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Coding Clinic Update – 1st Quarter 2016

By Connie Calvert RHIA, CCS, CCDS

Coders, if you have not had a chance to read your most recent edition of the Coding Clinic, then make time to do so! It is chock full of information – and lots of huge changes! The most significant of which, in my mind, is regarding Diabetes (or as my Granny would say, "the sugars").

We all should know by now that ICD-10-CM does NOT presume a linkage between diabetes and osteomyelitis. The provider would need to document a relationship in order to link the two. This is opposite of ICD 9 CM. Hmmm…interesting. Well, it gets better, folks. CC 1Q 2016 now tells us that for conditions included under the ICD 10 CM Alphabetic Index entry for "*Diabetes with*," the coder can now assume a causal relationship. CC states that, "according to the ICD 10 CM Official Guidelines for Coding and Reporting, the term 'with' means 'associated with' or 'due to,' when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List, and this is how it's meant to be interpreted when assigning codes for diabetes with associated manifestations and/or conditions. **The classification assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system**." CC goes on to state that, as always, if the provider specifically states the DM is not the cause of the other condition, then the two should not be linked. And we know they rarely do….

So….I'll give you a minute to process this.

Now, you will want to turn to your code books and look up the term *Diabetes, with* in the Index. Note the numerous conditions that are assumed to be due to diabetes and can be coded as such without need for the provider to link the two. Among the conditions: arthropathy NEC, cataract, foot/skin ulcer, neuropathy, peripheral angiopathy, retinopathy, and any circulatory, ophthalmic, kidney or skin complications NEC. Note that CKD is included in this list, which means if you have a patient with Hypertension, DM, and CKD, you will need to link the CKD to both the HTN (as that has not changed – yet!) and the DM – two combo codes and then the code for the stage of the CKD. Good times. Seriously, though, I was very happy to see that gastroparesis is now assumed to be associated with/due to Diabetes which means no need to query any longer for that diabetic patient with gastroparesis as principal diagnosis. Yay! I can get behind that change! The rest will take me time to get used to. This is a huge (HUGE!) change.

Coding Clinic 1st Quarter 2016 also contains other changes regarding coding of HFpEF and HFrEF for CHF patients, OB laceration repair clarification, BAL with brushing, and use of D68.32 for haemorrhage due to anticoagulant therapy (note that this apparently would only be used when haemorrhage is present, not in case of elevated INR/PT without any evidence of bleeding.

That's it for this time, folks. Time to go turn up the Bowie and embrace this new animal called ICD 10. ♫ *Ch-Ch-Ch-Changes* ♪ *Turn and face the strange* ♪♫ *Ch-Ch-Ch-Changes* ♫♪

Connie Calvert, RHIA, CCS, CCDS, AHIMA Approved ICD 10 CM/PCS Trainer *is RMC's Director of Hospital Coding and Review Services. In this role, she is ultimately responsible for the quality of services supplied by RMC and the excellence in the work provided to RMC clients. Connie has over 20 years of experience in HIM and enjoys coaching and mentoring staff, conducting audits, researching coding issues, developing coding tools, and providing education to coders as well as providers. Clinical Documentation is a particular passion and as such, Connie obtained her CCDS in 2011. She is active in AHIMA, SCHIMA, and ACDIS. And is an AHIMA ICD-10-CM & PCS Trainer.*

With or without abnormal findings? Finally some guidance!

By Monique Vanderhoof CPC

If you are like most of us you were probably second guessing your use of the codes for Well-Child and Adult Physicals in ICD-10, because of the inclusion of the classifications of with or without abnormal findings. There was no real guidance to help us understand what qualified these classifications…until now. AHA Coding Clinic came out with some very valuable guidance for these codes in their First Quarter 2016 publication.

Here is what we know now – Per Coding Clinic "An examination with abnormal finding refers to a condition/diagnosis that is newly found, or a change in severity of a chronic condition, such as uncontrolled hypertension, or an acute exacerbation of chronic pulmonary disease, during a routine physical exam."

When reporting a code WITH abnormal findings, coding notes state that an additional code is required to identify the abnormal findings. Diagnosis codes for abnormal findings are allowed to be reported regardless of whether the finding requires an additionally reported service. If the patient has stable chronic conditions, those chronic conditions can be coded as additional diagnoses along with the code for a medical exam WITHOUT abnormal findings, as long as the documentation supports the use of the additional code.

Example: A 6-year old boy is seen for a well child exam. He also has otitis media of the right ear, which was diagnosed last week at a visit and is still under treatment. For this scenario you would assign code Z00.129 (encounter for routine child health examination **without** abnormal findings as first listed diagnosis) and also list the appropriate code for the otitis media. An examination with an abnormal finding refers to a condition/diagnosis that has a change in severity or is new at the time of the visit, this child had otitis media currently under treatment and no changes or new problems were discussed.

Example: A 2-year old girl is seen for her well child exam. On examination it was noted the child had a rash over her trunk. The patient was diagnosed with allergic dermatitis. In this case you would assign code Z00.121 (encounter for routine child health examination **with** abnormal findings as first listed diagnosis) and also list the appropriate code for allergic dermatitis. The abnormal finding is the allergic dermatitis because it is new at this visit.

Remember that reporting additional findings/diagnoses during a preventative exam does not mean that you can also bill an additional Evaluation and Management Code. The rules for billing a preventative visit with a sick visit, still require significant and separately identifiable services to be documented. Always be sure to read and understand your coding guidelines and rules before billing for services.

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.*

Modifiers – Use Them, Don't Abuse Them!

By Chris Breithoff CPC, CPCO, CRC

If you missed the modifier presentation that was given last month this article will review the modifiers that are often misused for Physician Services.

Modifiers are used to accurately represent the circumstances of a procedure or service. They add information or change a description of a procedure/service; improve accuracy or specificity and affect how reimbursement is paid.

Modifier 24 – Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period. This is used to indicate that an E/M service was performed during a postoperative period for a reason(s) unrelated to the original procedure during a 10 or 90 day global period. If you answer yes to the following three question, then you can append the modifier 24 onto the E/M.

Was E/M service performed during a global period of a surgery performed by the same physician?
Is E/M serviced ***unrelated*** to the diagnosis for the original surgery?
Does the medical record documentation support the unrelated condition?

Example: Physician performed an intermediate wound repair on patient presenting with laceration. Five days later, the same patient returns to the office with bronchitis.

► Report the E/M with modifier 24 and diagnosis J40 (bronchitis).

Continued on following page...

"Modifiers" Continued...

Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. The use of modifier 25 has specific requirements. This is used when the Patient's condition required significant identifiable E/M beyond other service provided or beyond the usual pre or post-op care for procedure. The problem must warrant that the physicians work is medically necessary.

Example: A 10- year old girl is seen for her preventive medicine visit. All components for a preventive medicine E/M visit are documented including hearing and vision screening, appropriate tests ordered and immunizations up to date. The patient is also evaluated for her ADHD and the parent concerns are discussed. Medication was increased and follow-up appointment made for 1 month and enough documentation was done for 99213. The preventive Medicine visit would be reported 99393 with Z00.12 and 99213-25 for the ADHD.

Modifier 59 - Distinct Procedural Service – Distinct Procedural Service – used to indicate that a procedure or service was distinct or independent from other non-E/M services performed. Use when 2 codes are normally bundled or mutually exclusive, but the service was medically necessary and a distinct, separate service. Modifier 59 should only be used if there is no other, more appropriate modifier to describe the relationship between two procedure codes. If there is another modifier that more accurately describes the services being billed, it should be used instead of the 59 modifier.

Use to indicate:

- Different sessions or patient encounters
- Different procedure or surgery
- Different site or organ system
- Separate incision or excision
- Separate lesion
- Separate injury not normally encountered or performed on the same day by same physician

Example: If the patient was having a nerve conduction study with CPT codes 95900 and 95903 being billed. If the two procedures are done on separate nerves, then the 59 modifier should be used to indicate that. If the codes were performed on the same nerve, then the 59 modifier should not be used.

Effective January 1, 2015 there were 4 new subsets of Modifier 59 listed below with examples. There has been little guidance from CMS regarding the usage of these modifiers. While coders have been encouraged to use the modifiers for more specificity when applicable, the 59 modifier is still allowable and may be the best to use in many situations. Further guidance regarding the XU modifier would be extremely welcomed by facilities and coders.

XE Separate encounter
A service that is distinct because it occurred during a separate encounter
Example: One surgery procedure at 9AM and one at 6PM.

XS Separate structure
Performed on a separate organ/structure
Example: Injection into tendon sheath, right ankle (20550) and injection into tendon sheath, left ankle (20550-XS).

XP Separate practitioner
Performed by a different practitioner
Example: Modifier XP is a little unclear. One possible scenario might be:
The patient is seen in the office by a family practice physician, who in the course of the visit encounters a problem outside their scope of ability so calls in (or arranges an immediate transfer to) a specialist physician at the same claim to perform the needed service.

XU Unusual non-overlapping service
Does not overlap usual components of the main service
Example: A diagnostic procedure is performed. Based on the findings, a therapeutic and/or surgical procedure is required on the same day. For example, diagnostic cardiac catheterization is followed by a medically necessary cardiac procedure.

Remember: you will never use Modifier 59 in conjunction with one of the X(EPSU) modifiers. A full list of Physician Modifiers can be located in your CPT book. See also CCI Policy Manual, Chapter 1, modifier 59 guidelines.

We recommend that you talk with your providers and review the proper use of modifiers for your clinic/facility.

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.*

Hot Topics in the ED

By Jane Barta, RHIA & Carly Pryor RHIA, CCS-P

Summer is certainly on its way with waves of hot temperatures and wild weather (tornadoes!) being seen across the country. This can be a time of very high census in the Emergency Department. Many people are out and about with various summer activities – hiking, camping, swimming, etc. Are you ready for all the new ICD10 codes for injuries and fractures? There is much more detail available in code selection than with ICD9-CM. CPT coding, injections and infusions along with facility Evaluation and Management coding is often the responsibility of HIM coding at hospitals. These areas require a knowledge of ICD10 coding and also CPT coding expertise in three separate areas – E&M, surgical CPTs and injection and infusion coding. Keeping current on these areas is important to help ensure accurate coding of Emergency Department claims.

Fracture coding is one of the areas which has changed with implementation of ICD10. To select the appropriate ICD10 diagnosis code for a fracture, there are now multiple details to consider. There is much more than just open or closed, displaced or nondisplaced as in ICD9. Fracture codes include greater specificity in: type of fracture (open or closed); specific anatomic site; displaced or nondisplaced; laterality; routine vs. delayed healing; non union or malunion; 7th character value and Gustilo open fracture classification coding. All of these items can make a difference in which diagnosis code is used. What are the policies at the facility where you code? Are you allowed to use more definitive findings on the radiology exam? Coding to the most specific detail can help ensure rapid reimbursement of claims in the ED.

Capturing external cause status codes in ICD10 can be a challenge. Facilities should review their current policies regarding these codes to help ensure consistency in coding. Some states require a place of occurrence on all claims, even though there are times when there is no documentation to support a location. Guidelines for coders in this instance help immensely. Remember, there are 4 areas that need to be considered when selecting external cause status codes - cause of injury, activity, place of occurrence and patient status. Remember to not assume. For example, if the documentation states patient fell on playground at local school. A school can be used as the place of occurrence, but do you actually know they were a student? If the patient is 10 years old, do not assume it was an elementary school. Perhaps they were just playing at the local middle school? When it says a patient fell while at the local grocery store, do you know if the patient is an employee or a person buying groceries? Only code what can be supported by the documentation.

Modifier placement, especially 59 subset modifiers, is an ongoing learning process. Currently, Medicare has stated that 59 modifier is still applicable in many situations. Therefore, if choosing a subset modifier, such as XE, XS, XP, or XU, is not adding or clarifying the coding situation, modifier 59 may be the best choice in that situation. Claims are not being denied simply because a 59 was used instead of a more specific subset modifier. Be sure to check with your fiscal intermediary to see if they have any specific requirements regarding modifier 59 and the subset modifiers.

Jane Barta, RHIA *has worked in hospitals both small (5 bed) and large (350+ beds) in Colorado, Montana and Idaho before joining RMC 2000. Her past experience covers Quality Assurance, Utilization Review and departmental management in addition to Coding Quality. With RMC, Jane concentrates on the areas of Ambulatory Surgery, Emergency and Urgent Care coding. During the last 10 years, she has worked with over 38 hospitals in addition to multiple physician offices and insurance companies.*

Carly Pryor, RHIA, CCS-P *began her coding career with an internship site while working on her bachelor's degree. She earned her RHIA in 2002, immersed herself in emergency coding, and added the CCS-P credential in 2004. She has tackled the idiosyncrasies of emergency coding from every angle in facilities nationwide – from critical access hospitals in tiny rural towns, to the traditional hospital-based services just down the street, to well-known teaching facilities in major metropolitan areas, as well as helping establish start up ventures like free-standing emergency rooms and urgent care facilities. Throughout the adventure, she has most enjoyed training coders and educating providers.*

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