ICD-10
Delayed implementation and its effect on coders

The wait is over—CMS has announced a proposed rule that would postpone ICD-10 implementation from October 1, 2013, to October 1, 2014, if finalized.

Be prepared for just about anything, experts advised when CMS said in February that it would initiate a process to postpone the implementation date. The agency provided no specific information about a timeline for the delay until it announced the proposed rule April 9.

The initial announcement of a delay was made despite a final rule to adopt the new code set by October 1, 2013, issued more than three years earlier. Some wondered after the February announcement why CMS would delay ICD-10 at this stage of the implementation. In an April 9 press release announcing the proposed rule and new implementation date, CMS said:

Many provider groups have expressed serious concerns about their ability to meet the Oct. 1, 2013, compliance date. The proposed change in the compliance date for ICD-10 would give providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition to the new code sets.

What does the delay mean for coders who have spent the past several years psychologically preparing for a countdown to October 1, 2013?

For coders, in particular, a delay in ICD-10’s implementation has definitely caused angst, says Gloryanne Bryant, RHIA, CCS, CDIP, CCDS, regional managing director of HIM, NCAL revenue cycle, at Kaiser Foundation Health Plan, Inc. & Hospitals in Oakland, Calif. “I think this is a disappointment among coding professionals, and this can extend the anxiety of the change in general terms,” she says.

What are advantages, disadvantages of a delay?

Rather than seeing the delay as a setback, coders should view it as valuable time to continue to improve processes and enhance readiness, says Andrea Clark, RHIA, CCS, CPCH, chairman, CEO, and founder of Health Revenue Assurance Associates in Plantation, Fla. A delay will give coders more time to drill down into data, identify areas for documentation improvement, and implement CDI efforts, she says.

Bryant agrees. “More time in and of itself is an advantage,” she says. “This may spread cost out a little farther, which might help some. For those who are currently behind in planning and implementation, a delay will be an advantage.”

The delay could also serve as a foundation for more meaningful dialogue among coders and physicians, says...
James S. Kennedy, MD, CCS, managing director of FTI Consulting in Atlanta. “I hope that coders welcome this as an opportunity to engage their physicians, hear what their fears are, and negotiate win-win solutions,” he says.

Ideally, physicians should direct the development of ICD-10 with coders, hospitals, payers, and the Centers for Disease Control and Prevention, says Kennedy. “I believe that adding a physician group, such as the College of American Pathologists, the AMA, or the American College of Physicians, as a fifth Cooperating Party would be a strong move that unites all parties invested in the clinical language we are to use in our day-to-day patient care activities,” he says.

However, some disadvantages also accompany delayed implementation of ICD-10.

“There has been a lot of work already done in the healthcare industry in preparation for ICD-10,” says Bryant. “This work equates to monies spent already. The education and training timeline may need to be moved. Those that have already had some ICD-10 training may need refresher training now to retain the knowledge going forward.”

Another concern is the current ICD-9 code freeze, which would continue to be prolonged until ICD-10, says Kennedy. “This freezing of ICD-9 does not allow for improvements in the disease specificity that we need to measure outcomes,” he says.

Some wonder whether a delay could simply cause more procrastination. Sue Bowman, MJ, RHIA, CCS, director of coding policy and compliance at AHIMA in Chicago, fears that providers and others advocating the delay will continue to procrastinate and postpone ICD-10 preparation activities as close to the deadline as possible, defeating the purpose of a delay.

“People argue that it gives providers more time to prepare, which may be true, but the problem with the 2009–2013 time frame is that nobody started in 2009,” she says. “It’s not really clear whether the delay is going to really help people achieve compliance or just delay people’s worrying about compliance.”

Is waiting for ICD-11 a viable option?

The World Health Organization has said that ICD-11 will be released by 2015.

However, the United States then must clinically modify the code set and develop a procedural code set, says Bowman. She anticipates that seven or eight years will be necessary to do so. This means providers could realistically start using it in 2022 or 2023 at best, she says, adding that the United States can’t wait that long to replace the outdated and failing ICD-9-CM system.

“Waiting that long just does not make sense due to the many benefits the ICD-10 coding system can bring to healthcare,” says Bryant. “We really need ICD-10 and the benefits of improved clinical data. For those providers that have an integrated delivery system, this might bring.
be more challenging and have some logistics issues.”

**What should providers do now?**

Experts agree that halting ICD-10 preparations is not the answer.

“All hospitals should continue with their education plans,” says Clark. “Once we get a firmer foundation of what the date will be, you can always readjust the timeline. Hospitals can’t sit in fear and become immobile.”

Bryant says hospitals should determine the following:

➤ Which key milestones and steps may require revision because of the delay
➤ The effect on previously secured funding
➤ Whether a delay will extend implementation costs beyond current budget estimates, and by how much

Other plans for 2012 should include documentation assessment and preliminary coder training, says Bryant, with a focus on the following foundational core competency areas:

➤ Medical terminology
➤ Anatomy and physiology
➤ Disease process and pharmacology
➤ ICD-10 coding guidelines

In-depth ICD-10 coder training should begin approximately six months before the go-live date. Kennedy is aware of several hospitals that had planned to start using the new coding system January 1, 2013, prior to announcement of the delay. These hospitals will begin in-depth coder training as early as this summer, he says.

**ICD-10 implementation delay sparks questions, elicits mixed reactions**

CMS’ announcement in February that it would delay ICD-10 implementation set off an avalanche of mixed reactions from coders, providers, and other stakeholders.

The agency’s April 9 announcement of a proposed rule that would postpone implementation from October 1, 2013, to October 1, 2014, will likely do the same.

“What do you mean a delay? We’ve already had a delay! We’ve sort of been in this delay approach for 10 years now,” said Sue Bowman, MJ, RHIA, CCS, director of coding policy and compliance at AHIMA in Chicago, in describing her reaction to the February announcement.

The announcement of the ICD-10 delay was surprising, considering the time the healthcare industry has had to prepare, Gloryanne Bryant, RHIA, CCS, CDIP, CCDS, said after hearing the initial news in February.

“I do understand that some providers—especially small physician practices—may not be as ready as others,” said Bryant, regional managing director of HIM, NCAL revenue cycle, at Kaiser Foundation Health Plan, Inc. & Hospitals in Oakland, Calif. “However, I go back to the final rule, which provided nearly five years to plan.”

The decade-long delay has caused challenges with other types of data-driven initiatives that rely heavily on ICD-10, such as value-based purchasing, hospital-acquired conditions, payment reform, and meaningful use, said Bowman.

“How much longer can we expect ICD-9 to go limping along? It just continues a trend of deteriorating data. The data is actually going to get worse the more we try to use ICD-9 with all of the other initiatives,” said Bowman.

Providers have had more than enough time to prepare, Bowman said. “If everybody had started in 2008 or 2009, we’d be looking pretty good right now,” she said.

Not everyone completely opposed the delay, however. “I have mixed thoughts and feelings as I watch physicians, particularly the AMA and [Medical Group Management Association (MGMA)], oppose an improvement in the currently flawed ICD-9-CM diagnosis reporting system,” James S. Kennedy, MD, CCS, managing director of FTI Consulting in Atlanta, said after the February announcement.

“While I certainly relate to physicians’ frustration about the cost of all of the initiatives they are asked to participate in, ICD-10 provides a platform for the physicians to improve patient care by creating the potential for a more robust vocabulary and data set that can be abstracted, analyzed, and applied,” he said.

The AMA and MGMA’s reasons to resist ICD-10 aren’t necessarily valid, said Kennedy. “What is so different about ICD-10 that troubles them?” he said. “The diseases we’ve treated haven’t changed. The need for specificity has always been there, even in ICD-9.” Rather than attack the nosology
A delayed compliance deadline could be problematic with respect to scheduling training and perhaps incurring additional training costs, says Bowman. “Now, it raises the question of when will it be? This is an area where I think we will see additional cost. The people who have been trained to become trainers will have to maintain their skills and stay up to date,” she says. “Coders will need to be in some type of holding pattern with their knowledge. If you’re not using it every day, it’s hard to keep it up.”

The delay will affect anyone who modified curricula to accommodate the 2013 date, says Bowman. “It’s not an easy process to change an entire academic curriculum, particularly because you’ve got some students in the system already,” she says.

Hospitals should be reviewing queries to ensure that they are up to date and incorporate information necessary for ICD-10, says Kennedy. They should determine whether their EHRs are compatible with the specificity of ICD-10. If not, vendors should provide a

<table>
<thead>
<tr>
<th>ICD-10 implementation delay sparks questions, elicits mixed reactions (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>and length of the codes, physicians should lobby the Cooperating Parties to more proactively align ICD-10’s language with credible physician literature, he said.</td>
</tr>
<tr>
<td>A revised timeline at this point challenges CMS’ credibility, said Kennedy. “How many times has CMS and the other Cooperating Parties said that there would be no grace period to the October 1, 2013, deadline for ICD-10’s implementation? This was after CMS granted a two-year extension at the request of the AMA in 2009,” he said.</td>
</tr>
<tr>
<td>This delay could signal a litany of other delays as well, said Kennedy. “Given that CMS has already bowed to political pressure for this once, after having said that there would be no grace periods, who is to say that they won’t bow to political pressure again?” he said.</td>
</tr>
<tr>
<td>From a logistical perspective, Bowman said after the initial announcement that she would be surprised if the delay was less than a year. Implementing a new code set that drives the DRG, home health, and numerous other payment systems in the middle of a government fiscal year would be challenging, she said.</td>
</tr>
<tr>
<td>Bowman said it was likely that CMS would delay ICD-10 by a minimum of one year so that the change coincides with the regular coding updates in October. However, even a yearlong delay would be problematic for hospitals because it would create additional rework and training that could increase the cost of implementation exponentially, Bowman said. AHIMA and other organizations have advocated retaining the original compliance date.</td>
</tr>
<tr>
<td>Andrea Clark, RHIA, CCS, CPCH, chairman, CEO, and founder of Health Revenue Assurance Associates in Plantation, Fla., disagreed. CMS is more likely to delay implementation by three to six months rather than a year or more, she said after the February announcement.</td>
</tr>
<tr>
<td>“I think what CMS will be satisfying is the comment period for the provider community to send in their comments,” said Clark. “It might help as a sounding board, but because this train is already in motion—and we are so far behind the rest of the world—I think they’re going to take those comments and listen to them. I don’t think there will be a lengthy delay.”</td>
</tr>
<tr>
<td>CMS might suggest a phased-in approach, allowing one delay for physicians and another for hospitals, said Clark, noting that this option might pose more challenges, particularly on the outpatient hospital side.</td>
</tr>
<tr>
<td>A phased-in approach is not a solution, said Bowman. “I think there would be a lot of push-back,” she said. “To have some providers on one coding system and some providers on another coding system would be a horrendous nightmare. Also, the government has no intention, nor do they have the resources, to maintain two code sets.” This type of division would affect initiatives such as interoperable EMRs and accountable care organizations, said Bowman.</td>
</tr>
<tr>
<td>Editor’s note: CMS announced the proposed rule postponing ICD-10 implementation until October 1, 2014, at presstime. Briefings on Coding Compliance Strategies will publish information about reaction to announcement of the proposed rule and new implementation date next month.</td>
</tr>
</tbody>
</table>
clear timeline for activating this capability regardless of the compliance deadline, he says.

The timeline shouldn’t affect when or whether hospitals educate physicians about documentation necessary to support ICD-10, says Clark. “[Y]ou don’t teach doctors how to code,” she says. “You teach them how to build better documentation in order to assign an ICD-10 or ICD-9 code. You can continue that process of documentation improvement without uttering the words ICD-10.”

“I think that one thing this has taught everybody and shown is that this is a big transition that was perhaps underestimated by some in the beginning,” says Bowman. “So keep it at, and that will ensure that you’re ready.”

Tara Blum, RHIA, CCS, manager of clinical coding at Northwestern Memorial Hospital in Chicago, says her facility will move forward with implementation plans despite the delay. The prioritized to-do list includes:

➤ Finalizing ICD-10 coding salary structure
➤ Continuing to actively recruit new graduates and reducing reliance on contract coders
➤ Implementing computer-assisted coding to help offset productivity losses
➤ Assessing coder skills before training
➤ Developing and implementing tailored ICD-10 educational plans for each coder
➤ Dual coding in ICD-9 and ICD-10 until going live with ICD-10

Editor’s note: CMS announced the proposed rule and new ICD-10 compliance date at prestime. Access information about the proposed rule at www.cms.gov/apps/media/fact_sheets.asp. Select “April 9 HHS Proposed One-Year Delay of ICD-10 Compliance Date.” The fact sheet includes links to the press release and the proposed rule.

Comments on the proposed rule are due within 30 days of publication in the Federal Register, scheduled for April 17. Comment on the proposed rule at www.regulations.gov.

Upcoming events

May 3—Medical Necessity 2012: Case Studies and Top Documentation Risk Areas, featuring Ralph Wuebker, MD, MBA, vice president of audit, compliance, and education at Executive Health Resources in Newtown Square, Pa., and Jonathan G. Wiik, MSHA, MBA, director of patient access and case management at Boulder Community Hospital in Boulder, Colo.


To register or for more information, call 800/650-6787 or visit hcmarketplace.com and mention source code NEWSAD.

BCCS Subscriber Services Coupon

Start my subscription to BCCS immediately.

Options No. of issues Cost Shipping Total
Electronic 12 issues $249 (CCSE) N/A
Print & Electronic 12 issues of each $249 (CCSPE) $24.00

Order online at www.hcmarketplace.com. Be sure to enter source code N0001 at checkout!

For discount bulk rates, call toll-free at 888-209-6554.

© 2012 HCPro, Inc. For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, contact the Copyright Clearance Center at www.copyright.com or 978-750-8400.
Are your ICD-10 implementation fears justified?

by Robert S. Gold, MD

The healthcare industry has been aware of the impending transition to ICD-10 for years and has developed significant angst as a result.

Hospitals and healthcare groups have spent significant dollars on ICD-10 readiness. However, CMS announced in February that it would rethink the implementation timeline.

This comes in the wake of AMA pleas that there are too many initiatives for independent physician practitioners to juggle in a short period of time. The AMA has said that ICD-10 would create a massive financial burden for physicians on the front end and create billing confusion and payment reduction on the back end.

The system will change regardless of whether the industry converts to ICD-10 or whether it transitions directly to ICD-11 or SNOMED. This means that the healthcare industry will continue to wait, worry, and spend more money before all is said and done.

But does ICD-10 really merit all the worry—particularly for coders?

The diseases won’t change

Coders must realize that the names and causes of diseases won’t change in ICD-10.

As long as diseases have the same etiologies and the same effects on other organ systems, the terminology won’t change. Only the codes that represent the terminology will change. If physicians document the diseases as well as their causes and effects, coders can report them with ICD-10.

Some coders may worry about the additional specificity required by ICD-10, decreased productivity, increased accounts receivable, and staffing shortages. However, if your medical staff members are ready for ICD-9, they’re ready for ICD-10. If the information available in the medical record is present today, it will be present when ICD-10 becomes effective.

Congestive heart failure (CHF)

Consider CHF. If physicians know how to identify heart failure as acute or chronic or as an exacerbation of a chronic state, coders can report the condition accurately. This won’t change with ICD-10. If physicians can identify a patient’s left ventricular functional abnormalities as systolic, diastolic, or both, coders can report the condition accurately. This won’t change with ICD-10.

The term congestive currently requires coders to assign a second code in some cases. However, this won’t be necessary with ICD-10 because left ventricular dysfunction codes include a nonessential modifier built into the specific heart failure code. The fourth and fifth digits in ICD-10 will be exactly the same as they are in ICD-9. What’s different is that the rheumatic heart failure code no longer excludes the specificity of left ventricular dysfunction.

The industry will have the added benefit of being able to report both the rheumatic failure code and the left ventricular dysfunction code. If medical staff members know this now, there’s nothing new for them to learn when ICD-10 is implemented. Even though coders will no longer see a 428.xx code, encoders that have been updated correctly for ICD-10 will direct them to the correct code for patients with chronic diastolic heart failure due to aortic stenosis.

Stroke

Next, consider stroke. Physicians who currently document whether a stroke is occlusive from a left atrial clot in a patient with atrial fibrillation won’t need to change their documentation habits. Other documentation won’t likely require change either. For example, if
an event occurred in the patient’s middle cerebral artery circulation, a neurologist likely already documented it. If a patient’s embolic middle cerebral artery stroke is on the left side of the brain, the MRI likely shows this. If the resulting hemiparesis is on a patient’s nondominant side, the physical or occupational therapist likely already documented this.

**Hypertension**

Next, consider hypertension. Coders using ICD-9 can accurately report the cause of hypertension that is not essential hypertension if a physician documents it. The terms *malignant* and *accelerated* are deleted from ICD-10, and there is only one code set for hypertension. If a patient has hypertensive kidney disease, hypertensive heart disease, or hypertension caused by another condition, coders already look for that documentation.

Physicians already document whether pheochromocytoma (a tumor of the adrenal gland) is the cause of a patient’s hypertension. Thus, the ICD-10 code will appear different at first until coders become accustomed to seeing these new classifications. However, ICD-10 classifications are based on the same thought processes coders use with ICD-9.

**Diabetes**

Like ICD-9, ICD-10 divides diabetes into causative factors (i.e., type 1, type 2, secondary to other conditions, and gestational diabetes). Similarly, the codes reflect that diabetes affects the same body systems and requires the same documentation. For example, with nephropathy, physicians must document the stage of chronic kidney disease and the pathologic cause, when applicable. With neuropathy, physicians must document which nerve or nerves are affected. With retinopathy, physicians must specify proliferative or nonproliferative and mild, moderate, or severe.

ICD-10 includes additional body systems that can be affected, each of which has its own code sets. Examples include arthropathy (for Charcot foot), dermopathy (for diabetic skin ulcers), and dental disorders related to diabetes. However, coders will use the same thought processes that they did for ICD-9. The only exception is that ICD-10 doesn’t specify uncontrolled diabetes. Instead, this condition appears in the hyperglycemia code set.

**Laterality**

Although many coders are concerned about laterality, this information is almost always documented somewhere in the chart. Alternatively, coders can locate specificity in an x-ray report if the physician provides a diagnosis. As with other codable information, coders will likely be able to retrieve information about laterality from sources other than attending physicians.

**Skin ulcers**

All coders are concerned about obtaining the cause and stage of skin ulcers. However, if physicians are diagnosing the hole, this information is likely already provided, whether it’s an arterial ulcer, pressure ulcer, or diabetic foot ulcer.

Physicians don’t need to learn staging. Instead, they only need to tell coders what tissue is involved at the deepest level (i.e., skin, skin and subcutaneous tissue, tissue involving muscle, or tissue involving bone). If physicians actually look at the hole and document what they think caused it and what tissue is involved, coders will be able to report it.

---

Editor’s note: Dr. Gold is CEO of DCBA, Inc., a consulting firm in Atlanta that provides physician-to-physician CDI programs. Contact him at 770-216-9691 or rgold@DCBAInc.com.

---

Questions? Comments? Ideas?

Contact Contributing Editor Lisa Eramo
Telephone 401-780-6789
Email leramo@hotmail.com
Review guidelines for coding pregnancy, its complications

Depending on the demographics of the region a hospital serves, its coders could determine code assignment for hundreds of deliveries and pregnancy-related services annually—reviewing coding guidelines is helpful.

**Principal diagnosis**

Coders must remember that pregnancy is a disease process separate from other disease processes that patients may experience, says Lori-Lynne Webb, CPC, CCS-P, CCP, CHDA, COBGC. Even when patients present for other conditions (e.g., hypertension management), pregnancy is the principal diagnosis, says Webb, a coder at St. Alphonsus Regional Medical Center in Boise, Idaho, and an AHIMA-certified ICD-10-CM/PCS trainer.

A pregnancy diagnosis is always first, she says. This may seem counterintuitive to coders trained to report the principal diagnosis as the condition after study that is chiefly responsible for admission, she says.

Webb recently coded a case in which a pregnant patient was admitted for treatment of a broken leg. The principal diagnosis was pregnancy because it affected decisions regarding treatment of the leg (e.g., administration of certain drugs or sedation), she says.

Sequencing an actual delivery is somewhat different. The *ICD-9-CM Official Guidelines for Coding and Reporting*, §I.C.11.b.4 (p. 45/107) states: “When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery.”

This guideline further explains that for cesarean deliveries, coders should select the principal diagnosis based on the condition established after study that was responsible for admission. This means that if a patient is admitted with a condition that results in a cesarean delivery, the condition that prompts the delivery should be reported as the principal diagnosis. If the admission is unrelated to the condition that results in a cesarean delivery, the condition that relates to the admission should be reported as the principal diagnosis.

Current guidelines indicate that 648.21 is the principal diagnosis for a woman with a pregnancy complicated by anemia who undergoes a cesarean delivery due to fetal distress not present at admission, says Susan Proctor, RHIT, CCS, CPC, a coding consultant in Willits, Calif., and an AHIMA-certified ICD-10-CM/PCS trainer.

**Other complications**

Coders must also capture all other conditions that affect management of a pregnancy, says Proctor.

The *ICD-9-CM Official Guidelines for Coding and Reporting*, §I.C.11.a.1 (p. 44/107) states: “It is the provider’s responsibility to state that the condition being treated is not affecting the pregnancy.”

Report all documented conditions unless physicians indicate otherwise, says Proctor. “All conditions are complications unless stated otherwise by the provider, and the Chapter 11 codes are sequenced first,” she says.

**Signs and symptoms**

Signs and symptoms may also pose coding challenges. This is because physicians often document signs and symptoms that may indicate a more definitive condition, says Webb. Dehydration and excessive vomiting—commonly experienced and documented during pregnancy—could indicate metabolic syndrome. Elevated blood pressure, severe headaches, and edema could indicate preeclampsia. Query when documentation is vague; it may point to a more definitive diagnosis, she says.

**Failure to progress**

Physicians continue to document nonspecific terminology despite more specific codes and diagnoses available in ICD-9-CM, says Proctor. Failure to progress (i.e., inability to deliver without a cesarean) is one example, she says. *Coding Clinic*, July–August 1985, p. 11, instructs coders to report code 661.21 (uterine inertia, delivered) when physicians document failure to progress.
Decreased fetal movement

Decreased fetal movement (655.7x)—a condition in which a mother cannot feel the fetus move—can be an early sign of a problematic pregnancy. Physicians often document this term before administration and interpretation of a fetal non-stress test that indicates normal development, says Webb.

The following documentation is necessary to help determine whether decreased fetal movement is present:

➤ Was the fetus stressed during the fetal non-stress test?
➤ How many heartbeats per minute, including accelerations and decelerations, did the fetus have during the test? Is this normal?
➤ How many contractions occurred during the test?
➤ What was the patient’s blood pressure during the test?
➤ Was the patient hydrated or dehydrated during the test?

Query when documentation is unclear, says Webb.

Fetal conditions and management of mothers

Coders should assign codes from the following categories only when the fetal condition is responsible for modifying management of a mother:

➤ 655 (known or suspected fetal abnormality affecting management of the mother)
➤ 656 (other known or suspected fetal and placental problems affecting management of the mother)

For example, report fetal conditions that require termination of a pregnancy, diagnostic studies, additional observation, or special care. The mere existence of a fetal condition does not justify assigning a code for that condition, in accordance with the guidelines.

Complicating matters is that one physician could be treating the mother and another could be monitoring the fetus, says Webb. Interconnected EMRs help ensure documentation is updated and available. This isn’t always possible, making it difficult for coders to determine how and whether certain fetal conditions affect the mother, she explains.

Normal deliveries

Normal deliveries (code 650) are so rare that Proctor asks colleagues to review cases to ensure she didn’t forget to code something that was documented. Coders should remember that in addition to procedures listed under the description for code 650, normal deliveries include induction of labor by artificial rupture of membranes without any indication. Refer to Coding Clinic, Third Quarter 2000, p. 5, for more information.

Abortions

The term abortion has a legal connotation, but several more specific terms are also associated with this diagnosis, says Webb. These include the following:

➤ Spontaneous abortion, including miscarriage (634.x)
➤ Legally induced abortion (635.x)
➤ Illegally induced abortion (636.x)
➤ Unspecified abortion, including retained products of conception following abortion, not classified elsewhere (637.x)
➤ Failed attempted abortion (638.x)

Intrapartum care

Coders often forget to report codes for complications that occur during labor and delivery (codes 660–669), says Webb. For example, when a delivery trauma, such as an episiotomy (73.6), occurs, coders often forget to report a code for cervical laceration (655.3x).

ICD-10

ICD-10 pregnancy, childbirth, and puerperium codes are more detailed than their ICD-9-CM counterparts and often refer to the fetus as a product of conception, says Proctor. Furthermore, ICD-10-PCS fetal and obstetrical MRI codes will require coders to capture the specific fetal body part examined and whether contrast was used, says Webb.
Take time to learn what motivates your coding staff

Coders tend to be highly motivated by nature, but they’re constantly put to the test during times of increased demands, expectations, and change.

Experts agree that today’s coders face a variety of stressors. A few examples include:

➤ Learning ICD-10
➤ Meeting stringent productivity standards
➤ Withstanding third-party auditor scrutiny
➤ Surviving staffing shortages
➤ Satisfying demands for coding accuracy
➤ Keeping up with ever-changing coding guidelines

“The present environment of increased scrutiny and demand requires organizations to look hard for what motivates employees,” says Laura Legg, RHIT, CCS, a revenue control coding consultant at Providence Health & Services in Renton, Wash.

Diane Grapp, CCS, coding coordinator at Wheaton Franciscan Healthcare, a six-hospital system in southeastern Wisconsin, agrees. “When more is expected out of a coder, more motivation is needed to help the coder achieve their potential,” she says.

Coder retention

Motivated employees tend to work harder, and motivation is important with respect to coder retention, says Legg. “Coders are pretty hard to find. If you have a good coder, you want to keep them motivated and happy and keep them learning so that they stay with you,” she says.

Retention is particularly important as hospitals begin to budget for ICD-10 training. Some hospitals are concerned that considerable attrition between now and the ICD-10 compliance deadline will mean that providing extensive ICD-10 training to current staff may be a futile effort, says Legg. This attrition may be due to coders who retire, an inability to retain qualified coders, or both, she says.

Motivating coders is important with respect to retention and maintaining ICD-10 momentum, says Gloryanne Bryant, RHIA, CCS, CDIP, CCDS. Hospitals and coders must continue to move forward with training and preparations despite CMS’ announcement of an implementation delay, says Bryant, regional managing director of HIM, NCAL revenue cycle, at Kaiser Foundation Health Plan, Inc. & Hospitals in Oakland, Calif.

Money and promotions are obvious incentives, but experts say other factors also contribute to motivation.

ICD-10-CM/PCS

ICD-10-CM/PCS—along with its inherent learning and leadership opportunities—motivates some coders, says Legg. Consider involving coders in ICD-10 initiatives, such as a newsletter devoted to ICD-10 topics, monthly conference calls, or meetings that offer coders an opportunity to ask questions and share information, she says.

Conversely, some coders may be completely overwhelmed by ICD-10, says Bryant. “That much change demotivates some,” she says. “You have to find the balance. Change can take a certain group of employees and pull them down in terms of being motivated.” Working one-on-one with these individuals will help ensure a smooth transition in which motivation remains constant, she says.

Continuing education

Coding managers need to know which areas pose challenges and provide educational opportunities to address these needs. “Education and knowledge equal power,” says Grapp. “When a coder is empowered with information necessary to perform his or her job, the coder will succeed.”

Bryant agrees. “In professional coding and HIM, learning is inherent to the profession. To be able to support that and provide education and training is a motivator,” she says.

Unfortunately, hospitals provide varying degrees of educational opportunities for coders, says Legg. Hospitals that don’t value continuing education tend to struggle most with coder motivation. “It’s very defeating to feel as though you’re not appreciated enough to be worthwhile for investment,” she says. “Coders are expected to know
what they need to know, which isn’t going to happen unless they have those learning opportunities. ‘You need to know all of this, but we aren’t going to pay for it’ is not a good message.”

Allowing coders to conduct regular coding audits is one way to enhance more traditional avenues for learning (e.g., audio conferences, online courses, coding publication subscriptions), says Grapp. “I tell coders that auditing is a great educational tool to help enhance coding skills,” she says. “The audits can sharpen professional skills and help coders move forward.”

**Recognition and communication**

Coding managers should communicate regularly with coders, not just when a problem exists, says Legg. Low motivation can occur when coding managers or HIM directors interact with coders only to discuss errors during audit result meetings. “Coders need audit results because obviously it’s a learning opportunity, but it shouldn’t be the only time they’re communicated with,” she says.

Motivation is higher when coders are recognized for their work, says Legg. A simple “thank you” from management each morning can go a long way to motivate staff, she says.

When coders express concerns or ask questions, managers should take their comments seriously, says Bryant. For example, don’t ignore a coder’s concern about a query form or certain EHR functionality. “Your staff will be motivated if they can see that you’re working on resolving the problem,” she says. Something as simple as a coding tip sheet can motivate coders because it shows managers are trying to simplify coders’ work, she says.

Allow coders to vent their frustrations, says Bryant. “The work can be frustrating and challenging, and we don’t have all the answers,” she says.

Managers should consider hosting roundtables to discuss coding questions. The staff might agree on how to interpret a particular guideline or coding convention or decide that additional AHA clarification is necessary. Coding managers should support coders’ decisions to pursue additional clarification.

“Follow-through is really important to show your staff that you care about their work. This will motivate them because they can see that you’re dedicated, too,” says Bryant.

Allowing coders time to meet is helpful with respect to compliance; it also can provide psychological motivation, she says. Coders sometimes think they’re the only one with a question. A roundtable discussion is motivating because it’s inclusive and makes people feel like they’re part of a team, she says.

**Goals**

Goal-setting can be a powerful incentive, particularly when coders can provide input that lends specificity, says Legg. “This establishes a sense of ownership for meeting those goals,” she explains. For example, some coders may strive to undergo cross-training or training for a non-coding-related task, she says.

Grapp agrees. “A goal will challenge our talents and give us guidelines to achieve. It brings a sense of accomplishment to the coder to reach certain goals,” she says.

Coders don’t typically provide input regarding productivity goals, but reminding them that certain charts will take longer than others to code is important, says Grapp. This helps coders understand that ultimately, productivity is based on an average number of charts per hour.

**Remote coding**

Remote coding can improve motivation and productivity because coders know that trust exists between them and management, says Grapp.

Legg agrees. “I think coders really enjoy the flexibility of working at home,” she says. “It provides some freedoms not offered in the office setting, and it implies a sense of trust.”

**Ask coders what they want**

Coding managers shouldn’t assume that a successful incentive for one individual will be universally effective, says Legg. “I think the best strategy is to ask coders. Asking them is a sure way to know,” she says.
Grapp agrees. “Learn who your coders are as individual people. Learn their personalities and how each one responds to different styles of motivation,” she says.

Surveys can gauge what motivates staff, says Bryant. Also consider scheduling monthly departmental meetings or office hours for individual discussions, she says.

### Individual and team incentives

Use of individual and team incentives is ideal, experts say. Respective examples are an award for helping a colleague code a difficult case and a relaxed Friday dress code for all coders if the team meets a certain goal, says Legg.

### Advantages and disadvantages of individual and team incentives

#### Individual incentives

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizes individual performance</td>
<td>May encourage employees to withhold information to better themselves at the expense of less productive colleagues</td>
</tr>
<tr>
<td>Encourages individuals to use the most efficient work processes to achieve the goal</td>
<td>May encourage biased work selection if employees may self-select work</td>
</tr>
<tr>
<td>Rewards good work, attendance, and punctuality</td>
<td>Employees will be less likely to socialize with others, possibly causing a rift within the work group</td>
</tr>
<tr>
<td>Encourages individuals to learn and remember facts to improve their performance</td>
<td>Employees may be resistant to any change that they perceive as affecting them financially</td>
</tr>
<tr>
<td>Works well for individuals who are motivated by money</td>
<td>Does not work well for individuals who are not motivated by money</td>
</tr>
</tbody>
</table>

#### Team incentives

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourages staff members to share efficiencies discovered to improve everyone’s performance</td>
<td>Some team members may slack off because others will pick up the slack to achieve the common goal and receive the incentive</td>
</tr>
<tr>
<td>Encourages dialogue between coworkers and sharing of facts and knowledge</td>
<td>Creates frustration when one or more team members don’t carry their weight</td>
</tr>
<tr>
<td>Recognizes the team and the results of teamwork</td>
<td>Individuals who produce more don’t receive any additional compensation</td>
</tr>
<tr>
<td>Works well if all team members are motivated by money</td>
<td>The team suffers if one or more members are not motivated by money</td>
</tr>
<tr>
<td>May encourage brainstorming to improve processes</td>
<td>Can cause ill feelings and destroy teamwork</td>
</tr>
</tbody>
</table>

*Source: Adapted from The Coding Manager’s Handbook by Rose T. Dunn. HCPro, Inc., 2010.*
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.

I have a question about coding computer-assisted fluoroscopy.

Consider the following documentation:

Use and interpretation of intraoperative fluoroscopy. After positioning the patient, the posterior lumbar area was prepped and draped in the standard sterile fashion. The prior incision was marked with a marking pen. C-arm fluoroscopy was used to map an incision extending from the tip of the spinous process of L2 to that of L5.

After performing a timeout, this incision was infiltrated with local anesthetic and incised with a 10-blade scalpel. Dissection proceeded through the subcutaneous fat using Bovie® monopolar cautery. Self-retaining retractors were applied. Dissection then proceeded in the midline through the avascular plane through the lumbodorsal fascia and musculature using the Bovie. Self-retaining retractors were deepened.

Should I assign a procedure code for the fluoroscopy during this inpatient procedure, or is it included in this procedure? Confusion arises when considering this procedure in an inpatient setting vs. an outpatient setting.

Please explain what I should do.

Great question! You are correct that code assignment for procedures such as computer-assisted fluoroscopy can be quite different depending on setting. CPT® Professional Edition currently includes add-on codes in the Category III codes (0054T–0055T) to identify computer-assisted musculoskeletal orthopedic procedures using either fluoroscopy, CT, or MRI.

Recognition and payment for Category III codes may vary by payer because they are considered new and emerging technology codes. CPT Assistant, June 2011, indicates that each Category III code is used for five years from initial publication and is given a “sunset date” or a scheduled deletion/archived date. The current CPT Manual indicates that these two codes are scheduled to “sunset” in January 2014. After this date, they will either receive a permanent code assignment in the Category I codes or will require reporting with an unlisted code for the service.

However, use ICD-9-CM Volume 3 procedure codes for acute inpatient facility coding. AHA Coding Clinic, Fourth Quarter 2004, indicates that new code category 00.3x (effective October 1, 2004) was added to identify computer-assisted surgeries (CAS). Use of such modalities such as CT/CT angiogram (procedure code 00.31), magnetic resonance (MR)/MR angiogram (procedure code 00.32), fluoroscopy (procedure code 00.33), and even imageless CAS (procedure code 00.34) were assigned specific codes.

Reporting of such procedures will not affect overall MS-DRG assignment. However, this can facilitate hospital and payer data collection to identify the use of computer technology and its value in producing positive outcomes compared to traditional operative procedures.
that don’t use such technology. Use of CAS has become increasingly common in brain, spinal, orthopedic, and ear, nose, and throat procedures for which precision and accuracy is paramount.

In this scenario, you should assign procedure code 00.33 for the use of CAS fluoroscopy and an additional code(s) for the diagnostic or therapeutic procedure.

Shannon McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CCDS, director of HIM and coding at HCPro, Inc., in Danvers, Mass., answered the previous question that originally appeared on JustCoding.com.

How should I code the following scenario?

A patient is admitted for a revision of a knee arthroplasty. The patient’s prosthesis was previously removed due to an infection.

Refer to Coding Clinic, Fourth Quarter 2001, pp. 156–158, which advises coders to report code VS4.82 (aftercare following explantation of joint prosthesis) with a secondary diagnosis of V88.22 (acquired absence of knee joint).

How should I code the following scenario?

A patient is admitted for an autologous platelet graft. The report states that the patient had an “autologous platelet graft placed deep into the retinaculum.” Which ICD-9-CM procedure code should I report? The surgeon who performed the procedure reported CPT® code 20926.

Coding Clinic, First Quarter 2005, p. 16, advises coders to report ICD-9-CM procedure code 99.79 (other therapeutic apheresis or other injection, administration, or infusion of other therapeutic or prophylactic substance) for platelet grafting procedures.

A physician documents in an operative report debridement of a necrotic muscle (not due to an open wound). Must the physician also document how the muscle is removed to report ICD-9-CM procedure code 83.45 (other myectomy)? Is this considered excisional or nonexcisional debridement? What documentation is required to code the removal of a necrotic portion of a muscle?

Coding Clinic, First Quarter 1999, p. 8, advises reporting 83.45 for muscle debridement. This guidance doesn’t distinguish between excisional and nonexcisional debridement. The physician would need to document excision of the muscle or excisional debridement. Refer to Coding Clinic, First Quarter 2008, p. 3. If this information is unclear, query the physician.

Jean Stone, RHIT, CCS, manager of CDI at Lucile Packard Children’s Hospital at Stanford in Palo Alto, Calif., answered the previous three questions.

Are you an inpatient coding and compliance expert?

Do you enjoy researching inpatient-related coding questions? Do you stay up to date on Medicare transmittals and publications? If you answered “yes” to either question, you’d be a great addition to the Briefings on Coding Compliance Strategies editorial advisory board. Or perhaps you’d simply like to share your insight and experiences. If you’re interested in either opportunity, contact Contributing Editor Lisa Eramo at leramo@hotmail.com.