ICD-10-Procedure Conundrums Surface

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HCPro Boot Camps™

Objectives

- State the intended objectives of transitioning MS-DRGs from ICD-9-CM to ICD-10-CM/PCS
- Identify procedures that cause DRG changes with correct code assignment
- Identify procedures that may create DRG changes if incorrectly coded
- Present optional solutions to address the problematic procedures
- Explore how to identify potential risks associated with such procedures
- Debate potential solutions payers may impose to remedy the issues

MS-DRG Transition in "Theory"

- " The impact of conversion to ICD-10 on Medicare MS-DRG payments....[should result in] a minimal hospital payment decrease of 1.07 percent using the ICD-10 version 30 of MS-DRGs. "<*The Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments, JAHIMA, February 2015*>
- "The ICD-10 MS-DRGs are a replication of the ICD-9 MS-DRGs."
  - A replication means that the same hospital inpatient medical record coded independently in ICD-10 and ICD-9 would have the same MS-DRG assigned by the ICD-10 MS-DRGs using the ICD-10 codes and the ICD-9 MS-DRGs using the ICD-9 codes. <*The Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments, JAHIMA, February 2015*>

MS-DRG Transition in "Theory"

- "When the MS-DRGs are optimized to take advantage of the detail in ICD-10, there may be a substantial impact on payments. "<*The Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments, JAHIMA, February 2015*>
- "The earliest an ICD-10 optimized version of MS-DRGs can be implemented is FY2018. "<*The Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments, JAHIMA, February 2015*>
  - Historically, 2 years of data is gathered to determine the need for MS-DRG payment weight changes or reclassification of diagnoses/procedures.

MS-DRG Transition in "Theory"

- Known situations identified as causing expected DRG "shifts"
  - Sequencing guideline change (e.g. anemia due to neoplastic disease)
  - New default codes (e.g. depression NOS and major depressive disorder both equate to F32.9 – Assigned to MS-DRG 881 for Depressive Neuroses)
  - Changes in CC/MCC status (e.g., malignant hypertension no longer differentiated as a CC condition or specific code)
  - Combination procedures in ICD-9-CM (e.g., 30.4 Radical laryngectomy, with tracheostomy) but require separate ICD-10-PCS codes for laryngectomy and tracheostomy.

Diagnostic Vs. Therapeutic Paracentesis

- ICD-9-CM – 54.91 Paracentesis
  - No differentiation between diagnostic or therapeutic
    - Diagnostic refers to a small quantity of fluid obtained from the peritoneal cavity
    - Therapeutic refers to a large quantity of fluid > 5 liters
      - Performed for patient comfort, decreases dyspnea, early satiety, abdominal pain
    - Some patients may undergo both diagnostic and therapeutic paracentesis during an admission

Diagnostic Vs. Therapeutic Paracentesis

- *DRG Expert* (ICD-9)

54.91 is NOT a Surgical Procedure

54.72	Other repair of abdominal wall **74, 82, 104, 179**
54.73	Other repair of peritoneum **75, 82, 179**
54.74	Other repair of omentum **75, 82, 179**
54.75	Other repair of mesentery **75, 82, 179**
54.92	Removal of foreign body from peritoneal cavity **75, 118, 197**
54.93	Creation of cutaneoperitoneal fistula **64, 75, 82, 118, 179, 197**
54.94	Creation of peritoneovascular shunt **75, 81, 179**
54.95	Incision of peritoneum **14, 16, 64, 75, 82, 118, 179, 197**

Diagnostic Vs. Therapeutic Paracentesis

- ICD-10-PCS
  - Diagnostic Paracentesis – 0W9G3ZX (Drainage, peritoneal cavity, percutaneous, no device, diagnostic)
  - Therapeutic Paracentesis – 0W9G3ZZ (Drainage, peritoneal cavity, percutaneous, no device, no qualifier)

Diagnostic Vs. Therapeutic Paracentesis

- DRG Expert (ICD-10)

0W9F0ZZ	113, 217, 302, 355
0W9G[0,3,4]ZX	113, 121, 269, 293, 302, 355, 460
0W9G0[0,Z]Z	91, 254, 269
0W9G00Z	113, 121, 293, 302, 355
0W9G0ZZ	113, 121, 293, 302, 355
0W9H[0,3,4][0,Z]Z	91, 123, 217,

- 0W9G3ZX is a SURGICAL procedure
- 0W9G3ZZ is a NON-SURGICAL procedure

Diagnostic Vs. Therapeutic Paracentesis

- Example Surgical MS-DRG (420-Hepatobiliary Diagnostic Procedures)

MDC 7 — DRG 412–DRG 423

0FB[D,F,G]0ZX	Exc of [Pancreatic Duct, Accessory Pancreatic Duct, Pancreas], Opn Appr, Dx
0FJ0[0,3,4]ZZ	Inspect/Liver, [Opn, Perc, Perc Endo]
0FJ4[0,3,4]ZZ	Inspect/Gallbladder, [Opn, Perc, Perc Endo]
0FJD*	Inspect/Pancreatic Duct
0FJG[0,3,4]ZZ	Inspect/Pancreas, [Opn, Perc, Perc Endo]
0W9G00Z	Drain of Peritoneal Cavity with Drain Dev, Opn Appr
0W9G0ZZ	Drain of Peritoneal Cavity, Opn Appr
0W9G[0,3,4]ZX	Drain/Peritoneal Cavity, [Opn, Perc, Perc Endo]
0W9H[0,3,4]ZX	Drain/Retroperitoneum, [Opn, Perc, Perc Endo]

Diagnostic Vs. Therapeutic Paracentesis

- ICD-10-PCS Guidelines *<Biopsy followed by more definitive treatment* B3.4b>
  - If a diagnostic Excision, Extraction, or Drainage procedure (biopsy) is followed by a more definitive procedure, such as Destruction, Excision or Resection at the same procedure site, **both** the biopsy and the more definitive treatment are coded.

Diagnostic Vs. Therapeutic Paracentesis

- ICD-10-PCS Guidelines *<Selection of Principal Procedure>*
  - Procedure performed for definitive treatment of both principal diagnosis and secondary diagnosis
    - Sequence procedure performed for definitive treatment most related to principal diagnosis as principal procedure.
    - The principal procedure is one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.*<AHA, Coding Clinic, 2Q, 2011>*

Incision and Drainage (I & D) Skin and/or Subcutaneous Tissue

- ICD-9-CM – 86.04 Other Incision and Drainage of Skin and Subcutaneous Tissue
  - No differentiation between skin and subcutaneous tissue
  - Anatomical sites generally do not affect code assignment (as long as confined to skin/subcutaneous tissue)

Incision and Drainage (I & D) Skin and/or Subcutaneous Tissue

- *DRG Expert* (ICD-9)

86.04 is NOT a Surgical Procedure

85.89	Other mammoplasty **105, 201**
85.93	Revision of implant of breast **105, 201, 235**
85.94	Removal of implant of breast **105, 201, 235**
85.95	Insertion of breast tissue expander **105, 201, 235**
85.96	Removal of breast tissue expander (s) **105, 201, 235**
85.99	Other operations on the breast **105, 201, 235**
86.06	Insertion of totally implantable infusion pump **14, 17, 51, 64, 75, 82, 96, 104, 113, 118, 123, 129, 175, 201**
86.07	Insertion of totally implantable vascular access device (VAD) **104, 118**

Incision and Drainage (I & D) Skin and/or Subcutaneous Tissue

- I & D of the Skin on Left Thigh for abscess, 0H9JXZZ (Drainage, skin, left upper leg, external, no device, no qualifier)
  - Only approach option is EXTERNAL
- I & D of the Subcutaneous Tissue on Left Thigh for abscess, 0J9M0ZZ (Drainage, subcutaneous tissue, left upper leg, open, no device, no qualifier)
  - Approach options are only OPEN or PERCUTANEOUS

Incision and Drainage (I & D) Skin and/or Subcutaneous Tissue

- DRG Expert (ICD-10)

0H9JXZZ- is NON-SURGICAL

0H8MXZZ	236, 313
0H8NXZZ	236, 313
0H99X[0,Z]Z	211, 266, 274, 449
0H9T0ZX	222, 242, 336, 449
0H9U0ZX	222, 242, 336, 449
0H9V0ZX	222, 242, 336, 449
0H9W0ZX	222, 242, 336, 449
0H9X0ZX	222, 242, 336, 449
0HB[0,1,4,5,6,7,8,A,B,C,D,E, F,G,H,J,K,L,M,N]XZZ	259,253, 268

  - Non-SURGICAL; just like in ICD-9

Incision and Drainage (I & D) Skin and/or Subcutaneous Tissue

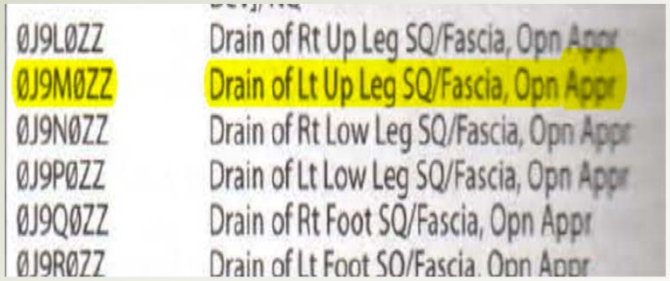
- DRG Expert (ICD-10)

0J9K3ZZ	450
0J9L0ZZ	212, 337, 450
0J9M0ZZ	212, 337, 450
0J9N0ZZ	212, 337, 450
0J9P0ZZ	212, 337, 450
0J9Q0ZZ	212, 337, 450

- 0J9M0ZZ is a SURGICAL procedure

Incision and Drainage (I & D) Skin and/or Subcutaneous Tissue

- DRG Expert (ICD-10)



0J9L0ZZ	Drain of Rt Up Leg SQ/Fascia, Opn Appr
0J9M0ZZ	Drain of Lt Up Leg SQ/Fascia, Opn Appr
0J9N0ZZ	Drain of Rt Low Leg SQ/Fascia, Opn Appr
0J9P0ZZ	Drain of Lt Low Leg SQ/Fascia, Opn Appr
0J9Q0ZZ	Drain of Rt Foot SQ/Fascia, Opn Appr
0J9R0ZZ	Drain of Lt Foot SQ/Fascia, Opn Appr

- 0J9M0ZZ is a SURGICAL procedure assigned to MS-DRG 579-581 (Other Skin, Subcutaneous Tissue and Breast Procedures)

Incision and Drainage (I & D) Skin and/or Subcutaneous Tissue

- If the abscess cavities were incised and opened, so that the site of the procedure was exposed it is considered an OPEN procedure and not percutaneous. *<AHA, Coding Clinic Q3, 2015>*
- "When the specific site is known, it should be coded as such" unless a specific body part cannot be used. *<AHA, Coding Clinic Q1, 2015>*
- If the root operations Excision, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded. *<PCS Guidelines Overlapping body layers B3.5>*

Excisional vs Non-Excisional Debridement

- Excisional – Assigned to root operation Excision and is assigned based off deepest layer
  - Skin – External approach only – Surgical DRG (PCS table 0HB-)
  - Subcutaneous tissue – Open approach (PCS table 0JB-) – Surgical DRG

Excisional vs Non-Excisional Debridement

- DRG Expert (ICD-10)

ØHBJXZZ	Exc of Lt Upr Leg Skin, Ext Appr
ØHBKXZZ	Exc of Rt Lwr Leg Skin, Ext Appr
ØHBLXZZ	Exc of Lt Lwr Leg Skin, Ext Appr
ØHBMXZZ	Exc of Rt Foot Skin, Ext Appr
ØHBNXZZ	Exc of Lt Foot Skin, Ext Appr
ØJB00ZZ	Exc of Scalp SQ/Fascia, Opn Appr
ØJB10ZZ	Exc of Face SQ/Fascia, Opn Appr
ØJB40ZZ	Exc of Ant Neck SQ/Fascia, Opn Appr
ØJB50ZZ	Exc of Post Neck SQ/Fascia, Opn Appr
ØJB60ZZ	Exc of Chest SQ/Fascia, Opn Appr
ØJB70ZZ	Exc of Back SQ/Fascia, Opn Appr
ØJB80ZZ	Exc of Abd SQ/Fascia, Opn Appr
ØJB90ZZ	Exc of Buttock SQ/Fascia, Opn Appr
ØJBB0ZZ	Exc of Perineum SQ/Fascia, Opn Appr
ØJBC0ZZ	Exc of Pelvic SQ/Fascia, Opn Appr
ØJBD0ZZ	Exc of Rt Up Arm SQ/Fascia, Opn Appr
ØJBF0ZZ	Exc of Lt Up Arm SQ/Fascia, Opn Appr
ØJBG0ZZ	Exc of Rt Low Arm SQ/Fascia, Opn Appr
ØJBH0ZZ	Exc of Lt Low Arm SQ/Fascia, Opn Appr
ØJBL0ZZ	Exc of Rt Up Leg SQ/Fascia, Opn Appr
ØJBM0ZZ	Exc of Lt Up Leg SQ/Fascia, Opn Appr

- Example - Both 0HB- and 0JB- are assigned to MS-DRGs 570-571 (Skin Debridement) if PDX is abscess/cellulitis

Excisional vs Non-Excisional Debridement

- If debridement is Non-Excisional – Assigned to root operation Extraction
  - Skin – External approach – Non-surgical DRGs
  - Subcutaneous tissue – Surgical DRGs

Excisional vs Non-Excisional Debridement

- DRG Expert (ICD-10)

- Example - 0JD- is assigned to MS-DRGs 579-581 (Other Skin, Subcutaneous Tissue and Breast Procedures)if PDX is abscess/cellulitis

Obstetrical Perineal Laceration Repairs

- Laceration repairs <AHA, *Coding Clinic*, Q1, 2016>
  - First-degree tears involve injury to the outermost layer of the perineum and vaginal mucosa.
    - PCS code 0HQ9XZZ
  - Second-degree tears involve injury to the vaginal wall and perineal muscle, but do not extend down into the anal sphincter muscle.
    - PCS code 0KQM0ZZ.
      - If the root operations Excision, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded. <*PCS Guidelines*>
        - The deepest layer is the perineal muscles.

Obstetrical Perineal Laceration Repairs

- The provider does not have to specifically state the perineal muscle if documented as a 2nd degree perineal laceration which by definition is through the perineal muscle. <AHA, *Coding Clinic*, Q4, 2014>

Obstetrical Perineal Laceration Repairs

- Laceration repairs (continued) <AHA, *Coding Clinic*, Q1, 2016>
  - Third-degree tears extend to the anal sphincter, but the anal/rectal mucosa beneath the anal sphincter are intact.
    - Anal sphincter – PCS code 0DQR0ZZ
  - Fourth-degree tears extend to the perineum, and the anal sphincter complex (external anal sphincter and internal anal sphincter), and the rectal mucosa. through the anal sphincter and into the anal/rectal mucosa.
    - Rectum – PCS code 0DQP0ZZ

Obstetrical Perineal Laceration Repairs

- Caution! If a repair of the anal sphincter or rectum (open approach) is coded it will group to:
  - 0DQR0ZZ – Anal sphincter – MS-DRGs 987-989 (Non-extensive O.R. Procedure Unrelated to the Principal Diagnosis)
    - Confirmed per 3M, "Pregnancy with perineal laceration and anal sphincter repair is assigned to the unrelated OR trio of DRGs. "
  - 0DQR0ZZ – Rectum via open approach – MS-DRGs 987-989 (Non-extensive O.R. Procedure Unrelated to the Principal Diagnosis)
    - Only approach covered under MS-DRGs 768 is via natural opening??

Bronchoalveolar Lavage

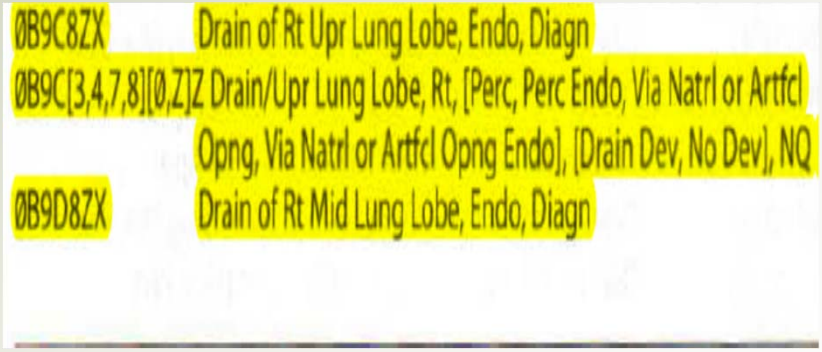
- ICD-9-CM code 33.24 (Closed [endoscopic] biopsy of bronchus)
  - Non-O.R. procedure = Non-surgical DRGs

Bronchoalveolar Lavage

- ICD-10-PCS code – PCS table *0B9-* *<AHA, Coding Clinic, Q1, 2016>*
  - Drainage is the root operation.
  - Also known as a "liquid biopsy"
  - Body part is BRONCHUS
    - If coded as "lung" is assigned to a SURGICAL DRG
  - Qualifier is DIAGNOSTIC (X)
    - If coded as "no qualifier" is assigned to a SURGICAL DRG

Bronchoalveolar Lavage

- DRG Expert (ICD-10)



- Assigned to MS-DRGs 166-168 (Other Respiratory System O.R. Procedures) if coded as "lung"

Ileostomy Takedown

- Assign the following ICD-10-PCS codes:
  - **0DBB0ZZ** Excision of ileum, open approach (for the ileostomy takedown)
  - **0WQF0ZZ** Repair abdominal wall, open approach (for parastomal hernia repair and stoma closure) *<AHA, Coding Clinic Q3, 2015>*
  - These procedure codes are assigned to the MS-DRGs 347-349 (Anal and Stomal Procedures)
    - Just like in ICD-9

Ileostomy Takedown

- However, ICD-10-PCS cross references "Repair" for takedown of a stoma
  - Since a takedown is restoring two body parts to their normal function one could argue Repair should be the root operation.
    - Repair of the ileum? (0DQB0ZZ)
    - Repair of the abdominal wall? (0WQF0ZZ)
  - If erroneously coded as Repair, these procedures group to MS-DRGs 344-346 (Minor Small and Large Bowel Procedures)
    - These DRGs pay more!

Options for Coding

- Code the procedures as per the coding guidelines.
  - "Refuse to participate in or support coding or documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or skew data by means that do not comply with federal and state statutes, regulations and official rules and guidelines. " *<AHIMA, Standards of Ethical Coding>*
  - Downfalls – Future restitution by payers
  - Benefits – Immediate increased revenue

Options for Coding

- Omit procedures that cause unnecessary shifts
  - Downfalls – Misrepresentation of services/resources provided, data gathering, resource utilization, undervaluing physician work
  - Benefits – Lessen financial exposure or "conservative route"

Identifying Risk

- Suggest running lists (comparative if possible) of identified procedures when coded in ICD-9-CM vs ICD-10-CM/PCS to look for MS-DRG shifts
  - Especially MS-DRGs 981-989 (Procedures performed that were unrelated to the principal diagnosis)
- Contact your MAC to see if specific guidance can be obtained on what is preferred for these situations

Payer/Authority Responses

- Some of these issues were drafted in a letter in February 2016 to AHA, CMS and 3M from ACDIS (Association for Clinical Documentation Improvement Specialists)
  - One response was received including this statement from 3M: ""*Hospitals may want to consider developing facility guidelines on how to handle these cases of unintended DRG shifts so the DRG shifts do not occur.* "
  - CMS has not commented nor AHA

Potential Actions by Payers

- Can payers consider unplanned DRG shifts due to correct coding an "error" and expect restitution?
- Will it just be "fixed" for FY 2017 even though DRG revisions are usually done every 2 years?
  - These issues were not included in the discussions at the ICD-10-CM Coordination and Maintenance Committee meetings in March 2016
- Will CMS impose an across the board "adjustment" to account for the unexpected losses for these procedure "overpayments" in the future?

Sources

- *The Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments*, <JAHIMA, February 2015>
- AHA, *Coding Clinic for ICD-10-CM/PCS*
- 2016 *DRG Expert* (ICD-10 version)
- 2016 ICD-10-PCS *Official Guidelines for Coding and Reporting*
- AHIMA *Standards of Ethical Coding*

QUESTIONS????

- Who is missing the ICD-9-CM Volume 3 Procedure Codes?????