

THE CODE

The Official Medical Coding Newsletter of MiraMed, A Global Services Company

Fast Weight Loss or Another Name for Bulimia?

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I read an interesting article last week on how the FDA just approved a new weight loss pump, called AspireAssist (made by Aspire Bariatrics of King of Prussia, Pennsylvania) that has the capability of dumping as much as 30 percent of stomach contents out through an external tube, for those with a Body Mass Index (BMI) of 35-55.

The premise of the new device is to assist the patient to a gradual healthy eating lifestyle. However, as seen with other non-invasive and invasive procedures, the patient needs to understand that these mechanisms of weight loss are not a panacea. It is up to the patient to want to succeed and assist in the process. Therefore, I tend to concur with those that are calling this “assisted bulimia.”

When the stomach is empty it is about the size of a human hand and can hold 45 to 75 millimeters or 1/5 cup of liquid. The stomach has the ability to stretch much like a balloon and when it is full it can hold about one liter of food or eight cups after a big meal. After eating, the food

travels immediately to the stomach where, during the next hour, peristalsis begins. Peristalsis is the process in which the bolus (chewed food) is mixed and churned (much like a blender) with gastric juices. The bolus is transformed into a semi-liquid substance called chyme. Stomach muscles mix up the food with enzymes and acids to make smaller digestible pieces. Food is kept from leaving the stomach by the pyloric sphincter (walnut-shaped muscular tube at the stomach outlet) until the right consistency is reached to pass into the small intestine. When chyme reaches the right consistency, it leaves the stomach in small squirts rather than all at once. Substances that can be absorbed right away while in the stomach are water, alcohol, salt and simple sugars. The rest of the stomach contents need to travel into the intestines before absorption can occur.

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If you have an article or idea to share for *The Code*, please submit to:
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Each day teaches us the value of time; be grateful for the daily opportunities!

Malika E. Nura

Fast Weight Loss or Another Name for Bulimia? *(Continued from page 1)*

How does AspireAssist work? This minimally invasive device works by inserting a thin tube into a patient's abdomen (much like a percutaneous endoscopic gastrostomy tube). The pump is then attached to the outside port, as needed, to remove about one-third of the stomach's contents at a time. After each meal, the device enables the patient to empty or "aspirate" up to 30 percent (1/3 of the meal) into the toilet through this tube. The process is performed after 20 to 30 minutes of consuming a meal and it takes about five to 10 minutes, whereby the food is drained directly into the toilet. This device is only approved for use in very obese patients and helps them lose on average more than 12 percent body weight.

So, why are skeptics calling the AspireAssist, assisted bulimia? Bulimia, by definition, consists of bouts of extreme overeating followed by self-induced vomiting, purging or fasting; which causes reduction in calories absorbed by the body. AspireAssist allows patients to remove about 30 percent of the food from the stomach before calories are absorbed into the body. Therefore, both bulimia and AspireAssist work by reducing the calories absorbed by the body, causing weight loss.

We live in a society where the expectation is a quick fix. If anyone is mindful of the process involved in digestion, then one way of trying to lose weight would be to chew slowly. Isn't that the advice you received as a child from your mother? She knew what she was talking about. When one chews slowly, the time lapse assists the fullness signals from the stomach to reach the brain. In turn, the brain then says "I am full, stop eating!"

This new device gives a whole new meaning to the phrase "I need to freshen up" when excusing oneself from the dinner table.



I believe in tomorrow even though today is all I've ever seen in my life. Afterall; the only thing separating them is a thin darkness called night.

Terry Mark

If Medicare Has Their Way, Surgical Global Days Will Soon Be Part of the Past

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In July of 2014, the Centers for Medicare and Medicaid Services (CMS) proposed to transition all 10- and 90-day global codes to 0-day global codes beginning in 2017 (all 10-day global codes) and 2018 (all 90-day global codes). Under this proposal, medically reasonable and necessary visits would have been billed separately during the preoperative and postoperative periods outside the day of the surgical procedure.

What is CMS' rationale behind this policy? CMS is concerned that the current reasons for global codes are a problem that may result in payments potentially too high, including:

- Payment rates for the global surgery packages that are not updated regularly based on any reporting of the actual costs of patient care.
- The relationship between the work relative value units (RVUs) for the 10- and 90-day global codes (which includes the work RVU associated with the procedure itself) and the number of included postoperative visits in the existing values is not always clear. Keep in mind that RVUs are directly associated with how much money the physician is getting paid.
- The 10- and 90-day global periods reflect a long-established but no longer exclusive model of postoperative care that assumes the same practitioner who furnishes the procedure typically furnishes the follow-up visits related to that procedure. In other words, are they reflecting the care actually furnished during that period by the surgeon or their staff? If there are four or more postoperative visits built into global, are all four postoperative visits being performed by the surgeon or their staff? Is the postoperative care being performed by the patient's primary care physician (PCP) or if the patient is still an inpatient; has a hospital employed advance practice providers (nurse practitioners, physician's assistants, etc.) been following the patient, while the surgeon is being paid the full global payment?

If CMS removes 10- and 90-global days codes, all surgical codes would be revalued (RVU) to exclude services currently included within the global period, i.e., the pre-post and surgical procedures to the surgical procedure, which will lower the value of each surgical codes of 10- and 90-global days. Only same-day, related services would be bundled into payment for any procedure, and any "medically reasonable and necessary visits during the pre- and postoperative periods" would then be separately billable.

What does this mean for the patients? The patient would have to pay 20 percent of Medicare's allowable, so in the patient's viewpoint, they will have to pay for visits on services that were once free which has garnered attention from physician organizations including the American Medical Association (AMA) and American College of Surgeons (ACS).

In September 2014, the ACS submitted a detailed comment letter to CMS describing reasons why CMS should refrain from implementing the policy. In the letter, the ACS stated that CMS should first complete a comprehensive analysis of the effect the policy would have on surgical patients and on access to surgical care, and develop a methodology for making the transition to 0-day global codes. Despite these and other efforts by the ACS regulatory staff to counter the policy, in November 2014, CMS finalized the policy to transition 10- and 90-day global codes to 0-day global codes.

Congress Intervenes

In parallel with its regulatory efforts above with Medicare, the ACS's legislative and political team spent several months working to bring about a legislative solution to the problems associated with CMS' proposal to eliminate 10- and

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If Medicare has Their Way, Surgical Global Days will soon be Part of the Past *(Continued from page 3)*

90-day global codes. The ACS' advocacy efforts were ultimately successful when President Obama signed the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA) into law on April 16, 2015. This law prevented CMS from implementing the policy to transition 10- and 90-day global codes to 0-day global codes.

CMS is now required to collect the data needed to value surgical services from a representative sample of physicians. This data must include information on the number and level of medical visits furnished during the global period and on other appropriate items and services related to surgery furnished during the global period. MACRA also allows five percent of the surgical payments to be withheld until this data is reported at the end of the global period and grants authority to discontinue the reporting requirement if sufficient information can be derived from qualified clinical data registries, surgical logs, electronic health records or other sources. Beginning in 2019, CMS must use this and possibly other data that the agency might identify to improve the accuracy of the valuation of surgical services.

What does this mean for surgeons and other physicians who perform surgical procedures of 10-days, i.e., dermatology, family practice, etc.? Any provider will be mandated to report all of their postoperative visits 99024 which will enable Medicare to do the required study on how many postoperative visits are being performed during the postoperative visits, and to see if they do reflect the number of postoperative visits that are built into the CPT codes.

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E-Cigarette Smoking: An Education

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An electronic cigarette, commonly known as “e-cigarette,” is a battery-powered device that produces vapor from a flavored liquid. The fluid in the e-cigarette usually has nicotine content and other substances which are reported to be carcinogenic in nature.

According to research, the existence of e-cigarettes has resulted in a decline in usage of regular tobacco-based cigarettes. In fact, according to the 2015 study conducted by Centers for Disease Control and Prevention (CDC), cigarette smoking among United States high school students was at its lowest level since the National Youth Risk Behavior Survey (YRBS) began in 1991. However, the usage of vapor products such as e-cigarettes poses new challenges.

Switching to e-cigarettes was positioned a way for a patient to quit smoking cigarettes. However, international organizations such as the World Health Organization (WHO) do not fully recommend the use of e-cigarettes as part of a smoking cessation program because of inadequate evidence of effectiveness and safety. Further research is needed in order to obtain a solid recommendation.

Coding Perspective:

In 2016, the main term in the alphabetic index from ICD-10-CM code book should be “tobacco” and, as always, verify your code to the tabular list.

ICD-10-CM Index

- Nicotine – see Tobacco

ICD-10-CM Index

- Tobacco (nicotine)
 - dependence - see Dependence, drug, nicotine
 - harmful use Z72.0
 - heart - see Tobacco, toxic effect
 - maternal use, affecting newborn P04.2
 - toxic effect - see Table of Drugs and Chemicals, by substance, poisoning
 - chewing tobacco - see Table of Drugs and Chemicals, by substance, poisoning
 - cigarettes - see Table of Drugs and Chemicals, by substance, poisoning
 - use Z72.0
 - complicating
 - childbirth O99.334
 - pregnancy O99.33-
 - puerperium O99.335
 - counseling and surveillance Z71.6
 - withdrawal state - see Dependence, drug, nicotine



Foley Catheter Placement and Replacement

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Introduction

The ability to insert a urinary catheter is an essential skill in medicine. Catheters are sized in units called French (FR), where one French equals 1/3 of 1 mm. Catheters vary from 12 (small) FR to 48 (large) FR (3-16mm) in size. They also come in different varieties including those without a bladder balloon and ones with different sized balloons. It is necessary to check how much the balloon can hold by inflating the balloon with water.

Indications

By inserting a Foley catheter, the provider is gaining access to the bladder and its contents, thus enabling drainage of bladder contents, decompression of the bladder, specimen collection and introduction of a passage into the genitourinary (GU) tract. This allows treatment for urinary retention and bladder outlet obstruction.

Urinary output is also a sensitive indicator of volume status and renal perfusion (and, thus, tissue perfusion also). In the emergency department, catheters can be used to aid in the diagnosis of GU bleeding. In some cases, as in urethral stricture or prostatic hypertrophy, insertion will be difficult and early consultation with urology is essential.

Contraindications

Foley catheters are contraindicated in the presence of urethral trauma. Urethral injuries may occur in patients with multisystem injuries and pelvic fractures, as well as straddle impacts. If this is suspected, one must perform a genital and rectal exam first. If one finds blood at the meatus of the urethra, a scrotal hematoma, a pelvic fracture or a high riding prostate then urethral tear can be suspected. One must then perform retrograde urethrography (injecting 20 cc of contrast into the urethra).

Complications

The main complications of a Foley catheter insertion are tissue trauma and infection. After 48 hours of catheterization, most catheters are colonized with bacteria, thus leading to possible bacteriuria and its complications. Catheters can also cause renal inflammation, nephrocystolithiasis and pyelonephritis if left in for prolonged periods. The most common short-term complications are inability to insert catheter and causation of tissue trauma during the insertion. The alternatives to urethral catheterization include suprapubic catheterization and external condom catheters for longer durations.

ICD10-CM diagnosis and CPT codes to consider in placement of a catheter CPT code:

- Insertion of temporary indwelling bladder catheter; simple (e.g., Foley): **51702**
- Insertion of temporary indwelling bladder catheter; complicated: **51703**
- Insertion of supra-pubic catheter placement: **51102**

ICD 10 Codes:

- Foley catheter removal or changes: **Z45.6**
- Complication of Foley catheter unspecified: **T83.9XXA**
- Complication of blocked Foley catheter: **T83.098A**
- Embolism of genitourinary prosthesis device/graft: **T83.81XA**
- Fibrosis of genitourinary prosthesis device/graft: **T83.82XA**

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Foley Catheter Placement and Replacement (Continued from page 6)

- Hemorrhage of genitourinary prosthesis device/graft: **T83.83XA**
- Infection and inflammation reaction due to genitourinary prosthesis device/graft: **T83.59XA**
- Mechanical complication, breakdown of urinary stent: **T83.112A**
- Displacement or malposition of urinary stent: **T83.122A**
- Leakage or specified or obstruction of perforation or protrusion: **T83.192A**

Resource/Reference List

WebMD Medical Reference from Healthwise

https://en.wikipedia.org/wiki/Foley_catheter

<http://emedicine.medscape.com/article/80716-overview>

radiopaedia.org/articles/foleycatheter

CPT 2016 professional edition

ICD-10-CM Book 2016



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.

This 26-year-old male patient with a history of cystic fibrosis and diabetes arrives at the emergency department with dry mouth and increased urination. Upon exam, he was noted to have a blood sugar reading of 350 mg/dL and was subsequently admitted for further treatment of his hyperglycemia. The patient was placed on an insulin drip and blood glucose was monitored throughout the stay. The patient also has chronic kidney disease stage three and was given his first hemodialysis session in the hospital stay. He also complains of abdominal cramping and bloody stools. He is scheduled for an endoscopy to rule out the cause of his symptoms. Further workup indicates a low blood count possibly from gastrointestinal bleeding. The patient then underwent an esophagogastroduodenoscopy and was found to have a duodenal ulcer. Patient was prescribed acid blockers and instructed to avoid eating oily foods to decrease the pain.

Final Diagnoses:

1. Uncontrolled diabetes mellitus from cystic fibrosis
2. Chronic bleeding duodenal ulcer causing iron deficiency anemia

	ICD-10-CM
Principal Diagnosis	E11.65
Secondary Diagnosis	N18.3
Secondary Diagnosis	K26.0
Secondary Diagnosis	D50.0

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Audit Remark
Principal Diagnosis	T51.0X1A	Assign as principal diagnosis since the patient is coming in because of overdose of alcohol and marijuana.
Secondary Diagnosis	T40.7X1A	Assigned as secondary diagnosis because of overdose of alcohol and marijuana.
Secondary Diagnosis	F10.121	Assigned as secondary code for alcohol abuse with intoxication delirium.
Secondary Diagnosis	F10.151	Assigned as secondary code for alcohol abuse with alcohol-induced hallucination.
Secondary Diagnosis	F12.121	Assigned as secondary code for cannabis abuse with intoxication delirium.
Secondary Diagnosis	F12.151	Assigned as secondary code for cannabis abuse with cannabis-induced hallucination.
Secondary Diagnosis	S89.212A	Assigned as secondary code for Salter-Harris type one fracture of the upper end of the left fibula.
Secondary Diagnosis	W13.2XXA	Assigned as secondary code for external cause of fall from roof.
Secondary Diagnosis	Y92.009	Assigned as secondary code for place of occurrence that happened in an unspecified residence area.

Coding Case Scenario



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

This 35-year-old woman was texting while driving her car. Because of this, she was involved in a rear-end collision with another vehicle that was at a stop on the interstate entrance ramp. She suffered a whiplash injury due to the collision and superficial right eye injury due to driver's airbag deployment. She was then admitted for further observation and treatment for these injuries. On the 2nd day of the hospital stay, she became extremely febrile. On initial exam, she was extremely lethargic, with altered mental status and became very violent. She was cultured and started on IV antibiotics and fluids. The next day, she defervesced from an initial temperature of 104.2 to 99.1 degrees and her mind was quite clear. Blood cultures came back positive for Pseudomonas.

Discharge Diagnosis:

1. Superficial right eye injury
2. Whiplash injury
3. Sepsis
4. UTI
5. Encephalopathy from sepsis

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Coding Remark
Principal Diagnosis	G89.3	Assign code as principal diagnosis. Patient came in because of pain management which was due to the neoplastic disease.
Secondary Diagnosis	M25.519	Assigned as secondary code for the specific site of the pain, which was in the shoulder.
Secondary Diagnosis	C50.911	Assigned as secondary code for primary malignant neoplasm of the right breast.
Secondary Diagnosis	C79.51	Assigned as secondary code for secondary malignant neoplasm of the bone.
Secondary Diagnosis	K85.9	Assigned as secondary code for acute pancreatitis.
Secondary Diagnosis	K86.1	Assigned as secondary code for chronic pancreatitis.
Secondary Diagnosis	K86.8	Assigned as secondary code for pancreatic duct stones.
Principal Procedure	3E033NZ	Assign code as principal procedure for IV introduction of morphine via peripheral vein.
Secondary Procedure	0FFDXZZ	Assign code as secondary procedure for ESWL of pancreatic duct stones.