2014-2015 Coding and Compliance Update for Pediatric Gastroenterology

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Credentials and Organizations

- **American Academy of Professional Coders**
- **American Health Care Information Management Association**
- **American Gastroenterological Association Member, Speaker and Columnist**
- **American Society for Gastrointestinal Endoscopy Columnist**
- **Illinois Nurses Association**
- **NASPGHAN Speaker and Columnist**
- **Professional Association of Healthcare Coding Specialists**
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2015 CPT for Pediatric GI

- You got your 2015 CPT book, hopefully? You opened it, didn't you?
- You looked to the GI chapter and saw Esophagoscopy, one change, not much with EGD and ERCP
- Next, enteroscopy, one major change. Now I really have to talk to my doctors.
- Then the lower endoscopy section, forget just a talk, we have to do a conference. Major changes and then there is one huge error in the CPT book that will be amended in a separate attachment from CPT, but when?
- Oh, yeah, forgot about some new E&M codes. Might apply to you but be prepared to create a log and it will be "audit friendly".
- Modifier 59 vs the X modifiers, Now what?

Esophagoscopy

- 43180   Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed

Endoscopy Small Intestine (enteroscopy)

- Antegrade transoral small intestinal endscopy (enteroscopy) is defined by the most distal (extensive) segment of small intestine that is examined. Codes 44360-44373 are endoscopic procedures to visualize the esophagus through the jejunum using antegrade approach (down from the mouth). Codes 44376-44379 are endoscopic procedures to visualize the esophagus through the ileum using antegrade approach. If the endoscope can't be advanced at least 50 cm beyond the pylorus, report EGD. If the endoscope is advanced at least 50 cm beyond the pylorus but only into the jejunum, see 44360-44373.
- To report retrograde exam of the small intestine via anus or colon stoma, use 44799, unlisted procedure, intestine.

Lower Endoscopy Definitions

- Proctosigmoidoscopy is the examination of the rectum and may include examination of a portion of the sigmoid colon
- Sigmoidoscopy is the examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon
- Colonoscopy is the examination of the entire colon, from the rectum to the cecum, and may include examination of the terminal ileum or small intestine proximal to an anastomosis
- Colonoscopy through stoma is the examination of the colon, from the colostomy stoma to the cecum or colon-small intestine anastomosis, and may include examination of the terminal ileum or small intestine proximal to an anastomosis

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Lower Endoscopy Definitions

- When performing a diagnostic or screening endoscopic procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report 45378 (colonoscopy) or 44388 (colonoscopy through stoma) with modifier 53 and provide appropriate documentation.
- If therapeutic colonoscopy (44389-44407, 45379, 45380, 45381, 45382, 45384, 45388, 45398) is performed and does not reach the cecum or colon-small intestine anastomosis, report the appropriate therapeutic colonoscopy code with modifier 52 and provide appropriate documentation.

Lower Endoscopy Definitions

CPT Error: Report flexible sigmoidoscopy (45330-45347) for endoscopic examination during which the endoscope is not advanced beyond the splenic flexure

THIS IS RIGHT BELOW THE INSTRUCTION TO ADD THE 52 AND 53 MODIFIER PARAGRAPHS AND CONTRADICTS THE PREVIOUS INSTRUCTION. CPT IS GOING TO RELEASE A FIX TO THIS PARAGRAPH INDICATING THAT THE INTENT WOULD BE A FLEXIBLE SIGMOIDOSCOPY.

Lower Endoscopy Definitions

- Report ileoscopy through stoma (44380-44384) for endoscopy examination of a patient who has an ileostomy.
- Report colonoscopy through stoma (44388-44408) for endoscopic exam of a patient who has undergone segmental resection of the colon (eg, hemicolectomy, sigmoid colectomy, low anterior resection) and has a stoma
- Report proctosigmoidoscopy, sigmoidoscopy or anoscopy, as appropriate for endoscopic exam of a defunctionalized rectum or distal colon in a patient who has undergone colecotmy, in addition to colonoscopy through stoma or ileoscopy through stoma, if appropriate
- Report flexible sigmoidoscopy (45330-45347) for exam of a patient who has undergone resection of the colon proximal to the sigmoid (subtotal colectomy) and has ileo-sigmoid or ileo-rectal anastomosis)

Lower Endoscopy Definitions

- Report pouch endoscopy codes (44385-44386) for endoscopic examination of a patient who has undergone resection of colon with ileo-anal anastomosis (eg, J-pouch)
- Report colonoscopy (45378-45398) for endoscopic examination of a patient who has undergone segmental resection of the colon (eg, hemicolectomy, sigmoid colectomy, low anterior resection)

- THE COLONOSCOPY DECISION TREE IS ALSO INCORRECT AND PLEASE IGNORE UNTIL THE CORRECTION IS RELEASED.

Ileoscopy

- 44381   Ileoscopy through stoma with transendoscopic balloon dilation
- 44383   DELETED
- 44384   with placement of endoscopic stent (includes pre and post dilation and guide wire passage, when performed

Pouchoscopy

- Revision in description of the procedure:
- 44385 now says: Endoscopic evaluation of small intestinal pouch, (eg, Kock pouch, ileal reservoir (S or J pouch); diagnostic
- 44386 with biopsy, single or multiple

Colonoscopy Through Stoma

New Codes:
- 44001   with ablation of tumor(s), polyp(s), or other lesions(s) (includes pre- and post-dilation and guide wire passage, when performed.
- 44002   with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed
- 44003   with endoscopic mucosal resection
- 44004   with directed submucosal injection(s), any substance
- 44005   with transendoscopic balloon dilation
- 44006   with endoscopic ultrasound exam, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures

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Colonoscopy Through Stoma

- 44007   with transendoscopic ultrasound guided intramural or transmural (FNA/biopsy(s)), includes EUS limited to the sigmoid, descending, transverse or ascending colon and cecum and adjacent structures
- 44008   with decompression (for pathologic distention)(eg, volvulus, megacolon), including placement of decompression tube, when performed

Flexible Sigmoidoscopy

Deleted Code: 45339

New Codes:

- 45346 with ablation of tumor(s), polyp(s), or other lesions(s) (includes pre- and post-dilation and guide wire passage, when performed.
- 45347 with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed
- 45349 with endoscopic mucosal resection
- 45350 with band ligation(s)(eg, hemorrhoids)
  - (Do not report with 46221)
  - (Do not report more than once per session)

Colonoscopy

- Deleted codes: 45383, 45387

New Codes:

- 45388 with ablation of tumor(s), polyp(s), or other lesions(s) (includes pre- and post-dilation and guide wire passage, when performed.
- 45389 with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed
- with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed
- 45390 with endoscopic mucosal resection
- 45393 with decompression (for pathologic distention)(eg, volvulus, megacolon), including placement of decompression tube, when performed

Colonoscopy

- 45398 with band ligation(s)(eg, hemorrhoids)
  - (Do not report with 46221)
  - (Do not report more than once per session)

Anoscopy

New Codes
- 46601   diagnostic, with high-resolution magnification (HRA)(eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed.
- 46607   with high-resolution magnification (HRA)(eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple

Unlisted Procedures

- Revised code: 44799 : Unlisted procedure SMALL intestine

- New code: 45399: Unlisted procedure, COLON

Other GI Procedures

- 91200   Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report

Chronic and Complex Care Management Services

This is really just a short synopsis. There are more than 3 full pages in the CPT book describing these codes in much more detail. Please look into the CPT book for more information.

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established , implemented, revised, or monitored.

Chronic and Complex Care Management Services

99487 (Revision) Complex chronic care management services, with the following required elements:

- Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Establishment or substantial revision of a comprehensive care plan
- Moderate or high complexity decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional

Chronic and Complex Care Management Services

99488 is DELETED.

Modifier 59

- No change at all in the description of modifier 59. However, there is a note at the end of the paragraph (See also page 684, Level II HCPCS National Modifiers listing)

- XE   Separate Encounter
- XS   Separate Structure
- XP   Separate Practitioner
- XU   Unusual Non-Overlapping Service

AT THIS TIME, THE IMPLEMENTATION DATE IS JANUARY 5, 2015, FOR CMS BUT THIS IS UNDERGOING ANOTHER MEETING IN MID-OCTOBER TO DISCUSS THE IMPLICATIONS FOR GI. THIS MAY BE DELAYED YET.

Category III Codes

New Code
- 0377T   Anoscopy with directed submucosal injection of bulking agent for fecal incontinence

Physician Fee Schedule

- Physicians are scheduled to receive a 25 percent payment cut on Jan. 1, 2015 unless Congress intervenes. MGMA is conducting a brief Legislative and Executive Advocacy Response Network (LEARN) member poll regarding the impact Medicare physician payment cuts may have on medical practices. Your response is critical to enhance MGMA's advocacy efforts to get Congress to repeal this flawed payment system. If you are MGMA members, please log-in and respond. Log-in to AGA, ASGE, and ACG for further updates and links .

RAC (Recovery Audit Contractors)
TOP 3 affecting GI practices

- Medical Necessity- Documentation not supporting the level of service provided in the outpatient setting
  - I am seeing multiple practices and answering multiple questions on RAC issues. If your practice has not yet had some type of internal audit done, it is definitely not too late
- E/M Billed During Global Periods
- Incident-to Errors- Physician assistants and nurse practitioners performing services for a physician but not following billing-specific guidelines related to the physician's relationship to the patient and the physician's presence in the office

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Other RAC Issues

- Date of service does not match date billed
- Inappropriate/Inaccurate modifier usage
- Signature not present on medical record
- Procedure documentation not on medical record
- Place of service issues
- Locations of lesions removed not properly documented
- Method of removal not specified
- Improper documentation for indications
- Diagnosis code non-specificity

Meaningful Use for Pediatrics

Question: Are there specific parameters/categories of MU that apply to Ped GI? from what I understand, MU has many different parameters and many do not apply to what specialists do?

Answer: For stage II meaningful use, pediatrics have to choose 6 measures. Listed below is the link that will help you sort through the measures:

http://www.gastro.org/practice/stay-uptodate-on-meaningful-use-requirements

ECONOMY PROOF YOUR PRACTICE

1. Obtain all demographics including insurance information at time of appointment scheduling.
2. Inform patient and referring office staff that all pertinent records including labs, progress notes, radiologic studies, etc., are required at time of patient visit or patient may have to be rescheduled.
3. Remind patient of appointment and inform of any no-show fees in your practice policy manual.

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ECONOMY PROOF YOUR PRACTICE

4. Verify benefits and eligibility on all patient prior to appointment and inform patient of their responsibilities. The new Affordable Health Care plans contain high deductibles and co-pays.
5. Upon arrival, verify patient demographics and copy insurance information. Verify HIPAA, patient information and practice policy forms have been signed. Obtain co-pays. Politely inform patients of wait time. Give patient history forms to fill out if office requires this prior to exam area.
6. When bringing patient into exam area, double-check to make sure all forms have been signed. If patient information forms not signed, claims cannot be filed.

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ECONOMY PROOF YOUR PRACTICE

7. Obtain or verify history forms have been filled out. Verify allergy status and enter into system or mark on outside of file folders.
8. Preauthorize and verify eligibility when scheduling patients for endoscopic and diagnostic procedures. Inform them of their potential financial responsibilities and attempt to set up payment plans.

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ECONOMY PROOF YOUR PRACTICE

9. Upon check-out, make sure co-pays have been collected and/or deductibles have been paid. Ask for payment on unpaid balances.
10. When submitting office charges, make sure diagnosis codes are specific and accurate. If any questions, go back to the billing provider.
11. When submitting procedural charges, verify procedures by reviewing endoscopy reports, assigning appropriate modifiers when required, enter preauthorization numbers, add comments when appropriate to multiple endoscopy charges in field 19, and make sure diagnosis codes match the procedure entered.

ICD-10-CM Are You Ready?

ICD-10 Overview

- ICD-9 is no longer supported by the World Health Organization (WHO)
- Majority of other countries have already adapted to ICD-10
- ICD-9 can't accommodate emerging disease affecting us internationally due to lack of specificity
- ICD-10 allows for improved disease management
- Fewer rejected claims with ICD-10
- On July 31, 2014, CMS posted that there would be no further delays and the effective date is October 1, 2015.

The Comparison

ICD-9	ICD-10
14,000+ codes	90,000+ codes
3-5 characters in length	3-7 characters in length
Mostly numeric only (E codes/V codes)	Character 1-Alpha, Character 2-Numeric, Characters 3-7-Alpha or Numeric
Lacks detail	Very specific
Limited space for new codes	Flexible for adding new codes ("x" placeholder)

ICD-10 Guidelines

- Divided into alphabetic index and the tabular list.
  - Do not code strictly from the alpha-index
  - Always confirm your code in the tabular list to verify notes, exclusions, digits required
- Format and structure
  - Tabular list contains categories, subcategories and codes.
    - All categories are 3 characters: A 3 character category that has no further subdivision is equivalent to a code.
    - Subcategories are either 4 or 5 characters.
    - Codes may be 3, 4, 5, 6 or 7 characters.
    - **BOTTOM-LINE:** EACH LEVEL OF SUBDIVISION AFTER A CATEGORY IS A SUBCATEGORY AND THE FINAL LEVEL OF SUBDIVISION IS A CODE. YOU ARE ONLY TO REPORT CODES NOT CATEGORIES OR SUBCATEGORIES. YOU HAVE TO REPORT OUT TO THE HIGHEST LEVEL OF SPECIFICITY.

ICD-10 Guidelines

Placeholder Character
- Placeholder "x" is used to fill in for a code that can be expanded upon in the future.
- Usually found in the poisoning, adverse effect and underdosing codes.
- Where a placeholder exists, the x must be used in order for the code to be considered a valid code.

ICD-10 (Placeholders)

- Some codes within ICD-10 assign "X" placeholders for the 4th, 5th, and 6th characters

Examples:

T88.52XA   Failed moderate sedation during procedure, initial encounter

T88.52XD   Failed moderate sedation during procedure, subsequent encounter

T88.52XS   Failed moderate sedation during procedure, sequela

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ICD-10 (7th Character)

- Some codes within ICD-10 have a 7th character
- Most common for Chapter 19 (Injury/Poisoning)
- Most categories give a choice of three options for 7th character:

    A – initial encounter
    - Used when the condition or problem is actively being treated during initial encounter (evaluation by new provider)

    D – Subsequent encounter
    - Used when the condition or problem is treated during the healing or recovery phase (follow up visits/medication adjustments)

    S – Sequela encounter
    - Used for complications or late effects of the condition or problem (chronic)

ICD-10 (7th Character)

Examples:

Initial Encounter

Patient presents to ER for food in esophagus causing swallowing problems:

✓7th T18.128 Food in esophagus causing other injury

    Since this is the first encounter, A is added: T18.128A

Subsequent Encounter

- Patient had ERCP with exchange of bile duct stent that was displaced.   Patient is following up in the office today and is doing well.

✓7th T85.520 Displacement of bile duct prosthesis

    Since this was a subsequent encounter, D is added: T85.520D

ICD-10 (7th Character)

Examples:

Sequela Encounter

Patient seen in hospital for elevated transaminase due to intentional acetaminophen overdose:

Primary diagnosis would be:

R74.8 Nonspecific elevation of levels of transaminase and lactic acid dehydrogenase (LDH)

✓7th T39.1X2 Poisoning by 4-Aminophenol derivatives, intentional self-harm

Since this was a sequela, S is added: T39.1X2S

Abbreviations

- Alphabetic index:

NEC "Not elsewhere classifiable

This represents "other specified". When a specific code is not available for a condition, the Alphabetic Index directs the coder to the "other specified" code in the Tabular List.

NOS "Not otherwise specified"

This means unspecified.

- Tabular List:

NEC "Not elsewhere classifiable

This represents "other specified". When a specific code is not available for a condition, the Tabular List includes an NEC entry under a code to identify the code as the "other specified" code.

NOS "Not otherwise specified"

This means unspecified.

ICD-9 versus ICD-10

Right upper quadrant abdominal pain
ICD-9: 789.01
ICD-10: R10.11 same

Vomiting
ICD-9: 787.03
ICD-10: R11.11 without nausea
            R11.12 projectile

RLQ abdominal tenderness
ICD-9: 789.63
ICD-10: R10.813   same
            R10.823   rebound

Failure to thrive
ICD-9: 783.41 same
ICD-10: P92.6 newborn

ICD-9 versus ICD-10

ICD-9 CM	Description	ICD-10 CM
271.3	Intestinal Disaccharide deficiencies	E74.39
None	Lactose intolerance, unspec	E73.9
	Congenital lactase deficiency	E73.0
	Secondary lactase deficiency	E73.1
	Other lactose intolerance	E73.8
V15.02	Allergy to milk products	Z91.011
None	Food additives allergy	Z91.02
None	Person consulting for test findings	Z71.2

ICD-9 versus ICD-10

Benign neoplasm of colon (colon polyps)

ICD-9: 211.3

ICD-10: D12.0 cecum
D12.1 appendix
D12.2 ascending colon
D12.3 transverse colon
D12.4 descending colon
D12.5 sigmoid colon
D12.6 colon, unspecified
Adenomatosis of colon
Polyposis (hereditary) of colon
Excludes 1: inflammatory polyp of colon (K51.4-)
polyp of colon NOS (K63.5)

ICD-10 Structure

ICD-10 code format

☐☐☐   ☐☐☐   ☐

Category   Etiology, anatomical site, severity   7th character

Alphabetic Index
Alphabetic Index is divided into three sections:

- Section 1 Index to Diseases and Nature of Injury (Neoplasm Table and Drug/Chemical Table)

- Section 2 Index to External Causes

- Section 3 Table of Drugs and Chemicals   (Note addition of *Underdosing*)

ICD-10 Structure

Tabular List

Chapter 1	Certain Infectious and Parasitic Diseases (A00-B99)
Chapter 2	Neoplasms (C00-D49)
Chapter 3	Diseases of Blood/Blood forming organs/Immune mechanisms (D50-D89)
Chapter 4	Endocrine, Nutritional and Metabolic Diseases (E00-E90)
	E08-E14 Diabetes mellitus
Chapter 5	Mental and Behavioral Disorders (F01-F99)
Chapter 6	Diseases of the Nervous System (G00-G99)
Chapter 7	Disorder of Eye and Adnexa (H00-H59)
Chapter 8	Diseases of Ear and Mastoid Process (H60-H95)
Chapter 9	Diseases of Circulatory System (I00-I99)
	I10-I15 Hypertensive Diseases
Chapter 10	Diseases of Respiratory System (J00-J99)

ICD-10 Structure

Tabular List (continued)

Chapter 11	Diseases of Digestive System (K00-K94)
Chapter 12	Diseases of Skin and Subcutaneous Tissue (L00-L99)
Chapter 13	Diseases of Musculoskeletal System and Connective Tissue (M00-M99)
Chapter 14	Diseases of Genitourinary System (N00-N99)
Chapter 15	Pregnancy, Childbirth and Puerperium (O00-O99)
Chapter 16	Conditions originating in Perinatal Period (P00-P96)
Chapter 17	Congenital Malformations, Deformations/Chromosomal Abnormalities (Q00-Q99)
Chapter 18	Symptoms, Signs, Abnormal Clinical & Laboratory Findings (R00-R99)
Chapter 19	Injury, Poisoning & other Consequences External Cause (S00-T88)
Chapter 20	External Causes of Morbidity (V01-Y98) *(OLD E CODES)*
Chapter 21	Factors Influencing Health (Z00-Z99)*(OLD V CODES)*

Infectious and Parasitic Diseases (A00-B99)

Contains following blocks:

A15-A19	**Intestinal infectious diseases**
A15-A19	Tuberculosis
A20-A28	Certain zoonotic bacterial diseases
A30-A49	Other bacterial diseases
A50-A64	Infections with a sexual mode of transmission
A65-A69	Other spirochetal diseases
A70-A74	Other diseases caused by chlamydiae
A75-A79	Rickettsioses
A80-A89	Viral infections of the central nervous system
A90-A99	Arthropod-borne viral fevers and viral hemorrhagic fevers

Infectious and Parasitic Diseases (A00-B99)

A04.7 - Enterocolitis due to Clostridium Difficile
    Foodborne intoxication by Clostridium Difficile
    Pseudomembranous colitis

A09 – Infectious Colitis
    Infectious colitis NOS
    Infectious enteritis
    Infectious Gastroenteritis NOS

EXCLUDE
colitis NOS (K52.9)
diarrhea NOS (R19.7)
enteritis NOS (K52.9)
gastroenteritis NOS (K52.9)
noninfectious gastroenteritis and colitis, unspecified (K52.9)

Infectious and Parasitic Diseases (A00-B99)

- B00-B09   Viral infections characterized by skin and mucous membrane lesions
- B10   Other human herpes viruses
- **B15-B19**   **Viral hepatitis**
- B20   Human immunodeficiency virus (HIV) disease
- B25-B34   Other viral diseases
- B35-B49   Mycoses
- B50-B64   Protozoal diseases
- B65-B83   Helminthiases
- B85-B89   Pediculosis, acariasis and other infestations
- B90-B94   Sequalae of infectious and parasitic diseases
- B95-B97   Bacterial and viral infectious agents
- B99   Other infectious diseases

Infectious and Parasitic Diseases (A00-B99)

Viral Hepatitis (B15-B19)

EXCLUDE   sequalae of viral hepatitis (B94.2)

EXCLUDE   cytomegaloviral hepatitis (B25.1)
    herpes viral [herpes simplex] hepatitis (B00.81)

- ✓4th   B18   Chronic viral hepatitis

    B18.0   Chronic viral hepatitis B with delta-agent
    B18.1   Chronic viral hepatitis B without delta-agent
            Chronic (viral) hepatitis B
    B18.2   Chronic viral hepatitis C
    B18.8   Other chronic viral hepatitis
    B18.9   Chronic viral hepatitis, unspecified

Neoplasms (C00-D49)

- C00-C14   Malignant neoplasms of lip, oral cavity and pharynx
- **C15-C26**   **Malignant neoplasms of digestive organs**
- C30-C39   Malignant neoplasms of respiratory organs
- C40-C41   Malignant neoplasms of bone and articular cartilage
- C43-C44   Malignant and other malignant neoplasms of skin
- C45-C49   Malignant neoplasms of mesothelial and soft tissue
- C50   Malignant neoplasms of breast
- C51-C58   Malignant neoplasms of female genital organs
- C60-C63   Malignant neoplasms of male genital organs
- C64-C68   Malignant neoplasms of urinary tract
- C69-C72   Malignant neoplasms of eye, brain and other parts of central nervous system

Neoplasms (C00-D49)

- C73-C75   Malignant neoplasms of thyroid and other endocrine
  C7A   **Malignant neuroendocrine tumors**
- **C7B**   **Secondary neuroendocrine tumors**
- C76-C80   Malignant neoplasms of ill-defined, other secondary, and unspecified sites
- C81-C96   Malignant neoplasms of lymphoid, hematopoeietic and related tissue
- **D00-D09**   **In situ neoplasms**
- **D10-D36**   **Benign neoplasms, except benign neuroendocrine tumors**
- **D3A**   **Benign neuroendocrine tumors**
- **D37-D48**   **Neoplasms of uncertain behavior, polycythemia vera and myelodysplastic syndromes**
- D49   Neoplasms of unspecified behavior

Neoplasms (C00-D49)

Note:

Functional activity

All neoplasms are classified in this chapter, whether they are functionally active or not. An additional code from Chapter 4 may be used, to identify functional activity associated with any neoplasm.

Translation: If there are any metabolic issues documented on pathology, these are to be reported separately.

Morphology (Histology)

Chapter 2 classifies neoplasms primarily by site, with broad groupings for behavior, malignant, in situ, benign, etc. The table of neoplasms should be used to identify the correct topography code.

Neoplasms (C00-D49)

Note continued

Primary malignant neoplasms overlapping site boundaries

A primary malignant neoplasm that overlaps two or more contiguous (next to each other) sites should be classified to the subcategory/code .8 (overlapping lesion), unless the combination is specifically indexed elsewhere. For multiple neoplasms of the same site that are not contiguous, such as tumors in different locations of the large intestine, codes for each site should be assigned.

Malignant neoplasm of ectopic tissue

Malignant neoplasms of ectopic tissue are to be coded to the site mentioned, e.g., ectopic pancreatic malignant neoplasms are coded to pancreas, unspecified (C25.9).

Neoplasms (C00-D49)

1. Treatment directed at the malignancy

> If treatment is directed at the malignancy, the malignancy is the primary diagnosis. Any secondary sites would be reported as additional diagnosis.

2. Treatment of secondary site

> When a patient is seen because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis.
>
> Example: Patient is being seen in consultation for carcinoma metastatic to the liver.
>
> Diagnosis would be:
>
> C78.7   Secondary malignant neoplasm of liver and intrahepatic bile duct

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Neoplasms (C00-D49)

3. Primary malignancy previously excised

When the primary malignancy has previously been excised or   eradicated from its site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignancy neoplasm, should be used to indicate previous site of malignancy. Any mention of secondary malignancy is coded as secondary malignant neoplasm to that site. The secondary site would be the principal diagnosis with the personal history of malignancy as the secondary diagnosis.

Neoplasms (C00-D49)

4. Neoplasms of uncertain behavior are only assigned when **histologic** confirmation of whether the neoplasm is malignant or benign cannot be made. It should not be used in lieu of waiting for pathology report or just because the lesion "looked" funny.

5. Neoplasms of unspecified behavior are those of unspecified morphology and behavior.

NOTE: NEOPLASM IS NOT TO BE USED UNLESS THE GROWTH IS NEOPLASTIC IN NATURE. THE TERM MASS DOES NOT MEAN THE MASS IS NEOPLASTIC.

Neoplasms (C00-D49)

✓4th C15 – Malignant neoplasm of esophagus

Use additional code to identify: alcohol abuse and dependence (F10.-)

Abdominal – C15.5	Cervical – C15.3
Distal (third) – C15.5	Lower (third) – C15.5
Middle (third) – C15.4	Overlapping lesion – C15.8
Proximal (third) – C15.3	Thoracic – C15.4
Upper (third) – C15.3	

C15.9 - malignant neoplasm esophagus, unspecified

Coding Tips: The neoplasm table in the Alpha index should be referenced first, however, if the histological term is documented such as "adenoma", that term should be researched to determine whether or not this would be considered a neoplastic process.

Diseases of the blood/blood forming organs/ Immune mechanisms (D50-D89)

- D50-D53   Nutritional anemias
- D55-D59   Hemolytic anemias
- D60-D64   Aplastic and other anemias and other bone marrow failure syndromes
- D65-D69   Coagulation defects, purpura and other hemorrhagic conditions
- D70-D77   Other disorders of blood and blood-forming organs
- D78   Intraoperative and postprocedural complications of the spleen
- D80-D89   Certain disorders involving the immune mechanism

Diseases of the blood/blood forming organs/Immune mechanisms (D50-D89)

D62 – Acute posthemorrhagic anemia

EXCLUDE
anemia due to chronic blood loss (D50.0)
blood loss anemia NOS (D50.0)
congenital anemia from fetal blood loss (P61.3)

D63.0 - Anemia associated with malignancy
Coding tips: When the encounter is specifically for the treatment of the anemia due to malignancy, the appropriate code for the malignancy is sequenced primary, followed by D63.0

Endocrine, Nutritional and Metabolic Diseases (E00-E90)

- E00-E07   Disorders of the thyroid gland
- E08-E13   Diabetes mellitus
- E15-E16   Other disorders of glucose regulation and pancreatic internal secretion
- E20-E35   Disorders of other endocrine glands
- E36   Intraoperative complications of endocrine system
- E40-E46   Malnutrition
- E50-E64   Other nutritional deficiencies
- E65-E68   Overweight, obesity and other hyperalimentation
- E70-E88   Metabolic disorders
- E89   Postprocedural endocrine and metabolic complications and disorders, not elsewhere classified.

Endocrine, Nutritional and Metabolic Diseases (E00-E90)

1. **Diabetes Mellitus**
   a. **Type of diabetes**
      The age of a diabetic is not the sole determining factor, though most type 1 diabetics develop the condition before reaching puberty. For this reason, type 1 diabetes mellitus is also referred to as juvenile diabetes.
   b. **Type of diabetes mellitus not documented**
      If the type of diabetes mellitus is not documented in the medical record, assign E11.-, Type 2 diabetes mellitus
   c. **Diabetes mellitus and the use of insulin**
      If the documentation in the medical record does not indicate the type of diabetes but that the patient uses insulin, Code E11.-, Type 2 diabetes and code Z79.4, Long term (current) use of insulin should be assigned. Do not code use of insulin if insulin is given temporarily to bring the type 2 patient's blood sugar under control

Endocrine, Nutritional and Metabolic Diseases (E00-E90)

1. Diabetes Mellitus (continued)

d. Secondary diabetes mellitus

Secondary diabetes is always caused by another condition or even (e.g., cystic fibrosis, malignancy neoplasm of pancreas, pancreatectomy, adverse effect of drug or poisoning)

- **Secondary diabetes mellitus due to pancreatectomy**

For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code E89.1, Postprocedural hypoinsulinemia plus code from category E13 and a code for subcategory Z90.41-, Acquired absence of pancreas.

- Secondary diabetes due to drugs

For secondary diabetes due to drugs, utilize codes from poisoning or sequeala poisoning

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Endocrine, Nutritional and Metabolic Diseases (E00-E90)

E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy

Type 2 diabetes with diabetic gastroparesis

E11 subcategory: Use addition code to identify any use of insulin Z79.4

E66.01 Morbid (severe) obesity due to excess calories

Excludes 1: morbid (severe) obesity with alveolar hypoventilation (E66.2)

E66 subcategory: Use additional code to identify BMI, if known (Z68.-)

Endocrine, Nutritional and Metabolic Diseases (E00-E90)

- Malnutrition (E40-E46)

EXCLUDE	*intestinal malabsorption (K90.-)*
	sequelae of protein-calorie malnutrition (E64.0)
	nutritional anemias (D50-D53)
EXCLUDE	*starvation (T73.0)*

✓ 4th E44   Protein-calorie malnutrition of moderate and mild degree
    E44.0   Moderate protein-calorie malnutrition
    E44.1   Mild protein-calorie malnutrition
  E46   Unspecified protein-calorie malnutrition
    Malnutrition NOS
    Protein-calorie imbalance NOS
        nutritional deficiency NOS (E63.9)

EXCLUDE

Endocrine, Nutritional and Metabolic Diseases (E00-E90)

- √4th E66   Overweight and obesity

  Code first obesity complicating pregnancy, childbirth and the puerperium, if applicable (O99.21-)

  Use additional diagnosis code to identify body mass index (BMI), if known (Z68.-)

EXCLUDE	adiposagenital dystrophy (E23.6)
	lipomatosis NOS (E88.2)
	lipomatosis dolorosa [Dercum] (E88.2)
	Prader-Willi syndrome (Q87.1)

Endocrine, Nutritional and Metabolic Diseases (E00-E90)

√5th   E66.0   Obesity due to excess calories

       E66.01   Morbid obesity due to excess calories

EXCLUDE	*morbid obesity with alveolar hypoventilation (E66.2)*

       E66.09   Other obesity due to excess calories

E66.1   Drug induced obesity

Use additional code for adverse effect, to identify drug (T36-T50 with 5th or 6th character

E66.2   Morbid obesity with alveolar hypoventilation

E66.3   Overweight

E66.8   Other obesity

E66.9   Obesity, unspecified

Mental and Behavioral Disorders (F01-F99)

These codes are only to be assigned with provider documentation of a mental or behavioral disorder not just based upon symptoms presented by the patient but by the clinical judgment of the provider.

Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)

- F01-F09   Mental disorders due to known physiological conditions
- F10-F19   Mental and behavioral disorders due to psychoactive substance use
- F20-F29   Schizophrenia, schitzotypal, delusional, and other non-mood psychotic disorders
- F30-F39   Mood [affective] disorders
- F40-F48   Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
- F50-F59   Behavioral syndromes associates with physiological disturbances and physical factors
- F60-F69   Disorders of adult personality and behavior

Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)

- F70-F79   Intellectual disabilities
- F80-F89   Pervasive and specific developmental disorders
- F90-F98   Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- F99   Unspecified mental disorder

Mental and Behavioral Disorders (F01-F99)

F10.229 – Alcohol Dependence with intoxication, unspecified
        Acute drunkenness (in alcoholism)
Excludes 1: alcohol dependence with withdrawal (F10.23-)

Coding Tips: If use and abuse are both documented, only code abuse. If both abuse and dependence are both documented, only code dependence. If all three use, abuse and dependence are documented, again only code dependence.

Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)

- ✓4th F50   Eating disorders
  - **EXCLUDE**   anorexia NOS (R63.0)
    - feeding difficulties (R63.3)
    - polyphagia (R63.2)
  - **EXCLUDE**   feeding disorder in infancy or childhood (F98.2-)
  - ✓5th F50.0   Anorexia nervosa
    - **EXCLUDE**   loss of appetite (R63.0)
      - psychogenic loss of appetite (F50.8)
  - F50.00 Anorexia nervosa, unspecified
    - F50.01 Anorexia nervosa, restricting type
    - F50.02 Anorexia nervosa, binge eating/purging type
    - **EXCLUDE** bulimia nervosa (F50.2)

Mental and Behavioral Disorders (F01-F99)

F98.1 – Encopresis not due to a substance or known physiological condition

- Functional encopresis
- Incontinence of feces of nonorganic origin
- Psychogenic encopresis
- Use addition code to identify the cause of any coexisting constipation

EXCLUDE   *Encopresis NOS (R15.-)*

Disease of the Nervous System (G00-G99)

- G00-G09   Inflammatory diseases of the central nervous system
- G10-G14   Systemic atrophies primarily affecting the central nervous system
- G20-G26   Extrapyramidal and movement disorders
- G30-G32   Other degenerative diseases of the nervous system
- G35-G37   Demyelinating diseases of the central nervous system
- G40-G47   Episodic and paroxysmal disorders
- G50-G59   Nerve, nerve root and plexus disorders
- G60-G65   Polyneuropathies and other disorders of the peripheral nervous system
- G70-G73   Diseases of myoneural junction and muscle
- G80-G83   Cerebral palsy and other paralytic syndromes
- G89-G99   Other disorders of the nervous system

Disease of the Nervous System (G00-G99)

G47.33 – Obstructive sleep apnea (adult) (pediatric)

EXCLUDE *obstructive sleep apnea of newborn (P28.3)*

G47.3 subcategory: Code also any associated underlying condition

G89.28 – Other chronic postprocedural pain

other chronic postoperative pain

Coding Tips: There is no time frame when the pain becomes chronic. Routine or expected postoperative pain should not be coded.

Disease of the Nervous System (G00-G99)

- ✓5th G93.4 Other and unspecified encephalopathy

  EXCLUDE *alcoholic encephalopathy (G31.2)*
  encephalopathy in diseases classified elsewhere (G94)
  hypertensive encephalopathy (I67.4)
  toxic (metabolic) encephalopathy (G92)

  G93.40 Encephalopathy, unspecified
  G93.41 Metabolic encephalopathy
  Septic encephalopathy
  G93.49 Other encephalopathy

G94 Other disorders of brain in diseases classified elsewhere
Code first underlying disease

Example: Encephalopathy and primary biliary cirrhosis

K74.5 Primary biliary cirrhosis
G94 Encephalopathy

Disease of the Circulatory System (I00-I99)

- I00-I02 Acute rheumatic fever
- I05-I09 Chronic rheumatic heart disease
- I10-I15 Hypertensive diseases
- I20-I25 Ischemic heart disease
- I26-I28 Pulmonary heart disease and diseases of pulmonary circulation
- I30-I52 Other forms of heart disease
- I60-I69 Cerebrovascular diseases
- I70-I79 Diseases of arteries, arterioles and capillaries
- I80-I89 Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified
- I95-I99 Other and unspecified disorders of the circulatory system

Disease of the Circulatory System (I00-I99)

✓4th I12   Hypertensive chronic kidney disease

Includes: hypertensive nephropathy

nephrosclerosis

EXCLUDE   hypertension due to kidney disease (I15.0, I15.1)

renovascular hypertension (I15.0)

EXCLUDE   acute kidney failure (N17.-)

I12.0   Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease

Use additional code to identify the stage of chronic kidney disease (N18.5, N18.6)

I12.9   Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease

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Disease of the Circulatory System (I00-I99)

I25.2 – Old myocardial infarction

Healed myocardial infarction

Past myocardial infarction diagnosed by ECG or other investigation, but currently presenting no symptoms

I48.2 – Chronic atrial fibrillation

Permanent atrial fibrillation

I69.891 – Dysphagia following unspecified cerebrovascular disease

Use additional code to identify the type of dysphagia, if known (R13.1-)

Disease of the Circulatory System (I00-I99)

✓4th I85 Esophageal varices

Use additional code to identify:

alcohol abuse and dependence (F10.-)

✓5th I85.0   Esophageal varices

Idiopathic esophageal varices

Primary esophageal varices

I85.00   Esophageal varices without bleeding

I85.01   Esophageal varices with bleeding

Disease of the Circulatory System (I00-I99)

✓4th I86   Varicose veins of other sites

| EXCLUDE | *varicose veins of unspecified sites* |
| EXCLUDE | *retinal varices (H35.0-)* |

I86.0   Sublingual varices
I86.1   Scrotal varices
I86.2   Pelvic varices
I86.3   Vulval varices
I86.4   Gastric varices
I86.8   Varicose veins of other specified sites
          Varicose ulcer of nasal septum

Disease of the Circulatory System (I00-I99)

✓5th I85.1   Secondary esophageal varices
          Esophageal varices secondary to alcoholic liver disease
          Esophageal varices secondary to cirrhosis of liver
          Esophageal varices secondary to schistosomiasis
          Esophageal varices secondary to toxic liver disease
          Code first underlying disease
          I85.10   Secondary esophageal varices without bleeding
          I85.11   Secondary esophageal varices with bleeding

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Diseases of the Respiratory System (J00-J99)

- J00-J06   Acute upper respiratory infections
- J09-J18   Influenza and pneumonia
- J20-J22   Other acute lower respiratory infections
- J30-J39   Other disease of upper respiratory tract
- J40-J47   Chronic lower respiratory diseases
- J60-J70   Lung diseases due to external agents
- J80-J84   Other respiratory diseases principally affecting the interstitium
- J85-J86   Suppurative and necrotic conditions of the lower respiratory tract
- J90-J94   Other diseases of the pleura
- J95   Intraoperative and post procedure complications and disorders of respiratory system, not elsewhere classified
- J96-J99   Other diseases of the respiratory system

Diseases of the Respiratory System (J00-J99)

✓4th J44 Other chronic obstructive pulmonary disease (COPD)

Includes: asthma with COPD

chronic asthma with obstructive bronchitis

chronic bronchitis with emphysema

chronic obstructive bronchitis

Code also type of asthma, if applicable (J45.-)

Use additional code to identify:

Exposure to environmental tobacco smoke (Z77.22)

History of tobacco abuse (Z87.891)

Occupational exposure to environmental tobacco smoke (Z57.31)

Tobacco dependence (F17.-)

Tobacco use (Z72.0)

Diseases of the Respiratory System (J00-J99)

✓4th J44 Other chronic obstructive pulmonary disease (COPD)

EXCLUDE *bronchiectasis (J47.-)*

chronic bronchitis NOS (J42)

emphysema without chronic bronchitis (J43.-)

J44.0 COPD with acute lower respiratory infection

Use additional code to identify the infection

J44.1 COPD with acute exacerbation

EXCLUDE *COPD with acute bronchitis (J44.0)*

J44.9 COPD, unspecified

Chronic obstructive airway disease

Chronic obstructive lung disease NOS

Diseases of the Respiratory System (J00-J99)

✓4th J69 Pneumonia due to solids and liquids

EXCLUDE *neonatal aspiration syndrome (P94.-)*

postprocedural pneumonitis (J95.4)

J69.0 Pneumonitis due to inhalation of food and vomit

Aspiration pneumonia

Aspiration pneumonia due to gastric secretions

Code also any associated foreign body in respiratory tract (T17.-)

EXCLUDE *chemical pneumonitis due to anesthesia (J95.4)*

Diseases of the Digestive System (K00-K94)

- K00-K14   Diseases of oral cavity and salivary glands
- K20-K31   Diseases of esophagus, stomach and duodenum
- K35-K38   Diseases of appendix
- K40-K46   Hernia
- K50-K52   Noninfective enteritis and colitis
- K55-K64   Other diseases of intestines
- K65-K68   Diseases of peritoneum and retroperitoneum
- K70-K77   Diseases of liver
- K80-K87   Disorder of gallbladder, biliary tract and pancreas
- K90-K95   Other diseases of the digestive system

Diseases of the Digestive System (K00-K94)

✓4th K20 Esophagitis

Use additional code to identify:

alcohol abuse and dependence (F10.-)

EXCLUDE *erosion of esophagus (K22.1-)*

esophagitis with GERD (K21.0)

reflux esophagitis (K21.0)

ulcerative esophagitis (K22.1-)

EXCLUDE *eosinophilic gastritis or gastroenteritis (K52.81)*

K20.0   Eosinophilic esophagitis

K20.8   Other esophagitis

Abscess of esophagus

K20.9   Esophagitis, unspecified

Diseases of the Digestive System (K00-K94)

✓4th K21   Gastro-esophageal reflux disease (GERD)

EXCLUDE *newborn esophageal reflux (P78.83)*

K21.0   GERD with esophagitis

Reflux esophagitis

K21.9   GERD without esophagitis

Esophageal reflux NOS

Diseases of the Digestive System (K00-K94)

✓5ᵗʰ K22.7   Barrett's esophagus

Barrett's Esophagus

Barrett's disease

EXCLUDE   *Barrett's ulcer (K22.1)*

Malignant neoplasm of esophagus (C15.-)

K22.70   Barrett's Esophagus without dysplasia
(Barrett's Esophagus NOS)

✓6ᵗʰ K22.71   Barrett's esophagus with dysplasia

K22.710 Barrett's Esophagus with low grade
dysplasia

K22.711 Barrett's Esophagus with high grade
dysplasia

K22.719 Barrett's Esophagus with dysplasia,
unspecified

Diseases of the Digestive System (K00-K94)

Noninfective enteritis and colitis (K50-K52)

✓4ᵗʰ K50   Includes: granulomatous enteritis

EXCLUDE   *irritable bowel syndrome (K58.-)*

Use additional code to identify manifestations, such as
pyoderma gangrenosum (L88)

✓5ᵗʰ K50.1   Crohn's disease of large intestine

Crohn's disease of colon

Crohn's disease of large bowel

Crohn's disease of rectum

Granulomatous colitis

Regional colitis

EXCLUDE   *Crohn's disease of both small and
large intestine (K50.8)*

Diseases of the Digestive System (K00-K94)

K50.10   Crohn's disease of large intestine without
complications

✓5ᵗʰ K50.11 Crohn's disease of large intestine with complications

K50.111 Crohn's disease of large intestine with bleeding

K50.112 Crohn's disease of large intestine with obstruction

K50.113 Crohn's disease of large intestine with fistula

K50.114 Crohn's disease of large intestine with abscess

K50.118 Crohn's disease of large intestine with other
complications

K50.119 Crohn's disease of large intestine with unspecified
complications

Diseases of the Digestive System (K00-K94)

✓4th K58 – Irritable Bowel Syndrome

    Includes: irritable colon, spastic colon
  K58.0 – Irritable bowel syndrome *with diarrhea*
  K58.9 – Irritable bowel syndrome without diarrhea
    Irritable bowel syndrome NOS

K76.6 – Portal Hypertension
  Use additional code for any associated complications, such as: portal hypertensive gastropathy (K31.89)

Diseases of the Digestive System (K00-K94)

✓4th K64 - Hemorrhoids and perianal venous thrombosis
Includes: piles

EXCLUDE *hemorrhoids complicating childbirth and the puerperium (O87.2)*

hemorrhoids complicating pregnancy (O22.4)

K64.0 – First degree hemorrhoids; grade/stage I; hemorrhoids (bleeding) without prolapse outside of anal canal

K64.1 – Second degree hemorrhoids; grade/stage II; hemorrhoids (bleeding) that prolapse with straining, but retract spontaneously

K64.2 – Third degree hemorrhoids; grade/stage III; hemorrhoids (bleeding) that prolapse with straining and require manual replacement back inside anal canal

K64.3 – Fourth degree hemorrhoids; grade/stage IV; hemorrhoids (bleeding) with prolapsed tissue that cannot be manually replaced

Diseases of the Digestive System (K00-K94)

K92   Other diseases of digestive system

EXCLUDE *neonatal gastrointestinal hemorrhage (P54.0-P54.3)*

  K92.0   Hematemesis
  K92.1   Melena

EXCLUDE *occult blood in feces (R19.5)*

  K92.2   Gastrointestinal hemorrhage, unspecified
    Gastric hemorrhages NOS
    Intestinal hemorrhage

EXCLUDE *acute hemorrhagic gastritis*

hemorrhage of anus and rectum
angiodysplasia of stomach with hemorrhage
diverticular disease with hemorrhage
gastritis and duodenitis with hemorrhage

Diseases of the Genitourinary System (N00-N99)

- N00-N08   Glomerular diseases
- N10-N16   Renal tubulo-interstitial diseases
- N17-N19   Acute kidney failure and chronic kidney disease
- N20-N23   Urolithiasis
- N25-N29   Other disorders of kidney and ureter
- N30-N39   Other diseases of the urinary system
- N40-N53   Diseases of male genital organs
- N60-N65   Disorders of breast
- N70-N77   Inflammatory diseases of female pelvic organs
- N80-N98   Noninflammatory disorders of female genital tract
- N99   Intraoperative and postprocedural complications and disorders of genitourinary system, not elsewhere classified

Diseases of the Genitourinary System (N00-N99)

Chronic kidney disease (CKD)

1. ICD-10 classifies CKD based on stages 1-5 based on low to high. End stage renal disease is assigned when the provider has documented ESRD.

2. Patients who have undergone a kidney transplant may still have some form of kidney disease in the transplanted kidney so the code of CKD plus the code, Z94.0, Kidney transplant status would be assigned.

3. Patients with CKD may also suffer from other conditions such as diabetes and hypertension. See the tabular for further clarification.

Diseases of the Genitourinary System (N00-N99)

✓4th N18 Chronic kidney disease (CKD)

Code first any associated:

diabetic chronic kidney disease (E08.22, E09.22, E10.22, E11.22, E13.22)

hypertensive chronic kidney disease (I12-, I13-)

Use additional code to identify kidney transplant status, (Z94.0)

N18.1 CKD, stage 1

N18.2 CKD, stage 2 (mild)

N18.3 CKD, stage 3 (moderate)

N18.4 CKD, stage 4 (severe)

N18.5 CKD, stage 5

N18.6 End stage renal disease

Chronic kidney disease requiring chronic dialysis

Use additional code to identify dialysis status (Z99.2)

Pregnancy, Childbirth and Puerperium (O00-O99)

- O00-O08   Pregnancy with abortive outcome
- O09   Supervision of high risk pregnancy
- O10-O16   Edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium
- O20-O29   Other maternal disorders predominantly related to pregnancy
- O30-O48   Maternal care related to the fetus and amniotic cavity and possible delivery problems
- O60-O77   Complications of labor and delivery
- O80, O82 Encounter for delivery
- O85-O92   Complications predominantly related to the puerperium
- O94-O9A   Other obstetric conditions, NEC

Pregnancy, Childbirth and Puerperium (O00-O99)

Coding Tips: Codes from this chapter are for maternal records only and are never to be used on newborn records.

The majority of codes have a final character indicating the trimester of pregnancy:

1st Trimester: less than 14 weeks 0 days
2nd Trimester: 14 weeks 0 days to less than 28 weeks 0 days
3rd Trimester: 28 weeks 0 days until delivery

If the pregnancy is incidental to the encounter, then code Z33.1 for pregnancy state, incidental should be indicated

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Pregnancy, Childbirth and Puerperium (O00-O99)

✓4th O21 Excessive vomiting of pregnancy

O21.0   Mild hyperemesis gravidarum   [M]

Hyperemesis gravidarum, mild or unspecified, starting before the end of the 20th week of gestation

O21.1   Hyperemesis gravidarum with metabolic disturbance

Hyperemesis gravidarum, starting before the end of the 20th week of gestation, with metabolic disturbance such as dehydration   [M]

Hyperemesis gravidarum, starting before the end of the 20th week of gestation, with metabolic disturbance such as electrolyte imbalance

Pregnancy, Childbirth and Puerperium (O00-O99)

O21.2 Late vomiting of pregnancy **M**

> Excessive vomiting starting after 20 completed weeks of gestation.

O21.8 Other vomiting complicating pregnancy **M**

> Vomiting due to diseases classified elsewhere, complicating pregnancy
>
> Use additional code, to identify cause

O21.9 Vomiting of pregnancy, unspecified **M**

Coding Tips: The symbol **M** indicates a maternity age diagnosis for ages 12-55 only

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Congenital Malformations, Deformations/ Chromosomal Abnormalities (Q00-Q99)

- Q00-Q07 Congenital malformations of the nervous system
- Q10-Q18 Congenital malformations of eye, ear, face, and neck
- Q20-Q28 Congenital malformations of circulatory system
- Q30-Q34 Congenital malformations of the respiratory system
- Q35-Q37 Cleft lip and cleft palate
- Q38-Q45 Other congenital malformations of the digestive system
- Q51-Q56 Congenital malformations of genital organs
- Q60-Q64 Congenital malformations of the urinary system
- Q65-Q79 Congenital malformations and deformations of the musculoskeletal system
- Q80-Q89 Other congenital malformations
- Q90-Q99 Chromosomal abnormalities, NEC

Congenital Malformations, Deformations/ Chromosomal Abnormalities (Q00-Q99)

Codes from this chapter may be used throughout the life of the patient. If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of the malformation or deformity. Although present at birth, malformation/deformation/or chromosomal abnormality may not be identified until later in life. Whenever the condition is diagnosed by the physician, it is appropriate to assign a code from this chapter.

Symptoms, Signs, Abnormal Clinical & Lab Findings (R00-R99)

- R70-R79   Abnormal findings on exam of blood, without diagnosis
- R80-R82   Abnormal findings on exam of urine without diagnosis
- R83-R89   Abnormal findings on exam of other body fluids, tissues without diagnosis
- R90-R94   Abnormal findings on diagnostic imaging and function studies, without diagnosis
- R97   Abnormal tumor markers
- R99   Ill-defined and unknown causes of mortality

Symptoms, Signs, Abnormal Clinical & Lab Findings (R00-R99)

Coding Tips: Signs, symptoms and abnormal findings are to be used when no definitive diagnosis has been established by the provider. Signs and symptoms that point specifically to a given diagnosis should not be coded.

Example:
Diarrhea and Irritable Bowel Syndrome are not to be reported separately since there is a combination code of IBS and diarrhea.
Example:
If the patient is having diarrhea and no diagnosis has been established, then diarrhea should be the primary diagnosis.

Symptoms, Signs, Abnormal Clinical & Lab Findings (R00-R99)

✓4th R10 Abdominal and pelvic pain
> EXCLUDE *renal colic (N23)*
> EXCLUDE *dorsalgia (M54.-)*
> *flatulence and related condition (R14.-)*

R10.0 Acute abdomen
> Severe abdominal pain (generalized) (with abdominal rigidity)
> EXCLUDE *abdominal rigidity NOS (R19.3)*
> *generalized abdominal pain (R10.84)*
> *localized abdominal pain (R10.1-R10.3-)*

Symptoms, Signs, Abnormal Clinical & Lab Findings (R00-R99)

✓5th   R10.1   Pain localized to upper abdomen

R10.10   Upper abdominal pain, unspecified

R10.11   RUQ pain

R10.12   LUQ pain

R10.13   Epigastric pain

Dyspepsia

`EXCLUDE`   *functional dyspepsia (K30)*

R10.2   Pelvic and perineal pain

`EXCLUDE`   vulvodynia (N94.81)

Symptoms, Signs, Abnormal Clinical & Lab Findings (R00-R99)

✓5th R10.3   Pain localized to other parts of lower abdomen

R10.30   Lower abdominal pain, unspecified

R10.31   RLQ pain

R10.32   LLQ pain

R10.33   Periumbilic pain

Codes   R10.811 thru R10.829 (abdominal tenderness) skipped

R10.83   Colic

Colic NOS

`EXCLUDE`   *colic in adult and child over 12 months old (R10.84)*

R10.84   Generalized abdominal pain

`EXCLUDE`   *generalized pain with acute abdomen (R10.0)*

Symptoms, signs, Abnormal Clinical & Lab Findings (R00-R99)

Example:

R19.4 – Change in bowel habits

`EXCLUDE`   *constipation (K59.0-), functional diarrhea (K59.1)*

R74.0 – Nonspecific elevation of levels of transaminase and lactic acid dehydrogenase (LDH)

R93.3 – Abnormal findings on diagnostic imaging of other parts of the digestive tract

Injury, Poisoning, & other Consequences of External Causes (S00-T88)

- S00-S09   Injuries to head
- S10-S19   Injuries to neck
- S20-S29   Injuries to thorax
- S30-S39   Injuries to abdomen, back, spine, pelvis and genitals
- S40-S49   Injuries to shoulder and upper arm
- S50-S59   Injuries to elbow and forearm
- S60-S69   Injuries to wrist, hand and fingers
- S70-S79   Injuries to hip and thigh
- S80-S89   Injuries to knee and lower leg
- S90-S99   Injuries to ankle and foot

Injury, Poisoning, & other Consequences of External Causes (S00-T88)

- T07   Injuries involving multiple body regions
- T14   Injury of unspecified body region
- T15-T19   Effects of foreign body entering through orifice
- T20-T25   Burns and corrosions of skin, by site
- T26-T28   Burns and corrosions to eye and internal organs
- T30-T32   Burns and corrosions of multiple body regions
- T33-T34   Frostbite
- T36-T50   Poisoning by adverse effect of and underdosing of drugs, medicaments and biological substances
- T51-T65   Toxic effects of substances nonmedicinal
- T66-T78   Other effects of external causes
- T79   Certain early complications of trauma
- T80-T88   Complications of surgical and medical care, NEC

Injury, Poisoning, & other Consequences of External Causes (S00-T88)

T18.128A Food in esophagus causing other injury, initial encounter

Bones in esophagus

Seeds in esophagus

T18.2XXA – Food in stomach, initial encounter

T88.52XA – Failed moderation sedation during a procedure

Failed conscious sedation during procedure

EXCLUDE   *personal history of failed moderate sedation (Z92.83)*

Injury, Poisoning, & other Consequences of External Causes (S00-T88)

Example: Toddler presented to ER after ingesting Drano who needs an upper endoscopy to evaluate any esophageal damage

T54.3X1A – Toxic effect of corrosive alkalis and alkali-like substances, accidental (unintentional) – initial encounter

Example: 36 year old male admitted with suicide attempt after ingesting several (almost an entire bottle) of Tylenol

T39.1X2A – Poisoning by 4-Aminophenol derivatives, intentional self harm

External Causes of Morbidity (V01-Y98)

- These codes are secondary and never primary codes.
- These codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event, and the person's status (e.g., civilian, military).
- These codes should be used for the length of treatment
- External codes for child and adult abuse take priority over all other external cause codes
- External cause codes for terrorism take priority over all other external cause codes except child and adult abuse

External Causes of Morbidity (V01-Y98)

- External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse and terrorism
- External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, child and adult abuse and terrorism.
- Activity and external cause status codes are assigned following all causal (intent) external cause codes.
- The first-listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order listed above.

External Causes of Morbidity (V01-Y98)

Y63.6 – Underdosing and nonadministration of necessary drug, medicament, or biological substance

Y90 Evidence of alcohol involvement determined by blood alcohol level

Code first any associated alcohol related disorders (F10)

Y90.0 - BAL of less than 20mg	Y90.1 - BAL of 20-39mg
Y90.2 - BAL of 40-59mg	Y90.3 - BAL of 60-79mg
Y90.4 - BAL of 80-99mg	Y90.5 - BAL of 100-119mg
Y90.6 - BAL of 120-199mg	Y90.7 - BAL of 120-199mg
Y90.8 - BAL of 200-239mg	Y90.9 - BAL of 240mg of more

External Causes of Morbidity (V01-Y98)

Example:

Don came in to the ER after being found at the bus station unconscious due to alcohol toxicity with level of 270.

Primary diagnosis would be:

T51.0X4A   Toxic effect of ethanol, undetermined, initial encounter

Secondary diagnosis would be:

Y90.9   BAL of 240mg of more

Y92.521   Bus station as the place of occurrence of the external cause

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Factors Influencing Health Status (Z00-Z99)

- Z00-Z13   Persons encountering health services for examinations
- Z14-Z15   Genetic carrier and genetic susceptibility to disease
- Z16   Resistance to antimicrobial drugs
- Z17   Estrogen receptor status
- Z18   Retained foreign body fragments
- Z20-Z28   Persons with health hazards related to communicable diseases
- Z30-Z39   Persons encountering health services related to reproduction

Factors Influencing Health Status (Z00-Z99)

- Z40-Z53   Encounters for other specific health care
- Z55-Z65   Persons with potential health hazards related to socioeconomic and psychosocial circumstances
- Z66   Do not resuscitate status
- Z67   Blood type
- Z68   Body mass index (BMI)
- Z69-Z76   Persons encountering health services in other circumstances
- Z77-Z99   Persons with potential health hazards related to family and personal history and certain conditions influencing health status

Factors Influencing Health Status (Z00-Z99)

- These codes are used when a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care for a current condition, to donate an organ, to receive prophylactic vaccination, or receive a screening procedure/service.
- These codes can also be used when the circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.   Such as personal or family history situations.

Factors Influencing Health Status (Z00-Z99)

✓4th Z12   Encounter for screening for malignant neoplasms

     Note: Screening is the testing for disease or disease precursors in asymptomatic individuals so that early detection and treatment can be provided for those who test positive for the disease

     Z12.0   Screening of stomach

✓5th   Z12.1   Screening of intestinal tract

         Z12.11   Screening of colon

            Encounter for screening colonoscopy

         Z12.12   Screening of rectum

         Z12.13   Screening of small intestine

Factors Influencing Health Status (Z00-Z99)

Z23   Encounter for immunization

    Code first any routine childhood examination

       Note: Procedure codes are required to identify
           the types of immunizations given

Z48.23 Encounter for aftercare following liver transplant

Factors Influencing Health Status (Z00-Z99)

✓4th Z79 Long term (current) drug therapy

      Includes: long term (current) drug use for prophylactic
          purposes

      Code also any therapeutic drug level monitoring (Z51.81)

           drug abuse and dependence (F11-F19)

      EXCLUDE *drug use complicating pregnancy*

Z79.0   Anticoagulants and antithrombotics/antiplatelets

      Z79.01 Anticoagulants

      Z79.02 Antithrombotics/antiplatelets

Z79.1 – Long term (current) use of non-steroidal anti-
      inflammatories (NSAID)

      EXCLUDE *long term (current) use of aspirin (Z79.82)*

Factors Influencing Health Status (Z00-Z99)

✓4th Z85 Personal history of malignant neoplasm

      Code first any follow-up examination after treatment of
        malignancy neoplasm (Z08)

      Use additional code to identify:

        alcohol use and dependence

        exposure to environmental tobacco smoke

        history of tobacco use

        tobacco use

Example:

✓5th Z85.0 Personal history of malignant neoplasm of digestive organs

    ✓6th Z85.04 Personal history of malignant neoplasm of rectum

      Z85.040 Personal history of malignant carcinoid

      Z85.048 Personal history of other malignant neoplasm

Preparing your Providers

- Providers need to be more specific in their documentation
  - Identify errors and nonspecific code use
  - Train each provider based on current lack of specificity and errors in your ICD-9 system and continue into ICD-10.
- Improving documentation will support medical necessity
  - Documentation is often requested by payers to ensure medical necessity is met
- Better quality and accurate medical record
  - Decrease in claim denials
- Improved documentation and accurate medical records translate into good patient care
- Documentation is not just a billing tool but a medical legal document. Accuracy is a must.

Preparing your Coders & Billers

- Anatomy and ICD-10 training sessions for Coders
- Don't forget your Billers, Schedulers, Clinicians, Managers, Administrators and other staff members. We encourage you to share this with all members of your team to ensure proper selection of codes according to specificity based on the documentation in the medical record. Specificity is the key to preauthorization of services. Specificity is the key to timely payment of services. Lack of specificity in both procedure and evaluation & management records can stall payments as well as trigger claims reviews before payment is rendered.
- Coders must retest to maintain certifications
  - Certified coders are given 2 years to pass ICD-10 exam
  - Test will be open book and online

ICD-10 conclusions

- Reimbursement
  - If we continue to use unspecified diagnosis codes, we could see claim denials (Many payers have informed practices/organizations that denial of non-specific diagnosis codes will become routine after October 1, 2015.) The average cost of a denied claim per MGMA statistical analysis is $40.
- Improvement of medical record documentation
  - Medical necessity results in fewer claim denials
  - Improve quality of patient care
  - Less likely a target for the OIG, RAC or ZPICS audits
- Better quality of data analysis and research

Evaluation and Management
THE BASIC PRINCIPLES

New Patients

- Self referred patients or those established patients not seen in the practice within the past 3 years.
- Letter back to the PCP not a requirement but highly recommended
- Used when the payer does not accept consultations.
- Used when the parent/guardian is requesting a second opinion
- Used for observation patients in place of consultation codes for those payers not accepting consultations.

Established Patients

- **There is a "three year rule" for observation and office visit fees. No matter what the patient comes in for or who the patient sees in the practice, if that patient had been seen by any provider of the same specialty group for any reason within the past three years, only an established patient visit (99211-99215) can be billed.**
- **Exception: There is no 3 year rule for those payers accepting consultations as long as consultation criteria met.**

Observation Status

- Observation place of service is considered outpatient hospital
- Observation can be anywhere from 23 hours to unknown depending upon utilization review from the insurance carrier.
- The physician may not be aware of the patient's "visit history" in the hospital and this should be verified prior to claim submission to avoid denial of the claim.

CPT Description of Consultation Requirements

- The request for a consultation including the name of the requestor and the need or reason for the consultation must be documented by the consultant in the inpatient's medical record; and,
- After the consultation is provided, a written report of the consultant's findings, opinions, and recommendations is documented in the inpatient record for the requesting provider to use in the management of and/or decision making for the patient; and,
- Intent is to return the patient to requesting provider for ongoing care of the problem.

Consultation Criteria

- During the service, the consultant may:
  - Perform or order diagnostic tests, or
  - Initiate a treatment plan, including performing emergent procedures.

When Not to bill a Consultation

- **Manage a patient's condition:**
  - **Example: Send to GI for management of Hepatitis**
- **When you have been asked to do a procedure**
  - **Example: Consult for PEG, consult for EGD**
- **When you don't see a request from another provider seeking your opinion of a problem**
  - **This applies to any location. All scheduling staff should attempt to get as much info from the requesting provider's office to back up consultation billing**
- **When you are admitting the patient since this is a transfer of care**
- **When the patient/guardian is seeking a second opinion**
- **When you are asked to see the patient again during the same hospitalization even if for a different problem**

Medicare Part B Tips for Preventing Most Common E/M Service Coding Errors

1. Indicate clearly the chief complaint and/or reason for the visit. (No chief complaint=no visit allowed)
   - Do not limit the chief complaint to "follow-up" without identifying the problem(s) being followed.
2. Describe the history of the present illness fully and in such a way that the nature of the presenting problem is clear.
3. The documentation guidelines specify elements that must be recorded about the present illness. Higher-level services require four or more elements or a description of the status of three or more chronic problems.
   - Medical necessity of an Evaluation and Management (E/M) encounter is often visualized only when viewed through the prism of its characteristics captured in specific History of Present Illness (HPI) elements.

Dimensions of the HPI: CC: Abd Pain

Location	Site of problem: Example: RUQ abdominal pain
Duration	Length of time existed: Example: since last Friday
Timing	Regularity of occurrences: Example: Denies previous episode
Severity	Intensity or degree: Example: Pain rating 5 out of 10
Quality	Description or characteristic Example: Sharp and radiating
Context	Events surrounding occurrence Example: Started after eating at McDonalds
Modifying Factor	Effect on symptom Example: Relieved with belching
Associated Signs & Symptoms	Significantly related to presenting problem: Example: Nausea with vomiting x 1

HPI: Elevated Liver Enzymes

Location	Site of problem
Duration	Length of time existed: Example: Since found on routine physical 1 month ago
Timing	Regularity of occurrences: Example: Denies previous abnormalities
Severity	Intensity or degree: Example: Values are only mildly elevated.
Quality	Description or characteristic
Context	Events surrounding occurrence Example: Denies any exposure to anyone with hepatitis, or use of IV drugs, or any transfusions.
Modifying Factor	Effect on symptom
Associated Signs & Symptoms	Significantly related to presenting problem: Example: Denies jaundice or abdominal pain

Medicare Part B Tips for Preventing Most Common E/M Service Coding Errors

4. Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services.
   - Do not use the term "non-contributory."
   - Record information about all three realms to document "complete" PFSH for the following services: new patient or initial services in office and inpatient hospital, observation, domiciliary and home, as well as comprehensive Nursing Facility (NF) assessments.
   - Do not record unnecessary information solely to meet requirements of a high-level service when the nature of the visit dictates a lower-level service to have been medically appropriate.

Medicare Part B Tips for Preventing Most Common E/M Service Coding Errors

5. Record the Review of Systems (ROS) appropriate for the clinical circumstance of the encounter.
   - Document an ROS for the system(s) related to the presenting problem. It is required for all levels of systemic review (meaning that it is required for all codes except the least codes in all code families).
   - Never note the system(s) related to the presenting problem as "negative."
   - Use notations such as "normal" or "negative" only for systems not related to the presenting problem.
   - **Do not record unnecessary information solely to meet requirements of a high-level service when the nature of the visit dictates a lower-level service to have been medically appropriate. Be aware that a "cloned" medicare record may be discounted upon payer review.**

Medicare Part B Tips for Preventing Most Common E/M Service Coding Errors

6. Physical Examination
   - Understand the difference between "Expanded Problem-Focused (EPF)" and "Detailed" examination under 1995/1997 guideline requirements.
   - Always examine the system(s) related to the presenting problem and do not describe it as "normal" or "negative." Use "normal," "negative" and "WNL" notations only to describe unaffected or asymptomatic organ systems.
   - **Code the physical examination considering the clinical circumstances of the encounter. Do not code based on excessive and unnecessary information recorded solely to meet the requirements of a high-level service when the nature of the visit dictates a lower-level service to have been medically appropriate.**

Physical Examination Guidelines

Level of Visit	1995	1997
Problem Focused Example: 99201, 99212, 99231	1 organ system/body area	1-5 bullets
Expanded Problem Focused Example: 99202, 99213, 99232	2-7 organ systems/body areas	6 bullets
Detailed Example: 99203, 99214, 99233, 99221, 99218	2-7 expanded organ systems/body areas (some audit criteria are 5-7 systems)	12 bullets
Comprehensive Example: 99204-99205, 99215, 99222-99223, 99219-99220	8-13 organ systems/body areas	2 bullets from 9 organ systems

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Medicare Part B Tips for Preventing Most Common E/M Service Coding Errors

7. Medical Decision-Making (MDM)
   - Record relevant impressions, tentative diagnoses, confirmed diagnoses and all therapeutic options chosen related to every problem for which E/M is clearly demonstrated in the record of the other key components.
   - Do not count existent old diagnoses unless the record clearly demonstrates their presence increases physician work related to the encounter.
   - Document all diagnostic tests ordered, reviewed and independently visualized as part of the work of the encounter.

Medicare Part B Tips for Preventing Most Common E/M Service Coding Errors

- Medical Decision Making continued
  - Do not code MDM based solely on the severity of or number of presenting problems; decision making also encompasses the numbers of and risk associated with diagnostic tests ordered/performed as well as the complexity of and risk associated with therapeutic options chosen.
  - Summarize old records or other outside information reviewed and incorporated into decision making.
  - **Beware of templates that overestimate decision-making. Understand the logic of templates and/or computer programs used for E/M service coding.**

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal 99201-99202, 99241-99242 99251-99252, 99281 99212	♦ One self-limited or minor problem, eg. Cold, insect bite	♦ laboratory tests ♦ Chest x-rays, EKG/EEG, Urinalysis ♦ Ultrasound	♦ rest ♦ gargles ♦ elastic bandages ♦ superficial dressings
Low 99203, 99213, 99243, 99253 99282, 99213, 99221, 99218, 99231	♦ two or more self limited or minor problems ♦ one, stable chronic illness, eg, well controlled Crohn's, Ulcerative colitis, GERD	♦ Non Cardiovascular Imaging studies with contrast, eg, barium enema	♦ OTC drugs ♦ IV fluids without additives

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Moderate 99204, 99214, 99244, 99254 99283-99284, 99214, 99222, 99219, 99232	♦ one or more chronic illnesses with mild progression, or side effects of treatment ♦ two or more stable chronic illnesses ♦ undiagnosed new problem with uncertain prognosis ♦ acute illness eg,, colitis	♦ diagnostic endoscopies with no identified risk factors ♦ deep needle or incisional biopsy ♦ obtain fluid from body cavity, eg, Paracentesis	♦ prescription drug management ♦ therapeutic nuclear medicine ♦ IV fluids with additives
High 99205, 99215, 99245, 99255 99285, 99215, 99223, 99220, 99233	♦ one or more chronic illnesses with severe exacerbation, progression or side effects of treatment ♦ acute or chronic illnesses or injuries that pose a threat to life or bodily function	♦ diagnostic endoscopies with identified risk factors	♦ parenteral controlled substances ♦ drug therapy requiring intensive monitoring for toxicity ♦ decision not to resuscitate because of poor prognosis

Amount and Complexity of data, Tests ordered/reviewed

- **Radiology:** Ordered, planned, scheduled or performed
- **Pathology:** Ordered, planned, scheduled or performed
- **Lab:** Ordered, planned, scheduled or performed
- **GI studies:** Ordered, planned, scheduled or performed
- **Personally reviewing films:** Direct visualization and interpretation
- **Personally reviewing patient records (2 tests)**: Relevant review of old records to present problem. This means separate from studies listed above. Example: Progress notes, referring provider letters, etc.
- **Personally speaking with another physician concerning patient care:** Discussion of results with performing physician not just mentioning spoke with MD. Have to document what was discussed.
- **Decision to obtain old records:** Documentation should indicate what records are requested and reason why.

Medicare Part B Tips for Preventing Most Common E/M Service Coding Errors

INPATIENT/HOSPITAL TIPS

- Physician coding should be based on the physician's personal Evaluation and Management (E/M) work (or work shared by a physician and non-physician practitioner in the same group).

- All history obtained and recorded by triage and other hospital nursing staff must be specifically repeated by the physician and either re-recorded or annotated with specific comments, additions, and/or corrections and notation of the elements of work personally performed by the physician.

Tests ordered/reviewed

- **0-1 test is straightforward/minimal**

- **2 tests are low complexity**

- **3 tests are moderate complexity**

- **4 tests are high complexity**

THIRD PART OF DECISION MAKING

# of Diagnosis/ Management Options	# of points	Type of Decision Making
1 pt for each minor problem	Minimal 1 pt or less	Straightforward
Chronic established problem 2 points	Limited 2 pts	Low
3 pts for new problem without work-up, acute illness, chronic condition that is worsening	Multiple 3 pts	Moderate
4 pts for each new problem with work-up planned	Extensive 4 pts	High

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Medicare Part B Tips for Preventing Most Common E/M Service Coding Errors

INPATIENT/HOSPITAL TIPS

- Subsequent Hospital Services.
  - Pay attention to medical necessity. When coding, strongly consider CPT's "nature of the presenting problem" contributory factors and/or other patient status descriptions.
    - 99231 – "Usually the patient is stable, recovering or improving." (equal to 99212 to 99213 in the office)
    - 99232 – "Usually the patient is responding inadequately to therapy or has developed a minor complication." (equal to 99214 in the office)
    - 99233 – "Usually the patient is unstable or has developed a significant complication or a significant new problem." (equal to 99215 in the office)

Medicare Part B Tips for Preventing Most Common E/M Service Coding Errors

INPATIENT/HOSPITAL TIPS

- Pay attention to CPT key component requirements. Because of the nature of hospital recordkeeping, the following deficiencies are very common:
  - History components are often documented to be no more detailed than Problem-Focused (PF) or Expanded Problem-Focused (EPF).
  - Examinations are rarely documented higher than EPF

"Incident to" (#1 RAC error)

- Office visits only
- Physician must examine the new patient and document the initial patient visit, not just cosign note.
- NPP (Non-physician practitioner) sees the patient in follow-up visit and continues treatment plan.
  - If treatment plan is revised and patient is seen by supervising physician on follow-up visit, documentation by supervising physician is contained in the progress note, "incident to" continues and the visit is billed under the name of the supervising physician
  - If treatment plan is revised by the NPP only (not seen by the physician), the visit is billed under the NPP and is not under "incident to" billing.

Split/Shared Visit (From CMS manual)

H. Split/Shared E/M Visit

A split/shared E/M visit cannot be reported in the SNF/NF setting. A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to critical care services or procedures.

"Incident to"

"You do not have to be physically present in the patient's treatment room while these services are provided, but you must provide **direct supervision**, that is, you must be present in the office suite to render assistance, if necessary."

Hospital Inpatient/Outpatient/Emergency Department Setting

When a hospital inpatient/hospital outpatient or emergency department E/M is shared

*between a physician and an NPP from the same group practice **and the physician***

***provides any face-to-face portion of the E/M encounter with the patient**, the service may*

be billed under either the physician's or the NPP's NPI number, provided the physician has documented their findings not just a cosignature.

Hospital Inpatient/Outpatient/Emergency Department Setting

However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by reviewing the patient's medical record) then the service may only be billed under the NPP's NPI.

Non-Medicare Payers

- Most follow "incident to."
- Some restrict services to credentialed providers.
- Most credential Nurse Practitioners but not all credential Physician Assistants.
- Get instructions **in writing** from major payers.

What is wrong with this picture?

A nurse practitioner working for a GI practice sees patients in the hospital. The physician reviews the NP's notes and discusses the patient with the NP. The services are billed under the physician.

Answer:

For the physician to bill, the physician must see the patient and document their involvement on that same date in order to bill under their NPI number

What is wrong with this picture?

A practice has just hired a new physician who does not yet have his provider numbers. The services provided by the new physician are billed under another physician in the practice.

Answer:

Physician services can not be billed "incident to".

What is wrong with this picture?

A dietician is employed by a practice to council IBD patients. Each patient receives a one hour dietary evaluation. The service is billed as a Level 4 Established Patient Visit.

Answer:

For services provided under the "supervision" or NPP by anyone who is not a NPP, the only E/M service billable is 99211. If the dietitian is registered and has an NPI number, it would be billed under dietary counseling codes.

When to Use Time Based Coding

- In an outpatient/office setting, the time used to code must be provided face to face with the patient.
- In the hospital, the time used to code is based on unit-floor time and includes time to review records, exam patient, speak with patient and/or family, write notes, orders, speak with other physicians and/or anything involved in the care of the patient that day while on the unit or patient's floor.
- When coding based on time, the <u>teaching physician</u> may not:
  - Add time spent by the resident in the absence of teaching physician to face-to-face time spent with the patient by the teaching physician with or without the resident present .

Counseling and Coordination of Care

- Discussion with patient and/or family with regards to:
  - Diagnostic results, impressions, and/or recommended studies;
  - Prognosis;
  - Risks and benefits of management or treatment options;
  - Instructions and/or follow up;
  - Importance of compliance with chosen treatment or management options;
  - Risk factor reduction; and/or
  - Patient and family education.

When to Use Time Based Coding

- In addition to documenting history and/or physical exam provided, the documentation should include:
  - Total visit time and time spent counseling and coordinating care, and,
  - Description of the medical decision making and counseling discussion and/or activities coordinated.

- Examples of documenting support for coding based on time based:
  - "I spent a total of 30 of 45 minutes on the floor coordinating David's care and in discussion with David regarding…"
  - "30 of 40 minutes of visit at Mary's beside discussing ….with Mary and her family was spent discussing…"

Documentation when Billing by Time in the Office

EXAMPLE:

Face-to-face time with patient _____. Time spent in counseling and/or coordination of care _____.

Discussion:

_____

_____

_____

_____

_____

_____

_____

_____

Evaluation and Management

CASE STUDIES

Date and Time of Consultation: 09/14/14 9:31:00

Requesting Physician: Left blank

Reason for Consultation: Hematemesis, abdominal pain.

History of Present Illness

23 month old who was admitted for a hematemesis, N/V, and epigastric pain. Symptoms started at 10pm on 9/12/12. Started with coffee-ground emesis and pain but then he started to have more N/V, increased pain, and development of bright-red vomiting. Mom denies fevers, chills, melena, hematemesis, diarrhea, constipation. Hgb and VS have been stable. CT scan shows ? thickening of ileum.

Medications

Inpatient Medications: *Ordered* Dilaudid Inj: 1 mg, IV Push, q1h, PRN: Pain, NS 1,000 mL: 125 mL/hr, IV, Nexium INJ: 40 mg, Slow IV Push, q12h, Zofran Inj: 4 mg, 2 mL, Slow IV Push, q4h, PRN: Nausea/Vomiting

Documented Medications: Xanax 1 mg oral tablet: 1 mg, 1 Tablet(s), Oral, qid

Allergies :NKA

Past Medical History Healthy infant except for hernia repair

Surgical History Rt inguinal hernia repair at 2 months of age

Social History Lives with parents and 2 sisters age 4 and 6

Family History No family hx of IBD or GI related cancers or illnesses.

Review of Systems
Except for what is listed in HPI, all remaining systems are negative.

Physical Examination

Vital Signs Temperature (Celsius) 36.2 DegC , Heart Rate 70 bpm, Respiratory Rate 16 breaths/min, SBP NIBP   125 mmHg, DBP NIBP 83 mmHg, SpO2 99 %

Constitutional Appearance: well nourished, in no acute distress.

Eyes Conjunctiva clear.   Sclera normal in color.

Ears, Nose, Mouth and Throat Oropharynx moist without erythema.

Respiratory Clear to auscultation.

Cardiovascular S1, S2: no murmurs, rubs or gallops, regular rate and rhythm.

GI/Abdominal Abdomen: soft but tender to palpation over the epigastric area. No guarding or rebound tenderness.

Extremities No clubbing, cyanosis or edema.

Skin Inspection of skin: normal without jaundice, rashes, lesions.

Psychiatric Alert and awake. Oriented: to time, to circumstance.   Memory intact.   Normal mood and affect.   Judgment and insight appropriate.

Impression and Plan #1 Hematemesis #2 Abdominal pain #3 N/V #4 Esophagitis - LA Grade C

Patient with N/V, hematemesis, and pain. EGD will be performed today
Plan
1. NPO 2. Antiemetics and pain control per primary service 3. Continue with clinical observation.

Patient seen with GI attending physician. Please call with questions.

Addendum by _____on September 14, 2014 10:10 (Verified)
I personally saw and evaluated the patient on 09/14/14. I discussed the management with the fellow and reviewed the fellow's note above. I agree with the documented findings and plan of care.
23 month old male admitted with multiple episodes of hematemesis after vomiting. Hb/ Hct stable. Fussy and held in mother's arms. Abdomen soft and patient cries upon palpation. Will plan on EGD today.

Thanks for the consult.

Coding Scenario

- Comprehensive History - 4 HPI elements, 3 histories, complete ROS
- Comprehensive Exam – 8 organ systems (using 95 guidelines)
- Medical decision making – moderate
- Teaching physician guidelines met with appropriate addendum

Endoscopic Billing Tips

- Cannot bill for multiple polyps removed by snare
  - Example:
    - 12 polyps removed by snare cautery in multiple areas. Can only bill for snare technique one time.
    - Modifier 22 for unusual procedure can only billed if documentation supports tremendous complexity and time spent to complete procedure

- Can bill for each technique utilized to different lesions
  - Example:
    - Snare in sigmoid and biopsy of transverse colon
    - Would need to add the 59 modifier to the bundled code
    - If unsure, billing staff should utilize CCI edits or claim scrubbing software

Endoscopic Billing Tips

ERCP procedures
- Unlike upper and lower endoscopic procedures which contain bundled procedures, there are few bundled with ERCP
- Exception:
  - Stent insertion and removal. Has to be a different stent/location to bill both separately.
    - Example: CBD stent removal and pancreatic stent insertion.
    Two different locations so removal code 43276 and insertion code 43274 can be billed. Modifier 59 would be applied to the bundled code, 43274.

Endoscopic Billing Tips

- Barrx (halo) procedure requires preauthorization and eligibility verification. Make sure your staff is provided with most specific diagnosis codes concerning low grade versus high grade dysplasia. Different payers have different rules.
- TIF- No specific CPT code. Has to also be verified with each payer. Make sure you and the surgeon are submitting same code. Should be 43499 (Unlisted procedure, esophagus)
- Double balloon enteroscopy: Oral approach, 44360 series if ileum not visualized, 44376 series if ileum visualized. Anal approach: 45378 and 44799.
- Fecal transplant: No specific code. Can bill colonoscopy code if done by anal approach.

Endoscopy Billing Tips

- Chromoendoscopy: Just part of standard diagnostic endoscopy codes
- Injection of collagenous material into anal sphincter: No specific CPT code. 44799 would be billed. Make sure eligibility is verified since most payers consider this "experimental".
- When banding or treating hemorrhoids, anoscopy is included in the procedure and not separately billable. No modifier will bypass the coding edit.
- Celiac plexus block is bundled into EUS and every endoscopic procedure but neurolysis is not bundled.
- CONTROL OF BLEEDING IS BUNDLED INTO EVERY PROCEDURE AND CAN'T BE BILLED UNLESS IT IS A SEPARATE SITE/LESION. MODIFIER 59 ALWAYS GETS ADDED TO THE CONTROL OF BLEEDING CODE.