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Inpatient Corner

Coder Alert! Take a Breath! COPD, Asthma, Emphysema

Coding Clinic Fourth Quarter clarifies these diagnoses:

Fourth Quarter 2017 released several coding clinics to clear up the confusion on how to code for COPD, Asthma, and Emphysema. Looking at these diagnoses all together helps to clarify the intent – it all depends on the **exact** wording in the chart. In fact, AHA has clarified that the term “COPD” is **not** synonymous with chronic obstructive bronchitis. A query to clarify the physician’s intent may be warranted in such cases.

Let’s start off by looking at the definition of each term:

Asthma is a long-term inflammatory disease involving the airways of the lungs. When it flares up, it causes the airways to narrow and swell, resulting in symptoms such as reversible airflow obstruction, bronchospasms, episodes of wheezing, coughing, chest tightness, and shortness of breath. These episodes can be reoccurring and differ depending on each person’s triggers and severity.

Chronic bronchitis, which is a form of chronic obstructive pulmonary disease (COPD), is an ongoing inflammation of the airways leading to the lungs (bronchi). It is characterized by a cough, mucus production, shortness of breath, and wheezing that persist for longer than three months.

Emphysema is also categorized under the chronic obstructive pulmonary disease (COPD) umbrella. This lung condition slowly destroys the air sacs in the lungs, making it more difficult to breathe. The tiny cluster-like air sacs in the lungs, called alveoli, are responsible for bringing oxygen to the bloodstream; however, as emphysema progresses, the inner walls of the alveoli form holes, weakening their internal structure and preventing oxygen from reaching the bloodstream. Emphysema also destroys the elasticity of the airways that lead to the air sacs. As a result, the air sacs collapse, trapping oxygen in the lungs. This causes sufferers to have labored breathing and shortness of breath.

Now let’s look at our coding instructions and AHA guidance. Please refer to your *Fourth Quarter Coding Clinic* release to see the specific explanation for each coding scenario.

Scenario 1: Exacerbation of Asthma and COPD are both documented and supported in the medical record - Code both J44.9 (Chronic obstructive pulmonary disease, unspecified) and J45.901 (Unspecified asthma with (acute) exacerbation). J45.901 is coded, in this case, because there is a *code also* note under J44 that instructs the coder to *code also* the *type* of asthma, if applicable. Although the *type* of asthma in this example is unspecified, the exacerbation is considered a specified term and, therefore, should be coded.

Scenario 2: Exacerbation of COPD and asthma are both documented and supported in the medical record - Only code J44.1 (Chronic obstructive pulmonary disease with (acute) exacerbation). This is because there is not specified wording for the *type* of asthma.

Scenario 3: COPD exacerbation and Emphysema are both documented and supported in the medical record - Only code J43.x (Emphysema). This is because COPD is not synonymous with chronic obstructive bronchitis.

Scenario 4: Chronic Obstructive bronchitis and emphysema are documented and supported in the medical record - Code only J44.x (Other chronic obstructive pulmonary disease). This is because of the excludes1: note under J43, which states:

Excludes1:

- Compensatory emphysema ([J98.3](#))
- Emphysema due to inhalation of chemicals, gases, fumes or vapors ([J68.4](#))
- Emphysema with chronic (obstructive) bronchitis ([J44.-](#))
- Emphysematous (obstructive) bronchitis ([J44.-](#))
- Interstitial emphysema ([J98.2](#))
- Mediastinal emphysema ([J98.2](#))
- Neonatal interstitial emphysema ([P25.0](#))
- Surgical (subcutaneous) emphysema ([T81.82](#))
- Traumatic subcutaneous emphysema ([T79.7](#))

Atrial Fibrillation/Atrial Flutter

HCC Category 96

ICD-10 Codes:

- I48.0 Paroxysmal atrial fibrillation
- I48.1 Persistent atrial fibrillation
- I48.2 Chronic atrial fibrillation
- I48.3 Typical atrial flutter
- I48.91 Unspecified atrial fibrillation
- I48.92 Unspecified atrial flutter

Atrial Fibrillation and Atrial Flutter are both types of cardiac arrhythmia. Both of these arrhythmias are caused by improper conduction of impulses across the AV node to the ventricles. In Atrial Fibrillation, the upper chambers of the heart (atria) beat irregularly and out of coordination with the lower chambers of the heart (ventricles), whereas in Atrial Flutter, the upper chambers of the heart beat faster than normal and at a higher rate than the ventricles. In both conditions, blood can pool in the atria putting the patient at risk for blood clots, a stroke, heart failure and other cardiac complications.

Atrial Fibrillation is often associated with conditions such as obstructive sleep apnea, hypertension, valvular heart disease, CHF, cardiomyopathy, CAD, Wolff-Parkinson-White syndrome, and pericarditis. It may also occur after surgical procedures, often seen documented as postoperative atrial fibrillation, or it can occur without any identifiable risk factors. Atrial Fibrillation can be paroxysmal (returns to normal rhythm on its own or with intervention within 7 days), persistent (lasting longer than 7 days), or chronic/permanent (lasting indefinitely). Specificity should be reflected in the provider's documentation.

Signs and Symptoms:

While some patients can be asymptomatic, in both Atrial Fibrillation and Atrial Flutter common symptoms include fatigue, dizziness, shortness of breath, a feeling of fluttering in the chest, chest pain or pressure, fainting, etc.

Diagnostics performed to confirm Atrial Fibrillation/Flutter may include:

- Physical Exam findings
- EKG
- Electrophysiology studies

Treatment:

From the American Heart Association, the goals of treatment for Atrial Fibrillation/Flutter should be directed toward:

- Restoring the heart to a normal rhythm (rhythm control)
- Reducing an overly high heart rate (rate control)
- Preventing blood clots and stroke
- Preventing additional heart rhythm problems
- Preventing heart failure

Common Pharmacological Interventions:

- Anticoagulation to prevent blood clots (Coumadin, Pradaxa, Xarelto, Eliquis, and Savaysa)
- Antiplatelet therapy (Plavix and ASA)
- Calcium channel blockers (Diltiazem and Verapamil), Beta Blockers (Propranolol, Metoprolol, Atenolol, Esmolol, and Nadolol), Cardiac Glycosides (Digoxin), and Antiarrhythmic (Quinidine, Procainamide, Flecainide, Propafenone, Disopyramide, Amiodarone, Sotalol, Dofetilide, Ibutilide, and Multaq)

Non-Pharmacological Interventions:

Atrial Fibrillation/Flutter includes:

- Cardioversion (the heart is shocked to convert it back to a regular rhythm)
- Catheter ablation (a procedure performed that destroys small areas of the heart responsible for the irregular rhythm).
 - o Catheter ablation is generally considered the best treatment for Atrial Flutter.
- AV node ablation (a procedure performed in which the entire AV node is destroyed necessitating the implantation of a permanent pacemaker)
- Left atrial appendage occlusion (a procedure to seal off the orifice of the LAA, which is the primary site of thrombus formation, with an occluder or excision of the LAA, or exclusion with suture or stapler is performed)
- Surgical ablation can be performed either through an open or thoracoscopic approach and is often referred to as the Maze procedure (procedure which creates scar tissue by use of cryotherapy or radiofrequency that interferes with the transmission of impulses that cause AF)

When performing an HCC coding review, it is important to carefully review medical record documentation to determine if Atrial Fibrillation/Flutter is a current condition. Procedures such as cardioversion and catheter ablation are not always successful.

The HCC auditor should perform a careful review, noting any medications that the patient may be taking for Atrial Fibrillation/Flutter and any diagnostic procedures performed. Medications used for Atrial Fibrillation may also be used for other conditions as well. If the documentation is unclear as to whether the patient has Atrial Fibrillation or Atrial Flutter, the provider should be queried.

Documentation Pitfalls

Proceed with caution!

An HCC auditor/coder is always looking for conditions that Risk Adjust and the documentation (MEAT or TAMPER) to support the condition(s) billed. An important aspect in documentation review is the ability to recognize conflicting information within the medical record. Common pitfalls that have resulted from the use of the EMR include: chart cloning (copy/paste and copy/forward), charting by exception, EMR programming issues, etc.

The word "cloning" refers to documentation that is worded exactly like previous entries or brought forward from outside records. Conditions from a past note may be resolved on the current date of service, but by the use of the copy/paste function has been brought forward to the current record making it appear as if the condition is still current. An example of cloning is as follows: A block of information, such as a hospital admission, has been copied and pasted into a current note indicating the patient had sepsis while in the hospital; however, the sepsis actually occurred a month ago and has been clearly resolved since then. Because the information in the note is "cloned" from a previous stay, the sepsis

was coded on the current DOS as well. In this example the sepsis should not be coded and the provider should be educated on only documenting what is current on that particular date of service. Another example would be a chart note indicating the patient is on Keppra for seizures when it was actually discontinued months ago and the patient has instead been on Dilantin. In this example the seizures would still be coded; however, the provider should be educated on the discrepancy.

Charting by exception can also be problematic. This EMR function gives the provider the option to check "all normal" for ROS and exams, which then populates the note with standard normal findings. It does, however, give the provider the opportunity to change any pertinent positive or abnormal findings that might be present on that DOS. Unfortunately, providers often forget to reflect these abnormal findings in their documentation. Examples of conflicting information are as follows: Malnutrition is listed in the assessment; however, a statement that the patient is well nourished is in the exam. In this example the malnutrition would not be coded unless there was overwhelming evidence that this condition was supported (otherwise it appears conflicting). Another example would be COPD with exacerbation being listed in the assessment with normal ROS and exam findings. COPD might be coded; however, the exacerbation is questionable.

Education to the provider would include reminding him or her to indicate the abnormal findings present on that date of service with emphasis on having the note flow from start to finish (Chief Complaint, ROS, Exam, Assessment, and Plan should all flow and make sense).

Another pitfall of EMR documentation lies in the EMR program itself, such as when the description does not match the code. An example of this is as follows: E11.52 Type 2 Diabetes with vascular disease is the description used in the chart note; however, this does not match the description according to ICD-10-CM, which is Type 2 Diabetes with diabetic peripheral angiopathy without gangrene. In this situation, the E11.52 would not be coded, as the description does not match the code and the specific vascular disease is not documented. Another example of conflicting information would be the provider listing Type 2 Diabetes with diabetic nephropathy in the assessment but only addressing

diabetic neuropathy underneath. In this case it would appear that the provider chose the wrong code and should have selected diabetic neuropathy. Therefore, the E11.21 would not be coded unless it had MEAT.

The provider should be queried if there is conflicting, contradictory, or unclear information documented in the chart note. Provider education should focus on the appropriate use of the EMR, avoiding questionable practices such as cloning and copy/pasting, as well as education on documentation to support correct coding.

Conflicting information can result in medical errors, improper coding, and legal ramifications. Employers may have different policies on conflicting information and questions should be addressed as they arise as each EMR is different as is the user.

Outpatient Corner

Anemia: What Code?

Anemia in ICD-10-CM has several options to pick from, spanning two pages in the ICD-10-CM alpha index. Understanding the signs & symptoms, etiology, and underlying cause, if known, is of utmost importance for accurate code assignment. If anemia specificity is unclear clinical factors may be present. A physician query may be needed before selecting the unspecified type of anemia. The difference in code selection could impact financial reimbursement, as some anemia code assignments are CC's or MCC's.

Per the *AHA 2018 Coding Handbook*, "The condition coding professionals must deal with most often in chapter 3 of ICD-10-CM is anemia. Anemia refers to either a reduction in the quantity of hemoglobin or a reduction in the volume of packed red blood cells, a condition that occurs whenever the equilibrium between red blood cell loss and red blood cell production is disturbed. A decrease in production can result from a variety of causes, including aging, bleeding, and cell destruction" (Chapter 17: Disease of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism).

Signs and symptoms of anemia range depending on the type of anemia. Common symptoms include weakness and fatigue; however, different types of anemia have a variety of sign and symptoms, as you will see below. Recognizing these different presenting problems, as well as lab values, could result in a basis for a physician query, if unspecified. Remember not to assign a code based on lab results only. Physician documentation must be present.

A few examples of anemia types including clinical indicators are as follows:

Iron Deficiency Anemia (D50) - A condition resulting from too little iron in the body. Symptoms can range from dizziness, irritability, fatigue, constipation and poor appetite. Chronic severe deficiency may lead to bizarre cravings, such as dirt and paint. Causes may be an iron deficient diet, malabsorption, parasite infestation, and chronic blood loss. Treatment is iron replacement therapy. Diagnostic lab tests performed range from a CBC, Plasma ferritin concentration, Total Iron-Binding Capacity (TIBC), UA and stool sample (occult blood).

Pernicious Anemia (D51.0) - Caused by an inability to absorb the vitamin B-12 needed for your body to make enough healthy red blood cells. Common causes include a weakened stomach lining or an autoimmune condition. Symptoms can range from glossitis, or a "burning tongue," to neurologic manifestations (vibrating sensation in the legs and/or ataxia). Diagnostic lab indicators – elevated MCV, decreased WBC (platelet), elevated serum LDH, bilirubin, and decreased vitamin B12 Serum. A Schilling test confirms pernicious anemia. Treatment medication is B12 (injections or oral).

Acquired Hemolytic Anemia (D59) - Due to a shortened survival of mature erythrocytes and the inability of the bone marrow to compensate

for their decreased life span. It may be hereditary or acquired due to infection, chemotherapy or an autoimmune disorder. Symptoms range from fatigue, bleeding tendency, dyspnea, hypotension, pruritus, jaundice, infection, and splenomegaly. Treatment ranges, depending on underlying causes, such as hydration, steroid therapy, blood transfusion and iron therapy. Diagnostic testing includes Coombs Test Direct - Positive, hemoglobin, bone marrow biopsy, hemoglobin electrophoresis, decreased RBCs, and hemoglobin, hematocrit. Medication treatment, depending on etiology, would consist of iron therapy, steroid therapy or immunosuppressive therapy.

Aplastic Anemia (D60, D61) - A rare condition in which the body stops producing enough new blood cells. The bone marrow and the hematopoietic stem cells that reside there are damaged. This causes a deficiency of all three blood cell types (pancytopenia): (1) red blood cells (anemia), (2) white blood cells (leukopenia), and (3) platelets (thrombocytopenia). **Aplastic** refers to the inability of the stem cells to generate mature blood cells, believed to be due to failure or suppression of myeloid stem cells. Signs and symptoms include weakness, dyspnea, petechiae and frequent infections. Treatment, depending on etiology, ranges from bone marrow transplants, immunosuppressive therapy, platelet and/or blood transfusions and steroid therapy. Clinical indicators may be found in bone marrow biopsy results, CBC, normocytic RBCs, liver function tests and decreased RPI (reticulocyte production index). Exposure to ionizing radiation from radioactive materials or radiation-producing devices is associated with the development of aplastic anemia, thus often found in cancer patients due to treatment. Marie Curie, famous for her pioneering work in the field of radioactivity, died of aplastic anemia after working unprotected with radioactive materials for a long period of time. The damaging effects of ionizing radiation were not then known.

Acute Posthemorrhagic Anemia (D62) (Acute Blood Loss Anemia) – Caused by a massive hemorrhage. The patient quickly loses a large volume of circulating hemoglobin. Acute blood loss is normally associated with trauma or a severe injury. Signs and symptoms are fatigue, thirst, fainting, rapid pulse and respiration and orthostatic hypertension. It is important to distinguish between anemias due to "chronic" blood loss and anemia due to "acute" blood loss, because the two conditions have entirely different codes in ICD-10-CM. Treatment directed at acute blood loss include blood transfusion, iron therapy, rest and oral fluids. Clinical lab indicators are elevated RBCs, platelets, hemoglobin and hematocrit during and immediately after the hemorrhage. Several hours after the hemorrhage the hemoglobin and RBCs decrease.

Anemia in chronic diseases classified elsewhere (D63) - A common example is D63.1 Anemia in Chronic Kidney Disease (CKD). Anemia commonly occurs in patients with CKD. Anemia might begin to develop in the early stages of CKD when someone has 20 to 50 percent of normal kidney function. Anemia normally worsens as the CKD progresses. Another example is anemia in neoplastic disease. Per the *AHA Coding Handbook*, if anemia in neoplastic disease and anemia due to antineoplastic chemotherapy (D64.81) are both documented, assign codes for both conditions. If a chronic disease is present with the statement of anemia, ensure to look for documentation from your provider for a possible linkage.

Angiography with Coronary Artery Intervention

Can a Cardiac Catheterization CPT be assigned appending Modifier 59 or XU?

Understand the basics of coronary artery revascularization procedure CPTs and their components.

Coronary artery interventions are defined as: Angioplasty, stent placement, atherectomy and thrombectomy. These procedures include contrast injections, angiography, fluoroscopic guidance, road mapping, vessel measuring for the intervention and follow-up angiography. CPT guidelines indicate diagnostic angiography may be performed at the same time as the intervention and may be separately reportable "if" no prior catheter based angiography is performed, available, and a decision to intervene is based on the diagnostic findings. If a prior study is available but documentation indicates the patient's condition has changed since the prior study, or there is inadequate visualization of the anatomy, or a clinical change during the procedure requires new evaluation outside of the target area of the intervention, diagnostic imaging reporting may be warranted. The medical record should reflect one of these elements if recent angiography was performed.

Can the diagnostic portion be billed appending 59 or X modifiers? Let's look at a few examples:

Case #1: Patient presents with recent intermittent chest pain. Order states "Chest pain. Cardiac Catheterization to evaluate for coronary artery disease. Family history of heart disease."

Summary of Operative Report: Patient presents to Cath Lab with frequent intermittent chest pain. Diagnostic imaging of right coronary, left anterior descending and left circumflex performed. Catheter is advanced across the aortic valve with LV pressures and left ventriculogram performed. Severe 90% stenosis is found in the right coronary artery. Based on these findings, the physician decides to intervene, placing a bare metal stent into the native circulation of the right coronary artery.

Coder assigns – 93458 and 92928. An NCCI edit will be generated for both of these procedures with the following warnings:

- 93458 – NCCI Edit: 93458 is a component of comprehensive procedure 92928 that is allowed if an appropriate modifier is present.
- 92928 – NCCI Edit: Review for anatomical modifier LC, LM, LD, RC or RI.

The key is understanding why these edits are in place. Per *NCCI 2018 Policy Manual*, you will find guidance in Chapter 11 Pg. XI-18-19: In this case, modifier 59 or XU would be appropriately appended to 93458 to

indicate angiography was diagnostic prior to intervention. Percutaneous coronary artery interventions (e.g., stent, atherectomy, angioplasty) include coronary artery catheterization, radiopaque dye injections, and fluoroscopic guidance. CPT codes for these procedures (e.g., 93454-93461, 76000) should not be reported separately. If medically reasonable and necessary diagnostic coronary angiography precedes the percutaneous coronary artery intervention, a coronary artery or cardiac catheterization and associated radiopaque dye injections may be reported separately...

To wrap up our understanding of Case #1, it would be appropriate to bypass the NCCI edits assigning 93458-59 (or XU) and 92928-RC, as no prior diagnostic angiography was performed and the decision to intervene is indicated after the diagnostic angiography.

Case #2: Order indicates: PCI to the LAD for coronary artery disease.

Summary of Operative Report: Patient underwent coronary angiography 2 weeks ago with findings of lesions in the right coronary artery and left anterior descending artery. Intervention was performed on the right coronary artery with stent placement at that time. Physician indicates patient is to return for staged intervention on the left anterior descending artery. Patient returns today for intervention to the LAD. Diagnostic coronary imaging is performed on the coronary arteries with repeat angiography confirming the lesion in LAD. Bare metal stent is placed in the LAD with optimal results.

Coder assigns – 93454 and 92928. NCCI edits are received as indicated in case #1. In case #2, however, accurate CPT assignment only warrants 92928-LD, as PCI was planned and diagnostic angiography performed with no significant changes from prior angiography results. Therefore, 93454 should not be assigned.

In addition to the NCCI edit warnings above, consult your CPT Assistants and CPT guidelines for coding guidance. Coding guidance for the diagnostic angiography meeting medical necessity is defined in the CPT Manual preceding CPT 92920 for the diagnostic angiography as well as coronary vessel definitions. Definitive guidance is also found in CPT Assistant, Dec 2014, Vol 24, Issue 12, Page 6: Reporting Coronary Therapeutic Services and Procedures (92920-92944).

This CPT assistant assists the coder in identifying the major coronary arteries and their perspective branches as indicated below:

Major Coronary Arteries: Left Main (LM), Left Anterior Descending (LD), Left Circumflex (LC), Right Coronary (RC), and Ramus Intermedius (RI).

Major Coronary Artery Branches: Coronary artery branches from the LD are the diagonal branches, from the LC are the marginal branches, and from the RC are the posterior descending and posterolateral branches. The left main and ramus intermedius coronary arteries do not have recognized branches for reporting purposes.

In other MARSİ news...

MARSİ/AHİMA Announce HCC Curriculum Affiliation

MARSİ is pleased to announce our recent affiliation with the American Health Information Management Association (AHİMA) as we join together to offer an online HCC curriculum. This Risk Adjustment Coding/Auditing course prepares professionals for risk adjustment coding while going a step further to address the necessary tools and skills required for precise chart auditing. The course offers a methodology for logically categorizing findings and helping ensure that these findings are appropriately addressed. It is worth 40 CEUs! If interested, please visit the AHİMA website for additional information (link provided below) and enjoy a 15% discount with code **HCCCA18**

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Medical Audit Resource Services, Inc.

Address: 3040 S. Tuskawilla Rd.
Oviedo, FL 32765

(P) 352-385-1881

(F) 352-385-1884

E-mail: marsi@himexperts.com

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