Briefings on
CODING COMPLIANCE STRATEGIES

Your inpatient coding, billing, documentation, and regulation resource

What would you do? Know your ethical obligations

In late June, Johns Hopkins' Bayview Medical Center in Baltimore agreed to pay nearly $3 million to settle allegations by two of its inpatient coders that the hospital's physicians reported secondary diagnoses they had not identified or treated, according to a June 30 press release from the United States Attorney for the District of Maryland.

During the period from July 1, 2005, through February 28, 2007, the medical center allegedly submitted to federal health benefits programs fraudulent claims stating, in many instances, that patients suffered from malnutrition and acute respiratory failure despite the patients never being diagnosed or treated for those conditions.

The two coders, whose primary responsibility included assisting with clinical documentation, claimed they were asked to review inpatient medical records to determine whether the hospital could increase reimbursement by changing the severity of certain patients' secondary diagnoses. Bayview denied all allegations but agreed to pay the settlement to avoid further litigation.

Coding ethics gets little attention because of more immediate concerns such as keeping accounts receivable days to a minimum. But the topic deserves attention all of the time, at least as coders' underlying theme, says **Kathy DeVault, RHIA, CCS,** manager of professional resources at the American Health Information Management Association (AHIMA) in Chicago. "As coders, we need to be aware of what we're being asked to do and how that fits within our standards of ethics," DeVault says.

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> —Kathy DeVault, RHIA, CCS

Do you know what ethical guidelines coders in your facility follow? How about whether they understand how they should and/or can proceed in ethically challenging situations? If you answered "no" or "I don't know" to either question, perhaps it's time to revisit the topic.

Know the ethical guidelines

Both AHIMA and the American Academy of Professional Coders (AAPC) have established coding ethics guidelines. AHIMA's 11 standards range from relatively straightforward suggestions (e.g., apply accurate and consistent coding practices, advance coding knowledge through continuing education) to those that are more complex and harder to implement (e.g., refuse to participate in or conceal unethical coding behavior).

The AAPC's code of ethics similarly focuses on helping coders maintain high personal and professional ethical standards. The organization's code states, for example, that AAPC members shall never:

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➤ Use illegal or unethical means in professional dealings

➤ Pardon or condone (by remaining silent) those who act fraudulently, deceptively, or illegally

➤ Exploit for personal gain relationships with patients, employees, or clients

Those who don't follow the AAPC's code of ethics risk losing their credentials and AAPC membership.

Coders don't need to memorize each and every ethics standard, DeVault says. However, they should know that the guidelines exist and read through them at least

once. "As coders, we just shouldn't be making assumptions [about how to handle situations]," she says. "We should be using the resources provided to us to make those decisions."

Realize potentially unethical situations

Sometimes it's easier said than done to use the resources available, particularly because reading guidelines in the abstract is quite different than putting them into practice. DeVault offers the following tips for how to proceed in scenarios that may pose ethical dilemmas:

➤ **Understand your personal limits.** Coders face stress from all sides—finance, physicians, and other coders. But stress shouldn't push coders to report diagnoses without having sufficient documentation just so they can send the claim, DeVault says. She says that one of the best managers she ever had used to tell coding staff members never to drop a chart they couldn't stand behind.

➤ **Stand your ground.** "Be true to yourself when you're coding," DeVault says. "That can be very hard," especially in a stressful environment. When you know a chart needs additional documentation to justify reporting certain codes, speak up. Conduct research ahead of time to strengthen your case. For example, search through and print out applicable issues of *Coding Clinic.* The more backup documentation you have, the more likely your superiors will support you.

➤ **Speak up.** If you see or hear other coding professionals acting in an unprofessional manner, don't confront them hostilely, but offer them a solution, DeVault suggests. Point out applicable *Coding Clinic* information or offer to talk through the case with them.

➤ **Use your manager as a resource.** Some situations require more weight behind them than others. For example, if your conversation with a colleague does nothing to dissuade unethical behavior, bring your manager into the loop. Or if you know you need to query a physician regarding a chart that might yield a high reimbursement, but that physician is out for seven days,

enlist your manager's help to keep the chart until the physician returns. If the hospital doesn't want to wait to code the chart, ask to be removed from the case.

➤ **Look at medical record notations from ancillary staff consults.** In most scenarios, coders are not allowed to code from documentation by anyone other than a physician, but notes from ancillary staff members may drive a physician query, DeVault says. For example, if a dietitian consultation suggests that a patient is malnourished, but the physician does not document this anywhere, you may be able to use the dietitian's clinical information as the impetus for querying the physician.

➤ **Foster a comfortable, open environment at your facility.** "Coders tend to be quieter people," DeVault says. "They're ... not necessarily comfortable walking in and having a confrontation or conversation, especially if they're in an environment that doesn't support that."

DeVault says she's been lucky to have always worked with managers who stood by their staff and offered an open-door policy. But not all facilities are like that, she notes. Those that are not can start by making small adjustments; set aside designated time to talk through issues or create a support system among colleagues. "As peers, we need to encourage each other," DeVault says. ∎

Malnutrition and respiratory failure codes

In a recent case at Bayview Medical Center in Baltimore, the hospital allegedly submitted fraudulent claims that stated secondary diagnoses of malnutrition or acute respiratory failure for patients never diagnosed with or treated for these conditions.

How can you ensure compliant documentation for these conditions and avoid becoming the target of a lawsuit?

The following ICD-9-CM codes denote malnutrition:

➤ 263.0, malnutrition, moderate

➤ 263.1, malnutrition, mild

➤ 263.2, arrested development following protein-calorie malnutrition

➤ 263.8, other protein-calorie malnutrition

➤ 263.9, unspecified protein-calorie malnutrition

These codes are quite specific and require the physician to document the malnutrition severity. *Coding Clinic,* fourth quarter 1992, reiterates this point.

When coding malnutrition, look for clinical indicators such as lethargy, constipation, skin lesions, and hair loss. Potential treatment for this condition includes calorie counts, daily weigh-ins, and dietary consultations. (***Note:*** These lists are not comprehensive.)

"I would always look for a dietary consult," says **Kathy DeVault, RHIA, CCS,** manager of professional resources at the American Health Information Management Association in Chicago. Coders may not use the dietitian's notes when assigning codes; however, they can use them as the rationale for submitting a query to the physician.

The following ICD-9-CM codes denote acute respiratory failure:

➤ 518.81, acute respiratory failure

➤ 518.82, other pulmonary insufficiency, not elsewhere classified (includes acute respiratory distress, acute respiratory insufficiency, and adult respiratory distress syndrome NEC)

➤ 518.84, acute and chronic respiratory failure

Check *Coding Clinic,* fourth quarter 1998 and first quarter 2005, for more information about when acute respiratory failure can be the principal diagnosis, as well as documentation requirements.

The sequencing of respiratory failure depends on the reason for admission. When respiratory failure from an underlying condition causes the inpatient admission, the failure becomes the principal diagnosis; when the patient develops respiratory failure after admission, it is the secondary diagnosis and should be coded as such.

Remember to refer to ER notes, DeVault says. Acute respiratory failure can be resolved fairly quickly in the ER, so it's possible that the physician will write it once in the chart and it won't appear again anywhere in the documentation. That doesn't mean it wasn't diagnosed or treated, she notes.

In general, coders need an awareness of each chart in its entirety, DeVault says, adding that this will help them focus on strong documentation and accurate reimbursement, rather than increased reimbursement.

Improve documentation with strong CDI specialist, program

By now, most coders are aware that ICD-10 will usher in expanded codes that will require additional specificity and more detailed documentation. A single diagnosis or procedure code in ICD-9-CM may be expanded to multiple codes in ICD-10-CM or PCS. (For information about CMS' general equivalence mappings [GEM], see the quick list on p. 9 or "Uncover this helpful GEM to assist with ICD-10 transition" on p. 1 of the July **BCCS.**)

More hospitals will likely develop clinical documentation improvement (CDI) programs as ICD-10 takes center stage. Those programs that are already in place will need to grow, expand, and mature, says **Heather Taillon, RHIA,** manager of coding compliance at St. Francis Hospital in Beech Grove, IN, and a board member of HCPro, Inc.'s Association for Clinical Documentation Improvement Specialists (ACDIS). CDI programs will become commonplace, Taillon says, adding that this is something she's already seeing on a national level.

One member of the CDI team, the CDI specialist, will play a significant role in the success of a facility's program and will be key in fostering strong relationships between coders, HIM professionals, physicians, and nurses.

It's crucial to hire the right person for the job. But who should it be? A coder? A nurse? Someone with experience in both arenas? The answer to that central question will determine how your hospital's CDI program runs.

Each background has its merits

There is no one-size-fits-all answer to the question about who should lead the CDI program, says Taillon, who runs her facility's program and whose own background is in coding.

At St. Francis Hospital, the job description for the CDI specialist role states that the individual must have an RHIA, RHIT, RN, or BSN credential. Hospitals might also consider candidates who have a BSN or CCS credential, according to ACDIS.

Taillon currently oversees four RNs who serve as CDI specialists. She says she decided to hire nurses because they would complement her own skills as a coder. A facility whose case management department runs the CDI program, on the other hand, would likely benefit from hiring an RHIT or RHIA for this position, she says.

The CDI program at Kaiser Northern California Foundation Health Plan, Inc. & Hospitals in Oakland is still taking shape, according to **Gloryanne Bryant, RHIA, CCS, CCDS,** an ACDIS board member and regional managing HIM director at Kaiser.

Although the program is a work in progress, Bryant says she envisions a process in which an HIM professional and a clinical nurse work collaboratively, on even ground, as CDI specialists.

"We need to be promoting that this can be a dual role," Bryant says, adding that one key attribute of an effective CDI specialist is the person's ability to articulate clinical documentation and coding knowledge. "It's about good communication skills," she says.

The CDI specialist's role

Although the task of documentation improvement rests on many staff members, the CDI specialist plays an explicit and extensive role in the process. Consider the tasks a CDI specialist must perform, including but not limited to the following:

➤ Review new admission charts daily
➤ Look for inadequate or incomplete documentation (e.g., conditions indicated somewhere in the chart but not included in physician documentation)
➤ Clarify conflicting or contrasting documentation
➤ Speak with physicians daily about documentation in their patients' medical records
➤ Follow up on previous cases every few days until the patient is discharged
➤ Offer provider education, when necessary

➤ Select ICD-9 codes, compare them with the coders' selection, and address any discrepancies

➤ Enter or track case review detailed data and those of the CDI program

Documentation improvement is and should be a CDI specialist's primary concern, Bryant says.

"We sometimes find that hospitals like to have a CDI person do another job too," she says. "I don't support that ... The best approach is dedicated individuals, an HIM professional/coder, and a nurse working together."

The CDI specialist can work concurrently (i.e., while the patient is still in the hospital) or retrospectively (i.e., after the patient gets discharged). Either way, the CDI specialist needs to understand what works best for his or her hospital and for individual physicians and coders.

A balancing act

A successful CDI specialist is someone who innately understands coding clinical documentation and is a people person, Bryant says. "A lot of it comes down to relationship skills and relation building," she says, adding that CDI specialists must embody a balance between clinical, coding, and interpersonal skills because they deal with many strong personalities.

When Taillon arrived at St. Francis in 2005, two years after the facility's CDI program began, her first task—and the one she considered the most important—was to strengthen trust between coders and the nursing staff. "It's all in how they approach each other," she says. "If they're set up to learn from each other, there's not going to be conflict."

Although Taillon continues to promote an environment in which coders and CDI specialists learn from one another, conflicts do occur occasionally, she says. When they do, she helps the CDI specialist and coder find the best answer and, in effect, removes the personalities from the situation. "It's okay to be passionate about coding and passionate about clinical documentation," she

says. "But each group has to recognize that it's passion, not anger [driving the situation]."

Taillon notes that passion is an easier emotion to address than indifference or resistance to change—sentiments that she and Bryant have experienced with physicians.

Sometimes, physicians aren't open to the querying and clarification processes or they don't try to understand their role in documentation improvement or the goals of the CDI program, Bryant says. "Without physician awareness, cooperation, and support, [the program] isn't going to succeed," she says.

Bryant and Taillon offer the following ways for CDI specialists to solicit physician buy-in:

➤ Set parameters early. Explain to physicians what's expected of them and how they can communicate with you.

➤ Schedule regular meetings to discuss CDI-related topics.

➤ Educate, educate, educate.

➤ Attend new physician orientation.

➤ Include code and documentation updates and changes in the medical staff memo.

➤ Offer to work one-on-one with physicians who need extra guidance (e.g., shadowing or mentoring).

➤ Embrace successes. Make physicians aware of colleagues who do something well.

➤ Enlist a physician champion or liaison.

In general, the CDI specialist must know how to communicate well with your facility's physicians, nurses, and coders and understand the nuances of your facility's clinical documentation and coding.

Who should your facility hire as a CDI specialist? That's a question each hospital needs to address individually, says Taillon. ∎

Editor's note: For information about HCPro's Clinical Documentation Improvement Specialist's Handbook *by Colleen Garry, RN, BS, visit HCPro's marketplace at* www.hcmarketplace.com/prod-5975.

Dissect documentation for psychiatric inpatients

Unique adjustments change reimbursement for every patient under IPF PPS

Unlike acute care inpatients, hospitals get paid for psych inpatients based on per diem rates set in the inpatient psychiatric facility's (IPF) PPS. The IPF PPS reimbursement system is unique in several ways. Annual updates take effect July 1—at the start of a new rate year (RY) rather than the calendar or fiscal year. Also, facility- and patient-level adjustments apply to every patient, meaning the per diem rate changes from one person to the next.

To make sure your facility receives proper reimbursement for psych inpatients, coders need a solid understanding of what documentation paints the clearest clinical picture for each patient, what they should look for in each chart, and what changed in the IPF PPS from RY 2009 to RY 2010.

In the past, inpatient psych coders only needed to capture the reason for admission provided by the psychiatrist, **Sara Clark, MLS, RHIA,** consultant at the New York–based Provider Consulting Solutions, said during the June 18 HCPro audio conference, "Inpatient Psych PPS: Clinical Documentation Improvement Strategies for Accurate CC Capture."

Now, coding an inpatient psych visit requires a fine-toothed combing of each record to extrapolate details such as whether providers treated any comorbidities and which ones, Clark said, adding, "We really have to look at the record and say, 'What is the reason, after study, for this patient to be admitted?' "

Accurate coding stems from the integrity of the data in each medical record, said **Linda Fisher, BSN, CCS-P,** a consultant at Provider Consulting Solutions, who also spoke during the audio conference. Each service a patient receives gets translated into medical codes, said Fisher.

Facility-level adjustments

Selecting the wrong codes can result in incorrect reimbursement and trend data for a given facility. It's crucial to understand the complexities of the IPF PPS, including how reimbursement under this system differs from reimbursement under the IPPS.

Under the IPPS, a DRG generates the same value for all inpatients whose care falls into that category. However, under the IPF PPS, the pay for every psych inpatient starts with the national base rate of $651.76. This rate then changes depending on facility- and patient-specific adjustment factors (AF). An AF of 1 has no effect on a facility's base rate, an AF greater than 1 increases the starting rate, and an AF less than 1 decreases it.

Let's look at the facility-level factors first. Rate adjustments occur for the following facility types:

➤ **Rural IPF:** Adjusted by 17%
➤ **Teaching IPFs:** Adjusted based on the number of full-time equivalent interns and residents training there, as well as daily patient census
➤ **IPFs in Alaska and Hawaii:** Adjusted by 1.18–1.25 based on the county in which the facility is located
➤ **IPFs with a qualifying (i.e., full-service) ED:** Adjusted by a rate of 1.31

"These facility-level adjustments are basically what I think of as brick-and-mortar issues. They are what they are," Fisher said, adding that the patient-level factors are what make this payment system unique.

Patient-level adjustments

Coding and healthcare professionals can affect the base rate of a given patient by paying attention to the following five patient-level adjustments:

➤ **DRG.** Into which DRG does the patient's care fall? To receive this adjustment, the patient's principal diagnosis must appear in the Mental Disorders chapter of the *ICD-9-CM Manual* or in the American Psychiatric Association's *Diagnostic and Statistical Manual*, Fourth Edition, Text Revision, according to the IPF PPS annual update published in the May 1 *Federal Register*.

Psychiatric principal diagnoses that don't group to an applicable DRG do not receive this particular adjustment. Some adjustments actually decrease the base pay, Fisher said. For example, alcohol and drug dependence has a DRG adjustment factor of 0.88.

➤ **Age.** CMS believes that older patients place more demands on the resources used for inpatient psych care, Fisher said. Therefore, any patient aged 45 or older generates an adjustment factor that increases base pay. Factors range from 1.01 (for patients aged 45–49) to 1.17 (for patients aged 80 and older).

➤ **Comorbidity.** Comorbidities can greatly affect reimbursement and therefore deserve considerable attention, Fisher and Clark said. "When patients have certain additional complicating issues that relate to their care, Medicare will pay more," Fisher said.

The IPF PPS includes 17 comorbidity categories. (For a complete list, see the sidebar on p. 8.) However, just because a comorbidity falls into one of these categories doesn't mean it generates additional payment. The adjustment applies only for conditions that:

- – Exist at time of admission or develop subsequently
- – Affect treatment received, length of stay, or both

"Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and must not be reported on IPF claims," according to the IPF PPS final rule. In addition, each claim can generate only one comorbidity adjustment per category. However, claims can receive adjustments for multiple categories.

Although the *Federal Register* does not provide a comprehensive list of ICD-9-CM codes that qualify for the comorbidity adjustment, it does spell out in tables six and seven additions and revisions for RY 2010. Table eight lists codes that no longer qualify for this adjustment.

➤ **Length of stay.** This factor is based solely on how long a psychiatric inpatient stays in the hospital. The per diem adjustment is highest on the first day of inpatient care, decreases every day through day 21, and plateaus on day 22. The rate remains flat from day 22 until the patient gets discharged. The day-one AF for a hospital

with a full-service ER is 1.31; that number drops to 1.19 for one without a full-service ER.

➤ **Outlier.** As with the outlier threshold for acute care hospitals, this adjustment under the IPF PPS protects psych hospitals from losing money when cases use resources that exceed a set threshold, Fisher said. According to the IPF PPS final rule, these payments also reduce incentive to underserve patients who require more care.

Updates to RY 2010 IPF PPS

The five factors discussed above greatly affect the base pay rate for a psychiatric inpatient. Typically, so will annual updates to the IPF PPS. However, this year's changes were relatively routine, Fisher said.

"For RY 2010, the Medicare regulations frankly aren't very exciting," she said. "The impact on MS-DRGs has not been particularly profound. Adjustment factors have not been tweaked or modified by CMS."

There were, however, a few noteworthy updates:

➤ CMS added to its list of ICD-9-CM codes that qualify for comorbidity adjustments 95 new codes in the infectious disease, oncology treatment, and chronic renal failure categories. The agency also noted 29 revised ICD-9-CM codes now applicable for this adjustment, all but one of which is classified in the oncology treatment category.

➤ The national starting base rate increased from $637.78 in RY 2009 to $671.56 in RY 2010.

➤ CMS standardized a rate of $280.60 per treatment for electroconvulsive therapy (ECT). ***Note:*** It's important to document, code, and bill for each instance and date of ECT treatment to earn separate payment for each, Fisher said. ICD-9-CM procedure code 94.27, other electroshock therapy, is the appropriate code.

Case study: Interrupted stay

Let's look at a case study to better understand how some of these factors affect payment in an IPF. An 87-year-old woman with a major depressive disorder lives in an assisted living facility, where she has typically done well.

Psychiatric inpatients   *< continued from p. 7*

Recently, however, she has a single, severe episode with psychotic features. She also begins to develop paranoid delusions, visual hallucinations, severe restlessness, and has difficulty being redirected. She is admitted to an inpatient psychiatric unit with a full-service ER on April 1.

The patient has a history of coronary artery disease, hypercholesterolemia, and gastroesophageal reflux disease (GERD); she also had a myocardial infarction (MI) in 1987. The initial physical exam shows an unkempt, distraught, elderly woman who does not make eye contact well and has a short attention span. Her vital signs are stable, but she has elevated blood pressure.

Upon admission to the inpatient psych unit, the patient receives and does well on a mixture of medications. However, on day 10, she starts complaining of chest pain. Given her history of MI, the patient is transferred to the telemetry unit to rule out a relapse. Two days later, she's readmitted to the inpatient psych unit with a diagnosis of flare-up of GERD. She's put back on the medication mixture and is discharged April 29, 28 days after her initial admission.

What factors affect the base rate for this patient? The appropriate principal diagnosis is schizoeffective disorder; the secondary diagnoses are hypertension, coronary artery disease, GERD, and high blood fat.

Start with the national rate of $651.76. There is no DRG adjustment, but the patient's age brings the rate to $762.56 (based on a 1.17 age adjustment). Because the IPF has a full-service ER, the base rate on day one gets multiplied by 1.31, bringing the starting payment to $998.95. Payment each day thereafter decreases slightly.

On day 10, the patient leaves the inpatient psych unit for two days, stopping the per diem rate. When she returns to the unit on day 12, the payment doesn't start over. Instead, the payment continues due to the interrupted stay (i.e., a stay during which a patient is discharged from one IPF and then readmitted to the same or another IPF within three consecutive days). "The per diem, in effect, will pick up where it left off," Fisher said.

For this patient, the rate returns to what it was on day 10. On day 28, the last day of the stay, the rate is $701.56. Reimbursement with the interrupted stay totals $21,177.30. Without the two days in telemetry, payment would have been $22,169.60, a difference of almost $1,000. ∎

Editor's note: To purchase a copy of the HCPro audio conference "Inpatient Psych PPS: Clinical Documentation Improvement Strategies for Accurate CC Capture," go to www.hcmarketplace.com/prod-6339.html. *To access the 2010 IPF PPS final rule, visit* http://edocket.access.gpo.gov/2009/pdf/E9-9962.pdf.

IPF comorbidity adjustments

Seventeen categories qualify for the comorbidity adjustment under the inpatient psychiatric facility (IPF) PPS. The categories and adjustment factors are as follows:

➤ Developmental disabilities: 1.04
➤ Coagulation factor deficits: 1.13
➤ Tracheostomy: 1.06
➤ Renal failure, acute: 1.11
➤ Renal failure, chronic: 1.11
➤ Oncology treatment: 1.07
➤ Uncontrolled diabetes mellitus with or without complications: 1.05
➤ Severe protein-calorie malnutrition: 1.13
➤ Eating and conduct disorders: 1.12
➤ Infectious disease: 1.07
➤ Drug- and/or alcohol-induced mental disorders: 1.03
➤ Cardiac conditions: 1.11
➤ Gangrene: 1.10
➤ Chronic obstructive pulmonary disease: 1.12
➤ Artificial openings—digestive and urinary: 1.08
➤ Severe musculoskeletal and connective tissue diseases: 1.09
➤ Poisoning: 1.11

Source: May 1 Federal Register *containing the inpatient psychiatric facilities PPS payment update.*

Quick list: Eight tips to better understand CMS' GEMs

To help facilities prepare for ICD-10, CMS has published two fact sheets that provide general information about the new coding system. The agency recently announced general equivalence mappings (GEM) that facilities can use to map codes from ICD-9 to ICD-10. *Note:* For more information about the GEMs, see "Uncover this helpful GEM to assist with ICD-10 transition" on p. 1 of the July **BCCS.**

But despite these educational tools, confusion still remains about how ICD-9 codes will translate to ICD-10 and vice versa, says **Sue Bowman, RHIA, CCS,** director of coding policy and compliance at the American Health Information Management Association in Chicago. Below are eight tips to help coders and others better understand the GEMs:

1. Understand which codes the GEMs include and how they map to and from ICD-10. The GEMs include all ICD-9 and ICD-10 codes, but there is not always a one-to-one match.

A concept that exists in ICD-10 may not have existed in ICD-9, Bowman says. For example, ICD-10-CM includes codes for blood type, whereas ICD-9-CM does not.

A May CMS fact sheet (available at *www.cms.hhs.gov/ MLNProducts/downloads/ICD-10Mappingfctsht.pdf*) provides the following additional reasons why a one-to-one match isn't always possible:

- Several ICD-10-CM codes may represent a single ICD-9-CM diagnosis code
- Multiple ICD-9-CM diagnosis codes may represent a single ICD-10-CM code
- Multiple ICD-10-PCS procedure codes may capture what one ICD-9-CM procedure code once represented

2. Decide which data to map to ICD-10. Facilities are not required to map all data that existed prior to the conversion, Bowman says. "It's perfectly okay to leave the old data in ICD-9 and have the new data in ICD-10," she says.

However, instances will likely arise in which a hospital wants to compare data across years. That will require mapping to ICD-10, she says. Whenever possible, hospitals should keep data in the system in which coders originally coded it.

3. Pay attention to subtle differences in code definitions or instructional notes. For example, in ICD-9, a myocardial infarction (MI) is considered acute if its duration is no longer than eight weeks. In ICD-10, that number drops to four weeks.

"When you map it, it looks pretty straightforward," Bowman says. "But because of that definition change, [the two codes] don't mean exactly the same thing. So your MI data could look different."

4. Acquaint yourself with the GEM formatting. In its May fact sheet, CMS provides an example from the ICD-10-CM GEM. The leftmost of the three columns in the map lists the ICD-10-CM source system code (i.e., the starting code). The middle column shows the ICD-9-CM target system code (i.e., the code being mapped to). The rightmost column includes a five-digit number that provides coders with information about the mappings.

The first three digits in this five-digit grouping are called flags. The last two are not. They stand for the following:

- **Flag one: Approximate meaning.** A 1 in the first column indicates that the translation from one code set to the other is an approximate match. A 0 in this spot indicates that there is an exact match. Exact matches, which rarely occur in the procedure code GEMs, are more common in the diagnosis code GEMs, according to the CMS fact sheet.
- **Flag two: No map.** A 1 in the second column means the source system code has no translation to the target system. A 0 in this spot means at least one plausible translation exists.

Quick list   *< continued from p. 9*

– **Flag three: Combination.** A 0 in column three means the source code maps to a single target code; a 1 in this position means the code maps to multiple codes.

– **Digit four: Scenario.** When the combination flag is turned on (i.e., a 1 appears in the third column), this position contains a number denoting the possible amount of variations in the source code system. CMS provides an example in the *GEM User's Manual:* For ICD-9 procedure code 30.4, radical laryngectomy, there are three possible clinical variations: the laryngectomy and neck dissection (scenario one), resection of the thyroid (scenario two), and tracheostomy (scenario three). So this position could contain 1, 2, or 3.

– **Digit five: Choice list.** As with flag four, when the combination flag is turned on (i.e., a 1 appears in the third column), this position contains

a number. Each scenario subdivides into two or more choice lists. Each choice list contains at least one target system code; when these codes from the target system link together, they equal the single source code. To get to the equivalent meaning of the source code, at least one code from each choice list must be selected.

5. Know when to expect updates. CMS will adjust the GEMs annually each January for a minimum of three years following the October 1, 2013, deadline. The updates take into account code changes or changes to the GEMs.

For ICD-10 diagnosis code updates, check *www.cms.hhs.gov/ICD10/02m_2009_ICD_10_CM.asp*. For ICD-10 procedure code updates, check *www.cms.hhs.gov/ICD10/01m_2009_ICD10PCS.asp*. According to the May fact sheet, CMS has not finalized the three-year time frame and has asked users to offer recommendations.

6. Don't expect facility-specific GEMs. Outcomes may change based on the purpose for which a facility uses the map, but everyone starts with the same data set, Bowman says. According to the *GEM User's Guide,* the GEM files attempt to meaningfully organize the code sets by linking a code in one set to all valid alternatives in the other.

7. Recognize that CMS will use the GEMs to switch MS-DRGs to ICD-10. CMS will convert all MS-DRGs from ICD-9 to ICD-10, so cases will end up in the same DRG regardless of which coding system the coder uses, Bowman says.

8. Learn the difference between the GEMs and reimbursement mapping. According to CMS' May fact sheet, the reimbursement mapping provides a one-to-one crosswalk for the non-Medicare industry. CMS used inpatient hospital frequency data to map every ICD-10 code back to a single code in the ICD-9 code set. This differs from the GEM because here, every code in one set translates to a single code in the other set. ∎

Know the adverse effects of atrial fibrillation

Clinically Speaking

by Robert S. Gold, MD

A few months ago, I wrote a description of how atrial fibrillation (AF) with rapid ventricular response (RVR) can lead to acute diastolic left ventricular heart failure.

Because of the rapidity of the systole-diastole cycle, the heart doesn't have enough time during the diastolic portion of the cycle to fill the left ventricle with blood from the left atrium. As a result, there is—by definition—acute diastolic dysfunction. When that leads to backup of blood in the lungs and acute pulmonary edema, it becomes acute diastolic heart failure.

Distinguish between AF and similar conditions

Let's look at some other manifestations of AF and see what it is that injures the patients—the AF or something else entirely.

The coronary arteries are the only arteries that fill during the diastolic portion of the heart cycle. When there's inadequate stroke volume during a rapid heart rate episode—which can happen in AF patients—and the heart is working hard to maintain that rate, some cells in the heart muscle become ischemic, and some can die. When this occurs, the troponin level rises.

Coders commonly see medical record documentation stating that a patient presents to the ED with crushing chest pain, and an EKG reveals AF with RVR. Physicians give these patients drugs to slow the heart rate, and blood studies often reveal a high troponin level that rapidly returns to normal.

According to the American Heart Association, when the troponin level is in the range for acute myocardial infarction (MI), and there are cardiac ischemia symptoms, this is a demand subendocardial MI, or non-ST-elevation MI (NSTEMI). What do ED physicians sometimes mistakenly call it? Chest pain.

Rapid heart rates that result in acute MI and acute diastolic heart failure also kill patients, which is why some public places, such as airports, provide easy access to defibrillators. Ventricular tachycardia leading to ventricular fibrillation does the exact same thing—and patients die.

Understand heart conduction system 'quirks'

These are not the only problems with AF. Physicians sometimes see slow rates (i.e., bradycardia) that are hardly enough to be concerned about from a coding perspective. Considering that a normal heart rate is approximately

Clinically speaking   < *continued from p. 11*

80 beats per minute, what happens if the heart rate suddenly drops to 40 beats or lower per minute? First, there would be inadequate blood supply to the brain, and the patient would become woozy; we call it "near syncope." Or the patient would faint because of inadequate oxygen supply to the brain, which we call "true syncope."

Bradycardia occurs because of inadequate stimulation of the normal conduction system, which prevents the ventricles from beating at the proper rate. This may cause the patient to pass out. For patients who frequently suffer from this condition, physicians insert a pacemaker, set it to beat 80 times per minute, and all is well.

A patient with heart conduction system quirks sometimes suffers from tachycardia; other times, he or she suffers from bradycardia (i.e., tachy-brady syndrome or sick sinus syndrome, ICD-9 code 427.81). These patients go from a high-output state to a low-output state. Between episodes of heart failure, they pass out. At some point, a physician may need to insert a pacer-defibrillator.

A patient with AF may function quite well with no tachycardia and no bradycardic episodes. However, the blood flow in the left atrium, which should flow smoothly from the left atrium to the left ventricle, becomes turbulent because of the fibrillation. It also doesn't empty well, which causes clots to form in the left atrial appendage, a part of the left atrium. These clots either stick to the wall of the atrium or flow freely in the cavity.

What do clots cause? Embolization. It's possible for the clots to travel into the left ventricle, out into the peripheral circulation through the aortic valve, and embolize to the brain, kidney, or intestines. Embolisms cause strokes, as well as renal and intestinal infarctions.

Again, it's not the AF that does the damage—it's the emboli that come from a clot in the left atrial appendage.

Nor does AF cause the damage of heart attacks, heart failure, or strokes. It's the rhythm disturbances or the clotting within the left atrium that occur in patients who have AF.

Assign correct codes for AF, other heart issues

What do coding guidelines tell coders to do in each of these situations?

In the case of emboli, assign a code for the damage done downstream, such as code 434.11 for embolic stroke. Also assign a code for the AF (code 427.31). There is no code for the clot in the left atrium—the clot that could kill the patient.

How do coders code AF with RVR when there is also acute diastolic heart failure or NSTEMI that occurs from the tachyarrhythmia? Assign code 427.31 for the AF and don't assign any code for the rapid heart rate. Physicians rarely provide documentation of NSTEMI—it's called chest pain due to AF. Coders are advised to report the same code (427.31) in cases of AF with a slow rate that leads to syncope. There is no specific code for the bradycardia, which often causes more damage than AF. For this condition, assign nonspecific code 427.89, other arrhythmia.

For these types of coding scenarios, coders need to take a look at all the diseases, health problems, and death AF causes, and ask themselves: Was it really the AF that did it? ∎

Editor's note: Dr. Gold is CEO of DCBA, Inc., a consulting firm in Atlanta that provides physician-to-physician programs in clinical documentation improvement. The goals are data accuracy, profile management, and compliance for physicians and hospitals in the inpatient and outpatient arenas. Reach him by phone at 770/216-9691 or by e-mail at DCBAInc@cs.com.

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Q What is the ICD-9 code for arteriosclerosis of the following:

➤ Common iliac artery

➤ Common internal and external iliac artery

A Report code 440.20 in both cases. Locate this code by referring to the *ICD-9 Manual* index entry "Arteriosclerosis, extremities."

Sandy Sillman, RHIT, PAHM, DRG coordinator at Henry Ford Health System in Detroit, answered the previous question.

Q What does an incidental pregnancy (code V22.2) mean? Is it related at all to an ectopic pregnancy (code 633.11)? Should I report the two together?

A *Coding Clinic,* fourth quarter 1996, pp. 50–51, states that code V22.2 is a secondary code only for use when the pregnancy is in no way complicating the reason for the visit. Otherwise, coders should report a code from the obstetric chapter.

For routine outpatient prenatal visits when no complications are present, report codes V22.0 (supervision of normal first pregnancy) and V22.1 (supervision of other normal pregnancy) as the first-listed diagnoses. Do not report these codes in conjunction with Chapter 11 codes. For more information, see Chapter 11 (Pregnancy/Childbirth) of the *ICD-9-CM Official Guidelines for Coding and Reporting* that took effect October 1, 2008.

Alison Stangeby, RHIA, CCS, CPC, senior consultant at BKD, LLP, in Little Rock, AR, answered this question.

Q When a patient has an aortic valve replacement and develops atrial fibrillation two days later, is this considered a cardiac complication (code 997.1) or simply a regular complication (code 427.31) because the patient doesn't have a history of atrial fibrillation?

A Given this scenario, the following codes should be reported:

➤ 424.1, aortic valve disorder

➤ 997.1, cardiac complication, not elsewhere classified

➤ 427.31, atrial fibrillation

➤ E878.8, other surgical operation with abnormal reaction/later complication, no surgical misadventure

➤ 35.22, replacement of aortic valve

Also, be sure to report the following present-on-admission indicators:

➤ Y, 424.1

➤ N, 997.1

➤ N, 427.31

You may need to report other codes as well; however, the codes listed above correspond with the limited information you've provided in your question. Note that *Coding Clinic,* second quarter 2002, pp. 12–13, states the following:

> The classification does not define a time limit for the development of a complication. It may occur during the hospital episode in which the surgery was performed, shortly thereafter, or years later.
>
> Codes in the complication chapter are early postprocedural complications, and those found in other chapters are late functional disorders.

Paula Schalen, CCS, CPC, APC coordinator at St. Joseph Medical Center in Reading, PA, answered the previous question.

Q **I have a question regarding how to code for multiple sessions of behavioral health treatment. Many of our therapists report diagnosis codes 799.9 (other unknown and unspecified cause), 995.51 (child emotional/psychological abuse), or V codes, for which insurance carriers do not reimburse at all.**

How can I stress to the therapists that they must report different codes? Shouldn't they consider the symptoms of the client's problem? Some therapists see a client six to 10 times and report diagnosis codes that are not billable to insurance carriers. I believe the therapists are afraid to label the child or teenager by assigning a billable diagnosis code that might affect the client later in life.

A I appreciate the therapists' concern for labeling a child with a psychiatric diagnosis. However, the law and medical ethics insist that treatments must be medically necessary. If the therapists refuse or are unable to confirm a mental health diagnosis, then at the very least, the therapists should document and coders should code the signs and symptoms.

Some insurance carriers reimburse for certain V codes; it depends on the V code and the procedure or service you report with it. For example, consider code V70.2 (general psychiatric examination, other and unspecified). Virtually all third-party payers require specific documentation before they will pay for an unspecified code. This is especially true when the provider reports the code for six to 10 sessions, as this raises suspicions.

It's understandable that payers would question frequent charges for the same patient from a physician who performs a general examination for unspecified reasons with a result of no specified diagnosis every time. Payers might ask, "If nothing was found the first time the physician performed the general exam, why would the physician perform another general exam?" If something was found during the first exam that led the physician to work with the patient further, the physician should define that "something," and coders should assign a code(s) accordingly.

Likewise, take a look at code 799.9 (other unknown and unspecified cause). This code does not provide any information, and it certainly doesn't support medical necessity for 10 therapeutic sessions. Essentially, reporting this code repeatedly would mean that even after 10 sessions of treating the patient, the physician still has no idea why he or she is treating the patient.

It may be reasonable in psychiatric cases that over a period of 10 sessions, there may not be a "breakthrough" that would specify a deep-seated, root cause of a mental illness. However, it is also reasonable that the physician would document more information than "totally unknown." After 10 sessions, the physician should at least be able to discern the condition (e.g., dementia, manic disorder, or phobias).

When you report code 995.51 (child emotional/psychological abuse), you should also report additional codes for any identifiable associated injuries, as well as E codes to identify the nature of the abuse and the perpetrator. Most states require legal intervention as well, which often results in courts—rather than health insurance carriers—paying for these services.

Shelley C. Safian, MAOM/HSM, CCS-P, CPC-H, CHA, of Safian Communications Services in Orlando, FL, answered this question. ∎