3M Quality Webinar Series

A close look at the IPPS final rule

October 21 & 22, 2020 1pm EDT

Handouts, Recording and Certificates

A PDF handout that contains all of the presentation slides is available for you to download, and that's located in the 'Handouts' section of your web meeting controls.

Look out for an email within the next week that includes a link to the webinar recording and slides.

We will provide a certificate of attendance to webinar attendees, and that will be emailed to you later today upon the completion of this webinar.

Learning objectives

At the completion of this presentation, the participant will be able to:

- Understand FY 2021 ICD-10-CM and ICD-10-PCS coding changes and guideline revisions which impact quality
- Understand FY 2021 CMS final rule changes related to quality
- Provide updates on FY 2020 impacting quality

FY 2021 ICD-10-CM & ICD-10-PCS coding updates related to quality

Summary of updates for FY 2021

ICD-10-CM summary

- New diagnosis codes: 490
- Invalid diagnosis codes: 58
- Revised diagnosis code titles: 47
- Total ICD-10-CM codes: 72,616

ICD-10-PCS summary

- New procedure codes: 556 (includes 12 new procedure codes effective August 1, 2020)
- Deleted procedure codes: 0
- Revised procedure code titles: 0
- Total ICD-10-PCS codes: 78,103

MS-DRG summary

- New MS-DRGs: 12
- Deleted MS-DRGs: 6
- Revised MS-DRGs: 4
- Total MS-DRGs: 767

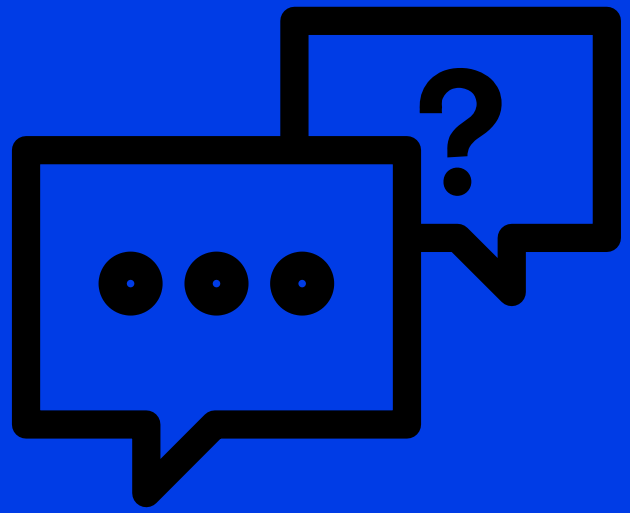
APR DRG summary

- New base APR DRGs: 4
- Deleted base APR DRGs: 2
- Revised base APR DRGs: 1
- Total number of base APR DRGs: 332
- Total APR DRGs: 1,330

Polling question

As part of your review of the annual inpatient prospective payment system (IPPS) updates, do you routinely review for changes to Excludes 1 edits and other changes to coding directives?

- Yes
- No



Pancytopenia

Revised instructional notes

Category	Description
D61	Other aplastic anemias and other bone marrow failure syndromes ~~Excludes 1: neutropenia (D70.-)~~ **Excludes 2: neutropenia (D70.-)**

Review of Excludes 1 v. Excludes 2

Excludes 1

- A type 1 Excludes note is a pure excludes note.
- It means “NOT CODED HERE!”
- An Excludes 1 note indicates that the code excluded should never be used at the same time as the code above the Excludes 1 note.
- An Excludes 1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.
- An exception to the Excludes 1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes 1 note are related or not, query the provider.

Excludes 2

- A type 2 Excludes note represents “Not included here.”
- An excludes 2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time.
- When an Excludes 2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

Febrile neutropenia and pancytopenia

Final diagnostic statement included

- Febrile neutropenia and pancytopenia due to chemotherapy

Assigned codes

- D61.810, Antineoplastic chemotherapy induced pancytopenia
- R50.81, Fever presenting with conditions classified elsewhere
- T45.1X5A, Adverse effect of antineoplastic and immunosuppressive drug, initial encounter

Explanation

- Since the pancytopenia and febrile neutropenia are both related to chemotherapy, then only the pancytopenia is reported because these conditions overlap, and neutropenia is a component of pancytopenia
- If the cause of the neutropenic fever is different than the cause of pancytopenia, then it would be reported separately

AHA Coding Clinic for ICD-10-CM/PCS, 2020 3Q, pp. 22-23

Pancytopenia

Final diagnostic statement included

- Anemia, neutropenia, thrombocytopenia

Response

- Assign separate codes for the anemia, neutropenia and thrombocytopenia

Explanation

- It is not appropriate to classify these three diagnoses as pancytopenia unless “pancytopenia” is explicitly documented by the provider
- Appropriate to query the provider for clarification

AHA Coding Clinic for ICD-10-CM/PCS, 2020 3Q, p. 24

Immunodeficiencies

Created new diagnosis codes

Code	Description	CC/MCC
D84.81	Immunodeficiency due to conditions classified elsewhere Code first underlying condition, such as: chromosomal abnormalities (Q90-Q99) diabetes mellitus (E08-E13) malignant neoplasms (C00-C96) Excludes 1: certain disorders involving the immune mechanism (D80-D83, D84.0, D84.1, D84.9) human immunodeficiency virus [HIV] disease (B20)	CC
D84.821	Immunodeficiency due to drugs Immunodeficiency due to (current or past) medication Use additional code for adverse effect, if applicable, to identify adverse effect of drug (T36-T50 with fifth or six character 5) Use additional code, if applicable, for associated long term (current) drug therapy drug or medication such as: long term (current) drug therapy systemic steroids (Z79.52) other long term (current) drug therapy (Z79.899)	CC
D84.822	Immunodeficiency due to external causes Code also, if applicable, radiological procedure and radiotherapy (Y84.2) Use additional code for external cause such as: exposure to ionizing radiation (W88)	CC
D84.89	Other immunodeficiencies	CC

MDC	MS-DRG
16 (Blood)	814/815/816 Reticuloendothelial and immunity disorders with MCC/with CC/without CC or MCC

Immunodeficiency, unspecified

Added inclusion terms

Code	Description
D84.9	Immunodeficiency, unspecified **Immunocompromised NOS** ← **Immunodeficient NOS** ← **Immunosuppressed NOS** ←

These terms were also added to the index

Cytokine release syndrome

Created new diagnosis codes

Code	Description
D89.83	Cytokine release syndrome Code first underlying cause, such as: complications following infusion, transfusion and therapeutic injection (T80.89-) complications of transplanted organs and tissue (T86.-) Use additional code to identify associated manifestations

D89.831	Cytokine release syndrome, grade 1	No
D89.832	Cytokine release syndrome, grade 2	No
D89.833	Cytokine release syndrome, grade 3	CC
D89.834	Cytokine release syndrome, grade 4	CC
D89.835	Cytokine release syndrome, grade 5	CC
D89.839	Cytokine release syndrome, grade unspecified	No

MDC	MS-DRG
16 (Blood)	814/815/816 Reticuloendothelial and immunity disorders with MCC/with CC/without CC or MCC

Other and unspecified encephalopathy

Revised instructional notes

Subcategory	Description
G93.4	Other and unspecified encephalopathy ~~Excludes 1: toxic (metabolic) encephalopathy (G92)~~ **Excludes 2: toxic (metabolic) encephalopathy (G92)**

Cerebrospinal fluid leak

Created new diagnosis codes

Code	Description	CC/MCC
G96.00	Cerebrospinal fluid leak, unspecified Code also, if applicable, head injury (S00.- to S09.-)	CC
G96.01	Cranial cerebrospinal fluid leak, spontaneous Otorrhea due to spontaneous cerebrospinal fluid CSF leak Rhinorrhea due to spontaneous cerebrospinal fluid CSF leak Spontaneous cerebrospinal fluid leak from skull base	CC
G96.02	Spinal cerebrospinal fluid leak, spontaneous Spontaneous cerebrospinal fluid leak from spine	CC
G96.08	Other cranial cerebrospinal fluid leak Postoperative cranial cerebrospinal fluid leak Traumatic cranial cerebrospinal fluid leak Code also, if applicable, head injury (S00.- to S09.-)	CC
G96.09	Other spinal cerebrospinal fluid leak Other spinal CSF leak Postoperative spinal cerebrospinal fluid leak Traumatic spinal cerebrospinal fluid leak Code also, if applicable, head injury (S00.- to S09.-)	CC

MDC	MS-DRG
01 (Neuro)	091/092/093 Other disorders of nervous system with MCC/with CC/without CC or MCC

Intraoperative and postprocedural complications and disorders of nervous system, not elsewhere classified

Added instructional notes and inclusion terms

Code	Description
G97.0	Cerebrospinal fluid leak from spinal puncture **Code also any associated diagnoses or complications, such as:** **intracranial hypotension following a procedure (G97.83-G97.84)**
G97.1	Other reaction to spinal and lumbar puncture **Other reaction to spinal dural puncture** **Code also, if applicable, any associated headache with orthostatic component (R51.0)**
G97.2	Intracranial hypotension following ventricular shunting **Code also any associated diagnoses or complications**
G97.41	Accidental puncture or laceration of dura during a procedure **Code also any associated diagnoses or complications**

Cardiac arrest

Revised instructional notes

Category	Description
I46	Cardiac arrest ~~Excludes 1: cardiogenic shock (R57.0)~~ **Excludes 2: cardiogenic shock (R57.0)**

Esophagitis

Created new diagnosis codes

Code	Description	CC/MCC
K20.80	Other esophagitis without bleeding Abscess of esophagus Other esophagitis NOS	No
K20.81	Other esophagitis with bleeding	MCC
K20.90	Esophagitis, unspecified, without bleeding Esophagitis NOS	No
K20.91	Esophagitis, unspecified, with bleeding	MCC

MDC	MS-DRG
06 (Digestive)	368/369/370 Major esophageal disorders with MCC/with CC/without CC or MCC (for K20.81 and K20.91)
06 (Digestive)	391/392 Esophagitis, gastroenteritis and miscellaneous digestive disorders with MCC/without MCC (for K20.80 and K20.90)

Gastro-esophageal reflux disease with esophagitis

Created new diagnosis codes

Code	Description	CC/MCC
K21.00	Gastro-esophageal reflux disease with esophagitis, without bleeding Reflux esophagitis	No
K21.01	Gastro-esophageal reflux disease with esophagitis, with bleeding	MCC

MDC	MS-DRG
06 (Digestive)	368/369/370 Major esophageal disorders with MCC/with CC/without CC or MCC (for K21.01)
06 (Digestive)	391/392 Esophagitis, gastroenteritis and miscellaneous digestive disorders with MCC/without MCC (for K21.00)

Diverticular disease of intestine

Deleted inclusion terms

Category	Description
K57	Diverticular disease of intestine Code also if applicable peritonitis K65.-

Subcategory	Description
K57.0	Diverticulitis of small intestine with perforation and abscess ~~Diverticulitis of small intestine with peritonitis~~
K57.2	Diverticulitis of large intestine with perforation and abscess ~~Diverticulitis of colon with peritonitis~~
K57.4	Diverticulitis of both small and large intestine with perforation and abscess ~~Diverticulitis of both small and large intestine with peritonitis~~
K57.8	Diverticulitis of intestine, part unspecified, with perforation and abscess ~~Diverticulitis of intestine NOS with peritonitis~~

Diverticulitis

Revised index

Diverticulitis (acute) K59.92
intestine K57.92
with
~~abscess, perforation or peritonitis K57.80~~
abscess, perforation K57.80 
large K57.32
with
~~abscess, perforation or peritonitis K57.20~~
abscess, perforation K57.20 
small intestine K57.52
with
~~abscess, perforation or peritonitis K57.40~~
abscess, perforation K57.40 

Intracranial injury

Revised instructional notes

Subcategory	Description
S06.3	Focal traumatic brain injury ~~Excludes 1: focal cerebral edema (S06.1)~~ **Excludes 2: focal cerebral edema (S06.1)**

Traumatic subcutaneous emphysema

Revised instructional notes

Code	Description
T79.7	Traumatic subcutaneous emphysema ~~Excludes 1: emphysema NOS (J43)~~ ~~emphysema (subcutaneous) resulting from a procedure (T81.82)~~ **Excludes 2: emphysema NOS (J43)** **emphysema (subcutaneous) resulting from a procedure (T81.82)**

COVID-19

Created new diagnosis code

Code	Description	CC/MCC
U07.1	COVID-19 Use additional code to identify pneumonia or other manifestations Excludes 1: Coronavirus infection, unspecified site (B34.2) Coronavirus as the cause of diseases classified to other chapters (B97.2-) Pneumonia due to SARS-associated coronavirus (J12.81)	MCC

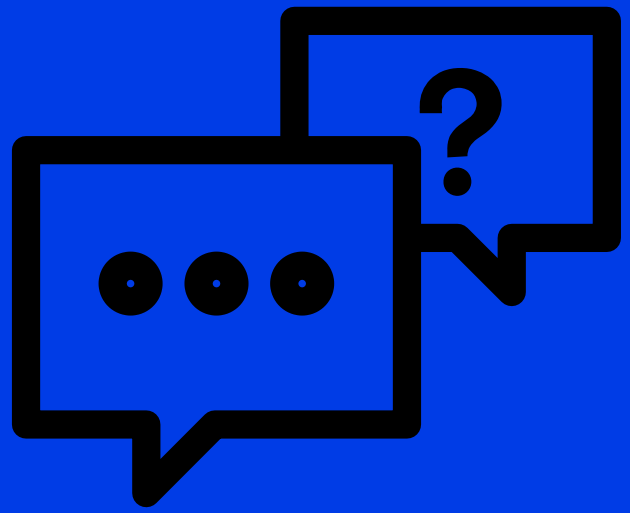
Implemented April 1, 2020

MDC	MS-DRG
04 (Respiratory)	177/178/179 Respiratory infections & inflammations with MCC/with CC/without CC or MCC
15 (Neonatal)	791/793 Prematurity with major problems/Full term neonate with major problems (added to newborn major problem list)
25 (HIV)	974/975/976 HIV with major related condition with MCC/with CC/without CC or MCC

Polling question

Does your organization routinely capture the following types of respiratory assistance? (Select all that apply)

- Bilevel positive airway pressure (BiPAP)
- Continuous positive airway pressure (CPAP)
- High flow nasal cannula (HFNC)
- Supplemental oxygen



Assistance with respiratory ventilation

Section	5	Extracorporeal or Systemic Assistance and Performance
Body System	A	Physiological Systems
Operation	0	Assistance: Taking over a portion of a physiological function by extracorporeal means

Body System		Duration		Function		Qualifier	
9	Respiratory	3	Less than 24 Consecutive Hours	5	Ventilation	7	Continuous Positive Airway Pressure
		4	24-96 Consecutive Hours			8	Intermittent Positive Airway Pressure
		5	Greater than 96 Consecutive Hours			9	Continuous Negative Airway Pressure
						A	High Nasal Flow/Velocity
						B	Intermittent Negative Airway Pressure
						Z	No Qualifier

What:	Added qualifier High Flow/Velocity to body system Respiratory in table 5A0
Why:	Identifies ventilatory assistance provided by high flow or high velocity nasal cannula devices
Where:	Non-DRG Impacting Procedure

COVID-19 therapies

Section	X	New Technology
Body System	W	Anatomical Regions
Operation	0	Introduction: Putting in or on a therapeutic, diagnostic, nutritional, physiological, or prophylactic substance except blood or blood products

Body Part		Approach		Device/Substance/Technology		Qualifier	
1	Subcutaneous Tissue	3	Percutaneous	F	Other New Technology Therapeutic Substance	5	New Technology Group 5*
3 4	Peripheral Vein Central Vein	3	Percutaneous	E	Remdesivir Anti-infective	5	New Technology Group 5*
3 4	Peripheral Vein Central Vein	3	Percutaneous	F	Other New Technology Therapeutic Substance	5	New Technology Group 5*
3 4	Peripheral Vein Central Vein	3	Percutaneous	G	Sarilumab	5	New Technology Group 5*
3 4	Peripheral Vein Central Vein	3	Percutaneous	H	Tocilizumab	5	New Technology Group 5*
D	Mouth and Pharynx	X	External	F	Other New Technology Therapeutic Substance	5	New Technology Group 5*

* New procedure codes for treatment of COVID-19 effective August 1, 2020

COVID-19 therapies

Section	X	New Technology
Body System	W	Anatomical Regions
Operation	1	Transfusion: Putting in blood or blood products

Body Part		Approach		Device/Substance/Technology		Qualifier	
3	Peripheral Vein	3	Percutaneous	2	Convalescent Plasma (Nonautologous)	5	New Technology Group 5*
4	Central Vein	3	Percutaneous	2	Convalescent Plasma (Nonautologous)	5	New Technology Group 5*

* New procedure codes for treatment of COVID-19 effective August 1, 2020

COVID-19 therapies

Remdesivir

- **XW033E5** Introduction of remdesivir anti-infective into peripheral vein, percutaneous approach, new technology group 5
- **XW043E5** Introduction of remdesivir anti-infective into central vein, percutaneous approach, new technology group 5

Sarilumab

- **XW033G5** Introduction of sarilumab into peripheral vein, percutaneous approach, new technology group 5
- **XW043G5** Introduction of sarilumab into central vein, percutaneous approach, new technology group 5

Tocilizumab

- **XW033H5** Introduction of tocilizumab into peripheral vein, percutaneous approach, new technology group 5
- **XW043H5** Introduction of tocilizumab into central vein, percutaneous approach, new technology group 5

COVID-19 therapies

Convalescent plasma

- **XW13325** Transfusion of convalescent plasma (nonautologous) into peripheral vein, percutaneous approach, new technology group 5
- **XW14325** Transfusion of convalescent plasma (nonautologous) into central vein, percutaneous approach, new technology group 5

New drug or other therapeutic substance when no unique code is available

- **XW013F5** Introduction of Other New Technology Therapeutic Substance into Subcutaneous Tissue, Percutaneous Approach, New Technology Group 5
- **XW033F5** Introduction of Other New Technology Therapeutic Substance into Peripheral Vein, Percutaneous Approach, New Technology Group 5
- **XW043F5** Introduction of Other New Technology Therapeutic Substance into Central Vein, Percutaneous Approach, New Technology Group 5
- **XW0DXF5** Introduction of Other New Technology Therapeutic Substance into Mouth and Pharynx, External Approach, New Technology Group 5

FY 2021 MS-DRG updates related to quality

Bone marrow transplants

Re-designated the following bone marrow transplant MS-DRGs from surgical MS-DRG to medical MS-DRGs

MS-DRG	Description	RW
014	Allogeneic Bone Marrow Transplant	12.7788
016	Autologous Bone Marrow Transplant with CC/MCC ~~or T-cell Immunotherapy~~	6.7262
017	Autologous Bone Marrow Transplant without CC/MCC	4.8302

Reason:	Bone marrow transplant procedures involve a transfusion of donor cells and do not involve a surgical procedure or require the resources of an operating room (O.R.)

Retitled MS-DRG 016 deleting the reference to CAR T-cell immunotherapy

- Reason: new DRG created for CAR-T cell immunotherapy.

Chimeric antigen receptor (CAR) T-cell therapies

Created new MS-DRG

MS-DRG	Description	RW
018	Chimeric Antigen Receptor (CAR) T-Cell Immunotherapy	37.3290

ICD-10-PCS	Description
XW033C3	Introduction of engineered autologous chimeric antigen receptor T-cell immunotherapy into peripheral vein, percutaneous approach, new technology group 3
XW043C3	Introduction of engineered autologous chimeric antigen receptor T-cell immunotherapy into central vein, percutaneous approach, new technology group 3
XW23346	Transfusion of Brexucabtagene Autoleucel immunotherapy into peripheral vein, percutaneous approach, new tech group 6
XW23376	Transfusion of Lisocabtagene Maraleucel immunotherapy into peripheral vein, percutaneous approach, new tech group 6
XW24346	Transfusion of Brexucabtagene Autoleucel immunotherapy into central vein, percutaneous approach, new tech group 6
XW24376	Transfusion of Lisocabtagene Maraleucel immunotherapy into central vein, percutaneous approach, new tech group 6

Reason: Improves payment for CAR T-cell therapies in the inpatient setting. Cases involving CAR T-cell therapies will no longer be eligible for new technology add-on payment in FY 2021.

Hip and knee joint replacements

Created new MS-DRGs

MS-DRG	Description	RW
521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC	3.0634
522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC	2.1891

Reason:	Clinically, individuals who undergo hip replacement following hip fracture tend to require greater resources for effective treatment than those without hip fracture Refer to Table 6P.1d for a list of ICD-10-PCS procedure codes that describe hip replacement procedures and are finalized for the logic of new MS-DRGs 521/522
	Refer to Table 6P.1e for a list of ICD-10-CM diagnosis codes that describe hip fractures and are finalized for the logic of new MS-DRGs 521/522
	https://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/AcuteInpatientPPS

Kidney transplants

Modified grouper logic for the following MS-DRG

MS-DRG	Description	RW
652	Kidney Transplant	3.1819
Reason:	To allow the presence of a procedure code describing transplantation of the kidney to determine the MS-DRG assignment independent of the MDC of the principal diagnosis except in MDC 24 and MDC 25	
	Remains in MDC 11	

Kidney transplants

Created new MS-DRGs

MS-DRG	Description	RW
019	Simultaneous pancreas and kidney transplant with hemodialysis	6.6619
650	Kidney transplant with hemodialysis with MCC	4.5131
651	Kidney transplant with hemodialysis without MCC	3.6936

Designate the following procedure codes as non-O.R. procedures affecting the MS-DRG

ICD-10-PCS	Description
5A1D70Z	Performance of urinary filtration, intermittent, less than 6 hours per day
5A1D80Z	Performance of urinary filtration, prolonged intermittent, 6-18 hours per day
5A1D90Z	Performance of urinary filtration, continuous, greater than 18 hours per day

Reason:	It requires greater resources to perform hemodialysis during an admission where the patient received a kidney transplant
	Maintained MS-DRG 008 and MS-DRG 652 for kidney transplant without hemodialysis

Addition of diagnoses to MDC 11 (kidney)

Reassigned the following diagnosis codes from MS-DRGs 314/315/316 in MDC 05 to MS-DRGs 673/674/675 Other Kidney and Urinary Tract Procedures with MCC/with CC/without CC or MCC and MS-DRGs 698/699/700 Other Kidney and Urinary Tract Diagnoses with MCC/with CC/without CC or MCC in MDC 11

ICD-10-CM	Description
T82.41XA	Breakdown (mechanical) of vascular dialysis catheter, initial encounter
T82.42XA	Displacement of vascular dialysis catheter, initial encounter
T82.43XA	Leakage of vascular dialysis catheter, initial encounter
T82.49XA	Other complication of vascular dialysis catheter, initial encounter

Reason: Mechanical complication of a vascular dialysis catheter is clinically related to the insertion of TIVADs or tunneled vascular access devices

Addition of diagnoses to MS-DRGs 673/674/675

Added the following diagnosis codes to the special logic for MS-DRGs 673/674/675 Other Kidney and Urinary Tract Procedures with MCC/with CC/without CC or MCC when reported with a secondary diagnosis of either N18.5 Chronic kidney disease, stage 5 or N18.6 End stage renal disease

ICD-10-CM	Description
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease

Reason:	Coding directives instruct to list these codes before codes that specify the stage of chronic kidney disease
	These diagnosis code combinations describe an indication that could require the insertion of a totally implantable vascular access device or a tunneled vascular access device to allow access to the patient's blood for hemodialysis purposes.

Removal of diagnoses from MS-DRGs 673/674/675

Removed the following diagnosis codes from the diagnosis list in MS-DRGs 673/674/675 Other Kidney and Urinary Tract Procedures with MCC/with CC/without CC or MCC

ICD-10-CM	Description
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.10	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2
N18.3	Chronic kidney disease, stage 3
N18.4	Chronic kidney disease, stage 4
N18.9	Chronic kidney disease, unspecified

Reason: These diagnoses do not describe renal failure and they do not describe indications that would generally require the insertion of totally implantable vascular access devices or tunneled vascular access devices for the purposes of hemodialysis

Review of procedure codes in unrelated MS-DRGs

- Totally implantable vascular access devices
  - Added the following TIVAD procedure codes to the MS-DRGs describing “Other” procedures within each of following MDCs

ICD-10-PCS	Description
0JH60WZ	Insertion of totally implantable vascular access device into chest subcutaneous tissue and fascia, open approach
0JH80WZ	Insertion of totally implantable vascular access device into abdomen subcutaneous tissue and fascia, open approach
0JHD0WZ	Insertion of totally implantable vascular access device into right upper arm subcutaneous tissue and fascia, open approach
0JHF0WZ	Insertion of totally implantable vascular access device into left upper arm subcutaneous tissue and fascia, open approach
0JHG0WZ	Insertion of totally implantable vascular access device into right lower arm subcutaneous tissue and fascia, open approach
0JHH0WZ	Insertion of totally implantable vascular access device into left lower arm subcutaneous tissue and fascia, open approach
0JHL0WZ	Insertion of totally implantable vascular access device into right upper leg subcutaneous tissue and fascia, open approach
0JHM0WZ	Insertion of totally implantable vascular access device into left upper leg subcutaneous tissue and fascia, open approach
0JHP0WZ	Insertion of totally implantable vascular access device into left lower leg subcutaneous tissue and fascia, open approach

MDC	MS-DRG	MDC	MS-DRG
04 (Respiratory)	166/167/168	08 (Musculo)	**515/516/517**
06 (Digestive)	**356/357/358**	13 (Female)	**749/750**
07 (Hepato)	**423/424/425**	16 (Blood)	**802/803/804**

Inferior vena cava filter procedures

Re-designated the following procedure code from O.R. procedure to non-O.R. procedure

ICD-10-PCS	Description
06H03DZ	Insertion of intraluminal device into inferior vena cava, percutaneous approach

Reason:	This procedure does not require the resources of an operating room and is not surgical in nature

Control of bleeding

Designation of the following procedure code changed from non-O.R. procedures to O.R. procedure

ICD-10-PCS	Description
0W3G0ZZ	Control bleeding in peritoneal cavity, open approach

- Added to the following MDC/MS-DRGs

MDC	MS-DRG
05 (Circulatory)	264 Other Circulatory System O.R. Procedures
06 (Digestive)	356/357/358 Other Digestive System O.R. Procedures with MCC/with CC/without CC or MCC
07 (Hepato)	423/424/425 Other Hepatobiliary or Pancreas O.R. Procedures with MCC/with CC/without CC or MCC
11 (Kidney)	673/674/675 Other Kidney and Urinary Tract Procedures with MCC/with CC/without CC or MCC
17 (Myelo)	820/821/822 Lymphoma and Leukemia with Major O.R. Procedure with MCC/with CC/without CC or MCC
17 (Myelo)	826/827/828 Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Major O.R. Procedure with MCC/with CC/without CC/MCC
17 (Myelo)	829/830 Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedure with CC or MCC/without CC or MCC
21 (Injuries)	907/908/909 Other O.R. Procedures for Injuries with MCC/with CC/without CC or MCC
24 (MST)	957/985/959 (Other O.R. Procedures for Multiple Significant Trauma with MCC/with CC/without CC or MCC
	981/982/983 Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC/with CC/without CC or MCC

FY 2021 updates to ICD-10-CM Official Guidelines for Coding and Reporting

Convention for the ICD-10-CM

I.B.14 Documentation by Clinicians Other than the Patient's Provider

- Code assignment is based on the documentation by patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions, such as codes for the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.
- For social determinants of health, such as information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses. **Patient self-reported documentation may also be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the health record by either a clinician or provider.**
- The BMI, coma scale, NIHSS codes and categories Z55-Z65 should only be reported as secondary diagnoses.

Chapter 15: Pregnancy, childbirth, and the puerperium (O00-O9A)

I.C.15.k Puerperal sepsis

- Code O85, Puerperal sepsis, should be assigned with a secondary code to identify the causal organism (e.g., for a bacterial infection, assign a code from category B95-B96, Bacterial infections in conditions classified elsewhere). A code from category A40, Streptococcal sepsis, or A41, Other sepsis, should not be used for puerperal sepsis. If applicable, use additional codes to identify severe sepsis (R65.2-) and any associated acute organ dysfunction.
- **Code O85 should not be assigned for sepsis following an obstetrical procedure (See Section I.C.1.d.5.b., Sepsis due to a postprocedural infection).**

Chapter 18: Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)

I.C.18.e Coma scale

- The coma scale codes (R40.2-) can be used in conjunction with traumatic brain injury codes~~, acute cerebrovascular disease or sequelae of cerebrovascular disease codes~~. These codes are primarily for use by trauma registries, but they may be used in any setting where this information is collected. ~~The coma scale may also be used to assess the status of the central nervous system for other non-trauma conditions, such as monitoring patients in the intensive care unit regardless of medical condition.~~ The coma scale codes should be sequenced after the diagnosis code(s).
- These codes, one from each subcategory, are needed to complete the scale. The 7th character indicates when the scale was recorded. The 7th character should match for all three codes.
- At a minimum, report the initial score documented on presentation at your facility. This may be a score from the emergency medicine technician (EMT) or in the emergency department. If desired, a facility may choose to capture multiple coma scale scores.
- Assign code R40.24, Glasgow coma scale, total score, when only the total score is documented in the medical record and not the individual score(s).
- Do not report codes for individual or total Glasgow coma scale scores for a patient with a medically induced coma or a sedated patient.
- See Section I.B.14 for coma scale documentation by clinicians other than patient's provider

Update on FY 2020 changes impacting quality

Updates from FY 2020 changes

- Subsegmental pulmonary embolism (I26.93, I26.94)
  - Multiple subsegmental pulmonary emboli without acute cor pulmonale (I26.94) was added to PSI 12 for v2020
    - Did not add single subsegmental pulmonary embolism without acute cor pulmonale (I26.93)
  - Both multiple and single subsegmental PEs (I26.93, I26.94) remain in HAC 10 (DVT/PE with total knee or hip replacement)
- Distal deep vein thrombosis (I82.45-, I82.46-) and thrombophlebitis (I80.24-, I80.25-)
  - New codes not added to PSI 12 for v2020
  - Acute embolism and thrombosis of peroneal vein (I82.45-) included in HAC 10 (DVT/PE with total knee or hip replacement)
- Pressure-induced deep tissue damage (L89.- - 6)
  - Added to PSI 03 (Pressure ulcer rate) for v2020
  - Not included in HAC 04 (Stage III and IV pressure ulcers)

New COVID-19 Compliance Reviews and Education

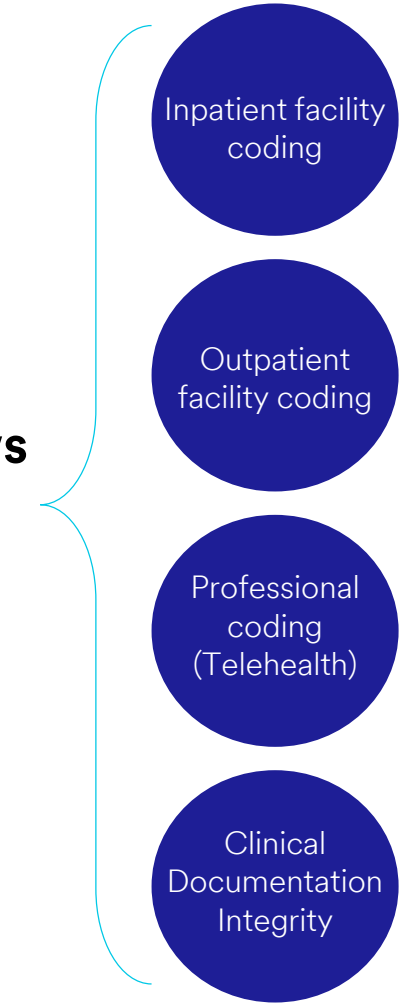
Addressing new coding and documentation challenges from COVID-19

Coding compliance and accuracy has never been more challenging. Or more important.

Coding quality has always been a critical objective of any coding team. The COVID-19 pandemic has made this effort more complex, and more important, than ever before. New code sets and guidelines are being developed to keep up with the diagnosis and treatment of the disease, making it challenging to keep up.

Meanwhile, CMS policies and regulations around virtual care have changed as the volume of telehealth visits has skyrocketed. For many, confusion and uncertainty remain regarding appropriate coding and billing for these patients.

We provide retrospective compliance audits to combined with education to keep coding and CDI teams up to speed as policies and regulations evolve.



Mastering the 2021 E/M changes

On-demand education to get you and your team ready

Get ready. The 2021 Evaluation and Management guidelines will take effect on January 1, 2021!

Two options for on-demand education for the E/M 2021 changes:

An in-depth series for coders, auditors and other key personnel

- The series consists of four modules that include coding scenarios and an assessment.
- This series has the prior approval of AAPC for 2.5 continuing education hours (CEUs).

A condensed series, tailored specifically to physicians' needs

- The series consists of four modules plus we have included 10 common office visits scenarios for physicians to learn to apply the new medical decision components for accurate E/M level assignment

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If you would like more information about topics in this webinar, please select your top interest.

- ❑ 3M™ Advanced CDI Services
- ❑ 3M™ Quality Services
- ❑ 3M™ COVID-19 inpatient, outpatient, and professional services audits
- ❑ Mastering E/M changes – On-demand education

Handouts, recording and certificates

A PDF handout that contains all of the presentation slides is available for you to download, and that's located in the 'Handouts' section of your web meeting controls.

Look out for an email within the next week that includes a link to the webinar recording and slides.

We will provide a certificate of attendance to webinar attendees, and that will be emailed to you later today upon the completion of this webinar.

Thank you!