ICD-10: Where are we now?

By Dana Brown RHIA, CHC

ICD-10 is on everyone’s minds. Where are we now? Where do we go from here?

With the delay of ICD-10, everyone within the community is thinking about ICD-10. Some folks are stressed and worried about another possible delay- whereas others are relieved about getting extra time to prepare. Where ever you are with your feelings toward ICD-10, we need to be prepared one way or another – delayed again or implemented in 2015. At the very minimum, we have a year to prepare, perfect and ensure that the transition from ICD-9 to ICD-10 is smooth. So how do we do that? What are others in the industry doing?

One facility has just finished the first phase of ICD-10 training (which had been delayed in April). The training included a boot camp style training session for all coders. Following this training coders went directly into coding practice in ICD-10 and is now continuing on with dual coding on a limited basis.

Another facility has delayed their training entirely and is just beginning to start thinking about the route they are going to take in training for ICD-10. Yet another facility simply kept pushing forward with the training that was started before the delay, and have now been dual coding 2 days per week for a year. In fact, RMC has just completed our first audit in ICD-10!!

At RMC’s we did stall our training internal training for our own staff for a few months and are now back in full swing. We have staff at varying stages of training (for a variety of reasons) and are moving folks forward in different groups through our online ICD-10 training program called “10x”.

As you can see from the above examples, we are all in different phases on our approach to ICD-10. Whether you are completely finished with your training, or haven’t begun- it’s OK! We still have time- in fact an entire year to prepare! At RMC, we really truly feel that we all need to prepare ourselves for implementation whether it is delayed or not. So start training, get coding exposure and practice! Start dual coding in ICD-10 as soon as reasonable.

From a coder perspective – training, support and mentoring are of critical importance. Coders need first training in how to code in ICD-10. Next coders need LOTS of coding practice – applying their new skills. Lastly coding from real charts – and mentoring to reinforce the rules. Its important coders receive this mentoring to ensure a successful transition to ICD-10.

As we all know, good coding comes from expertise and skills, but also from quality documentation. Reach out to your providers, educate them in ICD-10. If you have a CDI Team – partner with them to work with the providers. Get the documentation correct the first time.

Above all advocate for ICD-10 implementation in 2015- take action! Send emails to your senators and do what you can to ensure that ICD-10 isn’t delayed again. AHIMA has made it easy for you by simply clicking on this link http://capwiz.com/ahima/issues/alert/?alertid=63175786 and filling in the blanks, you CAN make a difference.

ICD-10 needs to happen, it will help everyone in the end so please make your effort to advocate and ensure this date October 1, 2015 as the compliance date for ICD-10.
Continued on following page...
Coding for Breast Procedures Continued...

**Excisional Breast Biopsy**

–19120 Excision cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion, open, male or female, 1 or more lesions (Physician excises entire tissue mass for biopsy reasons)

**Localization Biopsy**

–19125 Excision of breast lesion identified by preoperative placement of radiologic marker, open, single lesion (excision of an entire lesion using a localization technique, whereby a needle or clip is placed into the breast lesion preoperatively to assist in exact identification of the affected suspicious tissue)

–19126 each additional lesion separately identified by a preoperative radiologic marker (add-on code)

References:
breastcancer.Org
American Cancer Society
www.cdc.gov/cancer/breast/statistics

Stacy Young, CCS has 15 years experience in the Health Information Management field. She started her career working for a small rural Family Practice Clinic where her duties included coding, transcription and nursing assistant. Stacy moved into the hospital sector over 10 years ago at a small rural hospital performing transcription and coding. With progressive experience, Stacy has held various positions of Coder, Coding Compliance Coordinator and HIM Director. Stacy joined RMC in 2006, and is currently Regional Coding Manager for RMC.

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**Examples:**

#1
S: 56 year-old patient admitted from ER c/o dizziness.
O: BP today 200/130, HR 88. PE unremarkable. EKG normal. Pt given IV meds with BP drop to 150/100 and resolution of dizziness. Renal US shows stenosis with mild renal atrophy.
A: Renovascular hypertension due to fibromuscular dysplasia.
P: Admit to telemetry for BP control and monitoring

#2
S: 45 year-old male brought in by wife. C/O nonsensical speech. He awoke this am unable to find words or speak clearly and is anxious and frustrated.
O: Vital signs stable. EKG normal. PMH is significant for hypercholesterolemia for which he takes Lipitor. STAT labs drawn. Pt sent for CT which was nonconclusive. Cranial angio revealed 50% occlusion of right middle cerebral artery. No bleeding present.
A: TIA due to 50% right MCA occlusion
P: Admit for observation.

#3
S: 76 year-old female admitted for urgent cardiac cath after developing CP during bicycle stress test today. Pt has been c/o worsening angina on exertion. PMH includes AMI 4 years ago and 4 vessel CABG. Today’s procedure revealed new atherosclerotic lesion in the left circumflex artery with near total occlusion.
A: Chronic occlusion of native left circumflex with angina on exertion.
P: Pt declines surgery and wishes to treat symptoms if possible. She will follow-up in 1 week for medication adjustments.

*Answers on page 6...
Comprehensive Preventive Service, IPPE or AWV: Which one are you providing?

By Susan Morton, CPC, CPC-I, CEMC, CGSC, COBGC

Since the implementation of the Affordable Care Act (ACA) and, in turn, the initiation of two new services, the Initial Preventive Physical Examination (IPPE) and the Annual Wellness Visit (AWV), providers are having increasing difficulty coding preventive services for Medicare patients. This article will highlight the distinctions between the comprehensive preventive medicine services, those reported with CPT codes 99381-99397, the IPPE (G0402) and the AWV (G0438 and G0439).

Let’s start with the comprehensive preventive medicine service. The extent and focus of the service will largely depend on the age of the patient. Documentation requirements include a comprehensive age and gender-appropriate history and exam, counseling or anticipatory guidance and risk factor reduction interventions. Any immunizations or ancillary services identified with a specific CPT code are reported separately and are NOT bundled into the preventive medicine service. An insignificant or trivial problem/abnormality encountered during the performance of the preventive medicine service that does not require additional work by the provider should not be reported separately (e.g., a simple medication refill.)

The Initial Preventive Physical Examination (IPPE) or “Welcome to Medicare Visit” is a preventive evaluation and management service provided for any beneficiary within the first 12 months after the effective date of their Medicare Part B coverage and is a one-time benefit. Providers must provide, or provide and refer, ALL components. The seven components of the IPPE are as follows: (1) review of medical and social history; (2) review of risk factors for depression and other mood disorders; (3) review of functional ability and level of safety; (4) an examination to obtain routine measurements, visual acuity screen and other factors deemed appropriate; (5) end-of-life planning; (6) education, counseling, and referral based on the previous five components; and (7) education, counseling, and referral for other preventive services (including a brief written plan). Each of seven components contains specific requirements. Note that the examination is not a comprehensive exam, as in the comprehensive preventive medicine service (Table 1).

The Annual Wellness Visit (AWV) provides Personalized Preventive Plan Services (PPPS) for any beneficiary not within the first 12 months of their Medicare Part B coverage and who has not received an IPPE or AWV within the past 12 months. The first AWV (G0438) is allowed only once per beneficiary per lifetime and the subsequent AWV (G0439) is allowed once per year thereafter. Providers must provide, or provide and refer, ALL components of the AWV prior to submitting a claim. The nine components of the FIRST AWV are as follows: (1) health risk assessment; (2) establishment of medical/family history; (3) review of risk factors for depression; (4) review of functional ability and level of safety; (5) an assessment that includes height, weight, body mass index, blood pressure and other routine measurements deemed appropriate, based on medical/family history; (6) establishment of a list of current providers and suppliers; (7) detection of any cognitive impairment; (8) establishment of a list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or are underway; and (9) furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services. Each of these nine components contains specific requirements. Once again, it is important to note that the examination requirement is not a comprehensive exam (Table 1).

The eight components of the SUBSEQUENT AWV are as follows: (1) update of health risk assessment; (2) update of medical/family history; (3) an assessment that includes weight, blood pressure and other routine measurements deemed appropriate, based on medical/family history; (4) update of a list of current providers and suppliers; (5) detection of any cognitive impairment; (6) update of the written screening schedule; (7) update of the list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or are underway; and (8) furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services. Once again, the examination requirement is not a comprehensive exam (Table 1).

Providers should familiarize themselves with the differences in these services in order to assure correct documentation and coding as each one has its own set of requirements. Failure to document the necessary components can result in denial of payment.

References:
CPT 2014
CMS Pub 100-4, chapter 12, 30.6.1.1
FAQ from the Medicare preventive services national provider call on 3/28/12
MPS_QRI_IPPE001a.pdf
AWV_Chart_ICN905706.pdf

Susan J Morton, CPC, CPC-I, CEMC, CGSC, COBGC has been in the medical field since 1996, working within physician offices. Susan obtained her CPC certification in 2003, CGSC certification in 2007, CEMC certification in 2009, CPC-Instructor certification in 2012 and most recently, in 2013, COBGC certification.
### Table 1.

<table>
<thead>
<tr>
<th>Comprehensive Preventive Medicine Service &quot;Well Visit&quot; (CPT 99381 - 99397)</th>
<th>Initial Preventive Physical Exam (IPPE) or &quot;Welcome to Medicare Visit&quot; (G0402)</th>
<th>Medicare Initial Annual Wellness Visit (G0438)</th>
<th>Medicare Subsequent Annual Wellness Visit (G0439)</th>
</tr>
</thead>
</table>
| Comprehensive assessment/history of pertinent risk factors | Conduct health risk assessment:  
  - Demographic data  
  - Self-assessment of health status  
  - Psychosocial risks  
  - Behavioral risks  
  - ADLs  
  - Instrumental ADLs | Update health risk assessment:  
  - Demographic data  
  - Self-assessment of health status  
  - Psychosocial risks  
  - Behavioral risks  
  - ADLs  
  - Instrumental ADLs |  |
| Comprehensive age and gender-appropriate system review |  |  |  |
| Comprehensive or interval past, family and social history | Review medical/social history | Establish medical/family history | Update medical/family history |
| Screen for depression | Screen for depression |  |  |
| Review of functional ability and level of safety | Examination:  
  - Height, weight, blood pressure & body mass index  
  - Visual acuity screen  
  - Other factors deemed appropriate, based on medical/social history & current clinical standards | Assessment:  
  - Height, weight, blood pressure, body mass index (or waist circumference, if appropriate)  
  - Other routine measurements deemed appropriate, based on medical/family history | Assessment:  
  - Weight (or waist circumference if appropriate) & blood pressure  
  - Other routine measurements deemed appropriate, based on medical/family history |
| Comprehensive age and gender-appropriate physical exam |  |  |  |
| End-of-life planning, upon agreement with patient |  |  |  |
| Establish list of current providers, suppliers |  |  |  |
| Detection of any cognitive impairment |  |  |  |
| Ordering of appropriate immunizations or laboratory/diagnostic procedures |  |  |  |
| Management of diagnosed stable chronic conditions and insignificant/minor problems | Education, counseling & referral based on previous 5 components | Establish written screening schedule based on health status, screening history & age-appropriate preventive services recommendations for the next 5 -10 yrs | Update written screening schedule |
| Risk factor reduction interventions | Education, counseling & referral for other preventive services: Includes a brief written plan for obtaining a screening EKG/ECG, as appropriate, and other appropriate screenings & preventive services that Medicare covers | Establish list of risk factors & conditions for which interventions are recommended or underway | Update list of risk factors & conditions for which interventions are recommended or underway |
| Age and gender-appropriate counseling/anticipatory guidance | Furnish personalized health advice & referrals to health education or preventive counseling services/programs | Furnish personalized health advice & referrals to health education or preventive counseling services/programs |  |

**Covered by Medicare**

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ICD-10 IS COMING!!

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ICD-10 Sample Documentation Answers:

#1
I15.0 Renovascular hypertension
I77.3 Arterial fibromuscular dysplasia

#2
I66.01 Occlusion and stenosis of right middle cerebral artery
G45.9 Transient cerebral ischemic attack, unspecified
E78.0 Pure hypercholesterolemia

#3
I25.118 Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
I25.2 Old myocardial infarction