1st Quarter 2016 | Vol.6 Issue 1

RMC COMPLIANCE CONNECTIONS

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What a Dilemma?!?!?: Complication Coding in ICD-10

By Marquita Rawlins RHIA, CCS, AHIMA Approved ICD-10 CM/PCS Trainer

How many times have you experienced apprehension after reviewing documentation in an Operative Report that states "minor serosal tears repaired", "colon perforation during hemicolectomy", or "dissection in a coronary artery distal to a stent"? For me, it's been countless times. I immediately tense up as I wonder will a complication code be assigned or is this an incidental part of the surgery. In some cases these tears, perforations, and dissections are an inherent part of the surgery and are unavoidable and a complication code would not be assigned. According to our Official Coding Guidelines:

It is important to note that not all conditions that occur during or following surgery are classified as complications. First, there must be more than a routinely expected condition or occurrence. In addition, there must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. The coder cannot make the determination whether something that occurred during surgery is a complication or an expected outcome. Only a physician can diagnose a condition and the physician must explicitly document whether the condition is a complication. If it is not clearly documented, the coder should query the physician for clarification.

As coders, we should never make assumptions with regards to complications. However, if the documentation indicates the condition as a complication or as clinically significant, the specific complication code would be assigned. Additionally, the general coding rule for postoperative complications is that when the complication codes do not specifically identify the condition, an additional code should be assigned to more fully explain it. If the complication code describes the condition fully, then no additional code would be assigned.

As if we didn't already have enough codes, now in ICD-10 we have new complication of care codes within the body system chapters. These complication codes (intraoperative and postprocedural) are found within the body system chapters with codes specific to the organs and structures of that body system. These codes should be sequenced first, followed by a code(s) for the specific complication, if applicable. An example of these codes are K91.5 (Postcholecystectomy syndrome) or I97.120 (Postprocedural cardiac arrest following cardiac surgery). Careful attention to the Index entries is required to make sure the most appropriate code is assigned. An important reminder is also that the specific complication code is dependent on the body system involved in the surgery. For instance, when coding postoperative hematoma, the specific code is assigned based on the body system involved in the surgery. Therefore, if you have a postoperative hematoma following a cardiac catherization, then the correct ICD-10 CM code would be I97.610 (Postprocedure hemorrhage/ hematoma of a circulatory system organ following a cardiac catherization). According to Dorland's Medical Dictionary, a hematoma is defined as a localized collection of blood, usually clotted, in an organ, space, or tissue due to a break in the wall of the blood vessel. Although we usually see a hematoma as a skin disorder, our I-10 Coding guidance tells us the code is assigned based on the body system involved in the surgery.

To sum it up, documentation is key! Never assume. If the documentation does not clearly identify the condition/occurrence as a complication query the physician for clarity.

Marquita Rawlins, RHIA, CCS, AHIMA Approved ICD-10 CM/PCS Trainer *joined RMC in 2015 as Senior Manager of Coding Services. In this role, Marquita manages a team of coders providing coding services. Marquita is a graduate of the University of Alabama in Birmingham, with a Bachelor's of Science in Health Information Management and has numerous years of experience in HIM. Marquita's past positions include Manager of Audit Services, DRG RAC Auditor, and most recently an ICD-10 Auditor for acute care facilities nationwide. Marquita enjoys providing education to coders, mentoring team members, and performing audits.*

Knock, knock. Who's there? OCR.

By Chris Apgar, CISSP

Unfortunately, as anyone who's had the OCR show up on his or her doorstep knows, it's no laughing matter. The Omnibus Rule and its requirements are all encompassing, but we'll go high level here. Let's start with the Top 9 items to address:

1. Risk Analysis: CEs and BAs, this is a must – HIPAA or no HIPAA. And it involves more than your technology.
2. Risk Management: Implement the program and mitigate the ID'd risks (this is an ongoing, regularly updated practice). If you're a CE, remember that unaddressed BA risks may well become yours and if you're a BA your BA subcontractors may land on your doorstep too!
3. Policies & Procedures: Got 'em? Can produce them if OCR investigates or audits for current, accurate, enforceable P&P? These are a HIPAA Privacy & Security Rules requirement!
4. Training: New employees up on HIPAA? Great! What about your existing workforce? Training is not a one-time event; in fact, done well and regularly, it reduces your "people" risk.
5. Audit Program: HIPAA & OCR require it! IS activity, user login, audit log, evaluation, and so forth. Make note that if you generate an audit log without monitoring it equals Willful Neglect.
6. Security Incidents & Breaches: Do you have a Security Incident Response Program and is it tested? Do you know what's a security incident vs what's a breach? Incidents & breaches are a biggie – prepare for mitigation and notification! OCR just fined a CE because they didn't have a plan.
7. Update BA Agreement(s): If no BAA updates, must have been updated no later than September 22nd of 2014! Are those executed after March 26, 2013 compliant? (Yes there are still old BAAs out there)
8. Mobile Devices & BYOD: How are you limiting your risks if you have a BYOD program. If you don't have a mobile device management program, you are opening your organization to huge risk.
9. Business Continuity: Are you ready for data loss or corruption? Is your BA reliable and your plan tested?

Just keep in mind – OCR will be auditing and OCR does investigate. OCR also does not go away if you don't fully answer their questions and provide the right documentation. Don't be an OCR poster child!

HIPAA Myths – "Because HIPAA Says So"

By Chris Apgar, CISSP

Have you ever heard "I can't tell you because HIPAA says I can't?" Often, that's not true.

Understandably, traditional gatekeepers (receptionists, information desk staff, etc.) aren't sure what they can or can't share, so they don't share anything out of fear of violating a regulation. In actuality, if a patient hasn't opted out of the facility directory, there's no restriction against telling a visiting friend or relative what room the patient is in. A good training session, with example scenarios, would help alleviate those fears and provide well-intentioned people with needed information.

I've also heard, as a patient, "you can't look at [designated record set – DRS] because it's electronic. Also, I've been told I need to pay for a copy of my DRS but not view it. That IS a direct violation of my rights as outlined in the HIPAA privacy rule. Again, the training gap rears its head.

Refresher training is really helpful, as is updated training material that covers privacy and security related policies, procedures and practices that employees need to follow. New hires need reminders as much as covered entities need to bring their materials up to date.

Think about it. Imposing HIPAA requirements that aren't really HIPAA requirements gets in the way of patient care. For example, I have encountered a number of clinics who require patient authorization before sharing the patient's information with another clinic for treatment purposes, "because that would violate HPAA."

It is OK to adopt more stringent privacy requirements, such as requiring that patient authorization, but it is ***not*** a HIPAA requirement and it's not wise to characterize it as one. Making the sharing of patient information difficult between authorized entities can lead not only to a decrease in the quality of patient care, but also to adverse outcomes.

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"HIPAA Myths" Continued...

Avoid inadvertent red tape and inaccurate "HIPAA" categorizing. Instead:

- Schedule regular privacy & security training for both new and existing employees
- Update training material to cover patient rights and appropriate sharing of PHI
- Provide specialized training for those with "super access" (network engineers, records custodians, etc.)
- Focus on specific privacy policies and procedures rather than a fat binder and a "read this" directive (won't happen)
- Test understanding with situational activities to assure thorough learning
- Stick to the HIPAA facts, rather than create your own "HIPAA" myths

***Chris Apgar**, founder of Apgar & Associates is a Certified Information systems Security Professional (CISSP). He is one of the country's foremost experts and spokespersons on healthcare privacy, security, regulatory arriafs, state and federal compliance and secure and efficient electronic health information exchange. Chris has more than 19 years of experience in regulatory compliance and is a leader of regional and national privacy, security and health information exchange forums. As a member of Workgroup for Electronic Data Interchange, and serving on the Board of Directors since 2006, Chris is an honest, reliable, trustworthy expert in the field of privacy and security. Email capgar@apgarandassoc.com for more details.*

Paint a Clear Picture to Show Medical Necessity

By Monique Vanderhoof CPC & Chris Breithoff CPC, CPCO, CRC

According to the Centers for Medicare and Medicaid Services (CMS) incorrect coding is responsible for over $1,000,000,000 in overpayments each year. In 2014 over 50% of hospital visits billed and between 8-15% of office visits contained coding errors. Many of these errors were due to insufficient documentation and no proof of medical necessity.

Medical necessity can be one of the more difficult concepts to understand and document appropriately. Many providers believe that the documentation of their medical decision making (MDM) should be enough to prove medical necessity; when the truth is that MDM alone cannot validate medical necessity. There are many inaccuracies such as this out there, so it is important as coders that we educate our providers on what is required for proper documentation of services.

MDM is the clinical outcome of a face-to-face encounter. The chief complaint, history, and exam are based on the nature of presenting problem and these details are ultimately what prove medical necessity and determine the level of care when assigning an E&M code. CMS claims processing manual states "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code." So, while MDM can certainly be a driver in the determination of medical necessity, the rest of the documentation must also be supportive and describe the details of the care being provided.

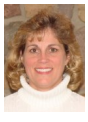
One way to help ensure medical necessity is proven is to confirm that there is an identifiable and well documented chief complaint or reason for visit listed. In fact, per CMS, documentation of the chief complaint is required to bill any level of E&M service. The problem we see too often is that the chief complaint simply states "recheck" or "follow-up" without any elaboration of symptoms, conditions, diagnosis, etc. This simple statement does not provide enough information to meet medical necessity and leaves the documentation lacking right from the start. A chief complaint is often stated in the patient's own words and should include a concise statement indicating the reason for the encounter. So if a patient is truly there for follow-up the chief complaint should include documentation of the diagnosis, symptom, etc. that they are there to follow-up on.

Additionally, make sure your provider understands the CPT guidelines for the nature of presenting problem. Understanding these guidelines will ensure that the documentation will include things like the severity of the problem, the probability of adverse outcomes, risk of morbidity, need for diagnostic studies and additional treatments, etc. Documenting in this way will help confirm the medical necessity of the service and support the medical decision making in the documentation as well.

Ensuring providers understand that the volume of documentation provided does not justify medical necessity is also important. Unfortunately, with features like copy/paste, check boxes, drop-down menus and templates, many electronic health record systems have a tendency to lead providers into creating documentation bloated with unnecessary information. Providers need to understand that the documentation must support the level of care necessary to treat the conditions the patient is being seen for on this date of service.

These are just a few of the ways to help ensure that your documentation proves medical necessity and justifies the level of service billed. Know your CPT guidelines and understand your different insurance contract requirements for medical necessity. Talk to your providers and provide ongoing education to help ensure that they understand how to do their part in supporting medical necessity in their notes.

***Monique Vanderhoof, CPC** joined RMC in September 2011 as Manager of Coding Services, focusing on HCC coding audits and client education. With over 15 years experience as a Clinic Manager, Monique has a extensive experience working in both outpatient and inpatient physician billing with emphasis in cardiology. Her skills also include EHR implementation, HIPAA, eRx and Meaningful Use readiness and attestation.*



***Chris Breithoff, CPC, CPCO, CRC** is the Manager of Physician Coding Services at RMC.. She has worked in the medical arena since 1985 with an emphasis on coding & compliance for 18 years. Her background includes managing large private practices, as well as managing a physician coding department for a large teaching hospital. Chris' areas of expertise are E/M, Critical Care, ER, GI, Pulmonary, Cardiology and Sleep Medicine.*

CPT Coding for Endoscopic Respiratory Procedures

By Stacy Hardin, CCS

Endoscopy is defined as looking inside. In healthcare, the term endoscopy is used when the physician or other designated health professional inserts a tubular device with a fiberoptic light and lens directly into an organ or cavity and performs a visual examination through an attached eyepiece. Images can also be transmitted to screens for capture. Endoscopy can be used to aid in diagnostic and therapeutic interventions such as biopsies.

For the respiratory tract, we utilize several endoscopic procedures. Endoscopy of the nose or nasal cavity is known as rhinoscopy and the lower respiratory tract endoscopy is known as bronchoscopy. We also see procedures of the chest done via thoracoscopy and mediastinoscopy.

The bronchoscopy procedures are accomplished by inserting a rigid or flexible bronchoscope through the oropharynx and vocal cords and beyond the trachea into the right and left bronchi. The fiberoptic bronchoscope, because of its size, can be passed only into the larger bronchial tubes, about the first 3 divisions out of approximately 23 divisions of the bronchi. The diagnostic bronchoscopy procedures can be found in CPT codes 31622-33629.

CPT 31622 is described as Bronchoscopy, rigid or flexible, diagnostic, with cell washing when performed. Cell washings may are may not be obtained from within bronchus via bronchoscope for diagnostic evaluation.

CPT 31623 is bronchoscopy with brushing or protected brushings. Lung tissue is obtained by brushing for diagnostic evaluation.

CPT 31624 is bronchoscopy with alveolar lavage. During this procedure lung tissue is irrigated with saline and then suctioned for evaluation.

CPT 31625 is bronchoscopy with bronchial or endobronchial biopsy(s), single or multiple sites. This procedure is performed when the physician takes a sample of bronchial or endobronchial tissue for evaluation. The code includes sampling from one site or multiple sites. Do not report additional codes for each site.

CPT 31626 is bronchoscopy with placement of fiducial markers, single or multiple. After inspection the physician places markers for later identification of landmarks on imaging studies.

CPT 31627 is an add on code for computer assisted, image-guided navigation. This code includes 3D reconstruction and can be used in addition to any of the bronchoscopy procedures.

CPT 31628 is bronchoscopy with transbronchial lung biopsy(s), single lobe. This procedure is performed by passing biopsy forceps through a space of the bronchoscope and going through the wall of the bronchus to take samples from the lung tissue. This code is for a single lobe. Additional lobes would be captured by assigning add-on code 31632.

CPT 31629 is bronchoscopy with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus. This procedure is performed similar to 31628 except that tissue is obtained using a needle for aspiration rather than biopsy forceps. This code is reported only once per lobe. For biopsies from additional lobes you would assign CPT 31633.

For 2016 there were also two new CPT codes added for bronchoscopy with transtracheal or transbronchial lymph node biopsies that include endoscopic ultrasound EBUS. These are CPT codes 31652 and 31653.

For a more comprehensive overview of some common CPT coding scenarios, be sure to join RMC in March for our ACE presentation on Comprehensive CPT coding. We will cover CPT coding of procedures for several body systems.

References:
2016 CPT Code Book
2016 Coder's Desk Reference for Procedures
https://en.wikipedia.org/wiki/Endoscopy

Stacy Hardin, 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.*

RMC IS HIRING!

RMC is currently looking for experienced, credentialed, hard-working coding experts to join our team. Positions are all remote, and all RMC staff are issued a company laptop.

Qualified candidates:

- Must have a minimum of 5 solid years of coding experience
- Must be AHIMA/AAPC credentialed
- Must pass RMC's coding test
- Must be reliable, friendly and flexible
- Full-time AND part-time positions available! Some positions qualify for sign-on bonus!

If you want to join our team and **LOVE** your job, please send your resume to employment@rmcinc.org

CONVENTION SEASON 2016!

RMC will have a booth at the following shows this year.

Please be sure to swing by and say hello. We look forward to seeing you!

IdHIMA - Boise, ID - March 31-April 1

AAPC National - Orlando, FL - April 10-12

HCCA National - Las Vegas, NV - April 17-20

WSHIMA - Lynwood, WA - April 28-30

OrHIMA - Portland, OR - May 12-14

CHIA - Long Beach, CA - June 5-8

TXHIMA - Galveston, TX - June 26-28

FHIMA - Orlando, FL - July 18-21

GHIMA - Atlanta, GA - August 3-5

AAPC Regional - Anaheim, CA - September 19-21

ORHC - Portland, OR - September 28-30

AAPC Regional - Atlantic City, NJ - October 6-8