CMS demonstration allows rebilling outpatient services after some inpatient denials

Perhaps you’re familiar with the following scenario: A hospital submits a short-stay inpatient (Part A) claim. An auditor, such as a RAC or MAC, reviews the claim and deems the admission to be not reasonable and necessary due to the hospital billing the wrong setting. The auditor issues a denial for the full amount of the claim. Although the hospital may rebill for certain Part B ancillary services before the timely filing limit, it may not bill for any of the other outpatient services denied as part of the inpatient claim.

Providers and professional associations have long lamented this inability to rebill outpatient services that meet the requirements for payment simply because the Part A inpatient stay is denied, said Connie Leonard, director of CMS’ Division of Recovery Audit Operations, during a CMS Open Door Forum call on November 30, 2011. Considering providers’ frustration, CMS decided to launch the RAC Part A to Part B rebilling demonstration program. The program, which began January 1, allows providers to rebill for all outpatient services (including Part B ancillary services) when they receive medical necessity denials for short-stay inpatient claims. The only exception is observation services (G0378), which hospitals may not rebill as part of the demonstration.

Rebilling for the outpatient services requires that providers resubmit denied inpatient claims with a code indicating they are being rebilled as part of the demonstration program. They will receive 90% of the Part B payment (i.e., 90% of the total payment after the coinsurance and deductible have been subtracted). The code will be provided to demonstration participants only. Participants may not share the code with other providers; doing so will constitute fraud.

Providers that complete a self-audit and identify an error may cancel an inpatient claim and resubmit it for 90% of the Part B payment with the same code indicating it is being rebilled as part of the demonstration.

CMS defines short stays as those involving two or fewer days within the same spell of illness. All IPPS hospitals were able to register to participate in the demonstration with the exception of the following:

- Providers receiving periodic interim payments
- Psychiatric hospitals
- Inpatient rehabilitation facilities
- Long-term care hospitals

This month’s tip: What new coding conventions will ICD-10 bring? Learn more about this topic by reading an excerpt from The Coder’s Guide to ICD-10 on pp. 11–12.
Cancer hospitals
Critical access hospitals
Children’s hospitals

CMS accepted 380 hospitals into the program on a first-come, first-served basis. This included 80 large-size facilities (300 or more beds), 120 moderate-size facilities (100–299 beds), and 180 small-size facilities (fewer than 100 beds).

One caveat is that participating providers waive the right to file an appeal for any denials related to short-stay inpatient stays. Several callers questioned why they must waive their rights so extensively. One caller said participants should only be required to waive the right to appeal short-stay denials they choose to rebill. CMS said it will consider these comments.

Providers participating in the demonstration must also agree that they will hold beneficiaries harmless. For cases in which patients are admitted, the admission is denied, and the hospital rebills for the outpatient services, hospitals may need to refund beneficiaries the difference between the inpatient coinsurance and the outpatient deductible, said Leonard. However, hospitals may not charge beneficiaries when the outpatient deductible exceeds the inpatient coinsurance they originally paid, she said.

RAC contingency fees will be based on the difference between the amount of the inpatient denial and the amount of the rebilled claim, said Leonard.

The voluntary program will extend through December 31, 2014, at which time the agency will determine the next step, if any, it will take.

Addressing providers’ concerns is not the only goal of the demonstration. CMS also aims to eventually reduce its improper payment rate from 8.6% to 5.4%. Mel Combs-Dyer, deputy director of the Provider Compliance Group in CMS’ Office of Financial Management, said during the call.

“We really need to take aggressive corrective action,” Combs-Dyer said. “Medicare receives over 4 million claims every day, and so there’s no way that every one of those claims can be reviewed. We have to be very innovative and forward thinking as we try to think about how we can lower that error rate.”

Providers can direct questions about the rebilling demonstration to ABRebillingDemo@cms.hhs.gov.

For more information about the demonstration program, including FAQs, please visit http://go.cms.gov/cert-demos.
**RAC demonstration**

**CMS announces MS-DRGs set for prepayment review**

RACs will soon have authority to review claims before they’re paid to ensure that providers comply with Medicare regulations.

The Recovery Auditor Prepayment Review Demonstration was supposed to begin January 1. However, CMS announced December 29, 2011, that it would delay the demonstration until further notice because of the many comments and suggestions it had received. The agency will provide at least 30 days’ notice before the demonstration begins. CMS hopes the demonstration will prevent improper payments and help lower the error rate.

The prepayment reviews include claims that have historically resulted in high rates of improper payments. Specifically, reviews will target the following MS-DRGs:

- 312 (syncope and collapse)
- 069 (transient ischemia)
- 377 (gastrointestinal [GI] hemorrhage with MCC)
- 378–379 (GI hemorrhage with CC and without CC/MCC respectively)
- 637–639 (diabetes with MCC, with CC, and without CC/MCC respectively)

“As we move forward, there will be additional DRGs added to the list that will be announced at a later date,” said George Mills Jr., director of the Provider Compliance Group in CMS’ Office of Financial Management. Mills discussed the prepayment demonstration during a December 21 CMS Open Door Forum call.

RACs will conduct reviews of providers in the following states:

- Florida, California, Michigan, Texas, New York, Louisiana, and Illinois—all of which have high populations of fraud- and error-prone providers
- Pennsylvania, Ohio, North Carolina, and Missouri—all of which have high claims volumes of short inpatient hospital stays (i.e., stays lasting two or fewer days)

“The facilities affected will be those physically located in [these states] and bill to the FI or MAC that is actually assigned to that state,” Amy Cinquegrani, a health insurance specialist in CMS’ Division of Recovery Audit Operations, said during the call.

Mills cited the following three major categories of errors related to short stays for the targeted DRGs:

- Incorrect coding that leads to incorrect MS-DRGs
- Inpatient claims that should have been billed as observation
- Claims for elective surgeries that should be performed on an outpatient—rather than short inpatient stay—basis

The demonstration, which concludes December 31, 2014, will not replace MAC/FI prepayment reviews. Instead, RAC prepayment reviews will be in addition to the more traditional MAC/FI prepayment reviews.

CMS expects MACs/FIs and RACs to coordinate review areas so providers aren’t subject to multiple reviews of the same issue, said Cinquegrani.

CMS prevents duplicate audits by referring to its data clearinghouse, which includes all claims activity for multiple auditors. Claims subject to prepayment reviews will not be subject to any future MAC/FI or RAC postpayment reviews, she said.

**Operational details**

How will the prepayment reviews actually work? Providers required to participate in the demonstration will submit claims for payment as they normally would. Claims selected for prepayment reviews will be suspended in the claims processing system, and an additional documentation request (ADR) will be sent “the next day or so,” Connie Leonard, director of CMS’ Division of Recovery Audit Operations, said.
during the call. The MAC/FI is the entity that will generate and send the actual electronic ADR for claims subject to prepayment review. This is the process these entities use to conduct their own prepayment reviews, Leonard said.

“We’re trying to mirror the two processes as much as we can so providers aren’t having to learn new rules,” said Cinquegrani.

Providers must respond to ADRs within 30 days. ADRs will indicate to which entity documentation must be sent—either the MAC/FI (for traditional prepayment reviews) or the RAC (for the prepayment demonstration program). Each ADR will include a specific address. RACs, in turn, must communicate payment determinations to the MAC/FI within 45 days of the original claim submission.

This 45-day time frame begins with the date a provider submits a claim for payment, Cinquegrani emphasized. Providers should know soon thereafter whether a claim is subject to a prepayment review because the claim will be suspended and an ADR will be generated. The time frame stops while the review entity (MAC/FI/RAC) waits for the provider to send documentation, and it resumes when the contractor receives the record.

“So any time that [the RAC] is waiting to request, that claim actually comes out of their time frame for them to review it on the back end,” she said.

The MAC/FI will send remittance advice indicating whether it will pay or deny the claim. RACs must provide a detailed review results letter that will include the patient- and claim-specific information that was reviewed, plus the reason for any denials, said Cinquegrani.

Limits on prepayment reviews will not exceed current post-payment ADR limits. However, note that prepayment review limits are in addition to post-payment limits, said Cinquegrani.

For example, if a hospital’s post-payment review limit is 50 records, it could theoretically also see 50 prepayment reviews. “We fully expect that the number of prepayment reviews will be significantly less than what the maximum is,” Cinquegrani said.

CMS did not provide a specific percentage of short-stay claims that RACs would review. The demonstration does not include a minimum number of prepayment reviews.

Providers may appeal any denial that occurs as a result of a prepayment review, said Cinquegrani. The time frame for appeal begins with the date of notification of a denial provided on the remittance advice, she said.

Direct questions about the prepayment demonstration to RAC@cms.hhs.gov. For more information about the demonstration program, please visit http://go.cms.gov/cert-demos.
Three-day payment window
Know how inpatient coders can ensure compliance

The three-day payment window requires hospitals to include the following information on inpatient claims:
➤ All outpatient services provided on the date of admission.
➤ Any outpatient diagnostic services provided within three days of admission.
➤ Any nondiagnostic services that are clinically related to the admission. If a hospital believes nondiagnostic services are unrelated, it may separately bill the services to Medicare Part B with condition code 51 on the claim, provided it can produce documentation supporting its position.

What should inpatient coders remember about these requirements? Although it may seem counterintuitive, inpatient coders need to be aware of certain outpatient services that they may need to include on inpatient claims, says Debbie Mackaman, RHIA, CHCO, an instructor for HCPro’s Medicare Boot Camp®—Hospital Version and Critical Access Hospital Version.

All outpatient diagnostic services that occur within three days of admission should include a revenue code and charge on inpatient claims. Billers typically review claims for the revenue codes and charges assigned. Inpatient coders, however, should convert CPT® codes for surgical/invasive procedures to ICD-9-CM procedure codes when reporting them on an inpatient claim. All outpatient services reported on an inpatient claim must include a corresponding diagnosis code to support medical necessity. This code may or may not match the principal diagnosis for the admission, says Mackaman.

For example, a patient presents to the ED for a laboratory test and EKG for a cardiac condition. The next day, the patient is admitted to the hospital for pneumonia. The laboratory test and EKG are diagnostic services, and they occur within three days of the admission; inpatient coders must include diagnosis codes for both the cardiac condition and the pneumonia on the inpatient claim, says Mackaman. Billers should include a revenue code and charge for each of the outpatient services on the inpatient claim, she explains.

“The diagnosis code [for the cardiac condition] has nothing to do with the pneumonia, but it’s going to have to go on that inpatient record to back up the medical necessity of those outpatient charges that were moved onto the inpatient claim,” she says. In some cases, these secondary diagnoses related to the outpatient services may even be CCs or MCCs, she says.

Inpatient coders should also note that converting CPT codes to ICD-9-CM procedure codes may change the DRG, says Mackaman. For example, a patient undergoes debridement in the ED and is then admitted to the hospital within three days for an infection at the wound site. No other procedures were performed during the inpatient stay. The hospital must move the debridement CPT code to the inpatient claim and convert it to an ICD-9-CM procedure code. This will change the DRG from a medical to a surgical one, she says.

Don’t make assumptions
Separately billing nondiagnostic services unrelated to an admission requires the documentation to clearly reflect that the services are unrelated, says Mackaman. When this is the case, hospitals should report condition code 51 on the outpatient claim, she says.

Inpatient coders may need to alert billers to assign this condition code. For example, a patient has a laceration repair in the ED and is admitted for pneumonia two days later. Clearly, the laceration repair is unrelated, says Mackaman. Assuming inpatient and outpatient coding occurs separately, an inpatient coder should notify a biller to report condition code 51 on the outpatient claim for the laceration repair so these charges are not bundled into the payment for the pneumonia admission, she says.

However, determining when the outpatient services should be separated isn’t always easy, says Marion G.
Kruse, RN, MBA, director of FTI Consulting in Atlanta. Most outpatient nondiagnostic services are related to the admission. Many hospitals continue to err on the side of caution and do not separately bill these services.

“Usually it’s a pretty obvious progression to an inpatient admission,” Kruse says. Finding nondiagnostic services clinically unrelated to an admission is often like “looking for a needle in a haystack,” she says. “Hospitals probably miss more opportunities than anything else.”

Mounting pressure from external auditors doesn’t make things any easier, says Kruse. “Unless [hospitals] can absolutely show that [separately billing] is the right thing to do, they’re not going to do it,” she says. “In the end, they’re just going to have to spend a ton of money fighting to get it back from the RAC.”

However, hospitals that assume all outpatient nondiagnostic services are related run the risk of receiving overpayments or triggering outliers, says Mackaman. “They may include charges on the inpatient record that should not be there so the inpatient coder inadvertently assigns codes that may have an impact on the DRG assignment,” she says. Hospitals that assume all services are unrelated risk receiving APC payments for services that should be paid as part of the DRG, she says.

Instead, inpatient coders should carefully review documentation and enlist the help of the attending physician or physician advisor, or consult with a CDI specialist to obtain clarification when necessary, says Mackaman.

### Note changes for freestanding clinics

The three-day payment rule applies to services furnished by a hospital or an entity wholly owned and operated by a hospital. It applies to entities when a hospital is the sole owner or has exclusive responsibility for conducting and overseeing routine operations.

Freestanding clinics that satisfy the definition of a wholly owned and operated entity (i.e., a hospital has exclusive responsibility for conducting and overseeing the entity’s routine operations) are subject to the three-day payment window. Inpatient claims must include all diagnostic services and the technical component (TC) portion of nondiagnostic services rendered at the clinic the day of admission as well as the following:

- The costs/charges of the TC portion of all diagnostic services rendered at the clinic within three days of admission to the hospital
- The costs/charges of the TC portion of clinically related nondiagnostic services rendered at the clinic within three days of admission to the hospital


The MPFS final rule states that freestanding clinics should report new modifier -PD to identify clinic services that fall within the three-day payment window and that are related to the hospital admission. Clinic coders or billers should append this modifier to any clinic services billed on a 1500 claim form that fit this description. This includes the professional and TC portions of the code. Only the professional component portion of the code will be paid under the MPFS, with the place of service reported as the hospital rather than the clinic. Regardless of whether the CPT code has a technical/professional component split, hospital billers must move the charges associated with the TC portion of the code to the inpatient claim. The TC portion will be reimbursed as part of the inpatient DRG.

As of presstime, CMS had not provided guidance for splitting clinic charges reported on inpatient claims.

What should inpatient coders remember about modifier -PD? Inpatient coders won’t directly assign the modifier, but they must be aware of charges, including those from freestanding clinics, on inpatient claims to ensure proper diagnosis and procedure code assignment, says Mackaman.

Editor’s note: See this month’s “Coding Q&A” insert for more information about modifier -PD.
Review ICD-9-CM guidelines for coding pain

Generally speaking, coders are taught not to code signs and symptoms that are integral to a disease process. However, when patients are admitted for pain control or pain management, the pain should be coded separately and it should be reported as the principal diagnosis.

For example, a patient with metastatic breast cancer presents with intractable neoplasm-related pain. She is admitted and treated with IV pain medication specifically for the pain. In this case, coders must assign a neoplasm-related pain code as the principal diagnosis, says Kathy DeVault, RHIA, CCS, CCS-P, manager of professional practice resources at AHIMA in Chicago.

Admissions for pain management often occur for patients with certain types of cancers and those with spinal and other back-related conditions, DeVault explains. “[Physicians] are really treating the pain—not the condition,” she says, explaining that much of the confusion occurs because assigning pain codes often seems ambiguous. This is particularly true when patients with pain have a more definitive underlying condition (e.g., cancer).

Monica Lenahan, CCS, agrees. “Long-term coders were trained that if pain is a symptom of another condition, then don’t code it,” says Lenahan, an AHIMA-certified ICD-10-CM/PCS trainer and coding education and compliance manager at Centura Health in Englewood, CO. “The changes to the guidelines for pain codes presented a whole new learning curve for the long-term coder.”

Coders often forget to assign pain codes entirely, or they sequence them incorrectly, Lenahan notes. For example, some coders forget to report a chronic pain code for patients with failed back syndrome or chronic degenerative disc disease. When treatment is focused on chronic pain and not the chronic condition, the pain must be coded separately and sequenced first, she says.

Examine documentation carefully

The ICD-9-CM Official Guidelines for Coding and Reporting state that physicians must specify pain as either acute or chronic for coders to assign a code from category 338. The only exceptions are post-thoracotomy pain, post-operative pain, neoplasm-related pain, and central pain syndrome.

The exceptions to the rule can sometimes be more confusing than the rule itself, says Lenahan. For example, a patient presents for insertion of a pain pump for neoplasm-related pain. Even if the physician does not specify whether the pain is acute or chronic, coders should report the pain as the principal diagnosis with cancer as a secondary diagnosis, she says. However, if a patient is admitted for treatment of back pain due to bone cancer—and the physician doesn’t specify whether the pain is acute or chronic—coders may not report the pain as the principal diagnosis. “Coders really need to consider the documentation of the pain and consider the circumstances of admission when making coding decisions,” she says.

Generally, physicians don’t document pain well, says Lenahan. This is because they may presume coders and other clinicians reviewing the record know that certain conditions cause pain. However, coders can’t make assumptions, and they should encourage physicians to document the length, intensity, and chronicity of pain, she says.

Still, some scenarios may require a query. Consider a patient with degenerative disc disease who is admitted for intractable back pain. He is treated with IV pain medication, and a physician orders an MRI to determine whether the disease has progressed or whether an acute problem has developed instead. Based on the treatment and tests ordered, determining exactly what the physician is treating can be difficult, says DeVault.

Coders must understand the purpose of different medications and thoroughly review all progress notes and orders. Documentation of IV pain medication
doesn’t necessarily imply a patient was admitted for pain control or management, but it may prompt a query for clarification, says DeVault. Patients admitted for pain often receive IV pain medication because their pain typically has worsened to the point that physicians are unable to manage it on an outpatient basis, she explains.

Know how pain justifies medical necessity

In addition to providing a more accurate clinical picture, reporting acute or chronic pain can help establish medical necessity for certain procedures, says Lenahan. She frequently sees denials for spinal cord stimulators when codes for chronic pain, in particular, are absent.

“It gives validation as to why a patient has to be admitted or have surgery,” says DeVault. When chronic pain, in particular, isn’t documented or coded, payers may question the urgency of surgery or admission to a hospital, she explains.

Some MACs require a chronic or acute pain code as a prerequisite for payment. For example, TrailBlazer Health Enterprises, LLC, the MAC for Jurisdiction 4, has a dual diagnosis requirement for implantable pain management devices. Claims must include the reason for the procedure (e.g., the chronic pain) sequenced as the principal diagnosis in addition to a secondary code for the condition that caused the pain, explains Lenahan. Reviewing your MAC’s guidelines to ensure compliance in this area is important, she says.

Beware of postoperative pain

ICD-9 guidelines indicate that coders should not report routine or expected postoperative pain that occurs immediately after surgery. Differentiating between postoperative pain and pain that occurs during the postoperative period is important, says DeVault. “Documentation is really the key,” she says.

Ask the following questions to determine whether pain is normal or whether it warrants assignment of a postoperative pain code:

- Is the patient receiving large amounts of IV pain medication three to four days (or more) after the surgery?
- Did the patient undergo any tests after surgery to investigate the pain?
- Does documentation state that nurses and other providers are monitoring the postoperative wound because of what appears to be an unusual amount of pain?

Postoperative pain often requires a query, says DeVault. Coders should always refer to clinical indicators in the chart, and they should consider attaching a portion of the ICD-9 guidelines related to pain coding for reference. Also consider educating neurosurgeons and orthopedic surgeons about postoperative pain coding and documentation requirements.

Prepare for potential RAC audits

RACs don’t seem to be targeting pain coding yet, but the potential for future audits always exists, says DeVault. “The RACs will just data mine for [these codes]. It’s an easy target. They can data mine for code 338 with any type of major procedure,” she says.

Coders also must adhere to many guidelines. The ICD-9-CM guidelines related to pain codes are extensive. “When there are this many guidelines associated with a particular diagnosis, there’s a higher likelihood of misinterpretation or misapplication,” says DeVault.

Ensure compliance

Consider these tips from Lenahan and DeVault to ensure compliance:

- Review pain coding guidelines during coding staff meetings.
- Discuss case examples during coding staff meetings to determine whether pain is the reason for an admission. What documentation supports your rationale?
- Generate a report of cases that include codes from category 338 to determine how often they are reported and whether coders apply the guidelines correctly.
Respiratory failure code description limitations

by Robert S. Gold, MD

In March 2011, the ICD-9-CM Coordination and Maintenance Committee updated the following code definitions and exclusions:

➤ 518.5: Pulmonary insufficiency following trauma and surgery

➤ 518.51: Acute respiratory failure following trauma and surgery
  - Respiratory failure, not otherwise specified, following trauma and surgery
    Excludes: acute respiratory failure in other conditions (518.81)

➤ 518.52: Other pulmonary insufficiency, not elsewhere classified, following trauma and surgery
  - Adult respiratory distress syndrome (ARDS)
  - Pulmonary insufficiency following surgery
  - Pulmonary insufficiency following trauma
  - Shock lung related to trauma and surgery
    Excludes: ARDS associated with other conditions (518.82)
  
  aspiration pneumonia (507.0)
  hypostatic pneumonia (514)
  shock lung, not related to trauma or surgery (518.82)

➤ 518.53: Acute and chronic respiratory failure following trauma and surgery
  Excludes: acute and chronic respiratory failure in other conditions (518.84)

➤ 518.8: Other diseases of lung

➤ 518.81: Acute respiratory failure
  Excludes: acute respiratory failure following trauma and surgery (518.51)

➤ 518.82: Other pulmonary insufficiency, not elsewhere classified
  Excludes: acute interstitial pneumonitis (516.33)
  ARDS associated with trauma or surgery (518.52)
  pulmonary insufficiency following trauma or surgery (518.52)

➤ 518.84: Acute and chronic respiratory failure
  Excludes: acute and chronic respiratory failure following trauma

I’d like to discuss some of the limitations and challenges of these codes and their current descriptions.

Postoperative and post-traumatic respiratory failure

ICD-9-CM codes 518.5–518.53 include the description “following trauma and surgery.” Combining trauma and surgery into one code is inappropriate. Patients with trauma, lung contusion, or bilateral traumatic pneumothoraces or hemothoraces will develop post-traumatic respiratory failure. The same is true for patients with crushed tracheas. These patients are distinctly different from those with postoperative respiratory failure. Each group should be tracked differently; therefore, they should be coded differently too.

Research is impeded by not coding and tracking each group separately. That’s because even when a patient experiences trauma, surgery may be the actual cause of the postoperative respiratory failure. The POA indicator does not help clarify the cause of post-traumatic respiratory failure because respiratory failure may or may not exist on admission.

Coders should report postoperative respiratory failure only when problems with a surgical procedure lead to respiratory failure. However, they should not report it when the respiratory failure occurs in the following situations:

➤ After an operation due to the reason for the surgery—and not the surgery itself (e.g., when a bullet wound causes hemorrhage into the lung—the hemorrhage would occur regardless of whether the patient requires surgery)
Due to aspiration completely unrelated to the operation
Due to an ARDS event related to sepsis or pulmonary embolism that occurs after admission but prior to the induction of anesthesia
Due to events totally unrelated to the surgical operation (e.g., heart failure or acute exacerbation of chronic obstructive pulmonary disease)

Consider this scenario: Two days after surgery, a patient develops atrial fibrillation with rapid ventricular response, subsequent acute pulmonary edema, and acute respiratory failure, and is placed on a ventilator. Ideally, coders should assign 518.81 rather than 518.51 even when the respiratory failure occurs during the postoperative phase. However, without more accurate code definitions, the acute respiratory failure will be incorrectly classified as a complication of the surgical procedure.

**Pulmonary insufficiency**

ICD-9-CM codes 518.52 and 518.82 often confuse coders because a uniform definition of pulmonary insufficiency simply doesn’t exist. This lack of a definition can lead to misinterpretation and even fraud. Some consultants advise coders to take advantage of these codes. This is wrong.

The terms “respiratory insufficiency” (regardless of whether it’s postoperative) and “respiratory distress” are totally misused and misunderstood, which leads to incorrect coding. For example, coders often are seen to assign 518.82 for children who have mild asthma attacks when the documentation says “acute respiratory distress.” They also assigned 518.5 (until the code changed) for patients who were purposely being weaned slowly from a ventilator after they undergo massive surgery and when documentation includes the term “postoperative respiratory insufficiency.” The code definitions are inadequate, and this puts coders at risk for unethical and fraudulent conduct. The term “respiratory insufficiency” should not be referenced with any ICD code. Codes already exist for atelectasis, pneumonia, tension pneumothorax, iatrogenic pneumothorax, and aspiration pneumonitis. They also exist for all permutations of events that can occur during the postoperative phase that can cause difficulty in clearing carbon dioxide from the lungs. None of these conditions constitute acute respiratory failure.

The code for respiratory insufficiency is misused and overused. I predict that the inappropriate assignment of this code will result in billions of dollars in overpayments and that the National Center for Health Statistics will eventually need to redefine it. Respiratory insufficiency is a useless concept. The intent of the code is to identify ARDS regardless of whether it progresses to acute respiratory failure, not to identify patients who experience pain when breathing due to an upper abdominal or chest incision and who benefit from pain medication and incentive spirometry.

Acute-on-chronic postoperative and post-traumatic respiratory failure don’t exist. The cause of the acute condition is virtually never the same as the cause of the chronic condition. Physicians should document each condition and its etiology separately. This is why 585.x codes exist for chronic kidney disease and 584.x codes exist for acute renal failure. It’s incorrect to combine acute and chronic respiratory failure into one code. Instead, codes should distinguish between patients with chronic respiratory failure (and its cause) who undergo surgery and patients who develop acute respiratory failure (and its cause) after surgery.

Don’t let your hospital become RAC fodder for over-reporting conditions that patients don’t have or for identifying conditions that do not meet the intent of the codes.

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Questions? Comments? Ideas?

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Understand new ICD-10-CM coding conventions

ICD-10-CM will bring some new coding conventions.

**Placeholders**

ICD-9-CM codes are three to five characters in length. However, ICD-10-CM codes may consist of up to seven characters. Some ICD-10-CM codes may have a seventh but no fifth and/or sixth character. Assigning a valid code will require using an x as a fifth and/or sixth character placeholder. For example, ICD-10-CM code T50.1x1A denotes an accidental poisoning of loop (high-ceiling) diuretics, initial encounter, and ICD-10-CM code T82.6xxA denotes infection and inflammatory reaction due to cardiac valve prosthesis, initial encounter.

Coders must understand that the positioning of the x within an ICD-10-CM code is very important. An X in the first character position denotes a code series within ICD-10-CM (i.e., X00–X99) in Chapter 20, External Causes of Morbidity, but when placed as the fifth and/or sixth character it is a placeholder. In ICD-10-PCS, the X may also be used as a character but will identify a specific element of a procedure code (e.g., diagnostic procedure).

**Seventh-character extensions**

Some ICD-10-CM codes require a seventh-character extension. These extensions are most common in Chapter 19, Injury, Poisoning, and Certain Other Consequences of External Causes. Generally, most code categories include a choice of these three extensions:

- **Initial encounter (A).** Report this extension when a condition is actively treated during the initial encounter (e.g., surgical treatment, emergency department encounter, evaluation by new physician[s]).

- **Subsequent encounter (D).** Report this extension for encounters after initial treatment has been provided but the patient continues to receive care during the healing or recovery phase (e.g., cast change/removal, follow-up visits). Note that in ICD-9-CM, codes for such situations should generally be reported with aftercare codes (V codes), but due to payer-related issues and other reasons, the acute injury codes are commonly misused multiple times during the healing phase, negating the effectiveness of data capture for these codes.

- **Sequela (late effect) (S).** Report this extension for complications or conditions that arise as a direct result of an acute condition.

For example, T39.1x1A—poisoning by 4-Amino-phenol derivatives, accidental (unintentional)—includes a seventh-character extension to denote the initial encounter.

Some code categories include seventh-character options other than those listed previously. For example, various extensions are available for fractures. Different categories of fractures may require a variety of options for seventh-character extension; however, most identify the following:

- Initial vs. subsequent vs. sequela
- Closed vs. open
- Absence or presence of complications during the healing phase:
  - Routine healing
  - Delayed healing
  - Nonunion
  - Malunion

Specifically, these seventh-character extensions are associated with most fractures:

- A—Initial encounter for closed fracture
- B—Initial encounter for open fracture
- D—Subsequent encounter for fracture with routine healing
- G—Subsequent encounter for fracture with delayed healing
- K—Subsequent encounter for fracture with nonunion
➤ P—Subsequent encounter for fracture with malunion
➤ S—Sequela

For example, report ICD-10-CM code S62.101B to denote an open fracture of the right wrist, initial encounter.

Generally and as with all seventh-character extensions, coders must be aware of ICD-10-CM codes that require seventh-character extensions. When a code requires this, coders must ensure that physician documentation supports assignment of a particular extension.

Laterality

Laterality (i.e., codes that specify whether a disease affects the left or right side) is a new concept specific to ICD-10-CM. For example, report ICD-10-CM code S62.611D to denote a displaced fracture of the proximal phalanx on the left index finger, subsequent encounter, with routine healing. The identification of the left index finger is included within this code.

Excludes notes

ICD-9-CM incorporates only one type of excludes notes—which, confusingly, can mean two different things—whereas ICD-10-CM incorporates two types to make it clear. The two types are:

➤ Excludes1—Indicates that a code that is excluded should never be used along with the code above the “Excludes1” note. For example, ICD-10-CM code S60.371A (other superficial bite of right thumb, initial encounter) should never be reported with the category of S61.05-, S61.15- (open bite of the thumb). In this example, it is interpreted that you would not assign code S60.371A along with S61.051A (open bite of right thumb without damage to nail, initial encounter) at the same time. Only one code would be assigned to identify the most severe description (open) of the wound on the right thumb.

➤ Excludes2—Indicates that the excluded condition is not part of the condition denoted by the code, but that a coder may assign an additional code (if applicable) for it in addition to a code for the condition that appears above the “Excludes2” note. For example, assign ICD-10-CM category S60.2 to denote contusion of the wrist and hand. This code excludes contusion of the fingers (S60.0-, S60.1); however, a coder may report both codes, when applicable. This means a patient can have a contused hand and/or wrist and not the fingers, but if fingers are also contused, two codes are necessary to identify both conditions.

These excludes notes may be familiar concepts, but ICD-9-CM has never explicitly distinguished between the two. Distinguishing them in ICD-10-CM may make it easier for coders to determine which exclusion applies to a specific scenario.

Default codes

Like ICD-9-CM, ICD-10-CM includes default codes. These codes, listed next to the main term in the ICD-10-CM Alphabetic Index, represent either the most common term associated with a main term or the unspecified code for that condition. Coders should assign them when further specificity or documentation is lacking. For example, in ICD-10-CM, the term otitis defaults to the most commonly associated term of otitis media (H66.90–H66.93), whereas the term stroke defaults to code I63.9 (cerebral infarction, unspecified), the unspecified option. Note that in ICD-9-CM, the code for otitis defaults to otitis media. But the term stroke defaults to code 434.91 (cerebral artery occlusion, unspecified, with cerebral infarction), identifying an ischemic stroke.

*Editor’s note: This article was excerpted from The Cod- er’s Guide to ICD-10, published by HCPro, Inc. For more information or to purchase a copy, visit www.hcmarketplace. com/prod-9661.*
We want your coding and compliance questions!
The mission of Coding Q&A is to help you find answers to your urgent coding/compliance questions.
To submit your questions, contact Briefings on Coding Compliance Strategies
Contributing Editor Lisa Eramo at leramo@hotmail.com.

Editor’s note: Answers to the following questions are based on limited information submitted to Briefings on Coding Compliance Strategies. Review all documentation specific to your scenario before determining appropriate code assignment.

A patient presents with end-stage renal disease and chronic kidney disease secondary to malignant hypertension. The patient is admitted for a cadaver renal transplant. How should we code this scenario?

Report the following codes:
➤ 403.01 for the malignant hypertensive chronic kidney disease with chronic kidney disease stage V or end-stage renal disease
➤ 585.6 for the end-stage renal disease
➤ 00.93 for the transplant from the cadaver
➤ 55.69 for the organ transplant procedure

A patient is admitted so he can donate a kidney to his son, for whom he is a suitable donor. A physician performs a total unilateral left donor nephrectomy without complications, and the patient is discharged. How should we code the donor nephrectomy?

Report code V59.4 for kidney donor as the principal diagnosis with ICD-9-CM procedure code 55.51 (nephroureterectomy).

Laura Legg, RHIT, CCS, revenue control coding consultant at Providence Health & Services in Renton, WA, answered the previous two questions.

I’ve heard that freestanding clinics that are wholly owned or operated by a hospital must append modifier -PD to nondiagnostic services billed on a professional services 1500 claim when the services are related to the inpatient admission and occur on the day of or within three days of the admission.

How can we ensure compliance and open the lines of communication with coders working in the freestanding clinic to better capture this information?

If a hospital owns a freestanding clinic—and both entities share the same information system—the hospital can use a billing scrubber report to identify any clinic visits that fall within the three-day payment window. The scrubber reviews the dates of service prior to the inpatient admission and alerts billers that they may need to take a closer look at certain accounts that are potentially subject to the three-day payment window.

Billers can then review the accounts to determine whether the technical component of clinic diagnostic and nondiagnostic charges should be moved onto the inpatient claim.

If a hospital and freestanding clinic don’t share the same information system, then hospital coders and billers must depend on clinic staff to send information regarding any outpatient services the patient may have had in the clinic along with the details and dates of those services.

Clinics must be aware of this regulation before billing their claims and consider adding a four-day bill hold (similar to hospitals) to their claims processing system.
Clinics know when patients are admitted because hospitals typically alert them so the clinics can begin tracking inpatient charges for the patient visits (i.e., when the physician visits the patient in the hospital). Once a patient is admitted, the clinic should, in turn, notify the hospital of any outpatient services performed on the day of and within three days of the admission.

If clinic (outpatient) services are diagnostic in nature or nondiagnostic and related to the inpatient admission—and subsequently moved to the inpatient claim—the clinic must append modifier -PD to codes that denote nondiagnostic services billed on the 1500 claim form. This ensures that the clinic does not receive an overpayment. The professional fees and nondiagnostic services will be paid as though the place of service was the hospital instead of the clinic. Inpatient coders will not be affected by the new -PD modifier; however, they need to be aware of the regulation to understand why there are—or should be—clinical charges on the inpatient admission before submitting the bill.

*Debbie Mackaman, RHIA, CHCO,* an HCPro Medicare Boot Camp®—Hospital Version and Critical Access Hospital Version instructor, answered the previous question.

**Will we be able to report any ICD-9 codes on claims after October 1, 2013?**

ICD-9 codes will not be accepted on claims after October 1, 2013. Instead, coders must begin reporting ICD-10 codes. However, ICD-10 codes will not be recognized or accepted on claims before October 1, 2013. Claims may not include both ICD-9 and ICD-10 codes. Institutional claims that are billed incorrectly will be returned to providers, who may correct their claims by reporting the appropriate ICD-9 or ICD-10 codes and resubmitting the claims.

In some cases, ICD-9 codes will be effective for a portion of the services rendered September 30, 2013, and earlier, while ICD-10 codes will be effective for the portion of the services rendered October 1, 2013, and later.

*MLN Matters* article MM7492 (available at www.cms.gov/MLNMattersArticles/downloads/MM7492.pdf) provides more information about processing requirements for claims that span the periods during which ICD-9 and ICD-10 codes may both be applicable.

*Antoinette Johnson,* a health insurance specialist in CMS’ Provider Billing Group, provided this information during a CMS-sponsored teleconference November 17, 2011. For more information, visit http://tinyurl.com/7tzpd6e.

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