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THE CODE

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

Do You Have Pet Peeves?

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Do you have pet peeves? I, of course, have many including the sun catcher (prism) that folks hang on the rear view mirrors which, on a sunny, day blinds the driver behind them.

So what is my Procedure Classification System (PCS) pet peeve? Let us discuss the root operations restriction and occlusion.

By PCS definition, **restriction** refers to the **partial** closing of an orifice or tubular body part which includes both intraluminal and extraluminal methods. In the example of a Nissen fundoplication, coding the approach to restriction makes sense because the fundus of the stomach is wrapped around the distal esophagus and sewn into place which serves as the treatment for gastroesophageal reflux disease (GERD) and hiatal hernia. The surgery strengthens the lower esophageal sphincter (between the esophagus and stomach), which stops acid from backing up into the esophagus, easily allowing the esophagus to heal.

Now we come to my problem with PCS assignment of restriction as the root procedure to craniotomy with occlusion of cerebral aneurysm rather than the root operation occlusion. There are two main options to treat brain aneurysms: open surgical clipping and endovascular therapy coiling. A cerebral aneurysm is a bulging weakened area in the wall of an artery in the brain, resulting in an abnormal widening or ballooning. Because of the weakened area in the artery wall, there is a risk for rupture of the aneurysm. With open surgical clipping an incision is made into the skin over the head and then an opening is made into the bone with dissection down to the aneurysm where it arises from the blood vessel. Placement of a metal clip across the "neck" of the aneurysm isolates the aneurysm from the rest of the circulatory system by blocking blood flow.

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If you have an article or idea to share for *The Code*, please submit to:
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There is only one corner of the universe you can be certain of improving, and that's your own self.

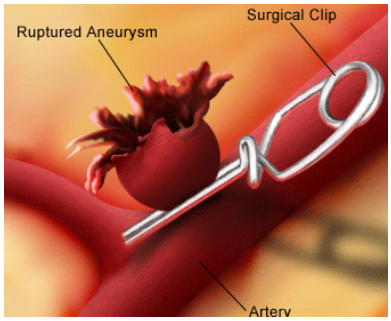
Aldous Huxley

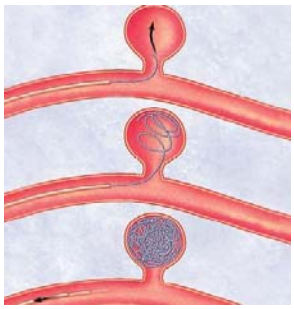
Do You Have Pet Peeves? *(Continued from page 1)*

This prevents the blood from entering the aneurysm, thereby preventing rupture. Often a neurosurgeon may perform a mini craniotomy or even an eyebrow incision to clip the aneurysm. Any of these procedures are still considered invasive and the patient takes longer to recover than with a coiling procedure.

Most endovascular coiling procedures are done by a neurointerventional surgeon. A coiling procedure is a minimally invasive procedure which is performed as an extension of the angiogram. A catheter is inserted into the femoral artery and then threaded to the brain vasculature and into the aneurysm via fluoroscopy where platinum coils are then packed into the aneurysm up to the point where it arises from the blood vessel. The coils induce embolization thereby preventing blood from entering the aneurysm avoiding rupture. Additionally, a stent or balloon may be necessary to help keep the coils in place inside the aneurysm.

With either procedurem, the intent is to not allow blood flow back into the aneurysmal sack which would cause a rupture.





Occlusion by PCS definition is the **complete closing** of an orifice or lumen of a tubular body part which includes both intraluminal and extraluminal methods. Per CMS guidelines the suggested coding of a cerebral artery aneurysm with a clip is 03VG0CZ; whereas, the suggested coding of the coiling procedure is 03LG3DZ (percutaneous approach via femoral artery). Why is each of the above root operations coded differently?

Section	**0**	Medical and Surgical
Body System	**3**	Upper Arteries
Operation	**V**	Restriction: Partially closing an orifice or the lumen of a tubular body part

Body Part	*Approach*	*Device*	*Qualifier*
0 Internal Mammary Artery, Right **1** Internal Mammary Artery, Left **2** Innominate Artery **3** Subclavian Artery, Right **4** Subclavian Artery, Left **5** Axillary Artery, Right **6** Axillary Artery, Left **7** Brachial Artery, Right **8** Brachial Artery, Left **9** Ulnar Artery, Right **A** Ulnar Artery, Left **B** Radial Artery, Right **C** Radial Artery, Left **D** Hand Artery, Right **F** Hand Artery, Left **R** Face Artery **S** Temporal Artery, Right **T** Temporal Artery, Left **U** Thyroid Artery, Right **V** Thyroid Artery, Left **Y** Upper Artery	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**C** Extraluminal Device **D** Intraluminal Device **Z** No Device	**Z** No Qualifier
G Intracranial Artery **H** Common Carotid Artery, Right **J** Common Carotid Artery, Left **K** Internal Carotid Artery, Right **L** Internal Carotid Artery, Left **M** External Carotid Artery, Right **N** External Carotid Artery, Left **P** Vertebral Artery, Right **Q** Vertebral Artery, Left	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**B** Intraluminal Device, Bioactive **C** Extraluminal Device **D** Intraluminal Device **Z** No Device	**Z** No Qualifier

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Do You Have Pet Peeves? *(Continued from page 2)*

Section	**0**	Medical and Surgical
Body System	**3**	Upper Arteries
Operation	**L**	Occlusion: Completely closing an orifice or the lumen of a tubular body part

Body Part	*Approach*	*Device*	*Qualifier*
0 Internal Mammary Artery, Right **1** Internal Mammary Artery, Left **2** Innominate Artery **3** Subclavian Artery, Right **4** Subclavian Artery, Left **5** Axillary Artery, Right **6** Axillary Artery, Left **7** Brachial Artery, Right **8** Brachial Artery, Left **9** Ulnar Artery, Right **A** Ulnar Artery, Left **B** Radial Artery, Right **C** Radial Artery, Left **D** Hand Artery, Right **F** Hand Artery, Left **R** Face Artery **S** Temporal Artery, Right **T** Temporal Artery, Left **U** Thyroid Artery, Right **V** Thyroid Artery, Left **Y** Upper Artery	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**C** Extraluminal Device **D** Intraluminal Device **Z** No Device	**Z** No Qualifier
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Using surgical logic, I would code the cerebral aneurysm clipping as 03LG0CZ because the intent of the clip is to occlude and not restrict the arterial flow, otherwise rupture would certainly occur.

In fairness, there is recommended literature that the coder should thoroughly research the procedure technique as well as careful review of the operative report before assignment of the final code is made. In conclusion, never assume that because there are numerous examples of particular procedures that the code assignment suggested fits all subsequent surgical cases that you might encounter in coding.

Everyone has the obligation to ponder well his own specific traits of character. He must also regulate them adequately and not wonder whether someone else's traits might suit him better. The more definitely his own a man's character is, the better it fits him.

Cicero (106 BC – 43 BC)

Coding Clinic: Drug Toxicity

Sharon Hughes, MBA, RHIA, CCS
Vice President of Coding and Auditing
MiraMed Global Services

The following articles are abstracted from *Coding Clinic*

Drug Toxicity – Adverse Effect vs. Poisoning: *Coding Clinic*, November – December 1984, Pages 14 – 15.

Question:

Our peer review organization (PRO) has advised us to code all drug toxicity as poisoning. It is my understanding, as a medical record practitioner trained in the use of ICD-9-CM, that we should code these cases as an adverse effect when due to a correct drug properly administered. Please clarify.

Answer:

The properties of certain drugs, medicinal and biological substances, or combinations of such substances, may cause toxic reactions. The occurrence of drug toxicity is classified in ICD-9-CM as follows:

(1) Code as adverse effect when drug was correctly prescribed and properly administered. Code the reaction plus the appropriate code from the E930-E949 series.

(2) Code as poisoning when an error was made in drug prescription or in the administration of the drug by physician, nurse, patient, or other person. Use the appropriate code from the 960-979 series. If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poison (960-979 series). If a non-prescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poison.

Adverse effects of therapeutic substances correctly prescribed and properly administered (toxicity, synergistic reaction, side effect, and idiosyncratic reaction) may be due to (1) differences among patients, such as age, sex, disease and genetic factors, and (2) drug-related factors, such as type of drug, route of administration, duration of therapy, dosage and bioavailability.

With the exception of E930-E949, the use of "E" codes in ICD-9-CM is optional. The E930-E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure or respiratory failure is coded and followed by the appropriate code from the E930-E949 series.

The PRO may face problems in reviewing coded data when the claims reporting form and the DRG system cannot accommodate an E930-E949 code. Because of this shortcoming, tabulation and analysis of coded clinical data from the Medicare prospective pricing reporting form will not identify adverse drug effects encountered with correctly prescribed and properly administered substances. However, the PRO is not authorized to change classification assignments within ICD-9-CM, such as classifying all drug toxicities to the 960-979 series for poisons.

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Coding Clinic: Drug Toxicity *(Continued from page 4)*

Overdose of Illicit Street Drug – Bath Salts: *Coding Clinic*, Second Quarter 2013, Pages 15 – 16; Effective with Discharges: July 8, 2013.

Question:

What is the appropriate code assignment for an overdose of a street drug called "bath salts"?

Answer:

Assign code 970.89, poisoning by other central nervous system stimulant, for an overdose of bath salts. Assign the appropriate E code to show the intent.

"Bath salts" is the street name for highly addictive psychoactive chemicals, which are presumed to include synthetic cocaine and an ecstasy variety in its components. These are designer drugs and should not be confused with bath salts that are legally sold and used for body cleansing and tub relaxation. Bath salts produce a "high" comparable to methamphetamine. The main ingredient is 4-methylenedioxypyrovalerone (MDPV), a psychoactive drug under Schedule V classification. MDPV is a stimulant introduced as a legal drug because of its research chemical status. Another chemical compound of bath salts is mephedrone. It is a synthetic stimulant that contains cathinone.

Comment from the author: Reminder – If the documentation is unclear whether it is a poisoning or adverse effect, query the physician for clarification. The above Coding Clinic is addressing a problem we are facing here in the United States with the sale of "bath salts" over the counter. It may be listed under several different names; if you are unsure as to what a certain drug is, please make sure you check with your supervisor for clarification.

When to Apply the 7th Character

Sharon Hughes, MBA, RHIA, CCS
Vice President of Coding and Auditing
MiraMed Global Services

The following article is abstracted from *Coding Clinic*

Applying the 7th Character for Injury, Poisoning and Certain Other Consequences of External Causes: *Coding Clinic, First Quarter ICD-10 2015, Pages 3 – 5; Effective with discharges: March 16, 2015.*

The following information is being provided in response to many requests for assistance in applying ICD-10-CM's 7th characters. The ICD-10-CM provides a 7th character in chapter 15, Pregnancy, Childbirth and the Puerperium, chapter 19, Injury, Poisoning and Certain Other Consequences of External Causes (includes complications of surgical and medical care), and chapter 20, External Causes of Morbidity. In the injury and external cause sections, the 7th character is used to provide specific information about the episode of care (e.g., initial encounter, subsequent encounter and sequelae). The 7th character is also applied to fracture codes to provide additional detail, such as closed fracture, open fracture (with type), routine healing, delayed healing and non-union. In the obstetrics section, the 7th character is used for certain complications of multiple gestational pregnancies to identify the specific fetus that is being affected by the condition. This article will only focus on the 7th character used for codes in chapters 19 and 20.

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When to Apply the 7th Character *(Continued from page 5)*

To provide clarification on the use of the 7th character, revisions (shown in blue below) have been made to the guidelines. The Official Guidelines for Coding and Reporting state:

> *"Most categories in chapter 19 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values (with the exception of fractures): A, initial encounter; D, subsequent encounter; and S, sequela. Categories for traumatic fractures have additional 7th character values. While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time."*

For complicated codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem. For example, Code T84.50XA, Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter, is used when active treatment is provided for the infection, even though the condition relates to the prosthetic device, implant or graft that was placed at a previous encounter.

7th character "A," initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter and evaluation and continuing treatment by the same or a different physician.

7th character "D," subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples of subsequent care are: cast change or removal, x-ray to check healing status of fracture, removal of external or internal fixation device, medication adjustment, other aftercare and follow-up visits following treatment of the injury or condition.

The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care. For example, for aftercare of an injury, assign the acute injury code with the 7th character "D" (subsequent encounter).

7th character "S," sequela, is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The "S" is added only to the injury code, not the sequela code. The 7th character "S" identifies the injury responsible for the sequela. The specific type of sequela (e.g., scar) is sequenced first, followed by the injury code.

Assign the external cause code with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter in which the injury or condition is being treated. Most categories in Chapter 20 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values: A, initial encounter, D, subsequent encounter; and S, sequela. While the patient may be seen by a new or different provider over the course of treatment for an injury or condition, assignment of the 7th character for the external cause should match the 7th character of the code assigned for the associated injury or condition for the encounter.

The complete set of ICD-10-CM Official Guidelines for Coding and Reporting is posted on the National Center for Health Statistics (NCHS) website, http://www.cdc.gov/nchs/data/icd/ICD10cmguidelines_2015%209_26_2014.pdf and the AHA Central Office website, www.ahacentraloffice.org.

Mohs Surgery

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Brief History:

In our cutting-edge technology, scientists have unfolded different types of treatment for skin cancer. In recent years, there is one surgical technique that has stood the test of time; Mohs micrographic procedure, also known as Chemosurgery. It was developed by general surgeon, Frederic E. Mohs in 1938. It is a microscopically controlled surgery that has come to be accepted as the single most effective treatment for Basal Cell Carcinoma and Squamous Cell Carcinoma, the two most common skin cancers. Over the past years, this technique has undergone a few refinements and is now being embraced by surgeons in treating skin cancer.

Mohs Surgery in the Perspective of Coding:

Some coders get confused when coding Mohs Surgery. In the Current Procedural Terminology (CPT), coders only need to remember three things:

1. Location or site.
2. Number of stage (in each stage of the procedure the standard tissue blocks removed by the surgeon is five tissue blocks).
3. Number of tissue blocks removed.

In Mohs surgery, the physician acts as both a surgeon and a pathologist. Biopsy is not an integral part of the procedure. Please note that in cases where there is no confirmed biopsy before the procedure and it is done during surgery, code the biopsy together with Mohs surgery and append modifier 59.

Example:

A patient came in to a surgery center for Mohs Surgery. The physician removes the tumor on patient's abdomen using Mohs micrographic surgery technique. During the first stage, the physician takes seven blocks and reviews them under a microscope. This examination reveals that a second stage is necessary. The physician subsequently removes three tumors.

Location/Site	Stage	Tissue Blocks Removed	CPT Codes
Abdomen	1 Stage	7	17313, 17315x2
	2 Stage	3	17314

Rationale:

17313: This is the first stage of the procedure with up to five tissue blocks removed. This code is appropriate for the site, abdomen.

17315 x 2: Indicates that the surgeon removed two additional tissue blocks (as mentioned earlier the standard tissue blocks removed each stage is five tissue blocks).

17314: This is the second stage of the procedure with up to five tissue blocks removed.

Stars of MiraMed

This month's star is …

Evelyn S. Abat
Country Head, Philippines
MiraMed Philippines Group, LLC - Philippine Branch

Evelyn S. Abat, Country Head, joined MiraMed Philippines Group, LLC – Philippine Branch on September 15, 2011, as a consultant tasked to build MiraMed Philippines (MMP). She built the organization from 12 certified medical coders when it began commercial operations on November 5, 2012 to a total of 229 certified coders and a total of 476 full time employees to date.

ESA, as she is fondly called by the MMP staff, graduated with a Bachelor of Science in Chemistry with a Master of Science Degree in Chemistry, and Master of Science Degree in Chemical Education from the University of Santo Tomas; which is the most prestigious and oldest university in Asia.

Over the last 16 years, Evelyn has served the Philippines' business process outsourcing (BPO) services industry. Her record from past multinational business process outsourcing companies speak of a deeply accomplished and results-driven senior management executive with a consistent, documented record of developing new and start-up business entities, opening new business opportunities to enable profitable revenue streams and championing the cause of specific industry sectors both nationally and internationally. Her core competencies include general management, operational efficiency, organizational building and business profitability.

Corporate Social Responsibilities Involvement and Industry Affiliations

- Initiated the first meeting and completed the incorporation of the Medical Transcription Industry Association of the Philippines, Inc. (MTIAPI) in 2003. MTIAPI has expanded further and is now known as HIMOAP (Healthcare Information Management Outsourcing Association of the Philippines).
- Served as the MTIAPI president from its inception in 2003 to 2006.
- Served as founding Trustee of the Business Processing Association of the Philippines, Inc. (BPAP) from its incorporation in 2004 to 2006.
- Initiated and led the first participation of MTIAPI and the Philippines to the Association of Health Information Management Association (AHIMA) Conference in 2004.
- Earned the Special Award of Distinction for Outstanding IT Professional of the Year, 2006 by the Philippine Cyber Services Award Committee and the Philippines Commission on Information and Communications Technology (CICT).
- Active member of the American Health Information Management Association (AHIMA) since 2003.

Are You a Good Auditor?

John Christian Sayo, RN, COC-A,
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MiraMed Philippines Group, LLC - Philippine Branch

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 30-year-old female presented to the clinic after being told she should see her physician because her husband had recently been treated for nongonococcal urethritis. The woman reported some vague pelvic discomforts and vaginal discharge that she did not consider serious. A physical examination, pelvic examination and Pap smear were performed. Based on her history and physical findings, the patient was diagnosed with acute chlamydial cervicitis and given a prescription for two weeks of antibiotic oral medications and an appointment for a follow-up examination in the next three weeks.

	ICD-9-CM	ICD-10-CM
Principal Diagnosis	099.54	A56.09
Secondary Diagnosis	616.0	N72

Correct Answer From Previous Case Scenario:

	ICD-9-CM	Audit Remark	ICD-10-CM	Audit Remark
Principal Diagnosis	389.21	Change 389.21 to 389.22, assign as PDX as documentation indicates that patient was admitted for treatment of this condition. Use 5th digit two as the patient was treated with a bilateral cochlear implant for the hearing loss.	H90.71	Change H90.71 to H90.6 for mixed conductive and sensorineural hearing loss, bilateral.
Secondary Diagnosis	744.00	Change code 744.00 to 744.05, the diagnosis documented as "congenital anomaly of the inner ear."	Q16.4	Change Q16.4 to Q16.5 for congenital malformation of inner ear.
Principal Procedure	20.96	No change.	09HD05Z	Add procedure code 09HE05Z since it is done bilateral.

Coding Case Scenario

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MiraMed Philippines Group, LLC - Philippine Branch

Each month we will offer a coding question for our staff to solve. If you'd like to quiz yourself, feel free. We will gladly let you know the results of your answer. The first coder from each team (United States, Philippines and India) who correctly answers will be given a prize and recognition in the next issue of our newsletter.

Direction: Code for ICD-9-CM Diagnosis and Procedure and its corresponding ICD-10-CM and PCS

A 41-year-old woman with history of primary left lower lobe lung cancer was admitted five days ago for her 5th cycle of chemotherapy. She came back today complaining of weakness and dizziness. CBC was done which showed a hemoglobin of 7.4 g/dl. Patient was diagnosed with anemia due to lung cancer. IV insertion was done and patient was transfused with four bags of nonautologous packed red blood cells via peripheral vein in a span of two days and patient was discharged in good condition. Patient will return next week for her 6th cycle of chemotherapy.

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.

Correct Answer from Previous Case Scenario:

	ICD-9-CM	ICD-10-CM	Remark
Principal Diagnosis	338.29	G89.29	(a) Category 338 Codes as Principal or First-listed Diagnosis (a) Category 338 Codes as Principal or First-listed Diagnosis Category 338 codes are acceptable as principal diagnosis or the first-listed code: • When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known. ICD-10- CM diagnosis codes PDX: G89.29 (Other chronic pain) - Chronic pain
Secondary Diagnosis	733.13	M80.08XA	Assign as SDX 733.01 (Senile osteoporosis) for the osteoporosis and 733.13 (Pathologic fracture of vertebra) for the severe compression fractures of the lumbar vertebrae. The fracture is coded as pathologic because it was related to the osteoporosis and there's no significant trauma involved. It is coded as SDX because the focus of treatment is pain management and not the underlying cause of pain. This is consistent with Coding Clinic, Fourth Quarter 2007 Page: 158 to 162 Effective with discharges: October 1, 2007 SDX: M80.08XA (Age-related osteoporosis with current pathological fracture, vertebra(e)) - Senile osteoporosis and lumbar fracture - ICD-10-CM provides a combination code for osteoporosis and pathologic fracture
Secondary Diagnosis	733.01		
Principal Procedure	03.91	3E0R3BZ	Assign either 03.91 (Injection of anesthetic into spinal canal for analgesia) or 03.92 (Injection of other agent into spinal canal) as PPX, both were therapeutic procedures related to the principal diagnosis. Assign 99.23 for the steroid injection because the 03.92 code doesn't specify the substance injected. This is based on Coding Clinic, Third Quarter 2000 Page: 15 Effective with discharges: September 1, 2000. Question: Central Office has received numerous requests for clarification since the publication of two questions in Coding Clinic, Second Quarter 1998, page 18 and First Quarter 1999 pages 7-8, regarding steroid and anesthetic injections into the spinal canal. In one question, both codes 03.91 and 03.92 were given. In the other question, code 03.91 and 99.23 were given. Readers are questioning why all three codes could not be assigned or why codes 03.91 and 03.92 should not be assigned in both cases? The question in Second Quarter 1998 does not specify whether there is one or two injections given. Does this matter? Answer: Code 03.92, Injection of other agent into spinal canal, does not identify the specific agent injected. Therefore, it would be appropriate to assign both codes 03.92, Injection of other agent into spinal canal and 99.23, Injection of steroid, for a single injection of steroid into the spinal canal. This code assignment may be repeated for each injection. If, however, the injection includes both steroids and anesthetics assign code 03.92, Injection of other agent into spinal canal, code 03.91, Injection of anesthetic into spinal canal for analgesia and code 99.23, Injection of steroid.
Secondary Procedure	03.92	3E0R33Z	
Secondary Procedure	99.23		