Develop an E/M level service matrix to capture facility-based ED revenue

A documentation matrix for ED services can help your facility stay compliant and capture all appropriate E/M revenue.

Hospitals must continue to follow their outpatient E/M level coding until the proposed national guidelines take effect, most likely in 2006, experts guess. Until then, your facility should focus on tightening any loopholes that may exist in your current E/M level system.

To ensure that your facility’s documentation supports the level of E/M service coded, develop an accurate matrix. Since E/M codes define the level of care provided, their accuracy drives the level of reimbursement.

During an HCPro audio conference in April, Yvonne Hoiland, CCS-P, CPC, CPC-H, RCC, and Charol Spaulding, CCS-P, CPC, CPC-H, PMCC, discussed methods to improve your facility’s

Appeal ED diagnosis testing denials
Medical necessity tips for reimbursement

If you receive denials for reasonable and necessary tests performed in your ED, faulty coding and incomplete documentation may not be to blame. If the practitioner documented that he or she ordered the test based on the patient’s complaints and symptoms to meet Emergency Medical Treatment and Active Labor Act (EMTALA) screening and stabilization requirements, you can appeal and probably get paid.

“The problem is that the edits cannot decipher that the admitting diagnosis, not the principle diagnosis, covers the code, so the claim will be denied,” she says.

The MMA section 944 states, “In the case of items and services required under EMTALA, determinations regarding whether the items and services were “reasonable and necessary” for purposes of Medicare coverage must be made on the basis of information available to the treating practitioner at the time the item or service was furnished. The frequency with which the item or service was provided before or after the patient’s emergency room visit may not be taken into account.”
E/M matrix

E/M coding documentation.

“Your E/M levels have to be very well-documented,” says Hoiland. “How embarrassing if you’ve set your own guidelines and then an audit finds you are not following them, not to mention opening your facility up to the risk of noncompliance and lost revenue.”

Point nursing acuity v. patient classification

Use a point system based on nursing acuity to determine the facility E/M levels, as opposed to the patient classification system used most commonly for inpatient services, Hoiland recommends. “The patient classification system is based on leveling the severity of illness or diagnosis and the intensity of service.”

Hoiland encourages facilities using the patient classification system for determining outpatient E/M levels to switch to a point nursing acuity system. “There is too much potential for subjectivity when using the patient classification system. It’s too complicated and there is big risk of double-dipping,” she says.

The point nursing acuity system is more defendable from an audit standpoint, and there is less risk of double dipping. The drawback is the system’s total reliance on nursing documentation. If a nurse does not document a service, the facility loses reimbursement for that service, Spaulding says.

Use the following guidelines to develop a matrix that will assist you in determining the level of service based on nursing acuity.

Who should help develop the ED matrix?

• Coding and compliance staff. Coders review records every day, and they know what is and isn’t available in medical records and what needs to be put on a matrix. “They know which cases are most often lacking the information they need to code them,” says Hoiland.

• Nursing staff. Nurses know what procedures are most often encountered in their ED, and are familiar with assigning different nursing functions a point value. “Nurses are invaluable in developing your matrix,” says Hoiland. “They are best suited to advise you from the facility-side on a point system.”

• Billing staff. Billers know which services get billed through the CDM and which are coded directly. They will be aware of quirks in the system. “Preferably, you want someone on board who is intimately acquainted with the chargemaster and how it functions,” says Hoiland.

What should be included in the matrix?

• Services that do not have a CPT code. Any service that has a CPT code should be coded separately and not listed on your matrix. If your facility does not code them as separate procedures, you are mistakenly bundling payment for these into your level of service and leaving money on the table.

• Procedures that the chargemaster will not allow you to charge from the ED revenue center. Your CDM may not allow specific procedures to be billed from the ED revenue center under certain circumstances. For example, initial respiratory treatment administered by a nurse is on the sample matrix under the 30-point value column because, although there is a CPT code for this procedure, this facility is not capable of charging respiratory care through the ED charging system because of a conflict in the chargemaster with revenue centers. “If the facility rectifies the conflict so it can code the CPT code, then it will have to remove the service from the matrix and update its guidelines to avoid double-dipping,” says Hoiland.
Your matrix
A sample matrix for charging services in an ED using an acuity level point system can be found on p. 4. Your matrix may need to list different procedures. Coding and billing staff can help decide what services are not captured by other methods. Nursing staff can help determine the appropriate point acuity system for those procedures and services. Each facility’s matrix will be different, says Hoiland. “It always surprises me how every facility has its own separate set of billing issues.”

Coders, not nurses, should code
Many facilities ask Hoiland who should code ED encounters and where staff should be located. Some facilities have nurses post charges linked to CPT codes on the chargemaster. Other facilities place a coder in the ED department, while others keep their coders in the HIM department. “It is best to have coders who have been properly trained on the matrix coding from the records,” says Hoiland. “Coders are best at making objective coding decisions. Where they are located is entirely up to your facility.”

Editor’s note: Go to www.hcmarketplace.com/Prod.cfm?id=2435 for information about how to purchase the tape of this audioconference, “Facility-based E/M coding made simple.”

About the sources
Yvonne Hoiland, CCS-P, CPC, CPC-H, RCC, is a senior coding consultant with Coding Continuum, Inc., of Tucson, AZ.
Charol Spaulding, CCS-P, CPC, CPC-H, PMCC, is vice president of Coding Continuum, Inc. of Tucson, AZ.

Matrix sample reviewed

Yvonne Hoiland, CCS-P, CPC, CPC-H, RCC, of Coding Continuum, Inc., of Tucson, AZ, explains some services on the sample matrix on p. 4:

Initial triage is worth 25 points
• Assign 25 points for **triage of an ED patient** because it takes the most time in the beginning of the patient visit and is the most resource-intensive.

Don’t forget these five-point assessments
• Assign five points every time **vital signs** are taken, including the first time.
• Assess five points when a nurse **applies a sling** and instructs the patient on its use. Do not confuse this charge with coding separately for the supply of the sling. The five points cover the cost of the nurse’s time and assistance, not the sling itself.

Clarifying 10-point assessments
• Add 10 points for a **consult request**. This includes the paperwork and time it takes the nursing staff to develop a consult for a patient.
• Document 10 points for each **replacement of a nonmedicated IV fluid** bag. Because the IV charge includes the initial IV bag, do not include points for the initial bag. That’s considered double dipping. Each time you change or replace a bag after the first one, apply 10 points.

Record these 20-point services
• Report 20 points for a **chaperone**, a person of the same sex who stays in the room when a physician of the opposite sex of the patient does an exam.
• Allocate 20 points for **ancillary services, monitored patient**. For example, this occurs when a patient is transported to the radiology department for x-rays and is monitored constantly for vital signs on the way. Nursing staff or a technician must stay with the patient the entire time. Do not confuse the description with bundling x-rays into the level of service.

Use a 30-point value for cases requiring numerous resources
• Add 30 points for addressing a **combative patient**, because this process usually requires the help of several nurses to make sure no one gets hurt.
• Add 30 points for monitoring a **suicidal patient**, because the situation requires constant surveillance and many facility resources.
# Sample ED acuity level charging

<table>
<thead>
<tr>
<th>POINT VALUE 5</th>
<th>POINT VALUE 10</th>
<th>POINT VALUE 20</th>
<th>POINT VALUE 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage Assessment</td>
<td>25</td>
<td>AMA left a/l assessment</td>
<td>Admit OR</td>
</tr>
<tr>
<td>Initial Vital Signs</td>
<td>Anal Exam</td>
<td>Bleeding Control</td>
<td>Anti-venom Admin.</td>
</tr>
<tr>
<td>Repeat Vital Signs (each)</td>
<td></td>
<td></td>
<td>Baer Hugger</td>
</tr>
<tr>
<td>Pelvic Obstetric – Vaginal/ether</td>
<td></td>
<td>Chaperone for Private Exams</td>
<td>Blood Administration Per Unit</td>
</tr>
<tr>
<td>Constant Monitoring</td>
<td>Charcoal Administration</td>
<td>Burn Care Extensive</td>
<td></td>
</tr>
<tr>
<td>Ace Wrap</td>
<td>Clean up Patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Collar</td>
<td>Consult Request</td>
<td>Culture/Specimen Processing</td>
<td></td>
</tr>
<tr>
<td>C-Spine Precautions</td>
<td>Discharge Intact Simp</td>
<td>Eye Patch</td>
<td></td>
</tr>
<tr>
<td>Ear/Eye/Nose Exam-Prap</td>
<td>IMED Pump/IV Pump</td>
<td>Defibrillation (Each)</td>
<td>Delivery</td>
</tr>
<tr>
<td>Fetal Heart Measurement</td>
<td>3M Pump</td>
<td>Discharge Instructions Extensive</td>
<td>Foley Cath (Assist Urology)</td>
</tr>
<tr>
<td>Ice Bag Application</td>
<td>IV Fluids-Non Medicated</td>
<td>Dressing Major (i.e. packing)</td>
<td>Immobilizer</td>
</tr>
<tr>
<td>Labs – Routine (each body fluid)</td>
<td>Count After 1st (each)</td>
<td>External Pacer (Pace)</td>
<td></td>
</tr>
<tr>
<td>Neuro Checks (each)</td>
<td>Nasogastric Tube</td>
<td></td>
<td>Invasive Pacemaker</td>
</tr>
<tr>
<td>O2 Cannula</td>
<td>Oxygen Masks</td>
<td>Gastric Lavage</td>
<td>IV Insertion 3 or more</td>
</tr>
<tr>
<td>Ortho Shoe</td>
<td>Pt Teaching</td>
<td>Gastrostomy Tube Care</td>
<td>Latex Allergy Cart</td>
</tr>
<tr>
<td>Pelvic Obstetric – Vimanual (no speculum)</td>
<td>Pulse Ox (O2 SAT) Count only 1X</td>
<td>Isolation</td>
<td>Mast Suit-Application</td>
</tr>
<tr>
<td>PO Meds</td>
<td>Slit Lamp Eye Exam (no FB)</td>
<td>IV Insertion 2 lines</td>
<td>Nitro (Nitro) / Cardiac Drugs – Drip</td>
</tr>
<tr>
<td>Portable x-ray</td>
<td>Subsequent Resp Tx by RN</td>
<td>IV Insertion-Difficult Hep/Baline Lock</td>
<td></td>
</tr>
<tr>
<td>Road Test</td>
<td>Suppositories/Enema</td>
<td>IV – Piggyback/Medicated</td>
<td>Restraint Application</td>
</tr>
<tr>
<td>Sling</td>
<td>Transport to Ancillary Services (each Svc)</td>
<td>Mast Suit- Applied Prior to Arrival</td>
<td>Resp TX by RN (Initial)</td>
</tr>
<tr>
<td>Steri-Strips</td>
<td>Tilt Test</td>
<td>TPA Administration</td>
<td>Transfer Other Facility</td>
</tr>
<tr>
<td>Sublingual Meds</td>
<td>Toilet Assist</td>
<td>Pelvic Non OB</td>
<td></td>
</tr>
<tr>
<td>Verbal Orders</td>
<td>Suture Assistance</td>
<td>Staff Interpreter</td>
<td></td>
</tr>
<tr>
<td>Topical Meds</td>
<td></td>
<td></td>
<td>SI Pt</td>
</tr>
<tr>
<td>Urinary output maint.</td>
<td>Wound Care &lt; 1cm</td>
<td>Ancillary Services – Monitored Pt (each Svc)</td>
<td>Victim Abuse Protocol</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEVEL 1 (0-40)</td>
<td>(99261)</td>
<td>Critical Care</td>
<td></td>
</tr>
<tr>
<td>LEVEL 2 (41-65)</td>
<td>(99282)</td>
<td>99291</td>
<td></td>
</tr>
<tr>
<td>LEVEL 3 (66-90)</td>
<td>(99283)</td>
<td>*(130+ points)</td>
<td></td>
</tr>
<tr>
<td>LEVEL 4 (91-115)</td>
<td>(99284)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEVEL 5 (116&amp;over)</td>
<td>(99285)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ED case study: How many points of care?

Using the sample acuity level charging matrix provided by Coding Continuum, Inc., on p. 4, add the number of points for this patient visit and determine the correct level. The answer is on p. 9.

The details of the visit:
A 16-year-old female presents to the ED complaining of nausea, vomiting, and dizziness. The ED staff take her vitals (blood pressure, respiratory, temperature) and perform pulse oximetry (99%) and a neurological assessment.

Staff note the patient’s allergies, medications, and her prior medical history of diabetes, post-traumatic stress disorder, bipolar disorder, and depression.

She is triaged at 16:45. According to the nurse’s notes, the patient was given 1,000 cc of IV fluid at 17:30 and another 400 CC at 18:30. Her routine fluid tests were sent to the lab at 17:30. Her Glasgow Coma Score (15) is assessed at 19:00. Her vitals are taken again at 19:35.

The patient states that she normally takes her insulin in the morning, but she had not had any in 36 hours. The nurse instructs the patient on diabetes and dehydration care and follow up.

The doctor’s notes show the results of a urine analysis, which are not documented in the nursing report. The doctor documented the results of the fingerstick blood sugar—234 the first time, 173 the second time. He notes the patient ambulates well and had positive urine output.

The doctor diagnoses the patient as hyperglycemic with uncontrolled diabetes. He recommends she return home and follow up if she is not feeling better within two to three days. Patient is released at 21:00.

Appeal testing denials

Encourage documentation at time of order
To ensure documentation at the time of the order, add a box in the order documentation for the ED physician to indicate that he or she ordered the test(s) based on the presenting condition of the patient, Rinkle recommends. This documentation will be useful if you need to appeal to Medicare. Also, other managed care plans that usually deny services ordered out of the ED may pay if you present the ordering documentation in this manner, she says.

To qualify for payment, the physician’s interpretation must take place before the EMTALA screening is complete and the patient has been stabilized, says Rose T. Dunn, RHIA, CPA, FACHE, FHFMA.

Documenting the time the physician makes the interpretation for ordered tests is crucial in reimbursement, so educate ED physicians on the importance of noting it in their dictation, written notes, or wet reads, she adds.

“If you can show the test was ordered for EMTALA and that the order was based on presenting conditions, you should get paid for that test,” Rinkle says. “As long as the test was ordered prior to the EMTALA screening being completed, payers have to pay because it falls under the umbrella of EMTALA.”

Interpretation report formats should include the following elements to support medical necessity:

1. A place to document the treating physician/practitioner’s ordering indications
2. A space to document the technologist’s indications taken from the patient
3. An area to document the interpreting physician’s final impression

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Appeal testing denials

LCDs and LMRPs may trip denials
Coding that involves local coverage decisions (LCDs) and local medical review policies (LMRPs) may create unjustified denials. According to Rinkle, payers don’t keep LCDs and LMRPs current with ICD-9 changes.

“You may be getting inappropriate rejections because payers have not refined their edits out to the fifth digit of the ICD-9 codes,” Rinkle says. “That is their system’s error.”

Rinkle is lobbying CMS to hold payers to the same degree of detail it expects from providers with regard to HIPAA transactions sets. “If providers must code to the greatest specificity, then payers need to upgrade their specificity, especially since grace periods have been eliminated,” she says.

Coach physicians to stay on top of LMRPs and LCDs to avoid missing ABN opportunities, says Dunn. “ABNs must be given . . . with enough information so patients can make informed decisions. It’s too late when they’re in their gown and swabbed,” she says.

Dunn knows facilities whose physicians use personal digital assistants or palm solutions to keep current with LMRPs and LCDs. “At least CMS has moved the LMRPs and LCDs to one Web site (www.cms.hhs.gov/mcd), and when all LMRPs are converted to LCDs by December 2005, it will be easier to keep track of changes,” she says.

LCDs and LMRPs differ somewhat, says Dunn. “LCDs were established by the Benefits Improvement Protection Act (BIPA), and fiscal intermediaries and carriers are allowed to explain whether they will cover a service . . . intermediarywide or carrierwide,” she says.

LCDs include a policy statement describing what is not covered, along with corresponding HCPCS codes. LMRPs describe what Medicare will cover.

“Fortunately LCDs cannot conflict with National Coding Decisions (NCDs). Therefore, it will be important for organizations to review LCD denials and compare the denied service to the services specified in the NCD.

If it is a covered service in the NCD, then the denial should be appealed,” she says.

For the most definitive guidelines for coding services and requirements of documenting the order, look in the September 26, 2001, Program Memorandum AB 01-144, says Rinkle.

“I recommend that facilities go back and compare how their policies measure up against the guidelines in this memo. Look at your coding, ordering, and documentation policies and see if you are following the rules,” she says. Go to www.cms.hhs.gov/manuals/pm_trans/AB01144.pdf to review the program memo.

Editor’s note: For more information about Medicare medical necessity for outpatient services, go to www.hcmarketplace.com/Prod.cfm?id=2441 to purchase the tape of the HCPro audioconference “Medicare medical necessity for outpatient services,” in which both Dunn and Rinkle participated.

About the sources
Valerie Rinkle, MPA, is the revenue cycle director at Asante Health System in Medford, OR.
Rose T. Dunn, RHIA, CPA, FACHE, FHFMA, is chief operating officer of First Class Solutions, Inc., in St. Louis.

Diagnostic tests require UPIN numbers

Only the treating physicians or physician or nonphysician practitioners acting under their scope of practice can order diagnostic tests.

For example, you can accept orders from nurse practitioners, physician assistants, clinical nurse specialists, and others acting under the scope of practice as long as you report the unique physician identification number (UPIN) of the nonphysician practitioner.
Review your LMRP before coding ‘gutcam’

BAPCs and its sister publication, APC Answer Letter, have received several inquiries about coding the new “gutcam” or capsule endoscopy. The procedure was recently assigned a new code, but coding for the procedure is not as simple as assigning the code. You must know your local medical review policy (LMRP), says Tiffany Neally, RHIA, CCS, director of quality/remote coding manager for Precyse Solutions in King Prussia, PA.

Review your own LMRP carefully “Don’t forget to check your LMRP to determine coverage conditions in your state for the capsule endoscopy procedure,” she says.

For example, Cahaba Government Benefit Administrators, a fiscal intermediary covering states in the Midwest, allows payment of the gutcam only for beneficiaries who have one of the following:

- Continuing gastrointestinal (GI) blood loss and anemia secondary to bleeding and who have undergone upper GI endoscopy, colonoscopy, and either push enteroscopy or small-bowel radiologic study within the same period of illness that failed to reveal a source of bleeding

- A prior small-bowel malignancy or radiologically identified small-bowel pathology suggesting malignancy, which requires this study in follow-up.

There are other limitations under this LMRP. The test is

- not reimbursable for colorectal cancer screening
- payable only for services using FDA-approved devices
- not reimbursable for the confirmation of lesions or pathology normally within the reach of upper or lower endoscopes (lesions proximal to the ligament of Treitz or distal to the ileocecal valve)
- not payable for patients with hematemesis
- covered when performed by physicians trained in endoscopy or independent diagnostic-testing facilities under general supervision of a physician trained in endoscopy procedures

Common denial causes Inaccurate ICD-9-CM codes, the absence of the treating physician’s order, or more than one service per episode of illness reported account for the most common denial reasons for this procedure under Cahaba Government Benefit Administrators LMRP.

And in some cases, Medicare coverage does not include screening procedures of the small bowel.

How the procedure works Capsule endoscopy is a non-invasive diagnostic-imaging device for viewing the GI tract, especially the small bowel, which is not accessible through standard upper endoscopy and colonoscopy.

The patient swallows a small capsule (approximately 11 mm x 26 mm) that contains a disposable minicamera that transmits video pictures as peristalsis propels the capsule through the GI tract. As the capsule passes through the GI tract, the signal calculates its position.

“The images are viewed on a computer terminal that can read the results once they are downloaded from the data recorder belt,” Neally explains.
Real-life coding: Ultrasound-guided paracentesis and fluid aspiration

Test your skills on this actual coding scenario

Editor’s note: BAPCs and Lolita M. Jones Consulting in Fort Washington, MD, bring you this month’s coding quiz on how to code more than one procedure performed on the same patient during the same visit.

Use the information provided to code the case, and check your answer against the one provided by Jones on p. 12.

Use modifier -59 to identify procedures/services that are not normally reported together, but may be performed during the same visit under certain circumstances.

This may represent a different session or patient encounter, procedure or surgery, site or organ system, incision, or injury not ordinarily encountered or performed on the same day by the same physician. Use this modifier to indicate that a procedure or service was distinct or independent from other services performed on the same day.

For example, procedures 23030 (incision and drainage, shoulder area: deep abscess or hematoma) and 20103 (exploration of penetrating wound [separate procedure]; extremity) are performed on the same patient on the same day.

If these two codes were billed together without modifier -59, code 20103 would be denied as duplicate billing.

Because the incision and drainage of the shoulder (code 23030) is the definitive procedure, any exploration of the area (20103) preceding this is considered part of the procedure. However, if the exploration procedure (code 20103) was conducted on a different part of the same limb or on a different limb, adding the -59 modifier to either code 20103 or code 23030 would explain the circumstance and prevent a denial.

Case study: Paracentesis, fluid aspiration in the ED

An elderly male with end-stage liver and heart failure presents for drainage of recurrent ascites, or accumulation of fluid in the abdomen. A needle is inserted through the abdominal wall into the peritoneal cavity to obtain a sample of fluid. This test may be done in an office setting, a treatment room, or hospital.

After a local anesthetic is applied, the needle is inserted 1 in–2 in into the abdomen. Sometimes a small incision is made to help insert the needle. A sample of fluid is then withdrawn into a syringe.

The needle is removed and a dressing is applied to the puncture site. If an incision was made, one or two stitches may be used to close it.

The operative report says ultrasound-guided paracentesis and ultrasound-guided fluid aspiration started at 10:20 a.m. and ended at 12:17 p.m.

Ultrasound was used to identify free ascites in the left-upper quadrant and a loculated pocket of ascites in the left-lower quadrant of the abdomen just lateral to the ostomy site.

The patient gave verbal consent after the risks and
benefits were explained. Patient’s left abdomen was prepped and draped in a standard sterile fashion.

Results of the ultrasound-guided paracentesis: Preliminary ultrasound revealed a moderate-sized area of ascites in the left-upper quadrant. A suitable entry site was chosen and the area was anesthetized with 1% lidocaine.

Under direct ultrasound visualization, a micropuncture needle was advanced into the peritoneal space.

A straw-colored ascitic fluid was immediately removed via the needle. Using standard guide wire and catheter technique, a 6 French APD was placed in the left-upper quadrant for drainage of the fluid.

This was followed by aspiration of 5600 cc of straw-colored, slightly cloudy peritoneal fluid. The catheter was then removed and hemostasis was obtained.

Results of the ultrasound-guided fluid aspiration: Preliminary ultrasound of the left-lower quadrant revealed a loculated fluid collection just lateral to the patient’s ostomy. A suitable entry site was chosen and the area was anesthetized with 1% lidocaine. Under direct ultrasound visualization, a micropuncture needle was then advanced into the fluid collection.

There was immediate return of clear ascitic fluid. Using standard guide wire and catheter technique, a 6 French APD was then placed into the left-lower quadrant for drainage of fluid.

This was followed by aspiration of 350 cc of clear ascitic fluid with multiple small mucous shreds.

Additional drainage was unsuccessful due to the mucous shreds. The APD catheter was removed. Ascitic fluid continued to drain from the access site for approximately five minutes. The site was then covered with a dressing.

The patient tolerated the procedure well without any immediate complications. The patient was then monitored for approximately 30 minutes, during which vital signs remained stable. He was transported back to hospice care.

He will return in one week for a repeat paracentesis. Written documentation of the procedure was sent with the patient back to hospice care.

Findings: Ultrasound revealed a moderate amount of free ascites in the left-upper quadrant and a small-sized loculated pocket of ascitic fluid in the left-lower quadrant just lateral to the patient’s ostomy site.

Impression: Technically successful drainage of the left-upper quadrant ascitic fluid by ultrasound guidance with 5600 cc of ascetic fluid removed and of left-lower quadrant loculated fluid pocket by ultrasound guidance with 350 cc of clear ascitic fluid with multiple mucous shreds removed.

Turn to p. 12 for the correct coding for this case.
Form steering committee for smooth transition to ICD-10

By Randy Wagner BSN, RN, CCS

The ICD-10-CM coding system could take effect as soon as 2007. When the data is announced in the Federal Register, providers will have only 24 months to prepare for implementation. With much to do, only good planning will make it happen.

Our facility has invested in researching best practices for the inevitable change to ICD-10. After attending several seminars and studying articles on the subject, we are now planning. The first order of business: deciding who in our facility needs to involved. We plan to use lessons learned during APC implementation to avoid some of the same pitfalls. Because pitfalls will vary from one organization to the next, each facility should review its challenges during the APC transition.

If you haven’t already, form a steering committee to provide guidance and support for the implementation. Take the following steps:

- Begin budget provision and information services (IS) analysis
- Organize an action plan for implementation
- Start education for documentation within six months to a year, and train coders not more than six months before the go-live date

Include staff from the following on the committee:

- IS
  Due to the increased specificity of ICD-10, the IS department will need to implement a system that allows up to seven alphanumeric characters instead of the five currently used for ICD-9, replace ICD-9 software with new ICD-10 software, and develop a system for conversion or a crosswalk to interface code entry and electronic billing.

- Financial services
  The financial department will have to rework the budget to include the expenses of implementation, conversion, and education needed to transition to ICD-10.

Restructuring a system with the foresight to make documentation available for coding could reap great rewards for the organization. If necessary, consider creating a way to facilitate accurate and timely documentation from physicians or other medical professionals, such as electronic charting. If you rush coding without specific documentation, the inaccurate...
billing that will result will severely affect strategic planning, resource utilization, facility and physician profiling, and contract negotiations.

• **Billing and coding personnel**
  Train each coder and biller in how to code a health record using ICD-10. Plan on some staff members leaving the organization as a result of this transition, particularly those nearing retirement, because they don’t want to learn a new coding system. By remaining positive and assuring them that the transition will not be difficult, you can keep your loss to a minimum. Go to www.aha.org for a report on field testing or go to www.ahima.org and click on the site’s “Body of Knowledge” for the complete ICD-10 field test report.

You will need to review and collect more clinical data from the health record for accurate coding. Management will have to allow more time for coders to receive those reports. Develop a system for prioritizing the charts for coding based on your most common payer (commercial or Medicare/Medicaid), as well as the priority of the facility and office manager.

Consider the need for staff coverage while coders train for ICD-10. Depending on the style of training that the organization selects, the coder will be in a classroom for 16–32 hours. You may also want to allow a grace period to ease coders into the new system.

In the American Health Association field test report, participants reported that although coding with ICD-10 initially took longer, ease of coding rapidly increased. Some reported the ICD-10 system was easier and less frustrating than ICD-9 and took equal or less time to code the chart.

• **Medical services**
  The coding system change will affect physicians, nursing, and other allied medical personnel documentation and diagnostic reports. Physicians must know the standardization of terminology of ICD-10 so they provide the right information in their documentation for accurate code selection. Train by department or specialty to address the terminology relevant to specific physicians, especially surgeons.

Assist physicians through this transition with tools to transform lists of symptoms, lab findings, and diagnostic reports into an accurate portrayal of their patients’ illnesses. It is important that they understand that all their documentation in every setting—inpatient, outpatient, or their own office—must be specific and expanded.

Once each department understands what it must accomplish, the steering committee must determine the best way to accomplish these goals. Try the following:

• Educate staff on coding system changes
• Develop capital and multi-year budgets
• Assist departments in determining their educational needs
• Develop an action plan and monitor progress
• Commit to achieving a smooth, successful transition

**Sources to prepare for ICD-10**

- Copy of article from For the Record, Preparing for ICD-10, www.3m.com/us/healthcare/his/icd-10.jhtml

**HIPAA glossary**

- www.3m.com/us/healthcare/his/HIPAA/resources.jhtml
- www.wedi.org/public/articles/ HIPAA_GLOSSARY.pdf


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Coding Coach

The capsule passes naturally from the body with the stool, and because it is disposable, is not recovered.

This test is used for the diagnosis of obscure GI bleeding when the site has not previously been identified by upper GI endoscopy, colonoscopy, push enteroscopy, or radiologic procedure. It may be especially helpful in the diagnosis of angioectasias of the GI tract.

Use code 91110
The new CPT-4 code assignment for this procedure, 91110, “Gastrointestinal tract imaging, intraluminal (e.g. capsule endoscopy) esophagus through ileum, with physician interpretation and report” took effect January 1, 2004, Neally says.

Check the index of the CPT-4 coding book under Gastrointestinal Tract. “You will find a subtitle of ‘Imaging, Intraluminal,’ and the code 91110. If you look up code 91110 in the tabular section of the CPT coding book, you will find two notations beneath the code description,” she says.

The notations state, “Visualization of the colon is an integral part of the procedure and is not reported separately; and because of this, if the physician does not perform the visualization of the ileum, he must report 91110 with modifier -52 appended to indicate that the procedure was reduced.”

Answer to real-life coding quiz

Use codes 49081 and 49081-59 to code the case on p. 8.

Per the operative report, the patient presents for drainage of recurrent ascites. Since this was not the first drainage procedure performed on this patient, assign code 49081 (subsequent peritoneocentesis, abdominal paracentesis or peritoneal lavage).

The second paracentesis was performed on a different site, making it a separate and distinct procedure from the first one, requiring modifier -59. “Modifier -59 signals the payer that your documentation will show why both procedures are legitimate and deserve reimbursement,” says Jones.