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THE CODE

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The Great Compromise

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Does it seem that the government comes out with major decisions that we in healthcare may not perceive as wise either on a Friday after 5:00 p.m. or, as in the recent compromise, over a holiday? I can't help but think of another Great Compromise which took place on July 16, 1887 which provided a dual system of congressional representation. The Centers for Medicare and Medicaid Services (CMS) did indicate that "a valid ICD-10 code will be required on all claims starting October 1, 2015." At least the dual coding (as suggested by some members of Congress) has been averted thus far. On July 4, 2015, the United States of America celebrated another Independence Day attributed to its tenacity of follow-through in achieving liberty and never compromising on principal. Yet, on July 6th, CMS caved in to the American Medical Association (AMA) and issued that it will not deny claims for a period of 12 months under the Part B physician fee schedule based on ICD-10 wrongly-coded claims (as long as a valid code from the right family is used), a decision supported by ICD-10 opponent, the AMA.

This policy will also be adopted by the Medicare Administrative Contractors, the Recovery Audit Contractors, the Zone Program Integrity Contractors and the Supplemental Medical Review Contractor.

The AMA and CMS reported that they have teamed up to make the transition easier for providers. Both CMS and the AMA plan to conduct a nationwide outreach effort to educate providers through webinars, on-site training, educational articles and calls to help physicians and other providers get up to speed before the October 1st deadline. Also available thru the CMS website "Road to 10," which contains a countdown clock and primers for clinical documentation, clinical scenarios and other specialty-specific resources to help with implementation.

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If you have an article or idea to share for *The Code*, please submit to:
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Never mistake knowledge for wisdom. One helps you make a living; the other helps you make a life.
Sandra Carey

The Great Compromise *(Continued from page 1)*

An AMA spokesperson said the change is "a culmination of a vigorous effort by medicine to ask the CMS for a transition period to avoid expected disruptions during this time of tremendous change in the healthcare landscape. This agreement with the CMS is in the best interest of patients and physicians, and in line with the policy set by the nation's physicians." In the announcement, the AMA conceded that the implementation deadline would not be changing, a step in the right direction.

CMS said it will also make sure ICD-10 errors don't trigger penalties (quality reporting completed for program year 2015) for the Physician Quality Reporting System, Value Based Modifier or Meaningful Use, which tied certain clinical outcomes and processes, like coding, to incentives or penalties. If the change causes issues for CMS that slow down payment, the federal agency will offer advanced payments to providers. Facilities would receive an advanced partial payment that would have to be paid back. CMS also revealed the hiring of an ICD-10 Ombudsman "to help receive and triage physician and provider issues. The Ombudsman will work closely with representatives in CMS's regional offices to address physicians' concerns. As we get closer to the October 1, 2015, compliance date, CMS will issue guidance about how to submit issues to the Ombudsman."

https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10-guidance.pdf

I have been touting for the past three years the benefits of ICD-10 based on:

- Better reflection of advances in medicine and technology;
- Better understanding and tracking of healthcare outcomes;
- Prevention and detection of fraud and abuse;
- Measure the quality, safety and efficacy of care;
- Lead effective resource utilization to ensure accurate payment; and
- Improve clinical, financial and administrative performance.

On July 8, 2015, CMS released the first proposed update to the physician payment schedule since the repeal of the Sustainable Growth Rate through the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015. The proposal includes a number of provisions focused on person-centered care and continues the transformation of the Medicare program to a system based on quality and healthy outcomes. So, my question, if CMS is allowing for flawed data to be collected for a 12 month period, how will any of the above be accurately measured?

Coronary Artery Bypass Graft: An Education

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Brief History:

Coronary artery bypass graft (CABG) is the most suitable open heart surgery used to treat coronary artery disease. Over the 100 years since its discovery, this procedure has undergone few refinements. Alexis Carrel, a French surgeon and biologist, was the first to describe the concept of coronary circulation. He first experimented on canines using the innominate and carotid artery. The procedure was unsuccessful in humans due to lack of technology and tools. The second era of open heart surgery was the utilization of the saphenous vein, which was triumphant for the treatment of obstructive coronary disease. The last and current era is the mix arterial and venous grafting.

CABG in the Perspective of Coding:

When dealing with CABG procedure in coding, the following information must be obtained:

- Number of grafts performed;
- Number of arterial grafting;
- Number of venous grafting;
- Type of procurement; and
- History of previous CABG performed to the patient.

Code Breakdown:

- 33510 to 33516 – Venous Grafting ONLY for Coronary Artery Bypass.
- As per CPT, these codes should NOT be used to report the performance of coronary artery bypass procedures using arterial grafts and venous grafts during the same procedure.
- 33533 to 33548 – Arterial Grafting for Coronary Bypass.
- As per CPT, these codes are used to report coronary artery bypass procedures using either arterial grafts only or a combination of arterial-venous grafts.
- +33517 to +33530 – Combined Arterial-Venous Grafting for Coronary Bypass.
- As per CPT, these codes are used to report coronary artery bypass procedures using venous grafts and arterial grafts during the same procedure. These codes may NOT be used alone.
- To report combined arterial-venous graft it is necessary to report two codes: (1) the appropriate combined arterial-venous graft code (33517-33523); and (2) the appropriate arterial graft code (33533-33536).
- +33530 is the reoperation of coronary artery bypass procedure or valve procedure, more than one month after the original operation.

Coding Case Sample:

A patient is admitted for CABG of three coronary arteries using saphenous vein grafts.

Answer: Code 33512 is the correct code selection. As per the case, saphenous vein graft was used in CABG of three coronary arteries.

Stars of MiraMed

This month's Star is …

Joette P. Derricks, MPA, CMPE, CHC, CPC, CSSGB
Vice President of Regulatory Affairs & Research
MiraMed Global Services

A results-oriented C-level executive, Joette Derricks has more than 30 years of experience in healthcare finance and operations management, ensuring productivity, profitability and compliance within every type of healthcare organization and physician specialty. Joette is a visionary, conceptual thinker with broad experience in strategic and organizational performance measurement, business reengineering, process and procedure development and revenue growth initiatives. She is a qualified expert witness and has provided testimony and expert reports for national health care clients.

A nationally-acclaimed writer, consultant and speaker, Joette has been invited to present at the American Health Information Management Association (AHIMA), Medical Group Management Association (MGMA), Health Care Compliance Association (HCCA) and many other national conferences. She possesses the education, credentials, and interpersonal skills necessary to build effective teams and accomplish top and bottom line performance objectives.

Joette P. Derricks, MPA, CMPE, CHC, CPC, CSSGB

CORE QUALIFICATIONS:

- ❖ Operations Management
- ❖ Innovative Leadership
- ❖ Resource Management
- ❖ Healthcare Regulatory Compliance
- ❖ Continuous Process Improvement
- ❖ Strategic Planning and Execution
- ❖ Business Reengineering
- ❖ Staff Development
- ❖ Technology Integration

PLEASE TAKE A MOMENT …

It is our mission to grow and improve this newsletter with each issue. In order to accomplish this goal we need your help! Your input is extremely valuable. Please take a moment to answer the following:

- Tell us what you would like to see in future publications.
- What types of articles would be most beneficial?
- Has this newsletter been of value to you?
- Would you be interested in submitting an article for publication?

You may send your responses via e-mail to kim.capello@miramedgs.com.

Brush Up On Medical Terminology: Circulatory System

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CIRCULATORY SYSTEM

Term	Word Origin	Definition
Acute myocardial infarction	**myocardi/o** heart muscle **-al** pertaining to	also known as "heart attack" usually resulted from prolonged cardiac ischemia that causes heart tissue necrosis
Bradycardia	**brady** slow **cardia** heart	a condition of slow heart rate, less than 60 beats per minute
Cardialgia	**cardia** heart **-algia** pain	pain felt in the region of the heart
Cardiomegaly	**Cardi/o** heart **-megaly** enlargement	a condition where in the heart is enlarged
Cardiomyopathy	**Cardi/o** heart **myo** muscle **-pathy** disease	generally refers to the heart muscle disease which can result to deterioration of the heart muscle contraction
Coronary atherosclerosis	**coron/o** heart **-ary** pertaining to **ather/o** fat, plaque **-sclerosis** abnormal condition of hardening	a condition where there is a plaque buildup in the arteries
Cyanosis	**cyan** dark blue **-osis** condition	bluish discoloration of the skin or mucous membranes resulted from inadequate oxygenation
Heart failure		a condition where the heart does not pump the blood normally to meet the body's demand of oxygenated blood supply
Hypertensive	**hyper** excessive **tension** pressure	a chronic condition which the blood pressure in the arteries is elevated
Ischemia	**isch/o** to hold back **-emia** blood condition	inadequate supply of the blood to body tissues
Palpitation		a condition where heart beats too fast and/or too hard, irregular
Rheumatic heart disease	**rheumat/o** watery flow	a heart condition which can be acute or chronic resulted from rheumatic fever
Tachycardia	**tachy** fast **cardia** heart	a condition of fast heart rate, more than 100 beats per minute
Tetralogy of Fallot	**tetra** four **-logy** study	a congenital heart defect involving four abnormalities of the heart (pulmonary infundibular stenosis, overriding aorta, ventricular septal defect, right ventricular hypertrophy)

Are you a Good Auditor?

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Direction: All Medical Coding staffs are encouraged to send their correct codes based from the case provided. They must present their codes along with coding clinics, coding guidelines or any coding references applicable for any codes that are to be **Added**, **Deleted** or **Revised**. Answers to this scenario will be published in our next issue.

A 45 year old patient with acute and chronic cholecystitis with gallstones is admitted for laparoscopic cholecystectomy. According to the operative report, the surgeon performed extensive lysis of peritoneal adhesions in order to gain access to the gallbladder. There were no complications from the procedure and the patient was discharged home.

	ICD-9-CM	ICD-10-CM
PDX	575.10	K80.00
	ICD-9-CM	**ICD-10-PCS**
PPX	51.22	0FT44ZZ

Correct Answer From Previous Case Scenario:

	ICD-9-CM	Audit Remark	ICD-10-CM	Audit Remark
Principal Diagnosis	707.03	No change.	L89.154	No change.
Secondary Diagnosis	707.24	Added code 707.24 since pressure ulcer stage is documented.	I50.32	No change.
Secondary Diagnosis	428.32	No change.	I25.10	No change.
Secondary Diagnosis	414.01	Revised code to 414.01. Documentation states that patient has CAD in the native coronary arteries.	L25.82	Revised code to I25.82, L25.82 is not a valid code.
Secondary Diagnosis	414.2	No change.		
	ICD-9-CM	**Audit Remark**	**ICD-10-PCS**	**Audit Remark**
Principal Procedure	77.69	No change.	0QBS0ZZ	Revised procedure code to 0QBS0ZZ. The site of debridement is on the coccyx.

Coding Case Scenario

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Direction: Code for ICD-9-CM Diagnosis and Procedure and its corresponding ICD-10-CM and PCS. Answers to this scenario will be published in our next issue.

A 36 year-old pregnant patient, in her 39th week of gestation, is admitted to the hospital because of continuous labor. The patient had a normal vaginal delivery of a live-born male baby. The physician documented that the patient has diabetes mellitus, type II and is a smoker. The patient is discharged home after three days.

Correct Answer from Previous Case Scenario:

	ICD-9-CM	ICD-10-CM	Remark
Principal Diagnosis	995.61	T78.01XA	Code only 995.61 on ICD-9-CM and T78.01XA on ICD-10-CM. Both codes have description of anaphylactic reaction due to peanuts. No code is necessary to assign from chapter. Factors Influencing health status and contact with health service (V-code in ICD-9-CM, Chapter 21 in ICD-10-CM) for the history of allergy to peanuts.

To achieve your goal you have to get into the character of a winner. Confident people have a certain way of presenting themselves. Observe people who are confident and successful and try to emulate them in your life.

Dr. Anil Kr Sinha