insurer subject to the uniform electronic claim transaction and code set standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is required to make changes to the Place of Service (POS) code from the POS code set maintained by the Centers for Medicare and Medicaid Services (CMS) effective January 1, 2016.

The POS code set provides setting information necessary to appropriately pay Medicare and Medicaid claims. Other payers may or may not use the POS codes in the same manner that they are used by CMS. Specifically, the current POS code set is being revised by adding new POS code 19 for "Off Campus-Outpatient Hospital" and revising POS code 22 from "Outpatient Hospital" to "On Campus-Outpatient Hospital."

Also, CMS is requiring their local contractor to make changes needed for Medicare to adjudicate claims with the new and revised codes in accordance with Medicare's national policy. Contractor editing shall treat POS 19 and POS 22 in the same way. The definition of a "campus" is found in Title 42 CFR 413.65(a)(2):

> *Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.*

Claims for covered services rendered in an Off Campus-Outpatient Hospital setting, or in an On Campus-Outpatient Hospital setting, if payable by Medicare, will be paid at the facility rate. The payment policies that currently apply to POS 22 will continue to apply and will now also apply to POS 19 unless otherwise stated.

(Continued on page 2)

TABLE *of* CONTENTS

If you have an article or idea to share for *The Code*, please submit to:
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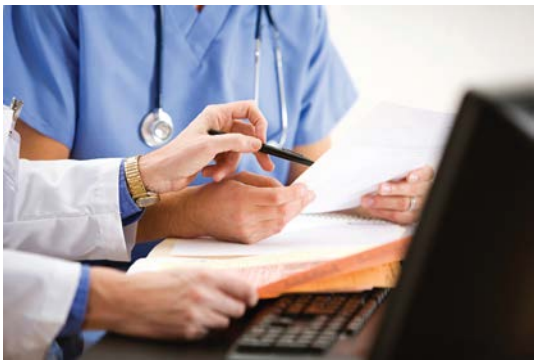
Wisdom is not a product of schooling but of the lifelong attempt to acquire it.

Albert Einstein

New and Revised Place of Service Codes for Outpatient Hospital *(Continued from page 1)*

The inclusion of POS 19 will allow Medicare contractors to better identify off campus facilities that previously may have been treated as a physician office (POS 11). The combination of both POS 19 and 22 will result in payments for services provided to outpatients who are later admitted as inpatients within three days (or, in the case of non-IPPS hospitals, one day) are bundled when the patient is seen in a wholly owned or wholly operated [hospital] physician practice. The three day payment window applies to diagnostic and nondiagnostic services that are clinically related to the reason for the patient's inpatient admission regardless of whether the inpatient and outpatient diagnoses are the same. Thus, as of January 1, 2016, the three day payment rule will also apply to services billed with POS code 1.



It is also important for physician/practitioners that provide the Professional Component (PC)/interpretation of a diagnostic test, from a distant site, remember that the POS code assigned by the physician /practitioner is the setting in which the beneficiary received the Technical Component (TC) service. The POS code for a teleradiology interpretation is generally the place where the beneficiary received the TC or face-to-face encounter.

For example: A beneficiary receives an MRI at an outpatient "on-campus" hospital near his/her home. The outpatient hospital submits a claim that would correspond to the TC portion of the MRI as POS code 22. The physician furnishes the PC portion of the beneficiary's MRI from his/her office location at an off-campus outpatient hospital site. In this case, the correct POS code 22 (On Campus-Outpatient Hospital) shall be used on the physician's claim to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, on the campus of an outpatient hospital.

New and Revised POS Codes Effective January 1, 2016

Code	Descriptor
POS 19 Off Campus- Outpatient Hospital	Descriptor: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
POS 22 On Campus- Outpatient Hospital	Descriptor: A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

ERCP with Exchange of a Common Bile Duct Stent

Denise M. Nash, MD, CCS, CIM
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Let's look at how to code for an exchange of a stent in the common bile duct (CBD) via ERCP in ICD-10-PCS. First, what is ERCP? ERCP is the acronym given to endoscopic retrograde cholangiopancreatography. ERCP is an imaging technique used to diagnose diseases of the pancreas, liver, gallbladder and bile ducts. The advantage to ERCP is that additionally it can also be used as a therapeutic device for removal of stones or obstruction from the bile ducts. During an ERCP a duodenoscope (about the diameter of a pen) is inserted through the mouth, through the back of the throat, down the esophagus, through the stomach and into the duodenum. Once the papilla of vater is identified, a small plastic catheter (cannula) is passed through the open channel of the endoscope into the opening of the papilla, and into the bile ducts and/or the pancreatic duct. The cannula is used to inject contrast dye into the ducts. The term retrograde refers to the backward direction of the dye.

The duodenoscope uses a thin fiber-optic bundle to transmit light to the tip of the endoscope and a thin wire with a chip also at the tip of the endoscope to transmit digital video images to a TV screen. A series of x-rays are then taken as the dye moves through the ducts. If the x-rays show that a biliary stricture exists, a stent may be placed into a duct to relieve the obstruction. In order to do this, special instruments are inserted into the endoscope and a sphincterotomy (a cut into the sphincter of oddi) is performed to provide access to the bile ducts. In some cases, the biliary stricture may first be dilated (expanded) using a catheter, followed by a balloon-type device that is inflated. The stent is then inserted into the bile duct.

There are two types of stents that are commonly used. The first is made of plastic and looks like a small straw. This can be pushed through the ERCP scope into a blocked duct to allow normal drainage. The second type is made of metal wires that look like the cross wires of a fence. The metal stent is flexible and springs open to a larger diameter than plastic stents. Both plastic and metal stents tend to clog up after several months and therefore would require another ERCP to place a new stent. Metal stents are permanent, while plastic stents are easily removed during a repeat procedure.

So how do we code this procedure? Below are the general guidelines on device guidance as provided by CMS.

- B6.1a: A device is coded only if a device remains after the procedure is completed. If no device remains, the device value "no device" is coded.

(Continued on page 4)

ERCP with Exchange of a Common Bile Duct Stent *(Continued from page 3)*

- B6.1b: Materials such as suture, ligatures, radiological markers and temporary post-operative wound drains are considered integral to the performance of a procedure and are not coded as devices.
- B6.1c: Procedures performed on a device only and not on a body part are specified in the root operations "change, irrigation, removal and revision" and are coded to the procedure performed. *Example*: irrigation of percutaneous nephrostomy tube is coded to the root operation, "Irrigation of indwelling device" in the administrative section.

  https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2015-PCS-guidelines.pdf

Let us now look at the differences in ICD-10 PCS for the roots *change* (root operation 2), *removal* (root operation P) and *dilation* (root operation 7).

The definition for the *change* root operation provided in the 2015 ICD-10-PCS Reference Manual is "Taking out or off a device from a body part and putting back an identical or similar device in or on the same body part without cutting or puncturing the skin or a mucous membrane." The root operation *change* represents only those procedures where a similar device is exchanged without making a new incision or puncture. Typical *change* procedures include exchange of drainage devices and feeding devices. Examples would be: urinary catheter change, gastrostomy tube change and drainage tube change. All *change* procedures are coded using the approach *external*. The definition for the *external* approach provided in the 2015 ICD-10-PCS Reference Manual is "Procedures performed directly on the skin or mucous membrane and procedures performed indirectly by the application of external force through the skin or mucous membrane." Therefore, based on the above root explanation and limit of approach, this would not fit our coding scenario.

For our coding scenario we will need to code both the removal of the stent and the insertion of a new stent as change is not applicable.

The definition for the *removal* root operation provided in the 2015 ICD-10-PCS Reference Manual is "Taking out or off a device from a body part." As noted above in *change*, if the device is taken out and a similar device is put in without cutting or puncturing the skin or mucous membrane, the procedure is coded to the root operation *change*. Otherwise, the procedure for taking out the device is coded to the root operation *removal*. This would apply to drainage tube removal, cardiac pacemaker removal, and central line removal. This definition also fits a portion of our coding scenario.

So the code for this procedure would be 0FPB8DZ Removal of intraluminal device from hepatobiliary duct, via natural or artificial opening endoscopic.

Note: A procedure to remove a device is coded to *removal* if it is not an integral part of another root operation and regardless of the approach or the original root operation by which the device was put in.

Let us move on to coding for the insertion of the new stent. The definition for the *dilation* root operation provided in the 2015 ICD-10-PCS Reference Manual is "Expanding an orifice or the lumen of a tubular body part." The orifice can be a natural or an artificially created orifice. The aim of the procedure is accomplished by stretching a tubular body part using intraluminal pressure or by cutting part of the orifice or wall of the tubular body part. This would apply to percutaneous transluminal coronary angioplasty (PTCA), laryngeal stenosis dilation, and dilation of the common bile duct. The root operation *dilation* is coded when the objective of the procedure is to enlarge the diameter of a tubular body part or orifice. *Dilation* includes both intraluminal and extraluminal methods of enlarging the diameter. A device placed to maintain the new diameter is an integral part of the *dilation* procedure, and is coded to a sixth-character device value in the *dilation* procedure code. So in our case scenario the second procedure would therefore be coded to 0F798DZ, Endoscopic retrograde cholangiopancreatography (ERCP) with balloon dilation of CBD with intraluminal device. Of course, we would need to check the operative note to make sure that the provider documented the dilation of the CBD was done prior to insertion of the stent; otherwise a query would need to be generated.

Laparoscopic Procedure: An Education

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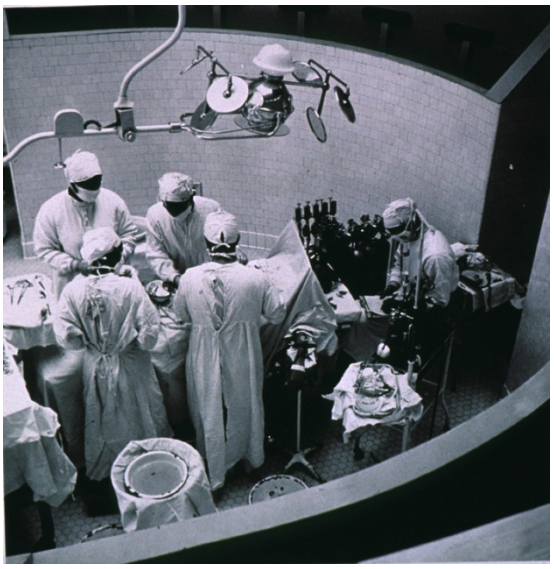
Brief History:



Surgery has been one of the most indispensable modes of treatment over the past decades. Through continuing research, several refinements have been made to surgery which is now becoming less invasive. George Kelling first introduced the use of laparoscopy (keyhole procedure) on dogs in 1901. He viewed the abdomen through a simple hollow tube. Then in 1910, the first laparoscopic keyhole procedure was performed on humans by Hans Christian Jacobaeus of Sweden. In 1951, Johns Hopkins developed an optical telescope to replace Kelling's simple hollow tube. This telescope represented a major advance over Kelling's simple tube. It was slightly less than a half inch in diameter and could also be introduced into the abdomen through a small puncture rather than through a large incision. However, visualization through it still remained very limited because under normal circumstances the entire abdominal cavity is filled with structures that all touch each other, leaving virtually no space inside the abdomen to visualize anything. In 1967, Kurt Semm invented a device (the automatic insufflator) that allowed the abdominal cavity to be filled with gas, creating visual space inside the abdomen by gently pushing structures away from each other.

What is Laparoscopic Surgery?

Keyhole procedure or minimally invasive surgery (MIS) is designed to perform abdominal surgery using cannulas to serve as channels into the body through small incisions. During the procedure, the surgeon makes one or more small incisions in the abdomen. These allow the surgeon to insert the laparoscope, small surgical tools and a tube, which is used to pump gas into the abdomen—this makes it easier for the surgeon to look around and operate. A video camera is used by the surgeon to view the operative field. After the procedure, the gas is let out of your abdomen, the incisions are closed using stitches and a dressing is applied. Patients often go home on the same day they have laparoscopy.

Carbon dioxide is insufflated in order to float the organs for better visualization. Currently, carbon dioxide is the most frequently used gas for insufflation into the abdomen during laparoscopic abdominal surgery. However, carbon dioxide is associated with various changes in physiological parameters that affect the function of the heart or lungs (cardiopulmonary changes). Patients with poor heart or lung function may not tolerate these changes. Furthermore, carbon dioxide, which still stays in the abdomen after laparoscopic surgery, may cause postoperative pain. Thus, other gases, such as nitrous oxide and helium, have been suggested as alternatives to carbon dioxide for establishing pneumoperitoneum.

Laparoscopic Procedure in the Field of Medical Coding:

When it comes to coding there are several ways on how we can determine if a procedure is laparoscopic or not. First, look for the documentation that a laparoscope was used. Second, look for the documentation of insufflation.

(Continued on page 6)

Laparoscopic Procedure: An Education *(Continued from page 5)*

Third, look for documentation that ports or cannulas were used. Stab incisions in different areas of the abdomen can also be a clue that a laparoscopic procedure was done. Robotic-assisted surgery (da Vinci® Surgical System) is major surgery performed also performed through small incisions.

Example:

A 32-year old female is found to have a three centimeter renal cell carcinoma in the lower pole of the left kidney discovered on CT scan for suspected gallbladder disease. The gallbladder was found to be normal. A decision is made to perform a radical nephrectomy.

Operative Note: An intraperitoneal approach is used. The abdomen is insufflated with carbon dioxide, and four operating ports are placed. The left colon is taken down at the white line and reflected medially. The kidney is mobilized without opening Gerota's fascia. The ureter and renal vessels are identified and ligated. The upper pole of the kidney is carefully dissected off the spleen, and the kidney is now entirely free within the abdomen. Two laparoscopic ports are connected by a five centimeter incision, and the kidney is removed. The wound is closed and the laparoscopic incision is closed.

Answer:

Diagnosis: 189.0 – Malignant neoplasm of kidney, except pelvis

CPT Procedure: 50545, LT – Laparoscopy, radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes and adrenalectomy).

We seem to gain wisdom more readily through our failures than through our successes. We always think of failure as the antithesis of success, but it isn't. Success often lies just the other side of failure.

Leo F. Buscaglia

ICD-10 Coding Clinic Corner: Diabetes and Osteomyelitis

Evan Lendle Ramos, RN, CCS, CIC
Senior Manager, Training Department
MiraMed Philippines Group, LLC - Philippine Branch

Pathophysiology:

Osteomyelitis is a type of bone infection where progressive inflammatory destruction occurs after the formation of new bone. Acute osteomyelitis is the clinical term for a new infection in bone. This infection occurs predominantly in children and is often disseminated via the blood stream (hematogenously). In adults, osteomyelitis is usually a subacute or chronic infection that develops secondary to an open injury to bone and surrounding soft tissue. In acute osteomyelitis, bacteria lodge in bones where circulation is slow. The bacteria then multiply and cause destruction of the bone. The destruction is the result of the body's response to the infection, which creates pus and increased pressure in the bone. Finally, there is decreased circulation and bone death (necrosis). As the disease progresses, areas of bone may become isolated by the infection and lack of circulation, forming islands or segments of necrotic bone that remain infected (sequestra). These areas become a source of recurrent episodes of acute infection and possible draining wounds. The infection can also spread to other areas of the body. This pattern of recurring infection or failure of the bone to heal is chronic osteomyelitis. When areas of the bone die, circulation through the bone stops and treatment is very difficult. Systemic drugs may not be effective at this point and surgery is necessary. Acute osteomyelitis develops within two weeks after disease onset, subacute osteomyelitis within one to several months.

The specific organism isolated in bacterial osteomyelitis is often associated with the age of the patient or a common clinical scenario (i.e., trauma or recent surgery). *Staphylococcus aureus* is often the cause in most patients with acute hematogenous osteomyelitis. *Staphylococcus epidermidis, S. aureus, Pseudomonas aeruginosa, Serratia marcescens* and *Escherichia coli* are commonly isolated in patients with chronic osteomyelitis.

The physician will order a complete blood count where the white blood count is expected to be elevated (leukocytosis), an increased level of erythrocyte sedimentation rate (ESR) will be found, and the blood or bone culture will identify the infectious organism. An x-ray, bone scan (most specific is gallium) or MRI will show any presence and extent of infection.

After the initial evaluation, staging and establishment of microbial etiology and susceptibilities; treatment includes antimicrobial therapy, debridement with management of resultant dead space and, if necessary, stabilization of bone. In most patients with osteomyelitis, early antibiotic therapy produces the best results. Antibiotic treatment management options are likely to consist of intravenous antibiotics such as Nafcillin or Oxacillin. Surgical drainage may be required to relieve pressure and abscess formation.

Dehydration, protein deficiency and anemia caused by draining wounds require nutritional supplementation as well as hydration therapy. Additional treatment with analgesics may be provided to relieve pain.

Note: Osteomyelitis is not a symptom of Diabetes; however, patients with diabetes are at higher risk in developing an infection. Osteomyelitis could be a complication seen in diabetic patients.

(Continued on page 8)

ICD-10 Coding Clinic Corner: Diabetes and Osteomyelitis *(Continued from page 7)*

Coding Clinic:

ICD-9-CM assumes a relationship between diabetes and osteomyelitis when both conditions are present *unless* the physician documentation indicates the osteomyelitis is unrelated to the diabetes.

ICD-10-CM does NOT presume a linkage between diabetes and osteomyelitis. The physician will need to document a linkage/relationship in order to code as such.

Stars of MiraMed

This month's Star is …

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

Denise M. Nash, MD, CCS, CIM, serves as Vice President of Compliance and Education for MiraMed Global Services and as such she handles all compliance and education needs including migration to ICD-10.

Denise M. Nash, MD, CCS, CIM

She has more than 20 years experience in the healthcare industry. Dr. Nash has worked for CMS in hospital auditing and has expertise in negotiation and implementation of risk contracting for managed care plans. She has also worked with individuals as well as physician groups on utilization and PQRS management to improve financial performance for the risk-based contracts and value-based purchasing programs. Dr. Nash has past experience with episode of care data and patient management in the ACO environment. She has also worked with both hospitals and physician practices on the legal and financial aspects of adding new services to the respective facilities. Dr. Nash is a consultant on coding/compliance audits at physician practices, hospitals and has worked for insurance plans conducting second level appeals. Her past experience also included consulting for the Office of the Inspector General of New Hampshire in its Fraud and Abuse Division.

Dr. Nash has a Bachelor of Science degree from the University of Scranton as well as a Doctor of Medicine degree from Georgetown University.

Are You a Good Auditor?

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

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.

A 15-year old girl was admitted with burns of her left hand and fingers up to the wrist. A boiling pot of water accidentally poured on her while cooking on her farm. She was taken to surgery for a split thickness skin graft harvested from the buttock applied over the dorsum and volar aspects of the hand. The patient was discharged without any signs of infections or other complications.

Discharge diagnosis: 2nd and 3rd degree burns of the left hand and fingers (five percent total body surface area burned, eight percent affected by 3rd degree).

	ICD-9-CM	ICD-10-CM
Principal Diagnosis	944.37	T23.321A
Secondary Diagnosis	948.00	X12.XXXA
Secondary Diagnosis	E924.2	Y92.79
Secondary Diagnosis	E849.0	T31.0
	ICD-9-CM	**ICD-10-PCS**
PPX	86.62	0HRFX74

(Continued on page 10)

Are You A Good Auditor *(Continued from page 9)*

Correct Answer From Previous Case Scenario:

	ICD-9-CM	Audit Remark	ICD-10-CM	Audit Remark
Principal Diagnosis	575.11	Revised code to 575.12. Documentation states that patient has *acute* and chronic cholecystitis.	K80.00	Revised code to K80.12. Documentation states that patient has acute and chronic cholecystitis.
Secondary Diagnosis	568.0	Add code 568.0 for the peritoneal adhesions. Coders should not code adhesions and lysis thereof, based solely on mention of adhesions or lysis in an operative report. Determination as to whether the adhesions and the lysis are significant enough to code and report must be made by the surgeon. Documentation of clinical significance by the surgeon may include, but is not limited to, the following language: numerous adhesions requiring a long time to lyse, extensive adhesions involving tedious lysis, extensive lysis, etc. If uncertainty exists regarding clinical significance, then query the provider.	K66.0	Add code K66.0 for the peritoneal adhesions. This is consistent with Coding Clinic, First Quarter ICD-10 2014 Pages: 4-5, According to the ICD-10-PCS Official Coding Guidelines, B3.1b, "Procedural steps necessary to reach operative site and close the operative site, including anastomosis of a tubular body part, are also not coded separately." Coders should not code adhesions and lysis thereof, based solely on mention of adhesions or lysis in an operative report. Determination as to whether the adhesions and the lysis are significant enough to code and report must be made by the surgeon. Documentation of clinical significance by the surgeon may include, but is not limited to, the following language: numerous adhesions requiring a long time to lyse, extensive adhesions involving tedious lysis, extensive lysis, etc. If uncertainty exists regarding clinical significance, then query the provider.
Principal Procedure	51.23	No changes.	0FT44ZZ	No changes.
Secondary Procedure	54.51	Add procedure code 54.51 for the lysis of peritoneal adhesions.	0DNW4ZZ	Add procedure code 0DNW4ZZ for the lysis of peritoneal adhesions.

Coding Case Scenario

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MiraMed Philippines Group, LLC - Philippine Branch

Direction: Code for ICD-9-CM diagnosis and procedure and its corresponding ICD-10-CM and PCS. Answers to this scenario will be published in our next issue.

The patient, a 47-year old female, has a history of low back pain and recently developed intractable left sciatic pain and paresthesia. A lumbar MRI procedure that was performed prior to admission showed lumbosacral disc herniation on the right. A lumbosacral microdiscectomy was performed for a protruded lumbosacral disc herniation, which also had a subligamentous extrusion. The patient was discharged to follow up with her physician in one week.

Correct Answer from Previous Case Scenario:

	ICD-9-CM	ICD-10-CM	Audit Remark
Principal Diagnosis	648.01	O24.12	Assigned code as the PDX as documentation states that patient has type 2 pre-existing diabetes mellitus in pregnancy. As per official guidelines for coding and reporting, whenever a delivery occurs during the current admission, and there is an 'in childbirth' option for the obstetric complication being coded, the 'in childbirth' code should be assigned.
Secondary Diagnosis	250.00	E11.9	Added code to further specify the type of diabetes and any existing complications.
Secondary Diagnosis	649.01	O99.334	Assigned code for smoking complicating childbirth.
Secondary Diagnosis	V27.0	Z37.0	Single live birth.
Secondary Diagnosis		Z3A.39	Added on ICD 10 for 39 weeks gestation of pregnancy.
Principal Procedure	73.59	10E0XZZ	Assigned code for the manually assisted vaginal delivery of a live-born male baby.