WARBIRD
CONSULTING PARTNERS

Diagnosis and Procedure Coding Including Common Issues

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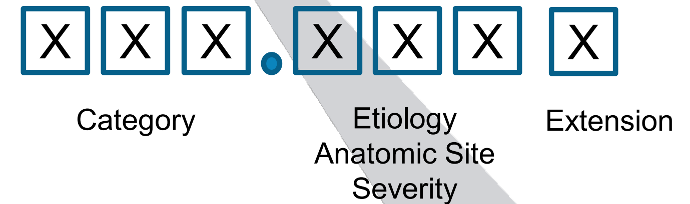
ICD-10

- First 3 characters represent category
  - May be a complete code
- Next 3 characters provide detail on disease, condition, location, severity etc. Extra characters may be populated with X.
- Seventh character characterizes
  - Episode of care
    - Initial
    - Subsequent
    - Sequela – Late effect
      - Complications
      - Conditions produced after the acute phase has ended
  - Type of fracture
  - Fracture care
  - Complication of pregnancy



ICD-10

- Index to disease and injury contains
  - Table of drugs and chemicals
  - Neoplasm table
  - Table of external causes of injury
- Z codes in chapter 21 *Factors Influencing Health Status and Contact with Health Services*

ICD-10

Excludes1 - Pure excludes note

- Indicates that the code excluded should never be used at the same time as the code above the Excludes1 note
- Used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition

Excludes 2

- “Not included here”
- Indicates that the condition excluded is not part of the condition represented by the code
- Both conditions may occur at the same time
- Acceptable to use both the code and the excluded code together, when appropriate

Code First

- Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology
  - Sequence underlying condition (etiology) first and manifestation second
  - If manifestation codes have in the code title, “in diseases classified elsewhere” are never permitted to be first listed or principal diagnosis codes
    - Use in conjunction with underlying condition
    - Code underlying condition first
- “use additional code” – Two codes required to fully describe a single condition that affects multiple body systems
  - Sequencing should be etiology/manifestation

Causal Relationships

- Coding Clinic, second quarter 2016: The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular.”
- The subterm “with” in the Index should be interpreted as a link between the primary condition and any of those conditions indented under the word “with.”
- The physician documentation ***does not need to provide a link*** between the diagnoses linked in this way to accurately assign the single diagnosis code
- These conditions should be coded as related, even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated and due to some other underlying cause
- Provider documentation must link conditions not specifically linked by these relational terms

Causal Relationships

- Diabetes Mellitus with complications includes:
  - The type of diabetes,
  - The body system that is affected and
  - The specific complication affecting that body system
- Assumed cause-and-effect relationship between diabetes and conditions listed under the term “with” in the Alphabetic Index including:
  - Cataract(s),
  - Dermatitis,
  - Gastroparesis,
  - Chronic kidney disease,
  - Osteomyelitis, retinopathy
  - [Poly]neuropathy
- ICD-10-CM does not presume a linkage between diabetes and osteomyelitis, as was assumed in ICD-9

Causal Relationships

- Diabetes due to underlying conditions
  - Code first, underlying condition
  - Then diabetes with causal relationship
- Example: Other chronic pancreatitis – K86.1
  - Code also exocrine pancreatic insufficiency - K86.81 if appropriate
- Then causal relationship:
  - E08.21 - Diabetes mellitus due to underlying condition with diabetic nephropathy
- Use additional codes to identify control using:
  - insulin (Z79.4)
  - oral antidiabetic drugs (Z79.84)
  - oral hypoglycemic drugs (Z79.84)

Causal Relationships

- *Autonomic neuropathy occurs when the nerves that control involuntary bodily functions are damaged. It can affect blood pressure, temperature control, digestion, bladder function and even sexual function*
- *Digestive autonomic neuropathy may include gastroparesis*
- Coding Clinic advises you to identify the manifestation, when possible, as in the case of gastroparesis

Causal Relationships

- Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy – E08.43
- Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy – E10.43
- Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy – E11.43
- Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy
- Gastroparesis – K31.84
  - Code first:
    - Underlying disease, if known, such as:
      - Anorexia nervosa (F50.0-)
      - Diabetes mellitus (E08.43, E09.43, E10.43, E11.43, E13.43)
      - Scleroderma (M34.-)
  - Excludes 2
    - Diabetic gastroparesis (E08.43, E09.43, E10.43, E11.43, E13.43)
    - diverticulum of duodenum (K57.00-K57.13)

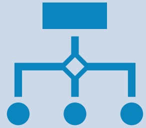
Causal Relationships

- Hypertensive heart disease
- Presumed causal relationship
- Code hypertension and heart disease
- Code condition "due to" hypertension
  - Hypertensive heart disease with heart failure - I11.0
    - Use additional code to identify type of heart failure – I50
- Other heart conditions that have an assumed causal connection to hypertensive heart disease
  - I51.4 - Myocarditis, unspecified
  - I51.5 - Myocardial degeneration
  - I51.7 - Cardiomegaly
  - I51.81 - Takotsubo syndrome
  - I51.89 - Other ill-defined heart diseases
  - I51.9 - Heart disease, unspecified

Causal Relationships

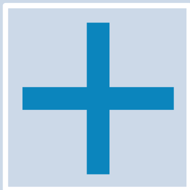
- Hypertensive chronic kidney disease 112
  - Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease – I12.0
  - Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease – 112.9

Causal Relationships



Documentation does not need to contain a link between primary condition and the complication listed in the tabular list and including “in”, “with”, or “due to”

The provider must document when the conditions are unrelated



“Use Additional” coding guidelines may also apply

Diabetes

- Sometimes you should question everything… Email received:
- *2 patients have complained that they are receiving information regarding DM but they do not have DM. Below are a few examples, if you would review the documentation, we would appreciate it.*
- E11.9 - Type 2 diabetes mellitus without complications was coded
- The progress note states *"…reviewed the notes from specialist regarding the PT diabetes and counseled the PT regarding etiology of diabetes, lifestyle recommendation and complications regarding diabetes"*
- Diabetes was not listed in the A/P, problem list or History
- Same exact note for both patients
- A review of provider documentation indicates the same exact phrase on a significant number of patient records, with no diabetes in A/P or History

Ulcers and Wounds

- Ulcers are associated with Hierarchical Category Condition Coding (HCC) while wounds are not. (These two conditions are not synonymous).
  - Wounds are due to trauma or surgery.
  - Ulcers are caused by skin break down from pressure or other chronic conditions.
- Be as specific as possible in documentation and coding to assure diagnostic accuracy and HCC coding.
- Documentation for wounds should include the following:
  - Location
  - Complications if present
- Ulcers - Document and code the condition causing an ulcer. Documentation for ulcers should include the following:
  - Type of ulcer
  - Chronic
  - Non-pressure
  - Pressure/Decubitus (include stage)
    - Stage I - Pressure pre-ulcer skin changes limited to persistent focal erythema
    - Stage II - Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
    - Stage III - Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue
    - Stage IV - Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone
    - Unstageable – ulcer covered by eschar or that has been treated with skin or other graft, or is documented as a deep tissue injury, but not due to trauma
  - Additional considerations - please document and code the following details when present:
    - Gangrene
    - Rest pain
    - Intermittent claudication
    - Cellulitis - Documentation should include location and organism
    - Amputation – Identify the specific extremity and level of amputation

Non-Pressure Ulcers

Location	ICD-10	Laterality	6th digit
Ankle	L973 _ _*	1 – Right	1 - Breakdown of skin
Back	L9842_*	2 – Left	2 - Fat layer exposed
Buttock	L9841 _*	0 – Unspecified	3 - Necrosis of muscle
Calf	L972 _ _*		4 - Necrosis of bone
Foot/toe	L975 _ _*		5 - Muscle w/o necrosis
Heel/midfoot	L974 _ _*		6 – Bone w/o necrosis
Lower Leg Other	L978 _ _*		8 – Other specified severity
Lower Leg Unspecified	L979 _ _*		9 – Unspecified severity
Thigh	L971 _ _*		
Other	L9849_		

Non pressure ulcers must be 2nd to DM, venous HTN, varicose vein, or post-thrombotic

Venous Stasis Ulcer (Varicose Veins)

Location	ICD-10	Laterality	Additional Instructions
Ankle	I830_3*	1 – Right	Order of coding -
Foot/toe	I830_5*	2– Left	1. Post thrombotic /postphlebtic
Heel/midfoot	I830_4*	0 – Unspecified	2. Venous hypertension
Calf	I830_2*		3. Varicose veins *
Leg	I830_8*		*can be coded in addition to post-thrombotic
Thigh	I830_1*		

* Covered under LCD

Pressure Ulcers

Location	ICD-10	Laterality	6th digit
Ankle	L895_ _*	1 – Right	0 - Unstageable*
Buttock	L893_ _*	2 – Left	1 – stage 1*
Heel	L896 _ _*	0 – Unspecified	2 – stage 2*
Hip	L892 _ _*		3 – stage 3*
Sacral	L8915_*		4 – stage 4*
Other	L8989 _*		9- stage unspecified*

*LCD – Non Covered

* LCD Covered

Infusion Documentation, Coding and Billing

Infusion Services

- The process for assigning drug administration codes should be the same for all payers
- Only one "initial" infusion service per site, per encounter can be reported
- Multiple sites must be identified by the appropriate modifier
- The AMA code assignments include a hierarchy of drug administration procedures
- The primary service not necessarily the initial service
  - All other services are considered secondary

Infusion Services

Primary Infusion Order	Secondary Infusion Order
Chemotherapy	Infusion
Non-Chemotherapy	Push
Hydration	Hydration

Add-on Infusion Services

- All time-based codes must pass the halfway mark to the next period
- Report additional hours of medications infused beyond 90 minutes
- All time-based codes must pass the half-way mark into the next time period
- Once this rule is satisfied, report the hour beginning at 1 minute over the previous 60 minutes
  - 96367 - Additional sequential infusion of a new drug/substance
    - Medicare allows four units per episode of care
  - 96368 - Concurrent infusion of a new substance or drug
    - Not time based
    - Report only once per day, regardless of the number of concurrent infusions
  - 96366 - Additional hour of the same substance or drug
    - May be an additional hour to initial (96365) or sequential (96367) medication
    - May report up to 24 units per episode of care
  - 96361 Additional hour hydration
    - May be additional to initial infusion, initial push or initial hydration

Infusion Services

- CPT defines hydration as “prepackaged” fluid and electrolytes… not the infusion of drugs or other substances.”
- Electrolytes include
  - Sodium
  - Magnesium
  - Potassium
  - Calcium
  - Chloride

Infusion Services

- Chemotherapy administration codes apply to
  - Parenteral administration of non-radionuclide anti-neoplastic drugs
  - Anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions)
  - Substances such as some specific monoclonal antibody agents, and certain biologic response modifiers
- Pharmacy should identify
  - Monoclonal antibody agents
  - Biologic response modifiers
  - Chemo medications used for non-chemo diagnoses
- Nursing can participate based on oversight required for administration
- Billing should identify payer specific guidelines

Infusion Services

Non-Chemo Medications Reporting Chemo Administration Codes	HCPCS	Route of Admin
Infliximab (Remicade), 10 mg	J1745	Infusion
Bevacizumab (Avastin), 10 mg	J9035	Infusion/ Push
Rituximab, 10 mg	J9312	Infusion
Methotrexate 5 mg	J9250	Chemo injection

Chemotherapy Infusion Services

- Only one initial chemotherapy code can be billed per encounter
- 96413 – Initial Chemo Infusion greater than 15 minutes up to one hour
- 96409 – Initial Chemo push, 15 minutes or less
- 96405 - Chemotherapy administration; intralesional, up to and including 7 lesions
- 96406 - Chemotherapy administration; intralesional, more than 7 lesions
- 96401 - Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic

Infusion Services

- Sequential and additional hours of chemo infusion can be billed if more than 30 minutes of infusion have been administered beyond the previous infusion hour.
- 96417 - Each sequential chemo medication with infusion time of greater than 15 minutes and up to one hour
- 96415 - Additional infusion hours of the same drug
  - Initial or Sequential drug
- 96411 Each additional chemotherapy substance pushed
  - Additional to initial chemo infusion (96413)
  - Initial chemo push (96409)

COVID-19 Infusions

- Bamlanivimab, and bamlanivimab with etesevimab have medication - specific infusion codes
  - Reimbursed as chemo administrations
  - Not included in the initial infusion code logic

Bamlanivimab 700 mg	Q0239	
Bamlanivimab Infusion	M0239	Paid at chemo rate
Bamlanivimab with etesevimab 2100 mg	Q0245	
Bamlanivimab/etesevimab infusion	M0245	Paid at chemo rate

Chemo Medications

- Prior Authorizations
  - Payer specific
  - Payer decisions can change quarterly
- Cost Sharing
  - Patent cost sharing can be significant
  - Implement financial counseling
  - Create payment arrangement structure

Common Procedure Code Errors

EGD (Esophagogastroduodenoscopy)

EGD		
Diagnostic	43235	
With Biopsy	43239	
Polypectomy	43250	Hot forceps
	43251	Snare
Dilation of Esophagus	43453	Guide wire
	43450	Maloney dilator (Bougies)
	43249	<30mm balloon
	43233	>30mm balloon
	43248	Savary - Gillard
FB removal	43247	Esophagus

Colonoscopy

- 45378 – Diagnostic Colonoscopy
- 45380 – With biopsy
- Polypectomy
  - 45384 – Hot forceps
  - 45385 - Snare
  - 45380 - Cold forceps
- Control Bleeding - 45382
- Medicare
  - Screening
    - G0121 – Low Risk
    - G0105 – High Risk*
- *High risk - family HX of colon CA, family hx of colon polyp, personal hx of colon CA, Crohn's or Ulcerative colitis
- Add PT modifier to report screening converted to diagnostic
- If a polypectomy and a biopsy are performed in separate areas, both are coded with a modifier 59 applied to the biopsy code
- If during a colonoscopy, the scope does not pass the splenic flexure, code as a sigmoidoscopy

Sigmoidoscopy

Procedure Type	CPT	Instrumentation
Diagnostic	45330	
With biopsy	45331	
polypectomy	45333	Hot forceps
	45338	Snare
	45331	Cold forceps

Questions?

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- Warbird's Revenue Cycle Optimization practice is composed of passionate practitioners who have specialized as operational professionals in providing all aspects of revenue cycle services and advisory strategies to healthcare organizations.

Tested, Comprehensive Solutions with Proven Results

- Warbird's Revenue Cycle advisors have partnered with healthcare organizations across the country, including critical access hospitals, community hospitals, academic medical centers, large multi-specialty physician groups, rural health clinics, and sole physician practices.

National Footprint, Scaled to Client Needs

- Warbird's Revenue Cycle Optimization practice works in partnership with experienced operators across Warbird's Healthcare Practice to deliver comprehensive solutions that drive sustainable changes across the personnel, processes, and infrastructure required to operate high-functioning revenue cycle operations.

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