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It's Time for the 2019 ICD-10 Coding Guidelines Updates!

By: Marsha Diamond, CPC, COC, CCS, CPMA, AAPC Fellow

Here are highlights of some of the changes in the 2019 ICD-10 Coding Guidelines- **Changes have been bolded** *(Refer to ICD-10-CM Official Coding Guidelines as indicated for additional clarification and direction).* With over 473 changes in ICD-10 for 2019, understanding the changes in the Official guidelines is essential to selecting the appropriate code(s).

"With" - The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index **(either under a main term or subterm)**, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. (*ICD-10 guideline I.A.15)*

Documentation by Clinicians Other Than Patient's Provider - For social determinants of health, such as information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses. *(ICD-10 guideline I.B.14)*

Sequencing of External Causes of Morbidity Codes - Codes for cataclysmic events, such as a hurricane, take priority over all other external cause codes except child and adult abuse and terrorism and should be sequenced before other external cause of injury codes. Assign as many external cause of morbidity codes as necessary to fully explain each cause. For example, if an injury occurs as a result of a building collapse during the hurricane, external cause codes for both the hurricane and the building collapse should be assigned, with the external causes code for hurricane being sequenced as the first external cause code. (*ICD-10 guideline I.B.19.b)* (Please see related article on hurricane aftermath coding in this issue).

Sepsis due to a postprocedural infection - For such cases, the postprocedural infection code, such as T80.2, Infections following infusion, transfusion, and therapeutic injection **infections following a procedure**, **a code from** T81.**40, to T81.43** Infection following a procedure, T88.0, Infection following immunization, or **a code from** O86.0**0 to O86.03**, Infection of obstetric surgical wound, **that identifies the site of the infection** should be coded first, followed by the code for the specific infection **if known**. **Assign an additional code for sepsis following a procedure (T81.44) or sepsis following an obstetrical procedure (O86.04). Use an additional code to identify the infectious agent.** If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction. *(ICD-10 guideline I.C.1.d.5) (b)* **For infections following infusion, transfusion, therapeutic injection, or immunization, a code from subcategory T80.2, Infections following infusion, transfusion, and therapeutic injection, or code T88.0-, Infection following immunization, should be coded first, followed by the code for the specific infection. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned, with the additional code(s) for any acute organ dysfunction.**

Postprocedural infection/postprocedural septic shock - If a postprocedural infection has resulted in postprocedural septic shock, the code for the precipitating complication such as code T81.4, Infection following a procedure, or O86.0, Infection of obstetrical surgical wound should be coded first followed by code T81.12-, Postprocedural septic shock. A code for the systemic infection should also be assigned. **Assign the codes indicated above for sepsis due to a postprocedural infection, followed by code T81.12-, Postprocedural septic shock. Do not assign code R65.21, Severe sepsis with septic shock. Additional code(s) should be assigned for any acute organ dysfunction.** (*ICD-10-CM Guideline I.C.1.d.5) (c)*

Current Malignancy vs Personal History of - Subcategories Z85.0 –Z85.7 should only be assigned for the former site of a primary malignancy, not the site of a secondary malignancy. Codes from subcategory Z85.8-, may be assigned for the former site(s) of either a primary or secondary malignancy included in this subcategory. *(ICD-10 guideline I.C.2.m)*

Factitious Disorders - Factitious disorder imposed on self or Munchausen's syndrome is a disorder in which a person falsely reports or causes his or her own physical or psychological signs or symptoms. For patients with documented factitious disorder on self or Munchausen's syndrome, assign the appropriate code from subcategory F68.1-, Factitious disorder imposed on self. *(ICD-10 guideline I.C.5.c)*. Munchausen's syndrome by proxy (MSBP) is a disorder in which a caregiver (perpetrator) falsely reports or causes an illness or injury in another person (victim) under his or her care, such as a child, an elderly adult, or a person who has a disability. The condition is also referred to as "factitious disorder imposed on another" or "factitious disorder by proxy." The perpetrator, not the victim, receives this diagnosis. Assign code F68.A, Factitious disorder imposed on another, to the perpetrator's record. For the victim of a patient suffering from MSBP, assign the appropriate code from categories T74, Adult and child abuse, neglect and other maltreatment, confirmed, or T76, Adult and child abuse, neglect and other maltreatment, suspected. (See *Section I.C.19.f. Adult and child abuse, neglect and other maltreatment*)

Subsequent acute myocardial infarction - If a subsequent myocardial infarction of one type occurs within 4 weeks of a myocardial infarction of a different type, assign the appropriate codes from category I21 to identify each type. Do not assign a code from I22. Codes from category I22 should only be assigned if both the initial and subsequent myocardial infarctions are type 1 or unspecified. (*ICD-10 guideline I.C.9.e.4)*

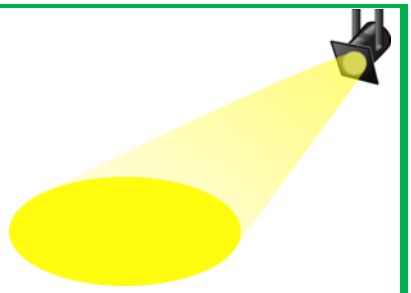
Underdosing - Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer's instruction. **Discontinuing the use of a prescribed medication on the patient's own initiative (not directed by the patient's provider) is also classified as an underdosing.** For underdosing, assign the code from categories T36-T50 (fifth or sixth character "6"). Codes for underdosing should never be assigned as principal. *(ICD-10 guideline I.C.19.e.5(c))*

Z68 Body Mass Index (BMI) - As with all other secondary codes, the BMI codes should only be assigned when **the associated diagnosis (such as overweight or obesity)** meets the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). **Do not assign BMI codes during pregnancy**. ***See Section I.B.14 for BMI documentation by clinicians other than the patient's provider.*** *(ICD-10 guideline I.C.21.c.3)*

In This Issue...

Highlights of ICD-10-CM Codes Changes:

√279 New Codes √143 Revised Codes √51 Deactivated Codes



Ch. 2: Neoplasms

- ✓ Additional codes for neoplasms of upper/lower eyelids.
  - Ex. C43.111 Malignant melanoma of right upper eyelid, including canthus

Ch. 4: Endocrine, Nutritional & Metabolic Diseases

- ✓ New codes:
  - E72.8- Other specified disorders of amino-acid metabolism
  - E75.2- Other sphingolipidosis
  - E78.4- Other Hyperlipedemia
  - E88.0- Disorders of plasma-protein metabolism

Ch. 5: Mental, Behavioral & Neurodevelopmental Disorders

- ✓ New codes:
  - F12.23/F12.93 Cannabis dependence and/or use with withdrawal
  - F53.0 Postpartum depression
  - F53.1 Puerperal psychosis
- ✓ Revised codes:
  - Factitious disorders imposed on self/imposed on another (F68 series)

Ch. 6: Diseases of the Nervous System

- ✓ New laterality codes:
  - G51.3- Clonic hemifacial spasm
  - G71.0- Muscular Dystrophy

Ch. 7: Diseases of the Eye & Adnexa

- ✓ Additional codes for diseases of upper/lower eyelids.
  - Ex. H01.00A Unspecified blepharitis right eye, upper and lower eyelids
- ✓ New laterality codes:
  - H10.82- Rosacea conjunctivitis
  - H51.81- Brow ptosis

Ch. 9: Diseases of the Circulatory System

- ✓ New codes:
  - I63.8- Other cerebral infarction
  - I67.85- Hereditary cerebrovascular diseases

Ch. 11: Diseases of the Digestive System

- ✓ New codes:
  - K35.- Acute appendicitis
  - K61.3- Ischiorectal abscess
  - K61.5- Supralevator abscess
  - K82.A- Disorders of gallbladder diseases
  - K83.0- Cholangitis

Ch. 13: Diseases of the Musculoskeletal System & Connective Tissue

New entries:

- M04 Autoinflammatory syndromes
- M97 Periprosthetic fracture around internal prosthetic joint

- ✓ New codes:
  - M79.1- Myalgia (site)

Ch. 14: Diseases of the Genitourinary System

- ✓ New codes:
  - N35.016/N35.116 Post-traumatic/Post-infective urethral stricture, male
  - N35.81- Other urethral stricture, male
  - N35.91- Unspecified urethral stricture, male
  - N35.82/N35.92 Other/Unspecified urethral stricture, female
  - N99.116 Postprocedural urethral stricture, male, overlapping sites

Ch. 15: Pregnancy, Childbirth & the Puerperium

- ✓ New subcategory/codes:
  - O30.13- Triplet pregnancy
  - O30.23- Quadruplet pregnancy
  - O30.83- Specified multiple gestation
  - O86.0- Infection of obstetric surgical wound

Ch. 16: Certain Conditions Originating in the Perinatal Period

- ✓ New codes:
  - P02.7- Newborn affected by chorioamnioitis
  - P04.1- Newborn affected by specific maternal medication
  - P04.4- Newborn affected by maternal use of drugs of addiction
  - P04.8- Newborn affected by maternal noxious substances
  - P35.4 Congenital Zika virus Disease
  - P74.- Specific transitory neonatal electrolyte & metabolic disturbances

Ch. 17: Congenital Malformations, Deformations & Chromosomal Abnormalities

- ✓ Other doubling of uterus code expanded to 5 characters:
  - Partial, complete, other and unspecified conditions (Q51.2-)
- ✓ New codes:
  - Q93.5- Other deletions of part of a chromosome
  - Q93.82 Williams syndrome

Ch. 18: Symptoms, Signs & Abnormal Clinical & Laboratory Findings, Not Elsewhere Classified

- ✓ New codes:
  - R82.99- Abnormal finding in urine
  - R93.81- Abnormal findings on diagnostic imaging of specified body structures

Ch. 19: Injury, Poisoning & Certain Other Consequences of External Causes

- ✓ New subcategory/codes:
  - T43.64- Poisoning by ecstasy
  - T74.51-/T76.51- Adult forced sexual exploitation
  - T74.61-/T76.52- Adult forced labor exploitation
  - T74.52-/T76.52- Child forced sexual exploitation
  - T74.62-/T76.62- Child forced labor exploitation
  - T81.4- Infection following a procedure

Ch. 20: External Causes of Morbidity

- ✓ New code:
  - Y07.6 Multiple perpetrators of maltreatment/neglect

Ch. 21: Factors Influencing Health Status & Contact with Health Services

- ✓ New codes:
  - Z04.81 Enc. for exam. and/or OBS reasons
  - Z20.821 Contact with/suspected exposure to Zika virus
  - Z28.83 Immunization not carried out due to unavailability of vaccine
  - Z62.813/Z91.42 Personal history of forced labor or sexual exploitation
  - Z13.30 Enc. for screening exam for mental health/behavioral disorders
  - Z13.4- Enc. for screening for developmental disorders in childhood

Coding for Healthcare Encounters in Hurricane Aftermath

By: Kathy Oyler, CCS

It is that time again, coders. That time of the year when updates and/or changes to the Official Guidelines for Coding & Reporting are released. The effective date for FY2019 ICD-10-CM guidelines is October 1, 2018 and, as always, there are some significant changes to prepare for.

One notable change is in the "General Guidelines" section. There is a new General Guideline, *No. 19: Coding for Healthcare Encounters in Hurricane Aftermath*, to help coding professionals when coding encounters for individuals affected by a hurricane. Coincidentally, this guideline will be released during hurricane season and one year after Hurricanes Harvey and Irma tragically struck and devastated cities in Texas and Florida. It reads as follows:

19. Coding for Healthcare Encounters in Hurricane Aftermath

a. Use of External Cause of Morbidity Codes
An external cause of morbidity code should be assigned to identify the cause of the injury(ies) incurred as a result of the hurricane. The use of external cause of morbidity codes is supplemental to the application of ICD-10-CM codes. External cause of morbidity codes are never to be recorded as a principal diagnosis (first-listed in non-inpatient settings). The appropriate injury code should be sequenced before any external cause codes. The external cause of morbidity codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event, and the person's status (e.g., civilian, military). They should not be assigned for encounters to treat hurricane victims' medical conditions when no injury, adverse effect or poisoning is involved. External cause of morbidity codes should be assigned for each encounter for care and treatment of the injury. External cause of morbidity codes may be assigned in all health care settings. For the purpose of capturing complete and accurate ICD-10-CM data in the aftermath of the hurricane, a healthcare setting should be considered as any location where medical care is provided by licensed healthcare professionals.

b. Sequencing of External Causes of Morbidity Codes
Codes for cataclysmic events, such as a hurricane, take priority over all other external cause codes except child and adult abuse and terrorism and should be sequenced before other external cause of injury codes. Assign as many external cause of morbidity codes as necessary to fully explain each cause. For example, if an injury occurs as a result of a building collapse during the hurricane, external cause codes for both the hurricane and the building collapse should be assigned, with the external causes code for hurricane being sequenced as the first external cause code. For injuries incurred as a direct result of the hurricane, assign the appropriate code(s) for the injuries, followed by the code X37.0-, Hurricane (with the appropriate 7th character), and any other applicable external cause of injury codes. Code X37.0- also should be assigned when an injury is incurred as a result of flooding caused by a levee breaking related to the hurricane. Code X38.-, Flood (with the appropriate 7th character), should be assigned when an injury is from flooding resulting directly from the storm. Code X36.0.-, Collapse of dam or man-made structure, should not be assigned when the cause of the collapse is due to the hurricane. Use of code X36.0- is limited to collapses of man-made structures due to earth surface movements, not due to storm surges directly from a hurricane.

c. Other External Causes of Morbidity Code Issues
For injuries that are not a direct result of the hurricane, such as an evacuee that has incurred an injury as a result of a motor vehicle accident, assign the appropriate external cause of morbidity code(s) to describe the cause of the injury, but do not assign code X37.0-, Hurricane. If it is not clear whether the injury was a direct result of the hurricane, assume the injury is due to the hurricane and assign code X37.0-, Hurricane, as well as any other applicable external cause of morbidity codes. In addition to code X37.0-, Hurricane, other possible applicable external cause of morbidity codes include:

- ✓ *W54.0- Bitten by dog*
- ✓ *X30- Exposure to excessive natural heat*
- ✓ *X31- Exposure to excessive natural cold*
- ✓ *X38- Flood*

d. Use of Z codes
Z codes (other reasons for healthcare encounters) may be assigned as appropriate to further explain the reasons for presenting for healthcare services, including transfers between healthcare facilities. The ICD-10-CM Official Guidelines for Coding and Reporting identify which codes maybe assigned as principal or first-listed diagnosis only, secondary diagnosis only, or principal/first-listed or secondary (depending on the circumstances). Possible applicable Z codes include:

- ✓ *Z59.0 Homelessness*
- ✓ *Z59.1 Inadequate housing*
- ✓ *Z59.5 Extreme poverty*
- ✓ *Z75.1 Person awaiting admission to adequate facility elsewhere*
- ✓ *Z75.3 Unavailability and inaccessibility of health-care facilities*
- ✓ *Z75.4 Unavailability and inaccessibility of other helping agencies*
- ✓ *Z76.2 Enc. for health supervision and care of other healthy infant and child*
- ✓ *Z99.12 Enc. for respirator [ventilator] dependence during power failure*

The external cause of morbidity codes and the Z codes listed above are not an all-inclusive list. Other codes may be applicable to the encounter based upon the documentation. Assign as many codes as necessary to fully explain each healthcare encounter. Since patient history information may be very limited, use any available documentation to assign the appropriate external cause of morbidity and Z codes.

It is important to note the sentence in the last paragraph that tells you to code as many codes as necessary to fully explain each healthcare encounter.

Example: The patient was sitting in his living room when hurricane force winds caused the tree in his backyard to propel through the patio door and the patient was trapped under the debris of his patio door and the fallen tree. During the examination the physician learned that the patient was being physically abused by his parents. Focusing only on the external causes this scenario would be coded as follows:

- ✓ T74.12XA Child physical abuse, confirmed, initial encounter (sequencing guideline states that this code must be sequenced first)
- ✓ Y07.11 Biological father, perpetrator of maltreatment and neglect
- ✓ Y07.12 Biological mother, perpetrator of maltreatment and neglect
- ✓ X37.0XXA Hurricane, initial encounter
- ✓ W20.8XXA Other cause of strike by thrown, projected or falling object, initial encounter (this code covers both the tree and the patio door)
- ✓ Y92.018 Other place in single-family (private) house as the place of occurrence of the external cause

It is extremely important to have good documentation of the encounter to code to the highest level of specificity. As you can see, if coded properly, ICD-10 brings the clinical picture to life. We hope this article helps further your understanding of this new guideline. Please refer to the *2019 ICD-10 Official Coding Guidelines* for additional information or clarification.

CMS Proposes Changes to E/M Levels as Early as **Jan. 2019**!

By: Marsha Diamond, CPC, COC, CCS, CPMA, AAPC Fellow

Take a deep breath and understand that the following information is only proposals from the Centers for Medicare & Medicaid Services (CMS). In order for any of these proposals to take effect, the comment period has to be completed and provider feedback reviewed thoroughly. Due to the potential impact of these proposed changes, stakeholders are encouraged to share their thoughts with CMS. The final physician fee schedule changes will be announced towards the end of 2018.

It would be advantageous to have some idea of the changes that may take effect and prepare your providers for these potential upcoming changes. It is also imperative that your providers know that these changes may, or may not, take place depending upon the comments CMS receives. If they feel strongly for or against any of the proposals, encourage them to respond to the CMS website. The deadline for submitting comments on the proposed rule is September 10, 2018.

These proposals pertain only to office/outpatient visit codes 99202-99205 and visits for office/outpatient services codes 99212-99215.

Proposal 1 – Allow the provider to choose between the current coding guidelines from 1995 and 1997 of MDM or time for determining the appropriate E/M levels. Providers will continue to report level assignments despite the potential one visit reimbursement discussed in Proposal 2.

Proposal 2 – Adopt a single G-code to describe office/outpatient visit levels 2-5 in conjunction with the proposal to establish a single PFS payment rate for those visits. Single payment rates are proposed as follows:

- ✓ $135.00 for New Patient 99202-99205
- ✓ $93.00 for Established Patient 99212-99215

Proposal 3 – Simplify the documentation of history and exam for established patients where practitioners would only be required to focus on what has changed since the last visit rather than re-documenting for "counting" purposes. This would still require the provider to document that the previous information was reviewed and updated appropriately. Also, allow other clinician personnel to document chief complaint and history with billing provider appropriately documenting information was reviewed and concurred.

Proposal 4 – Propose as part of the single fee for service payment rate to reduce the least expensive procedure or visit by 50% when performed on the same day as commonly billed together services.

Proposal 5 – In addition to the single PFS payment amount, propose the following add-on codes:

- ✓ GPC1X Primary Care (Visit complexity inherent to E/M associates with primary medical care services)
- ✓ GCG0X Specialty (Visit complexity inherent to E/M associated with endocrinology, rheumatology, hematology /oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology or interventional pain management)
- ✓ GPR01 Prolonged Physician Services (Only face-to-face additional 30 minute direct time)

Stay tuned as more information is being provided by CMS. If you wish to review comments already made by providers, please visit the CMS websites' Public Comments page.

Wound Care Debridement Clarification

By: Theresa Rosa, AAS, CCS, CPC

What is wound care? Wound care is just what it sounds like, the treatment of non-healing wounds and/or ulcers. The treatment of wounds varies from simple dressings, wound vacs, debridement (both surgical and active wound care treatments), Unna boots, compression wraps, and Hyperbaric Oxygen Therapy (HBOT). Each of these treatments have their own documentation requirements and rules for coding/billing. This article will focus on debridement.

Debridement can be either excisional debridement or active wound care. The excisional debridement codes are the 11042-11047 series of codes, and the active wound care codes are 97597, 97598, and 97602.

Let's take a look at the 11042-11047 series of codes: For each level of debridement the documentation must indicate that tissue from that level was removed; it is not enough to say "down to" the level. It must be clear that tissue from the level described in the CPT code has been removed. The instrument used, the size of the area debrided, as well as the size of the area remaining after debridement are also important pieces of information required to satisfy documentation guidelines for wound care debridement.

Some of the basic coding rules are as follows:

- ✓ Multiple wounds of same debridement depth are combined together to get the total size.
- ✓ Only the most extensive debridement service should be coded per wound.
- ✓ Dressings, compression wraps, and/or wound vac placements are considered incidental to the debridement procedure and should not be coded when debridement is performed on the same wound.
- ✓ Burn debridement is reported with the 16020 series of codes.
- ✓ Do not report a separate acuity level with modifier 25 unless there is a significantly separately identifiable service performed at the same time. Debridement includes assessing the wound, treating the wound, review of progress since last visit, any new orders based on progress, and follow up instructions, so these services would not allow for separate E\M acuity level if these are the only services performed in addition to the wound debridement.

Coding Example: Fibrin and slough were removed from the surface of Wound #1. Following this, excisional debridement was performed through the subcutaneous tissue and into the muscle with a scalpel. I debrided a 3x5 cm area from the wound. The new wound size after debridement is 4x3x6 sq cm.

Answer: 11043 Debridement, muscle and/or fascia (including epidermis and subcutaneous tissue if performed), first 20 sq cm. Size of area debrided was 3x5 cm for a total of 15 cm sq. (Note: the size of the wound post debridement is NOT considered when selecting the code, only the size of the area debrided is considered for coding.)

HCC Category 124 - Macular Degeneration

By: Julie Scarborough, CCS, RHIT, CHCCS

ICD-10 Codes
H35.321 Exudative age-related macular degeneration, right eye
H35.322 Exudative age-related macular degeneration, left eye
H35.323 Exudative age-related macular degeneration, bilateral
H35.329 Exudative age-related macular degeneration, unspecified eye

Also required, appropriate 7th character to designate the stage of the disease:

0 Stage unspecified
1 With active choroidal neovascularization
2 With inactive choroidal neovascularization with involuted or regressed neovascularization
3 With inactive scar

Macular Degeneration (AMD): AMD is a common eye condition and a leading cause of vision loss among people ages 50 and older. It causes damage to the macula, a small spot near the center of the retina and the part of the eye needed for sharp, central vision, which lets us see objects that are straight ahead of us. In some people, the disease is slow to progress and vision loss does not occur for a long time. In others, the disease progresses quickly and may lead to loss of vision in one or both eyes. As AMD progresses, the blurred area may grow larger or you may develop blank spots in your central vision. Objects also may not appear to be as bright as they used to be. Although AMD by itself does not lead to complete blindness, the loss of central vision can interfere with simple everyday activities, such as the ability to see faces, drive, read, write, or do close work such as cooking or fixing things around the house.

Who is At Risk? Certain genetic and environmental factors increase the risk of a person developing AMD.

Genetic factors: age, women, Caucasians, lightly-pigmented people, and a family history of AMD;
Environmental factors: smoking, high blood pressure, high cholesterol, and obesity;

Symptoms: AMD has few symptoms in the early stages so it is important to have your eyes examined regularly.

How is AMD detected?

Visual acuity test: This eye chart measures how well you see at distances.
Dilated eye exam: Your eye care professional places drops in your eyes to widen or dilate the pupils. This provides a better view of the back of your eye. Using a special magnifying lens, he or she then looks at your retina and optic nerve for signs of AMD and other eye problems.
Amsler Grid: Your eye care professional may ask you to look at an Amsler Grid. Changes in your central vision may cause the lines in the grid to disappear or appear wavy, a sign of AMD.
Fluorescein angiogram: This is a test in which a fluorescent dye is injected into your arm. Pictures are taken as the dye passes through the blood vessels in your eye. This makes it possible to see leaking blood vessels, which occur in a severe, rapidly progressive type of AMD.

Stages of AMD

Early AMD: Early AMD is diagnosed by the presence of medium-sized drusen, which are about the width of an average human hair. People with early AMD typically do not experience vision loss.
Intermediate AMD: People with intermediate AMD typically have large drusen, pigment changes in the retina, or both. Again, these changes can only be detected during an eye exam. Intermediate AMD may cause some vision loss, but most people will not experience any symptoms.
Late AMD: In addition to drusen, people with late AMD have vision loss from damage to the macula. There are two types of late AMD:

1.) In geographic atrophy (dry AMD), there is a gradual breakdown to the light-sensitive cells in the macula that convey visual information to the brain, and of supporting tissue beneath the macula. These changes cause vision loss.
2.) In neovascular AMD (wet AMD), abnormal blood vessels grow underneath the retina ("neovascular" literally means "new vessels"). These vessels can leak fluid and blood, which may lead to swelling and damage to the macula. The damage may be rapid and severe, unlike the more gradual course of geographic atrophy. It is possible to have both geographic atrophy and neovascular AMD in the same eye, and either condition can appear first.

Treatment for Early/Intermediate/Late AMD: Currently no treatment exists for Early AMD, which in many cases shows no symptoms or loss of vision. Research has shown that a daily intake of certain high-dose vitamins and minerals can slow progression of the disease in people who have Intermediate AMD, and those who have Late AMD in one eye. It is important to remember that this is not a cure. It does not help people in Early AMD, and will not restore vision already lost from AMD; however, it may delay the onset of late AMD. It also may help slow vision loss in people who already have late AMD. Please check with your healthcare provider before starting any supplements.

Treatment for Advanced Neovascular AMD
Injections: One option to slow the progression of neovascular AMD is to inject drugs into the eye. With neovascular AMD, abnormally high levels of vascular endothelial growth factor (VEGF) are secreted in your eyes. VEGF is a protein that stimulates the growth of new abnormal blood vessels. Anti-VEGF injection therapy blocks this growth.
Photodynamic therapy: This technique involves laser treatment of select areas of the retina. First a drug called Verteporfin is injected into a vein in your arm. This drug travels through the blood vessels in your body and is absorbed by new, growing blood vessels. Your eye care professional shines a laser beam into your eye to activate the drug in the new abnormal blood vessels which sparing normal ones. Once activated, the drug closes off the new blood vessels, slows their growth, and slows the rate of vision loss.
Laser surgery: Eye care professionals treat certain cases of neovascular AMD with laser surgery, though this is less common than other treatments. It involves aiming an intense "hot" laser at the abnormal blood vessels in your eyes to destroy them. This laser is not the same one used in photodynamic therapy, which may be referred to as a "cold" laser. This treatment is more likely to be used when blood vessel growth is limited to a compact area in your eye, away from the center macula, that can be easily targeted with the laser.

Medication: Lucentis (Ranibizumab), Avastin**,** Macugen**,** Eylea**,** Visudyne (Verteporfin); AREDS and AREDS2 are two different supplements that may help slow the progression. The ingredients are: 500 milligrams (mg) of Vitamin C, 400 international units of Vitamin E, 80 mg zinc as zinc oxide, 2 mg copper as cupric oxide, and 10 mg lutein and 2 mg zeaxanthin.

In terms of HCC coding/auditing, PCP's do not always document this appropriately. They will code Macular Degeneration without specifying wet or dry. If it is unclear and there are no ophthalmology consults in the chart, you may query Exudative Macular Degeneration. Look in the medication list to see if any medications are listed that treat Exudative Macular Degeneration as secondary support to query this condition. We would not query this condition if the ophthalmology consult clearly states dry Macular Degeneration.

Specificity in HCC: Time's Running Out!

By: Laura Brink, RHIT, CHCCS

Quality documentation is key to ensure that the conditions addressed are supported for proper reimbursement, but is documentation enough?

Documentation is just one side of the coin. Vague and nonspecific charting goes hand in hand with inaccuracies in medical coding. This, in turn, creates discrepancies in the provider's clinical assessment, severity of illness, and billing. Medical coders and HCC auditors are trained to review errors in documentation and address these scenarios; however, the issue of specificity continues to be an uphill battle even when a condition is documented correctly.

Why it matters in HCC

The grace period from the Centers for Medicare and Medicaid Services (CMS) has allowed providers to have flexibility in coding each condition to the highest known specificity during the implementation process of ICD-10-CM. This flexibility is running out and plays a vital role not only in claim denials, but also in correctly capturing and reporting conditions that risk adjust.

As stated in the *CMS Guidance, "*For 12 months after the ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/ practitioner used a valid code from the right family of codes."

Staying ahead of the curve with specificity means more than just medical necessity. The impact of documenting and capturing conditions to the highest clinical certainty at the time of the encounter also affects the HCC Risk Adjustment Factor, as it may risk adjust in a different category or not at all.

Areas of Improvement:

Codes without descriptions cannot be picked up by coders - The provider lists F33.0 in the Assessment and only "depressive disorder" is documented in the chart. In this case the most specific code that can be picked up is F32.9 (Major depressive disorder, single episode, unspecified), which does not RA in some models.

Diabetes mellitus with other specified complications - The provider documents diabetes mellitus and chronic kidney disease correctly; however, E11.29 (Type 2 diabetes mellitus with other diabetic kidney complication) is coded. The correct code assignment would be E11.22 (Type 2 diabetes mellitus with diabetic chronic kidney disease). The codes are within the same family and both codes RA in the same HCC category, but are not documented to the highest level of specificity.

Unspecified codes - The provider documents that the patient has ischemic cardiomyopathy and codes I42.9 (Cardiomyopathy, unspecified). According to ICD-10-CM Coding Guidelines, "Codes titled 'unspecified' are for use when the information in the medical record is insufficient to assign a more specific code." In this scenario, the correct code assignment would be I25.5 (Ischemic cardiomyopathy), which does not RA, whereas I42.9 does.

Diabetes Mellitus with complications - The provider documents and codes E11.9 (Type 2 diabetes mellitus without complications) under the Assessment and Plan; however, polyneuropathy is documented under the History of Present Illness. *ICD-10-CM Coding Guidelines* state for the terms "with" and "in" that "the classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List." Therefore, the correct code assignment is E11.42 (Type 2 diabetes mellitus with diabetic polyneuropathy), which RA's in a higher category than E11.9.

Pressure ulcers - The provider documents that the patient has an unstageable decubitus ulcer of the right ankle that was coded to L97.319 (Non-pressure chronic ulcer of right ankle with unspecified severity). The correct code assignment for this condition is L89.510 (Pressure ulcer of right ankle, unstageable). Improper coding in this case means that the codes are not in the same family and do not RA in the same category. The pressure ulcer RA's higher than the non-pressure ulcer and, if not addressed, becomes lost revenue.

Small Steps for Improvement - Where to begin?

Unspecified codes – Identify the most common unspecified codes that are being reported. It may be that the documentation is not sufficient enough for a more specific code to be assigned or a more specific code was documented and not assigned. What is the underlying issue?

Provider and coder education - Time for a refresher? Choose a member in your office to take the lead on monitoring and addressing current areas of opportunity, guidance from CMS, and ICD-10-CM code updates. Determine how often and what should be addressed first. Small consistent steps lead to quantifiable results.

Document acuity levels – Is the condition acute, chronic, resolved/history of? Mild, moderate, severe, in remission? Acuity can affect what HCC's will or will not be submitted. Do not miss out on revenue!

Laterality – Although right, left, and bilateral are often times documented, laterality can be missing in the code assignment.

Causation – Do not forget to link conditions! For combination coding, determine whether or not the condition is linked under the subterm "with" or "in" in the *ICD-10-CM Index*. Educate providers to document if a symptom or disease is due to another condition.

Reference: Centers for Medicare and Medicaid Services. "Clarifying Questions and Answers Related to the July 6, 2015, CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities." www.cms.gov/Medicare/Coding/ICD10/Clarifying-Questions-and-Answers-Related-to-the-July-6-2015-CMS-AMA-Joint-Announcement.pdf.

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