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To Everything There Is A Season

Living in an agricultural community teaches the importance of seasons, suggests Ardith Campbell, CPC, CPC-H, CCP. Similarly, she writes, there are times of fallowness with few code changes, and a time of bountiful code changes. While the trees and fields lay dormant at this time, most medical facilities are gearing up for a time of rapid-fire changes with the suggested updates to the ICD-9 diagnosis and procedure codes. Campbell displays all the changes before your very eyes, much like you'd see at the Farmer's Market.

DOC2DOC



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Physician Documentation: Link to Quality

Assuming that physicians haven't had a chance to peruse The Affordable Health Care for America Act, Denise Nash, MD, CCS, CIM, tells docs what's in it for them: enhanced scrutiny of the patient's medical record and enhanced documentation. These, she writes, will become essential as to the health outcomes and presence of impairment as well as functional status.

TALKING POINTS



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FY 2011 IPPS Final Rule – MS-DRG Changes

The Inpatient Prospective Payment (IPPS) Final Rule for FY 2011 has something for everyone. One item, however, is sure to catch your attention: the latest MS-DRG changes as reported by Dawn M. Lui, RHIT.

MODIFIERS CORNER



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Using Modifiers to Report Reduced or Cancelled Procedures: Part II, Modifier 52

Modifier 52 may now be used when reporting certain radiology procedures, which do not require the use of anesthesia, when the procedure is discontinued after the patient is prepared or prepped, and has been brought to the room where the radiology procedure would have been performed, or when the procedure has been partially performed, writes Sandy Palmer, RHIT.

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2010 ICD-9 Changes for 2010: To Everything There Is A Season

LIVING IN AN AGRICULTURAL community teaches the importance of seasons. In February, trees are pruned to promote larger fruit during the harvest time. March through May has trees budding and flowering. Then, the fruit season is upon us. Juicy cherries, luscious peaches and nectarines, yummy pears, and crunchy apples are abundant at various times. During the fall and winter, however, the trees must be watched for the danger of frost.

Similarly, we have times of fallowness with few code changes, and a time of bountiful code changes. While the trees and fields lay dormant at this time, most medical facilities are gearing up for a time of rapid-fire changes.

The suggested updates to the International Classification of Diseases, 9th Revision, Clinical Module (ICD-9) diagnosis and procedure codes were published in the Inpatient Prospective Payment System (IPPS) Proposed Rule. Diagnosis codes discussed during the March ICD-9 Coordination and Maintenance (C&M) Committee may not have been finalized in time to be included with the IPPS proposed rule, and are subsequently finalized.

These codes are distinguished by use of an asterisk (*) after the code number. Depending upon when you download the information from the National Center for Health Statistics Website or the Centers for Medicare and Medicaid Services (CMS) Website, you will want to make sure that you have the most recent version of the

revisions. This is critical advice, as there were several code changes (including a deletion), that were not published in the proposed rule.

The following is a chapter overview of the code changes which will become effective Oct. 1, 2010. This is not an exhaustive listing. A thorough review of the changes will be needed to become familiar with coding updates that are relevant to your area. As in previous years, there are no truly "deleted" diagnosis codes. The list of newly "invalid" diagnosis codes is simply the result of fifth-digits added for specificity.

Code freeze prior to ICD-10?

To freeze, or not to freeze: that was the question: Whether 'tis nobler to freeze code changes on the ICD-9 and ICD-10 systems prior to the implementation of ICD-10. Shakespeare aside, during the Sept. 2009 and March 2010 ICD-9 C&M meeting, the proposal was brought forward to have minimal changes made to the ICD-9 and ICD-10 systems when we get closer to the transition date. A permanent resolution was not provided, but advance notification of a possible freeze will be published.

At the Sept. 15, Coordination and Maintenance Committee C&M Committee meeting, the decision was finalized and they made the announcement of a partial freeze. The following timeline is from the meeting agenda, and is available on the CMS website:

- "The last regular, annual updates to both ICD-9-CM and ICD-10 code sets will be made on Oct. 1, 2011.
- On Oct. 1, 2012, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.
- On Oct. 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.
- On Oct. 1, 2014, regular updates to ICD-10 will begin.

Depending upon when you download the information from the National Center for Health Statistics Website or the CMS Website, you will want to make sure that you have the most recent version of the revisions ... there were several code changes not published in the proposed rule.

- The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation on and after Oct. 1, 2014, once the partial freeze has ended.”

Chapter 2 Neoplasms (140-239)

The first chapter to see changes is chapter 2 Neoplasms, and right away we have a word of caution. There are two new codes: 237.73 Schwannomatosis and 237.79 Other neurofibromatosis. According to the notes provided in the June update, code 237.78 was proposed as the new code for the “other” condition, but was modified to new code 237.79. The National Institute of Neurological Disorders and Strokes (NINDS) provides information regarding neurofibromatosis (NF) disorders. These are genetic disorders of the nervous system, and which affects the development and growth of nerve cell tissues. Neurofibromatosis disorders are divided into two types. The most common type is NF1, and manifests with skin changes, tumors and bone abnormalities. NF2 is much rarer and occurs as tumors on the eighth cranial nerve, bilaterally. Nerve tissues develop tumors and can be seen as soft, fleshy growths.

Schwannomatosis is a type of NF that has recently been recognized. According to MedlinePlus, Schwannomatosis is the rarest type of neurofibromatosis, occurring in only about one in every 40,000 people. Schwannomas consists only of Schwann cells (nerve sheath cells) while neurofibromas may include all other cells.

Chapter 3 Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders (240-279)

For chapter 3, two diagnosis codes are expanding from four digits to five. Code 275.0 Disorders of iron metabolism is expanding to allow for differentiation between 275.01 Hereditary hemochromatosis and

275.02 Hemochromatosis due to repeated red blood cell transfusions. Hemochromatosis occurs when your body has stored up too much iron and is generally a genetic problem. While there are some diseases that may also cause hemochromatosis, the disease may also be seen when a patient receives repeated red blood cell transfusions; hence, the separate diagnosis codes.

Hereditary hemochromatosis is a fairly common disorder, and may be treated by routinely removing blood to reduce the amount of iron. Basically, this patient will come in for therapeutic phlebotomy, aka a blood donation. Hemochromatosis due to repeated red blood cell transfusions may be caused when an anemic person has had multiple blood transfusions and develops the disorder.

Codes in the 276.6 Fluid overload section are expanding. One of the new diagnosis codes is 276.61 Transfusion associated circulatory overload (TACO). TACO is now recognized as a significant cause of posttransfusion morbidity and mortality and increased hospital stays. TACO may also be concomitant with Transfusion-Related Acute Lung Injury (TRALI).

A new code will be added to the 278.0 series. Code 278.03 Obesity hypoventilation syndrome will be recognized under its own merits. This is a condition that occurs in obese people, where poor breathing leads to lower oxygen levels and higher carbon dioxide levels in the blood. Almost always, some form of sleep apnea is present.

Chapter 4 Diseases of Blood and Blood-Forming Organs (280-289)

In chapter 4, diagnosis code 287.4 Secondary thrombocytopenia is expanding digits. Codes 287.41 Posttransfusion purpura and 287.49 Other secondary thrombocytopenia have been added. Secondary thrombocytopenia is low platelet count secondary to another disease or process. Posttransfusion purpura is most often linked to trauma cases where more than 10 units of packed red blood cells are given in a 24-hour period. Since there are no platelets in the packed red blood cells, PTP becomes a possibility.

Chapter 5 Mental Disorders (290-319)

There is a new code to be added to the mental disorders chapter. Code 315.35 Childhood onset fluency disorder was created to provide an opportunity to distinguish childhood onset from adult onset of this speech disorder. Due to this update, code 307.0 Adult onset fluency disorder has been revised. You may want to review the Includes and Excludes notes for updates as well. Fluency disorders may also be associated with Parkinson’s or due to the late effects of a cardiovascular accident (CVA). If Parkinson’s patients or those with the late effects of CVA are common to you, please be sure to review new code 784.52 Fluency disorder in conditions classified elsewhere. Originally presented in Sept. 2008, and again in Sept. 2009, the American Psychiatric Association worked in conjunction with the American Speech-Language-Hearing Association to assure accurate placement of this new code in the classification system.

There is a new V code that may be of interest to those in the mental health field. Code V62.85 Homicidal ideation has been approved. Additionally, code V49.87 Physical restraints status may help track those patients who require physical restraints during their hospital stay. Patients who are physically restrained during their hospitalization require additional services. Regulations state that the patient must be evaluated within specific time frames by a physician/psychiatrist.

Chapter 6 Diseases of the Nervous System and Sense Organs (320-389)

There were no codes added or deleted to chapter 6 this year. You may still wish to review the section for any changes to Includes or Excludes notes due to code updates in other chapters.

Chapter 7 Diseases of the Circulatory System (390-459)

A new subsection has been added to chapter 7 for aortic ectasia. Code range 447.70 – 447.73 is in place for the disorder, and code selection is dependent up on the site of the ectasia. Ectasia, or the swelling of a hollow organ of the body, as a vein, can be termed a mild aneurysm.

Chapter 8 Diseases of the Respiratory System (460-519)

There are two codes updated in chapter 8, and are very similar in their change. Codes 488.0 Influenza due to identified avian influenza virus and 488.1 Influenza due to identified novel H1N1 influenza virus are expanding digits. The same digits with the same definitions added are:

- 1 – with pneumonia
- 2 – with other respiratory manifestations
- 9 – with other manifestations

With flu season upon us, be sure to use the new codes to avoid claim delays. Also, remember not to assign the bird flu or H1N1 diagnosis without documentation of the confirmed illness.

Chapter 9 Diseases of the Digestive System (520-579)

A separate diagnosis code of 560.32 Fecal impaction has been added to the digestive system chapter. Previous Coding Clinic for ICD-9 guidance previously assigned this to code 560.39 Other impaction of intestine.

There are other changes in chapter 16 regarding fecal incontinence for changes.

Chapter 10 Diseases of the Genitourinary System (580-629)

While there are no new codes to chapter 10, there is one revised description. Code 629.81 Recurrent pregnancy loss without current pregnancy has been updated to coincide with changes to codes 646.30 – 646.33.

Chapter 11 Complications of Pregnancy, Childbirth and the Puerperium (630-679)

As mentioned above, codes 646.30 – 646.33 Recurrent pregnancy loss have been revised. The fifth digit specificity is to indicate an unspecified episode of care, delivered, or as an antepartum condition. Also revised is code V26.35 Encounter for testing of male partner of female with recurrent pregnancy loss.

Chapter 12 Diseases of the Skin and Subcutaneous Tissue (680-709)

There are no new codes in chapter 12 this year.

Chapter 13 Diseases of the Musculoskeletal System and Connective Tissue (710-739)

Code 724.02 Spinal stenosis, lumbar region, without neurogenic claudication has been revised, and new code 724.03 Spinal stenosis, lumbar region, with neurogenic claudication has been added for use. Lumbar spinal stenosis does not always manifest with neurogenic claudication, or pain, paresthesia or cramping of the legs relieved by sitting.

Chapter 14 Congenital Anomalies (740-759)

Over the years, chapter 14 has grown by leaps and bounds. This year, code 752.3 Other anomalies of uterus has expanded digits for greater specificity. New uterine diagnoses include:

Diagnosis	Description
752.31	Agenesis of uterus
752.32	Hypoplasia of uterus
752.33	Unicornuate uterus
752.34	Bicornuate uterus
752.35	Septate uterus
752.36	Arcuate uterus
752.39	Other anomalies of uterus

A new subsection for cervical and vaginal anomalies has been created under code 752.4

Diagnosis	Description
752.43	Cervical agenesis
752.44	Cervical duplication
752.45	Vaginal agenesis
752.46	Transverse vaginal septum
752.47	Longitudinal vaginal septum

Chapter 15 Certain Conditions Originating in the Perinatal Period (760-779)

There are no new codes for chapter 15.

Chapter 16 Symptoms, Signs and Ill-Defined Conditions (780-799)

In chapter 16, the updates touch on many aspects of care. A careful review of this section is always warranted, as the changes touch so many different areas.

New code 780.33 Post traumatic seizures is available as of Oct. 1. Code 780.66 Febrile nonhemolytic transfusion reaction distinguishes that this complication is due to the transfusion of a non-blood product.

Code 786.3 Hemoptysis has expanded digits, and this is where you will find code 786.31 Acute idiopathic pulmonary hemorrhage in infants [AIPHI]. Cases of AIPHI are characterized by the sudden onset of pulmonary hemorrhage in a previously healthy infant. Evidence of pulmonary hemorrhage includes hemoptysis, and finding blood in the nose or airway with no evidence of upper respiratory or gastrointestinal bleeding.

Another code expanding digits is 786.7 Incontinence of feces. New codes allow you to select between full incontinence of feces, incomplete defecation, fecal smearing and fecal urgency.

At the Sept. 2008 C&M meeting, a topic of discussion was traumatic brain injury (TBI), presented by the Department of Defense (DoD) in conjunction with the Veteran's Administration. There was much discussion on the difficulty of providing a diagnosis code specific to TBI, as the diagnosis would need to report the initial injury and provide for the different manifestations which may crop up. Each patient's injuries can manifest in different ways and at different times.

There were several new codes added in 2010, but many suggested diagnosis codes required additional review. Due to the broad spectrum of the disease manifestations, caution was taken to ensure the correct classification of the appearance of the disorders. Different specialties were involved in the review process as all wished

to maintain the integrity of the classification process and the structure of ICD-9. New manifestation codes have been added under 799.5. Another word of warning here, as code 799.50 Unspecified signs and symptoms involving cognition, which was listed in the proposed rule was deleted and will not be implemented on Oct. 1. Be sure to review your code book to ensure that code 799.50 is listed as a valid diagnosis code.

Code 970.8 Poisoning by other specified central nervous system stimulants has expanded digits, and will allow you to specify one drug more expressly. Code 970.81 Poisoning by cocaine is for instances of off-label use of cocaine that have caused poisoning. Code 968.5 Poisoning by surface and infiltrative anesthetics and other poisoning including cocaine as an instructional note, and may be used by dentists during treatment. The 968.5 code would be 'labeled' uses and the 970.81 code would be for 'off-label' uses. The C&M Committee mentioned that code 970.81 would be used more frequently than the other code.

Chapter 17 Injury and Poisoning (800-999)

While there are only three subcategories involved with the changes to chapter 17, the implications of use may pack a punch. Codes 999.6 ABO incompatibility reaction and 999.7 Rh incompatibility reaction are expanding digits. At first glance, the changes are very similar; however, code 999.7 will add codes that are for non-ABO related reactions. Fifth digit specificity will include codes for acute reactions as well as delayed reactions. A new subsection 999.8 has been added, with the fifth digit to represent acute or delayed reaction, with the incompatibility unspecified.

Supplementary Classification of External Causes Of Injury And Poisoning (E000-E999)

Last year, updates to the E codes added "status" codes that may be reported in conjunction with other E codes. As an example, codes added would describe if a patient is paid, unpaid or a student. Additional codes were added to include the activity undertaken by the patient. A new code E000.2 Volunteer activity has been created. If

While there are only three subcategories involved with the changes to chapter 17, the implications of use may pack a punch.

you've volunteered to cook at summer camp and burn yourself on the stove, this will now be an option that may be reported. There is one code revision, E017.0 Roller coaster riding, may be reported for those patients who were injured during a roller coaster ride.

Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01-V91)

The bulk of changes this year occur in the V code section. In the personal history section, a careful review of V13.2 and V13.6 may be in order. New codes V13.23 Personal history of vaginal dysplasia and V13.24 Personal history of vulvar dysplasia have been created to distinguish between the sites of the dysplasia. Additional diagnosis codes have been added to the V13.6 codes to further break down the site of the congenital malformations that may or may not be corrected. Code V13.68 Personal history of (corrected) congenital malformations of integument, limbs, and musculoskeletal systems is changed from the description that was printed in the proposed rule.

Code V25.1 Encounter for insertion of intra-uterine contraceptive device has expanded to distinguish between an insertion only, a removal only, or a removal and reinsertion.

Another code expanding digits is V85.4 Body Mass Index 40 and over, adult which will now top out at V85.45 Body Mass Index 70 and over, adult.

For patients who have had their pancreas removed, there are two new status codes. For a total absence, there is code V88.11 Acquired total absence of pancreas and code V88.12 Acquired partial absence of pancreas is available.

An entirely new category has been created – V90 Retained foreign body. Codes in the V90.01 – V90.9 range encompass retained items, such as V90.01 Retained depleted uranium fragments to V90.31 Retained animal quills or spines to V90.83 Retained stone or crystalline fragments.

A second new subcategory is V91 Multiple gestation placenta status. To select the appropriate diagnosis, you will need to know how many babies, as there are different numbers for twin, triplet, quadruplet and other specified. Additionally, the specificity allows you to indicate the number of placenta and the number of amniotic sacs.

ICD-9 Procedure Code updates

There are several exciting new ICD-9 procedure codes that should make life easier. While there are procedure codes for the subcutaneous implantation and removal of neurostimulator pulse generators, there were no codes for cranial implantation. The surgical technique used for the site of implantation varies greatly. Due to this, code 01.20 Cranial implantation or replacement of neurostimulator pulse generator and 01.29 Removal of cranial neurostimulator pulse generator have been created. Code 02.93 Implantation or replacement of intracranial neurostimulator lead(s) and code 86.95 Insertion or replacement of dual array neurostimulator pulse generator will be updated to point you to the new codes. C&M Committee notes indicate that code 86.05 Incision with removal of foreign body or device from skin and subcutaneous tissue should still be assigned for the removal of the pulse generator.

Mitral valve repair is generally provided as an open heart procedure. There is a newer procedure that is catheter based, and less invasive to the patient. There is no new code for this procedure. There are two updates to the 35.9 Other operations on valves and septa of heart to accommodate the new procedure. Revised code 35.96 Percutaneous balloon valvuloplasty will direct coders to new code 35.97 Endovascular mitral valve repair with implant.

Another section with a revision to one code and the addition of another 37.34 Excision or destruction of other lesion or tissue

The ICD-9 updates are the first in our season of changes. Soon the Outpatient Prospective Payment System and Physician final rules will be published, and the major changes that come with the beginning of the year.

of heart, endovascular approach as the revised code. New code 37.37 Excision or destruction of other lesion or tissue of heart, thoracoscopic approach was created for the newest approach for the maze procedure. Codes already exist for the open approach, which is the eldest.

New code 38.97 Central venous catheter placement with guidance has been created to report those services using electrocardiographic guidance to assist with proper catheter positioning. This procedure involves use of a new device that combines electrocardiography with the catheter insertion. The intent is to provide feedback to quickly correct catheter tip misplacements. According to the C&M guidance, both code 38.97 and 89.52 Electrocardiogram (with ECG) should be reported to accurately report the services rendered.

Only code 39.8 has expanded digits. The code will now be broken out into the implantation or replacement, revision and removal of the total system, leads, or pulse generator. Instead of the one code for all, there will be nine codes as possible replacements.

There are a plethora of code revisions in category 81. You may wish to review codes 81.02 – 81.08 and 81.32 – 81.38 to understand the nuances of the code title changes.

In order to facilitate tracking the outcome results to prevent sterna dehiscence and

deep sterna wound infections after cardiac surgery, it was necessary to create a new code to capture the internal fixation of the sternum using rigid plates. Current guidance was to report code 78.51 Internal fixation of bone without fracture reduction, scapula, clavicle, and thorax [ribs and sternum]; however, this term was too generic because of the broad spectrum of body areas that would use this code. New code 84.94 Insertion of sterna fixation device with rigid plates will be used for capturing this procedure.

There were five new codes proposed relating to the grafting of fat for reconstructive surgery. Generally, this is done after a lumpectomy or post mastectomy. Not all of the codes were accepted, so there are only three new codes for this area. The new codes are 85.55 Fat graft to breast, 86.87 Fat graft of skin and subcutaneous tissue and 86.90 Extraction of fat for graft or banking. Fat grafting may be done as a single procedure, but is most commonly provided during the same operative session as the other reconstruction, such as the myocutaneous flaps or TRAM flaps.

In Conclusion

The ICD-9 updates are the first in our season of changes. Soon the Outpatient Prospective Payment System and Physician final rules will be published, and the major changes that come with the beginning of the year.

As sure as the seasons change, we can be certain that additional changes are in store for us. ■

About the Author

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REFERENCES

2010 IPPS Proposed Rule

www.cms.hhs.gov/AcuteInpatientPPS/FY2010RULE/list.asp#TopOfPage

ICD-9-CM – Summary Tables

www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07summarytables.asp#TopOfPage

ICD-10 – CMS site

www.cms.hhs.gov/ICD10/01_Overview.asp#TopOfPage

Medline Plus

medlineplus.gov

NINDS

www.ninds.nih.gov/disorders/neurofibromatosis/neurofibromatosis.htm

National Cancer Institute

www.cancer.gov

National Center for Health Statistics

www.cdc.gov/nchs/dataawh/ftperv/ftpicd9/ftpicd9.htm#addenda

CORRECTION

An error appeared in the article, *FY 2011 IPPS Final Rule: Good News, Not So Good News*, in the August edition of CCFN. In reporting on the Three-Day Payment Window, a sentence stated the following: "Under this interim rule, hospitals must include diagnostic services and admission related non-diagnostic services provided in hospital outpatient departments within three calendar days (including the day of admission) on the inpatient claim."

Please note that the three days are in addition to the date of admission; therefore, this sentence has been corrected below for clarification.

Under this interim rule, hospitals must include diagnostic services and admission related non-diagnostic services provided in hospital outpatient departments on the date of the inpatient admission or during the three days immediately preceding the date of admission on the inpatient claim.

We apologize for any confusion this may have caused.



Physician Documentation: Link to Quality

DON'T KNOW IF IN YOUR "LEISURE" time away from your busy practices you have had a chance to peruse the ever-popular bill H.R. 3962 (formerly known as HR 3200) The Affordable Health Care for America Act.

Title IV of the bill deals with quality measures that are patient centered, while Title VI deals with program integrity. What does this mean for you? There will be enhanced scrutiny of the patient's medical record and enhanced documentation will become essential as to the health outcomes and presence of impairment as well as functional status.

Increasing in importance will be the continuity and coordination of care and care transitions for patients across providers and healthcare settings, including end of life care. These will all be captured as quality measures eligible for additional reimbursement or a decrease in reimbursement (the bill does not address decreased reimbursement) if found lacking in the chart documentation.

And there will also be the patient experience. As physicians, we have all been asking for this one — the patient engagement in his or her treatment. We have seen this one demonstrated with Medicare's Acute Care Episode (ACE) program, whereby the patient is incentivized to participate in the outcome of care. There is an expectation of collaboration between the patient and the physician on cost sharing 50 percent of the savings to a maximum of premium cap

currently set at \$1,157. Other measures will concentrate on the safety, effectiveness, and timeliness of care. And yet other measures will deal with health disparities including those associated with individual race, ethnicity, age, gender, place of residence or language; and the efficiency and resource use in the provision of care. All of this, of course, is tied to the implementation of an Electronic Medical Record (EMR), because it is virtually impossible to collect all of the required data manually. But what does this mean for you in terms of requirements? It means the requirement of a better-designed medical record.

The commonly used SOAP (Subjective, Objective, Assessment and Plan) will not suffice to meet the federal objectives because it lacks flexibility and does not encourage a more proactive approach to patient care. You will need a medical record that not only contains demographics, H&P, progress notes, orders, prescriptions and test results, but now you will need to include options, an agreed upon plan as well as compliance and coordination of care and documentation of the existence of any advance directive for healthcare. There is also the possibility of adding a patient survey section so that all the work that your office does relative to patient care may be counted in order for your practice to be reimbursed.

This format prompts two-way communication, patient participation and informed consent collection. It provides a means to record the patient's acceptance of responsibility for following through with

the healthcare plan. It also leaves no room for speculation, thus leaving practices to assume financial risk for non-compliance, which led to the demise of capitation.

In addition, you will need to document all informed consent discussions, documenting the material risks, benefits and alternatives that were discussed, the fact that patient questions were invited and answered, and that the patient consented to or refused treatment.

If global episode-of-care payment is adopted, you will need to document the rationale for excluding a differential diagnosis or deviating from evidence-based standards of care. You will also need to document the rationale for care provided or not provided when there is a discrepancy with the observations or recommendations of another practitioner.

When dealing with conflicting matters between providers, such as a disagreement on a diagnosis or plan of care, review your notes and the other provider's notes and all other pertinent reports. Again, this will also aid you in the global payment methodology arena which also means that you will need to...

- Give specific instructions to patients
- Keep copies of follow-up instructions in the medical record; and,
- Describe pertinent patient behavior such as missed appointments or failure to follow treatment recommendations as part of compliance with treatment plan.

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2011 IPPS: The Four 4's for MS-DRG Changes: Reclassify, Reassign, Replace and Recoup

CURRENTLY UNDER INPATIENT Prospective Payment System (IPPS), the MS-DRG payment is based upon the principal diagnostic code, including up to eight additional diagnostic codes, and up to six procedures performed during the patient's inpatient hospital stays. Beginning Jan. 1, 2011, however, the Centers for Medicare & Medicaid Services (CMS) will now be accepting a total of 25 diagnostic codes and 25 procedure codes on the inpatient claim.

In the process of developing the MS-DRG, all principal diagnoses flow into one of the 25 Major Diagnostic Categories (MDCs). For 2011, each claim processed will be assigned to one of the 747 MS-DRGs in 25 MDCs.

MS-DRG Reclassification and Reassignment for 2011

CMS made the following changes to the MS-DRG classifications for 2011. The following are brief summarizations of the MS-DRG changes that will take effect on Oct. 1, 2010.

For the Pre-Major Diagnostic Categories (MDCs), CMS made changes to postsurgical hypoinsulinemia and bone marrow transplants.

Postsurgical Hypoinsulinemia: When secondary diabetes is surgically induced following a pancreas transplant, this may be identified with ICD-9 diagnostic code 251.3 (Postsurgical hypoinsulinemia). CMS has added 251.3 to the list of principal

or secondary diagnostic codes assigned to MS-DRG 008 (Simultaneous Pancreas/Kidney Transplant) and to MS-DRG 010 (Pancreas Transplant).

Bone Marrow Transplants: MS-DRG 009 (Bone Marrow Transplant) was deleted, and replaced with two new MS-DRGs, MS-DRGs 014 and 015.

MS-DRG 014 (Allogeneic Bone Marrow Transplant) includes claims that contain one of the following ICD-9 procedure codes:

- 41.02 – Allogeneic bone marrow transplant with purging
- 41.03 – Allogeneic bone marrow transplant without purging
- 41.05 – Allogeneic hematopoietic stem cell transplant without purging
- 41.06 – Cord blood stem cell transplant
- 41.08 – Allogeneic hematopoietic stem cell transplant

MS-DRG 015 (Autologous Bone Marrow Transplant) includes those claims that contain one of the following ICD-9 procedure codes:

- 41.00 – Bone marrow transplant, not otherwise specified
- 41.01 – Autologous bone marrow transplant without purging
- 41.04 – Autologous hematopoietic stem cell transplant without purging
- 41.07 – Autologous hematopoietic stem cell transplant with purging
- 41.09 – Autologous bone marrow transplant with purging

After review of the data for the following MDCs, CMS made the decision to not make any modifications to them at this time. CMS says it will continue to monitor each of the MDCs for future reviews of the IPPS.

- MDC 1 – Nervous System
- MDC 5 – Diseases and Disorders of the Circulatory System
- MDC 6 – Diseases and Disorders of the Digestive System
- MDC 8 – Diseases and Disorders of the Musculoskeletal System and Connective Tissue

MDC 15 – Newborns and other Neonates with Conditions Originating in the Perinatal Period

First, CMS added discharge status code 05 (Discharged/transferred to a designated cancer center or children's hospital) to the MS-DRG GROUPER logic for MS-DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility). This modification will cause all newborn claims that are assigned a discharge status of 05 and assigned to MS-DRGs 790 through 795 to be reassigned to MS-DRG 789 for transferred neonates.

Second, in regards to the vaccinations of newborns, CMS removed ICD-9 diagnostic code V64.05 (Vaccination not carried out because of caregiver refusal) from MS-DRG 794 (Neonate with Other Significant Problems) and added it to the only secondary diagnosis list for MS-DRG 795 (Normal Newborn).

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Using Modifiers to Report Reduced or Cancelled Procedures: Part II, Modifier 52

ED. NOTE: This article is a continuation of the August Modifiers Corner and will discuss specific uses for Modifier 52 - Reduced Services.

MEDICARE PROGRAM MEMORANDUM A-00-73 and Change Request 937 provided clarification of modifier use in the Hospital Outpatient setting in Oct. of 2000. These documents stated that modifiers for discontinued services were implemented so that hospitals could be reimbursed for the expense of preparing patients and rooms for procedures that were not completed. Currently, Medicare will reimburse procedures reported with Modifier 52 at 50 percent of the full OPPS payment amount.

Ten years ago, Modifier 52 was not allowed when reporting discontinued radiology procedures. Advancements in radiology services have led to more complex procedures being performed in the radiology areas of a hospital, using more staff and resources. Modifier 52 may now be used when reporting certain radiology procedures, which do not require the use of anesthesia, when the procedure is discontinued after the patient is prepared or prepped, and has been brought to the room where the radiology procedure would have been performed, or when the procedure has been partially performed.

Radiology Services Reduced

Providers should be careful to not report a radiology procedure code with Modifier 52 when a radiology procedure is reduced if a HCPCS code exists that appropriately describes the actual procedure performed. When a HCPCS code exists for the service that has been completed, report that code

instead. As stated in the Medicare Claims Processing Manual, the correct reporting is to "code to the extent of the procedure performed."

The Centers for Medicare & Medicaid Services (CMS) provides an example where a two-view chest, CPT code 71020, is ordered. When only one frontal view is performed, it is not appropriate to report 71020 with Modifier 52. Instead the following CPT code for a single view should be reported:

71010 – Radiologic examination, chest: single view, frontal

Procedures other than radiology services can also be reported with Modifier 52, if they do not require anesthesia or when anesthesia is not planned. These procedures may be reduced due to a time factor, cancellation of the procedure by the physician who feels it is in the best interest of the patient, and when a reduction in the procedure as described is required.

Procedures other than radiology services can also be reported with Modifier 52, if they do not require anesthesia or when anesthesia is not planned.

There are times when coding to the extent of the procedure performed is not suggested. We will discuss these circumstances in next month's article as they usually relate to procedures reported with Modifiers 73 and 74.

Timed Codes

Some procedure codes have descriptions that include services based on time. CPT® Assistant refers to these as "time-based" codes. When one of those visits is shorter than the amount specified in the available codes, then the procedure code may be reported with Modifier 52 appended. Here are a few examples of psychotherapy codes that could be reported with Modifier 52 if the session was less than 20 minutes.

90804 – Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;

90805 – Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services

Reduced Due to Anatomy

Some procedure codes are inherently bilateral and describe procedures performed on contralateral anatomy. Other codes describe procedures that are performed on specific anatomy. A patient, however, may

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have been born with a variation in his or her anatomy or the anatomy might have been altered due to surgical or accidental reasons. When these types of procedures are reduced due to the different anatomical variations Modifier 52 may be appended to describe a reduction in the service.

One example is the screening mammogram code:

77057 – Screening mammography, bilateral (two-view film study of each breast)

Since 77057 does not have a companion code for a unilateral screening mammogram, when a screening mammogram is performed on a patient who has had one breast surgically removed it would be appropriate to report 77057 appended with Modifier 52 to indicate only one breast was screened.

Another example from CPT Assistant includes the following code which is inherently bilateral.

93922 – Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (e.g., ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)

The scenario described a patient with a previous above-the-knee amputation. CPT Assistant suggests reporting Modifier 52 with code 93922, indicating the full arterial study was not performed on the patient due to the amputation.

Providers and coders, however, should be careful not to overuse Modifier 52 in cases when there is a variation that does not affect the full performance of the described procedure. Code descriptions should be reviewed to determine if codes are inherently or conditionally bilateral. The following codes may be performed unilaterally

OR bilaterally and would not require a reduced services modifier if the procedure was performed on only one side.

31231 – Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
54420 – Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral
58900 – Biopsy of ovary, unilateral or bilateral (separate procedure)

Reduced Versus Failed

There are times when a procedure does not achieve the intended goal. HCPCS Coding Clinic, for example, responded to an inquiry related to ERCPs. In the scenario presented, an ERCP was performed for stone removal, however only sludge and debris were removed. Since the full procedure was performed as intended, even though the outcome was not met, a reduced modifier was not appended and the following CPT code could then be reported:

43264 – Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts

Other Scenarios

Another use for Modifier 52 is reported in a CPT Assistant article where a surgeon had begun a procedure and required the skill of a urologist to perform a stent insertion. The urologist performed the stent insertion, but did not surgically open or close the site. In this case the following code should have been reported by the urologist appended with Modifier 52:

50605 – Ureterotomy for insertion of indwelling stent, all types

(Note: CPT code 50605 is an inpatient-only procedure for Medicare reporting.)

Summary

It is challenging to understand all the various uses of modifiers for reduced and cancelled procedures. Medicare contractors may also require modifiers or deny modifiers or provide specific reporting of reduced services modifiers depending on the CPT/HCPCS codes being reported and the circumstances of the reduced or discontinued services.

We will discuss the individual reduced/cancelled services Modifiers 73 and 74 along with examples for the use of each in a future article for the Modifier Corner.

About the Author

Sandy Palmer, RHIT, is a Coding and CDM Analyst for MedAssets, Integrity Services. Her expertise includes inpatient and outpatient facility coding with a specific emphasis on the Outpatient Prospective Payment System (OPPS). She has more than 12 years experience in Health Information Management and is currently responsible for researching and responding to complex facility coding inquiries as well as database maintenance and management. ■

REFERENCES

100-04 Claims Processing Manual Section 020, Chapter 04-Part B Hospital, Section 20 – Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS) www.cms.gov/manuals/downloads/clm104c04.pdf

Medicare Program Memorandum A-00-73 'Clarification of Modifier Usage in Reporting Outpatient Hospital Services' www.cms.gov/transmittals/downloads/A0073.PDF

CPT® Assistant August 2009, Volume 19, Issue 8. Subject: Coding Brief: Peripheral Artery Assessment

CPT® Assistant September 2003, Volume 13, Issue 9. Subject: Coding Update: Hospital Outpatient Reporting Part IV: Use of the CPT Modifiers '52,' '58,' '59,' '73,' '74,' '76,' '77,' '78,' and '91'

HCPCS Coding Clinic, Vol 1 No 3, 3rd Qtr 2001

FREQUENTLY ASKED QUESTIONS

In this section, MedAssets has reviewed and analyzed the questions that are received via our compliance help desk. We offer some of the most frequently asked questions and the MedAssets response for your convenience.

Correction:

In the August edition of CCFN, we incorrectly recommended Modifier 59 be appended to an E/M code. The correct modifier to append to an E/M code to indicate a separately identifiable E/M service provided on the same date of service as other services is Modifier 25.

We apologize for this error and any confusion it may have caused.

Q A patient comes to our outpatient oncology department for a Neupogen injection. Patient had a CBC drawn. Our oncology nursing staff is charging 96372 and 99213 (E&M level) that brings up a CCI modifier edit. Since the patient came in for a scheduled injection, and nothing else was done except for the lab work, is it appropriate to charge the E&M level and add Modifier 59 to the charge?

MedAssets Response

When a patient has a scheduled appointment for specific services as referenced in the scenario provided, only the specific CPT/HCPCS codes should be reported for these services rather than evaluation and management (E&M) codes. Evaluations are integral to the scheduled procedure and therefore not separately reportable.

However, if the patient condition warrants evaluation and management services that are above and beyond the scope of the scheduled visit, it may be appropriate to separately report an E/M level visit based on the facility E/M level assignment guidelines, in addition to the scheduled visit services. For example, during the scheduled visit the patient complains of chest pain, the physician is notified, an E/M evaluation is provided, and the physician orders an EKG. In this scenario, it may be appropriate to report an E/M level with Modifier 25 to indicate a separate identifiable E/M services was provided.

Medical record documentation must support the separate and identifiable service was reasonable and medically necessary, and supports the reporting of Modifier 25.

Q Can the hospital charge separately for a point of care pregnancy test performed in Radiology and Surgery? If so, what CPT code is used to report this service?

MedAssets Response

Point of care testing is often carried out with kits certified as CLIA-waived tests. To determine if a specific manufacturer's kit has been approved for use and reporting as a CLIA-waived test, refer to the quarterly updates of new waived tests published by CMS. The most recent updates, effective Oct. 1, 2010, were recently published in transmittal R2038CP (also in KnowledgeBase). You will want to verify that the kit used by your Radiology or Surgery department has been CLIA approved.

For qualitative urine pregnancy testing, the following CPT code is classified as a CLIA-waived test. This CPT does not require the QW modifier to be recognized as a waived CLIA test:

81025 – Urine pregnancy test, by visual color comparison methods

If all of the above criteria are met, the test is ordered by the physician, and medically necessary, it may be appropriate to report the point of care pregnancy test.

Q Could you please provide the coding reference regarding coding for the following scenario: Colonoscopy is scheduled, however, a flexible sigmoidoscopy was carried.

MedAssets Response

If a patient is scheduled for a procedure but it could not be completed due extenuating circumstances facilities may append Modifier 73 or 74 as appropriate to signify a discontinued procedure.

Modifiers 73 and 74 are informational modifiers used for documentation purposes and can affect the processing or payment of the HCPCS code billed under OPSS. Modifier 73 may be reported when a procedure is cancelled due to extenuating circumstances or those that threaten the well being of the patient. The physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure

Continued on page 13

FAQs (continued)

is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure code with Modifier 73 appended.

Modifier 74 may be reported due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure was started but terminated after anesthesia and can be reported by its usual procedure number and the addition of Modifier 74. Surgical or certain diagnostic procedures that are discontinued after the procedure has been initiated and/or the patient has received anesthesia for which Modifier 74 is coded, will be paid at the full OPPS payment amount.

Modifiers 73 and 74 are only used to indicate discontinued procedures for which anesthesia is planned or provided.

The Claims Processing Manual, Chapter 4, Section 20.6.4 also states that Modifier 52 is used to indicate partial reduction or discontinued services after the patient is prepared and taken to the procedure room and when anesthesia is not planned. Modifier 52 will be paid at 50 percent of the full OPPS payment amount.

Please note: An elective cancellation (cancelled by the patient) of a procedure should not be reported.

Correct and accurate coding should be based on the extent and the purpose of the procedure as documented in the medical record. The appropriate code selection must accurately describe the procedure performed. If the patient was scheduled for a colonoscopy and only a sigmoidoscopy was performed, then based on the above coding guidelines, it may be appropriate for the facility to report the appropriate colonoscopy CPT code with the appropriate modifier based on facility documentation. ■

REFERENCE

Medicare Claims Processing Manual, Chapter 4, Section 20.6.4

Physician Documentation: Link to Quality (continued)

All of this will, of course, needs to be tracked and submitted to CMS in the form of quality measures unidentified to date.

Funding for this endeavor has been appropriated to the Secretary of Health and Human Services for \$2,000,000 per year for the period 2010-2014. Keep in mind that participation will be voluntary. What if you choose not to participate? You will be stuck between a rock and a hard place because all of the measures listed above will be available to the public showing transparency in healthcare.

How much has been appropriated to fight fraud and abuse? Would you believe \$100 million per year starting with 2011? You will need to make sure that every time you document it is thorough since so many more people are watching and salivating to get a chunk of that change. It is not just the PROs or the OIG anymore. They had no vested interest other than recovering money that was paid inaccurately. But the RACs are a different story as they get a piece of the recoveries.

It has come down to making sure that all the i's and t's are crossed because it will cost you \$50,000 for each false statement, omission, or misrepresentation of a material fact and \$15,000 for each day of delay. So start to document what the patient is saying in quotes. This not only demonstrates your attention to the patient, but also, it documents a patient's competence and credibility in a treatment plan and removes bias. When going over the Review of Systems, always ask if the patient has any other concerns

that she/he would like to bring up, and then document either the concerns or the fact that the patient does not have any additional concerns during the visit.

To gauge the adequacy of your documentation, consider what you would want to know if you were assuming the management of care of a patient unknown to you. Also, with ICD-10 right around the corner (Oct. 1, 2013), it is important that you start to document with specificity in mind, as this will lend to easier coding, and you're less likely to be queried by your staff to add an addendum with clarity on the patient's diagnosis. Remember that documentation is not only important for the quality measures and reimbursement. It also serves as a patient snapshot, and it can be subpoenaed. ■

About the Author

Denise M. Nash MD, CCS, CIM, is the Medical Director and Product Owner for Episodes of Care with MedAssets. Denise has over 20 years experience in the healthcare industry. She has worked for CMS in hospital auditing and has expertise in negotiation and implementation of risk contracting for managed care plans. Denise has also worked with individuals as well as physician groups on utilization improvements to improve financial performance for the risk-based contracts. She has worked with both hospitals and physician practices on the legal aspects of adding new services to the respective facilities. Denise is a consultant on compliance/HIPAA at physician practices, hospitals, and insurance plans and has worked for the OIG of NH for the Fraud and Abuse Division.

2011 IPPS (continued)

Diagnostic and Procedure Codes in MS-DRGs 981 through 983, 984 through 986, and 987 through 989: In regards to CMS reviewing and making modifications to ICD-9 diagnosis or procedure codes in MS-DRGs 981 through 983, 984 through 986, and 987 through 989: Upon review of the data, CMS made the final decision to not make any modification to this area for FY 2011.

For additional details on these topics and other updates from CMS on the IPPS Final Rule for 2011, please refer to the IPPS Final Rule FY 2011. CMS published the 2011 IPPS final rule on their web site in article CMS-1498-F and it is available for review in a PDF file and in HTML format. You may locate this article on their site by clicking the following link: www.cms.gov. ■

About the Author

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www.hfmaemc.org

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Oct. 3-6 • Las Vegas, NV • Booth 200
www.caham.org/calendar.php

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Oct. 5-6 • Nashville, TN • Booth 223/332
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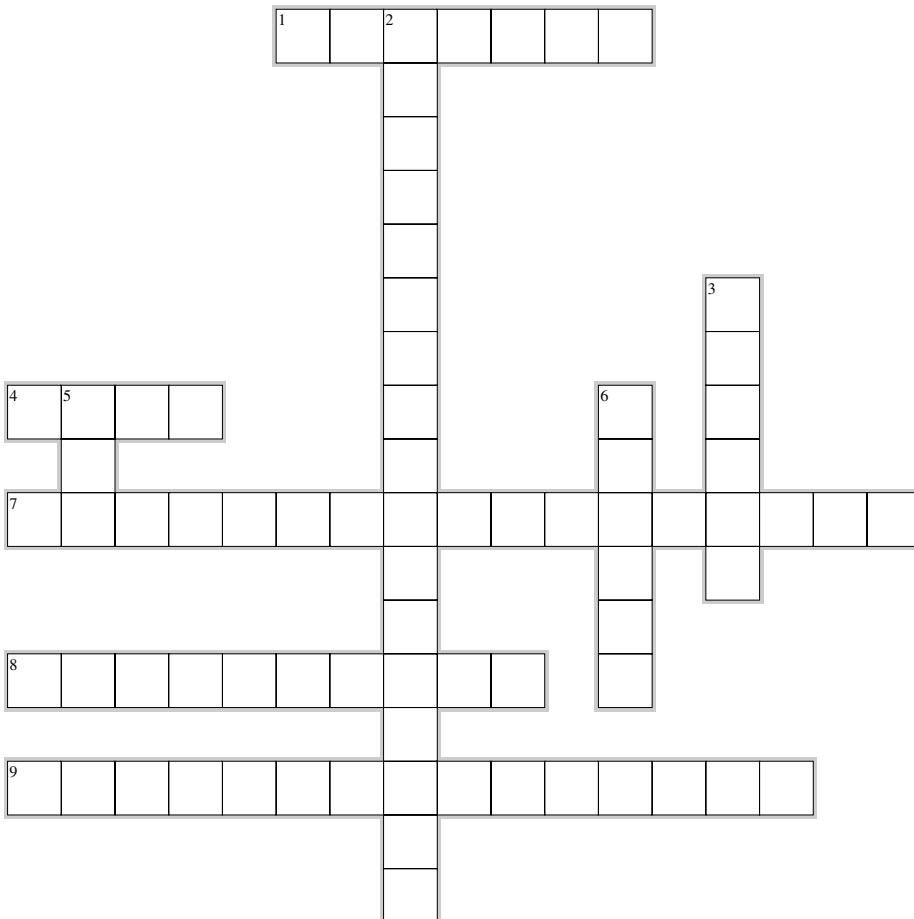
By Nikita Ashford, MBA/HCM, CPC-H, CPhT

Across

- Codes 646.30 – 646.33 Recurrent pregnancy loss has been ____.
- One of the new diagnosis codes found in Chapter 3, is 276.61 Transfusion Associated Circulatory Overload, also known by this acronym.
- This new V code, V62.85 has been created and may be of interest to those in the mental health field. (2 words)
- In Chapter 7, a new ____ has been added for aortic ectasia.
- Code 315.35 Childhood onset fluency disorder is being added to the ____ chapter, to distinguish childhood onset from adult onset of this speech disorder. (2 words)

Down

- This new E code, E000.2 has been added to include the activity undertaken by the patient. (2 words)
- This change occurs in Chapter 4, where diagnosis code 287.4 Secondary thrombocytopenia is expanding ____.
- In the injury and poisoning section, code 999.7 is expanding digits to add codes that are for non- ____ related reactions.
- Within the Congenital Anomalies chapter, code 752.3 Other anomalies of ____ has expanded digits for greater specificity.



ANSWERS
ACROSS 1. REVISED 4. TACO 7. HEMODIALYSIS 8. SUBSECTION 9. MENTAL DISORDERS
DOWN 2. VOLUNTEER ACTIVITY 3. DIGITS 5. ABO 6. UTERUS

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