Coming soon to an ED near you: ICD-10-CM

The transition to ICD-10-CM/PCS will be here sooner than you think, so now is the time to start looking at how the transition will affect coding and documentation for facility EDs.

Although it is still a little early for coders to start learning the actual ICD-10-CM codes, AHIMA states that by mid-2011, outpatient coders should have a basic understanding of the structure, organization, and unique features of ICD-10-CM and begin learning about the general equivalence mappings between ICD-9-CM and ICD-10-CM.

“It is true that the code sets are in a draft format currently, but they may likely remain that way until the last revision to the ICD-10 code sets,” says Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CCDS, director of coding and HIM at HCPro, Inc., in Danvers, MA. Now is the perfect time for coders and other health information professionals associated with the coding process to at least get basic training on the structural differences as well as documentation differences that the new code set will require, McCall says.

ICD-10-CM is far more detailed and granular than ICD-9-CM and may help facilities reap the benefits of an electronic medical record. It will also greatly increase providers’ ability to monitor quality outcomes by allowing them to be more specific in their diagnosis coding, says Joanne M. Becker, RHIT, CCS, CCS-P, CPC, CPC-I, CEMC, associate director in the Joint Office for Compliance at the University of Iowa Hospitals and Clinics in Iowa City, IA.

It may even help facilities garner more accurate reimbursement because it will allow them to more accurately report the services providers performed, explains Becker.

Start with the basics

Each department within a facility will face different challenges with the transition to ICD-10-CM, but everyone will need to build on the same foundation—the code structure for ICD-10-CM.

Current ICD-9-CM codes are three to five characters in length. Valid ICD-10-CM codes contain anywhere from three to seven characters:

- Character one is alpha (all letters used except “U”)
- Character two is numeric
- Characters three through seven are alpha or numeric

The decimal point is used after three characters. A dummy placeholder “x” is also sometimes used. This
ICD-10-CM allows for future expansion of the codes, or fills out empty characters when a code contains fewer than six characters and a seventh character applies.

Seventh character extensions exist in some chapters of ICD-10-CM, primarily in the obstetrics, injury, and external cause chapters. They may be alpha or numeric and are placed at the end of the code in the seventh position when applicable. They provide additional information about the characteristics of the encounter.

ICD-10-CM ED challenges

That seventh character may prove challenging, especially for ED coders, in part because it means different things in different chapters. For fractures, the seventh character identifies whether a fracture is the initial encounter, subsequent encounter, or sequelae; the type of fracture (e.g., open or closed); or the type of healing (e.g., routine, delayed, malunion, or nonunion).

Often, the documentation already specifies which specific limb and side of the body is involved. However, it may not contain the additional information needed to assign a seventh character under ICD-10-CM.

“Maybe we aren’t always clear if this is an initial encounter, so that is something to think about as we improve our documentation,” Becker says.

ICD-10-CM also uses additional codes to identify laterality. Conditions coders might see in the ED include Colles’ fractures and sprains. With ICD-9-CM, coders would choose between codes 813.41 (Colles’ fracture [closed]) and 813.51 (Colles’ fracture [open]).

However, with ICD-10-CM, coders will need to know the specific location of the Colles’ fracture, as well as whether it is open or closed, and whether this is the initial visit.

For a Colles’ fracture of the right radius, for example, coders will choose from the following list:

- S52.531A, Colles’ fracture of right radius, initial encounter for closed fracture
- S52.531B, Colles’ fracture of right radius, initial encounter for open fracture type I or II
- S52.531C, Colles’ fracture of right radius, initial encounter for open fracture type IIIA, IIIB, or IIIC
- S52.531D, Colles’ fracture of right radius, subsequent encounter for closed fracture with routine healing
- S52.531E, Colles’ fracture of right radius, subsequent encounter for open fracture type I or II with routine healing
- S52.531F, Colles’ fracture of right radius, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
- S52.531G, Colles’ fracture of right radius, subsequent encounter for closed fracture with delayed healing
- S52.531H, Colles’ fracture of right radius, subsequent encounter for open fracture type I or II with delayed healing
➤ S52.531J, Colles’ fracture of right radius, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
➤ S52.531K, Colles’ fracture of right radius, subsequent encounter for closed fracture with nonunion
➤ S52.531M, Colles’ fracture of right radius, subsequent encounter for open fracture type I or II with nonunion
➤ S52.531N, Colles’ fracture of right radius, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
➤ S52.531P, Colles’ fracture of right radius, subsequent encounter for closed fracture with malunion
➤ S52.531Q, Colles’ fracture of right radius, subsequent encounter for open fracture type I or II with malunion
➤ S52.531R, Colles’ fracture of right radius, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion
➤ S52.531S, Colles’ fracture of right radius, sequela

And those 16 codes are for just one fracture type at one site; ICD-10-CM includes this much detail for each type of fracture and site. Coders must dig deep into the record to gather the information necessary to select the most appropriate code.

“There will definitely be some additional information needed, especially when some fracture codes [e.g., femoral fractures] will add a greater amount of detail, such as using the Gustilo-Anderson classifications for open fractures,” McCall says.

For fractures, if the physician does not document whether it was open or closed, the coder defaults to closed, just as in ICD-9-CM. However, when it comes to subsequent visits, physicians will need to document whether the fracture is considered routine healing, delayed healing, malunion, nonunion, or sequela because ICD-10-CM currently does not include a default code, McCall says.

ED coders will see similar specificity for other common visits, such as sprains and lacerations.

**E codes**

ED coders also use plenty of E codes to describe the accident, circumstance, event, or specific agent that caused a patient’s injury. In ICD-10-CM, those E codes will be located in either Chapter 19 (Injury, poisoning and certain other consequences of external causes) or 20 (External causes of morbidity and mortality).

Consider this example: A student is struck by a softball on an athletic field and suffers a contusion of the lower right leg. If the patient comes into the ED for treatment, coders would assign the following ICD-10-CM codes:
➤ S80.11xA, contusion, right lower leg, initial encounter
➤ W21.07xA, struck by a softball
➤ Y92.328, other athletic field
➤ Y93.64, activities involving other sports and athletics played as a team or group—softball
➤ Y99.8, other external cause status, student

Coders will see many of the same coding conventions they currently see in ICD-9-CM. But in ICD-10-CM, they will see more codes and more-specific codes, Becker says.

**More documentation needed**

To take advantage of the increased specificity in ICD-10-CM, coders will need to first find the information in the physician’s documentation. Becker has heard many people say that physicians need to change the way they document in order for coders to select the most appropriate ICD-10-CM code. She doesn’t believe that is necessarily true. If a physician needs to improve documentation for ICD-10-CM, he or she probably needs to improve documentation for ICD-9-CM as well.

“I think it’s important that physicians understand how their documentation impacts ICD-10-CM coding, just like it impacts ICD-9-CM coding,” Becker says. Physicians should understand the benefits that can be gained by the additional detailed information that ICD-10-CM provides.
**E/M modifiers**

**Significant, separately identifiable E/M: Modifier -25**

Assigning the most appropriate E/M level can be a challenge since no national guidelines exist and physicians don’t always document everything they do during an exam.

Another potentially confusing situation arises when a patient comes in for a minor procedure and the physician performs a history, physical exam, and medical decision-making—all the elements of an E/M service. Should you separately bill an E/M service along with the procedure? The answer, not surprisingly, is “it depends.”

To separately bill for an E/M service in addition to a procedure, the E/M visit must be significant and separately identifiable. In other words, the physician has to document that he or she did more than what was required for the procedure.

As part of the standard of care, a physician or nurse will record the patient’s vital signs and examine him or her before performing the procedure. This work is considered part of the procedure. Coders should only append modifier -25 when the E/M service is significantly above and beyond the norm or focused on a different area than the procedure, says Sarah L. Goodman, MBA, CHCAF, CPC-H, CCP, FCS, president/CEO and principal consultant for SLG, Inc., in Raleigh, NC.

When you do have enough documentation for the E/M visit to stand on its own, bill the appropriate level of E/M service with modifier -25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service). Make sure the E/M visit with modifier -25 isn’t the only thing on the claim, says Goodman. “Otherwise, you’ll trigger an OCE edit and quite possibly an OIG audit as well.”

Also keep in mind that modifier -25 attaches to the E/M service even though its description is written as if it goes on the procedure code, says Alice Reybitz, RN, CPC, CPC-H, CPC-I, curriculum instructor with the American Academy of Professional Coders in Salt Lake City.

Modifier -25 can only be appended to these codes:
- 92002–92014 (eye exams)
- 99201–99499 (E/M visits)
- G0101 (cervical or vaginal cancer screening)
- G0175 (scheduled interdisciplinary team conference)

Also be sure to review payer guidelines for use of modifier -25. One Blue Cross/Blue Shield carrier recently issued a statement that it would only reimburse E/M services with modifier -25 at 50% of the usual rate, Goodman says.

**Read the procedure and E/M guidelines**

One reason coders incorrectly code an E/M visit with modifier -25 along with a procedure is that they aren’t familiar with the guidelines for some simple procedures, says Reybitz. Coders may stumble when it comes to suture removal or removal of a percutaneous endoscopic gastrostomy (PEG) tube. A coder might think, “This is a procedure, and the physician touched the patient, so I can charge for the procedure and append modifier -25 to the E/M service.”

That’s not true, Reybitz says. If coders really read the guidelines for those procedures, they’ll see that the guidelines say, for example, that the removal of a PEG tube is included in the E/M service. The same is true with suture removal—it’s included in the E/M service. “That’s what really trips them up,” she says. “They aren’t as familiar with the guidelines as they should be.”

Reybitz recommends reading the guidelines every year when the AMA publishes the new CPT codes. Sometimes the codes don’t change, but the guidelines do. “They really have to be aware that keeping up with the guidelines is really as important as keeping up with the codes,” she says.

If the AMA adds a new procedure, it will always include guidelines that specify what can and can’t be coded with that new procedure.
Consider the intent of the visit

Coders also need to look at the intent of the visit when determining whether to append modifier -25, Goodman says. Remember that if a patient presents specifically for a procedure or service, and the provider does not perform a separate E/M service beyond those necessary for the procedure, do not assign an E/M code with modifier -25.

When a patient makes an appointment for an E/M, it is usually just an office visit. The medical staff could be reviewing medications, checking the patient’s blood pressure, or performing an annual physical, Reybitz says. The coder is then reading the documentation of what took place during the office visit and may see something like, “The patient came in for an annual physical and everything went great except [doctor] heard a heart murmur.” At that point, the physician decided to perform an EKG while the patient was in the office.

“Well, the guidelines say the EKG isn’t part of their preventative care for that visit, they can charge for that EKG,” Reybitz says. That diagnosis of what the doctor heard and why he or she decided to perform the EKG will be there. Sometimes it’s only a sentence in the middle of the exam, such as, “The doctor hears something he doesn’t like and decides to do an EKG.”

“If you miss those simple things, then you’re not going to catch it,” Reybitz says. “So they have to make sure they are reading exactly what the physician did.”

Consider this example: A 35-year-old female presents to the infusion clinic for her weekly peripherally inserted central catheter (PICC) line flush. The nurse records her vitals, assesses and flushes the PICC line, applies a clean dressing, and schedules the patient’s next appointment. How should this be coded?

The term “weekly” suggests that the patient is established and well known to the facility, Goodman says. Even though the nurse triages the patient and performs a line flush, the coder should only report code 96523 for the irrigation of the implanted venous access device with no separate E/M service. “There’s nothing to suggest a separate exam justifying an E/M was performed,” Goodman says.

On the other hand, a patient may present for the evaluation of an injury or illness and the physician also performs a procedure during that visit. For example, a 46-year-old male presents to the ED for evaluation after a minor traffic accident. According to the facility’s guidelines, the physician performs a level four ED service. During the visit, the physician determines that the patient requires a simple repair of a 1.7-cm facial laceration.

In this case, the coder can report a separate E/M service. Coders would report 99274-25 for the level four ED visit and 12011 for the simple repair of the superficial facial wound. “It all goes back to the documentation and the intent of the visit,” Goodman says.

Review your own records

One way to make sure coders are correctly charging for a separate E/M visit and appending modifier -25 appropriately is to perform a self-audit.

Start by examining how frequently your facility assigns particular diagnosis codes. Separately distinct and identifiable procedures are usually easily identified with a diagnosis, so coders should ensure that they don’t overlook a diagnostic statement.

Remember, though, if you can’t make two complete operative notes out of the documentation, you don’t have enough to bill an E/M service with modifier -25.

Check to be sure modifier -25 is not appended automatically or arbitrarily, Goodman says. Before appending modifier -25, make sure the documentation supports the separate E/M code.

Some facilities hard-code modifier -25 into their chargemaster for ED and clinics. That way the department is responsible for adding the modifier instead of HIM staff having to code it. Be very careful with this methodology and make sure the modifier is set up correctly in the chargemaster, Goodman says. “If you do choose to hard-code modifier -25, you should have a credentialed coder reviewing the claim before it drops. That way you will have peace of mind and ensure compliance.”
It’s a classic example: Ragweed season is in full swing. An asthma patient presents to your ED two or three times on the same day with difficulty breathing. Although he or she doesn’t need to be admitted, medical staff must ensure that the patient’s airway remains open.

In this case, how does your hospital receive reimbursement for each encounter?

The answer: Modifier -27 (multiple outpatient hospital E/M encounters on the same date).

“When that happens, modifier -27 has to be appended to each subsequent visit that day,” says Alice Reybitz, RN, CPC, CPC-H, CPC-I, curriculum instructor with the American Academy of Professional Coders in Salt Lake City. “You will get paid for all of the visits, but not if the modifier -27 isn’t there.”

Outpatient hospital coders may append modifier -27 to the second and any subsequent E/M code when multiple, separately identifiable E/M visits take place on the same day. The visits can take place in the same outpatient department, such as the ED, or in separate departments, such as the gastrointestinal department and the ear, nose, and throat (ENT) department.

However, some important restrictions apply when using modifier -27. Coders should not use modifier -27 to report any type of service other than an E/M visit. If a patient comes in for multiple procedures on the same day, don’t use modifier -27 for the procedures. “You have to make sure it’s an E/M service that you’re appending it to,” Reybitz says. Appropriate codes include the following:

➤ 92002–92014, eye exams
➤ 99201–99499, E/M visits
➤ G0101, cancer screening
➤ G0175, scheduled interdisciplinary team conference

In addition, modifier -27 is limited specifically to hospital outpatient departments—do not use it for physician practices.

Apply condition code G0

Condition code G0 must accompany modifier -27 on all paper and electronic claim forms. The condition code G0 specifies that multiple medical visits occurred on the same day with the same revenue center, and that these visits are distinct and constitute independent visits.

“Condition code G0 may come from a non-coder. It may come from billing staff,” says Lolita M. Jones, RHIA, CCS, an AHIMA-certified ICD-10 trainer and principal of Lolita M. Jones Consulting Services in Fort Washington, MD. “The key is it needs to be there.”

Have full supporting documentation

The documentation must support the use of modifier -27, Jones says. It’s not enough just to have the patient registered twice for two separate encounters on the same date of service in the registration system. The documentation must show that both visits were actually carried out and specify what types of services the provider rendered during each visit.

Each visit must be able to stand on its own when it comes to determining whether to bill it as an E/M service. When reviewing documentation for each E/M visit, look for all three key components:

➤ A complete history
➤ A complete physician exam
➤ Medical decision-making

“‘Records reviewed’ does not medical decision-making make,” Reybitz says.

Use modifier -27 correctly

Consider this example: Adam comes into the gastrointestinal department of the hospital for a routine follow-up E/M visit in the morning. In the afternoon, he comes into the ENT department because he has an upper respiratory infection. Each physician documents Adam’s visit and specifies the history, problem, and
medical decision-making involved. Using the hospital’s E/M criteria, both visits map to level three.

When the chart reaches the coding and billing departments, the coder will assign the exact same code twice because both visits mapped to the same E/M level. Unless the coder also appends modifier -27 to the second visit, the facility will only be paid for one visit.

Modifier -27 tells the contractor that this is not a mistake. “We truly did intend to give you two visit codes for the same patient on the same date of service,” Jones says. Modifier -27 tells the payer that the hospital has documentation for the additional visit and should be paid for those services.

Modifier -27 is not used to bypass edits, says Reybitz. “You’re explaining to the payer that this patient was indeed back for more than one visit.” Remember that the documentation must support the complete E/M visit.

**Capture multiple visits**

So how do you make sure you are capturing all of the visits a single patient makes in one day to the various departments in your hospital? Remember, having the patient scheduled for two or more visits isn’t enough. The facility must show that the patient actually did show up for each visit, was seen by a provider during each visit, and received some E/M service as well.

Facilities can track patient visits in different ways. One way is to track the visits manually by having a member of the coding or billing staff look through each record for the number of visits each patient made. A staff member could also manually check the charts against the appointment log for each department to see who was scheduled and who showed up. Alternately, this tracking can be done automatically. See the chart below for an example.

Whether your facility tracks visits automatically or manually, you need to make sure you can determine how many times the patient actually came in to an outpatient department and received services. Sometimes a patient is a no-show but is still on the appointment schedule. Or perhaps a patient is scheduled for follow-up in the afternoon and the physician determines during a morning visit that the patient doesn’t need to come back. Or the physician may have to admit the patient after the first visit.

“You need someone to confirm that multiple visits did occur,” Jones says. An automated report also helps when different coders are coding the visits. One coder may

> continued on p. 8

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### USA University Outpatient Daily Visit Report for 2/21/2011

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Source: Adapted from a chart created by Lolita M. Jones, RHIA, CCS.
work only with ENT cases, while another codes only OB/GYN visits. In some cases, the staff within the clinic itself performs some of the coding. Without some form of hospital-wide tracking, those coders won’t know to append modifier -27 to the second visit because they won’t know the patient was seen twice on the same day.

“You need some way to bring everything together so that at a higher level someone can track those visits and report the modifiers as appropriate,” Jones says.

Review records for missed modifiers

It’s a good idea to review records and make sure coders aren’t missing billable services. When you review records for missed E/M visits on the same day, determine whether each physician documented a complete E/M visit. Did the physicians document all three key components?

In some cases, you may end up with a lower-level E/M service for additional visits on the same day. Low-level E/M visits could actually be hidden in just three or four sentences of documentation, Reybitz says. But the physician still performed all three key components.

“ Coders have to learn to look at what they have,” Reybitz says. She recommends using good audit sheets, such as the ones created by CMS. Perform some spot audits using those sheets to get a good idea of where your facility stands on E/M visits and where you may need to capture more of those charges.

Modifiers -25 and -27: Multiple E/M visits with procedures

In some cases, you may need to append more than one modifier to explain what happened with a particular patient on a particular day. Let’s consider one example.

Steve, an established patient with chronic obstructive pulmonary disease (COPD), comes into the ED at 10 a.m. because he is having trouble breathing due to high humidity. Dr. Walsh sees Steve, performs a level two E/M service, and sends Steve home.

At 2:30 p.m., Steve returns to the ED because he is having trouble breathing again. Dr. Smith sees Steve, performs another level two E/M visit, and orders a nebulizer treatment.

What should the coder report for this case?

➤ 94640 for the nebulizer treatment
➤ 99282-25 for the first level two ED E/M service
➤ 99282-25-27 for the second level two ED E/M service

For Steve’s case, you need both modifier -25 and -27 on the second visit code. Modifier -25 indicates that the E/M service was separately identifiable from the nebulizer treatment. Modifier -27 tells the payer that Steve did indeed come into the ED twice on the same day.

Airway problems are scary for patients, so they come into the ED, says Alice Reybitz, RN, CPC, CPC-H, CPC-I, curriculum instructor with the American Academy of Professional Coders in Salt Lake City. The coder has to realize that if you do a nebulizer treatment while the patient is in the ED, it is a separate service and the coder should append modifier -25 to the E/M visit.

Consider a second example: Lisa, an established patient with COPD, comes into the ED at 10 a.m. because she is having trouble breathing due to high humidity. Dr. Walsh sees Lisa, performs a level two E/M service, and orders a nebulizer treatment.

At 2:30 p.m., Lisa returns to the ED because she is having trouble breathing again. Dr. Walsh sees Lisa again and orders a nebulizer treatment. However, Dr. Walsh does not document an additional E/M visit.

In this case, you can bill both nebulizer treatments but only one E/M service, again with modifier -25 appended. Since Dr. Walsh did not document a second full E/M service, you can’t code it.

If Dr. Walsh sees Lisa twice on the same day for the same problem, he might decide that since he saw her earlier in the day, he will simply order the treatment again.

“If the documentation isn’t there for an E/M for the second visit, you can’t charge for it,” Reybitz says.
Differentiate between modifiers -33, -PT

Please explain the difference between using modifier -PT and modifier -33 for screening colonoscopy encounters that turn to diagnostic. We have received advice to use modifier -PT, but we’ve also seen advice to use modifier -33. Does it differ by payer?

The AMA created modifier -33, effective January 1, 2011, for purposes of identifying preventive services mandated by the Patient Protection and Affordable Care Act. These services are to be provided to covered beneficiaries without cost-sharing requirements such as copays, coinsurance, or deductibles.

When the primary purpose is the delivery of an evidence-based service in accordance with a U.S. Preventive Services Task Force A or B rating or other preventive service identified in preventive services mandates (legislative or regulatory), you can identify this by appending modifier -33. When these services are an integral part of an office visit (i.e., the primary reason for the office visit is the provision of preventive services), the insurance payer cannot hold the beneficiary accountable for cost-sharing requirements.

When a planned preventive service starts and then converts to a therapeutic service, you should append modifier -33. A common clinical scenario is a screening colonoscopy converted to a diagnostic colonoscopy on the basis of clinical findings during the screening colonoscopy. The coder would append modifier -33 to the diagnostic colonoscopy code, such as CPT code 45379 (colonoscopy with removal of foreign body).

Please refer to a recent AMA article, “New CPT Modifier for Preventive Services” (CPT Assistant, December 2010). This article summarizes and outlines the proper and appropriate use of modifier -33.

Modifier -PT, created in January 2011, indicates the reporting of a diagnostic procedure code—instead of a screening colonoscopy or screening sigmoidoscopy HCPCS code—when the visit began as a preventive screening service. Use modifier -PT when the visit began as a colorectal cancer screening service and then became a diagnostic procedure. Append the modifier to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening sigmoidoscopy HCPCS code.

Modifier -33 is designated for use in appropriate clinical instances when the payer is a commercial insurer other than Medicare. Modifier -PT is designated specifically for use when a screening colonoscopy or sigmoidoscopy converts to a diagnostic colonoscopy and the payer is Medicare. Please refer to the WPS Medicare MAC Web page highlighting the proper and appropriate use of modifier -PT: www.wpsmedicare.com/part_b/education/modifiers/pt_modifier.shtml.

You can also access an easy-to-use WPS reference page outlining proper and appropriate use of modifiers at www.wpsmedicare.com/part_b/education/modifiers.shtml. Keep in mind that some of these modifiers may only be used for Medicare Part B professional billing.

Correct assignment of modifier -25

Our coders are in a quandary about modifier -25. We don’t know whether it applies to the E/M physician side or the E/M facility side. We cannot seem to find an answer to this question.

After reading as much information as I could find, it seems this is a physician charge for work above and beyond the norm. Can you please direct me to an answer to this problem?

Modifier -25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) is applicable to both
Coding Q&A < continued from p. 9

physician and facility outpatient reporting. The modifier indicates to the payer that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided, or beyond the usual preoperative and postoperative care associated with the procedure.

When using modifier -25, remember that CPT guidelines do not require different diagnoses to report the E/M service and procedure separately. Also, the E/M service must meet CPT guidelines for reporting the level of E/M service.

For physician reporting, you should only append modifier -25 when a separately identifiable E/M is provided on the same day as a minor surgical procedure. Preoperative and postoperative visits are included in the payment for the procedure. If the decision to perform a minor procedure is made immediately before the service, the E/M visit is considered to be a routine preoperative visit and would not be billed in addition to the minor procedure.

If during the global fee period the physician provides an E/M service that is above and beyond the usual pre- and postoperative work of a procedure, it would be appropriate to append modifier -25 to the E/M code. However, documentation must support the additional service. (See CMS Transmittal R954CP, at www.cms.gov/transmittals/downloads/R954CP.pdf.)

Modifier -25 in OPPS reporting is much the same as on the physician side; however, since there are no assigned global periods, there are a few exceptions:

▷ Modifier -25 applies only to E/M codes and then only when an E/M service was provided on the same date as a diagnostic or therapeutic medical-surgical procedure (i.e., status indicator “S” or “T”)

▷ It is not necessary that the procedure and the E/M service be provided by the same physician or practitioner for modifier -25 to be utilized in the facility setting

➤ The diagnosis associated with the E/M service does not need to be different from the diagnosis reported for the procedure

➤ It is appropriate to use modifier -25 with the ED codes 99281–99285 when these services lead to the decision to perform a diagnostic or therapeutic procedure (CMS Transmittal A-00-40)

When to code causative organisms

A patient presents to the ED with a urinary tract infection (UTI). The physician documents the patient has a UTI, orders a culture, and prescribes an antibiotic. If the patient has a documented, diagnosed UTI and the culture results are available at the time of coding, can the coder use the culture results for further coding specificity or does the physician have to add an addendum stating UTI “due to ...”? We have been adding the additional code for many years but are wondering whether that is old advice now.

I think many coders would code the causative organism in the scenario described above, but, strictly speaking, they should not unless a provider documents, say, that E. coli (041.4) was the causative organism of the UTI. Coders should look for specific physician or nonphysician practitioner documentation that makes the connection of a lab finding to a causal organism and to a diagnosis—they should not make the connection themselves based on the lab tests. If, as in the example above, the documentation included only a lab result without any documentation connecting the two, the coder should either query the physician or code as-is using UTI (599.0) without the infection/parasitic code.

In the ICD-9-CM coding guidelines for outpatient services, section L states, “For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented
in the interpretation. Do not code related signs and symptoms as additional diagnoses.” In general, ICD-9-CM guidelines related to Abnormal Findings instruct coders that lab findings themselves are not coded unless the provider discusses their clinical significance.

Faye Brown’s ICD-9 Coding Handbook 2011 also addresses this topic. It states that physicians don’t always provide complete information for a specific diagnosis. However, coders can refer to the diagnostic reports within the medical record and then query the physician for appropriate confirmation. Some facilities may develop their own additional coding guidelines to provide assistance in determining when a physician query is appropriate.

Coders should query the provider so the additional causative organism detail may be provided and coding can be completed accurately and compliantly. Per the October 1, 2010, ICD-9-CM Official Guidelines for Coding and Reporting:

Multiple coding for a single condition
For example, for infections not included in chapter 1, a secondary code from category 041, Bacterial infection in conditions classified elsewhere and of unspecified site, may be required to identify the bacterial organism causing the infection.

Further, the Ingenix 2011 Coders’ Desk Reference for Diagnoses states:
Specified Organism:
When the causative organism has been identified, it is reported as an additional code to the urinary tract infection (599.0).

ICD-10 and modifiers

Q Since laterality will be identified in ICD-10-CM diagnosis codes, will we still need to use HCPCS II/CPT modifiers such as -RT (right side), -LT (left side), or -50 (bilateral procedure)?

A This is a great question. Even though the addition of laterality (right/left) to the ICD-10-CM diagnosis codes adds specificity not seen in ICD-9-CM, the concept of unilateral/bilateral in a diagnosis code isn’t new. So I think it is helpful to explore how both appear in ICD-9-CM versus ICD-10-CM and their relation to CPT codes.

For instance, the ICD-9-CM diagnosis code for an initial bilateral inguinal hernia (without gangrene or obstruction) would be 550.92. The fifth digit identifies whether the hernia is unilateral or bilateral, as well as whether it is recurrent. The ICD-10-CM code for this same diagnosis is K40.20 (bilateral inguinal hernia, without obstruction/gangrene, not specified as recurrent), and as you can see, it is the same.

Repairs in CPT for this type of inguinal hernia (in a patient 5 years and older and stated as reducible) would be either 49505 (open) or 49650 (laparoscopic). The CPT guidelines identify in a parenthetical note that it would be appropriate to append modifier -50 identifying a bilateral

> continued on p. 12

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Coding Q&A  < continued from p. 11

procedure when a physician performs it. The diagnosis code 550.92 already identified that the hernia was bilateral, but it is still necessary to append the modifier.

The concept of unilateral/bilateral codes currently exists in ICD-9-CM, but the concept of identifying right side versus left side is new in ICD-10-CM.

For example, coders will assign one ICD-9-CM code, 813.23, for the initial encounter for a traumatic closed fracture of the shaft of the radius and ulna. The combination code identifies that the fracture was of both bones in the forearm, but it does not state whether the fracture was on the right or left side. So if a patient suffered bilateral closed fractures of the shaft of the radius and ulna, coders would only report ICD-9-CM code 813.23 once.

The ICD-9-CM Official Guidelines for Coding and Reporting states, “Each unique ICD-9-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions or two different conditions classified to the same ICD-9-CM diagnosis code.”

However, if a patient suffers traumatic bilateral fractures of these same bones, coders will report four codes in ICD-10-CM:

➤ S52.301A (unspecified fracture of shaft of radius, right radius)
➤ S52.302A (unspecified fracture of shaft of radius, left radius)
➤ S52.201A (unspecified fracture of shaft of radius, right ulna)
➤ S52.202A (unspecified fracture of shaft of radius, left ulna)

ICD-10-CM does not include a combination code to identify fractures of both the radius and ulna; rather, coders report each separately.

Regarding CPT codes for repairs of fractures, for a closed reduction without manipulation of the bilateral radial and ulnar shaft fractures, coders would report CPT code 25560. To identify that the provider performed this procedure bilaterally, coders would report either 25560-RT and 25560-LT or 25560-50 (depending on payer requirements) because the CPT code does not inherently state that the procedure is bilateral in the code description.

Even though ICD-10-CM’s added specificity is evident in codes for right/left sides (e.g., for fractures), the concept of unilateral/bilateral has existed for many years (e.g., for hernias).

The instructional notes in CPT indicate it is still necessary to append modifiers to CPT codes when a physician performs a procedure on only the right or left side, as well as when the physician performs the procedure bilaterally—even though some diagnosis codes already state this information. ■