26 ISSUE – April 2023
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# The HIM Times Newsletter

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## INSIDE THIS ISSUE:

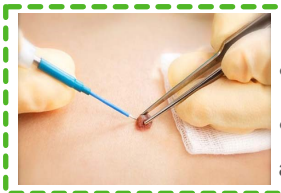


## A BRIEF OVERVIEW OF LESION EXCISIONS

*Author: Rebecca Dyke, CPC, CPMA*

A skin ***lesion*** is any area that has different characteristics from its surrounding skin, such as color, size, shape, and texture. Skin lesions are common and are often a result of damage to the skin, like *contact dermatitis*. Lesions can also be manifestations of underlying disorders like *autoimmune disorders, diabetes, or infections*.[1] There are two types of skin lesions – primary and secondary.

### Primary Lesions



- Originate in healthy skin and are associated with a specific cause.
- Examples of primary lesions include tubercles, tumors, blisters, and moles.

**Secondary lesions are a result of primary lesions and may be scars or ulcers.[1]**

Skin lesions can be benign or malignant

### Benign

Benign are non-cancerous growths that do not spread to other sites in the body.

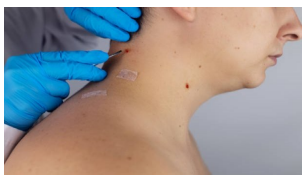
Examples
- ⇒ *benign neoplasm*
- ⇒ *dermoid cyst*
- ⇒ *sebaceous cyst*
- ⇒ *skin nevus*
- ⇒ *fibrous lesion*

### Malignant

Malignant lesions can spread to sites beyond the skin by the process of metastasis.

Examples
- ⇒ *malignant melanoma*
- ⇒ *Merkel cell carcinoma*
- ⇒ *basal cell carcinoma*
- ⇒ *squamous cell carcinoma*
- ⇒ *melanoma in situ*[2]

Lesions can also be classified as **uncertain histologic behavior**, which is a lesion sample that has been thoroughly evaluated by a pathologist who is unable to classify the tissue's cells as either malignant or benign. Only a pathologist can assign uncertain nature. When a surgeon receives this classification, they will treat the lesion as if it's malignant by removing it with larger margins to make sure the questionable tissue is gone. If this re-excision comes back as benign, it is still appropriate to code as a malignant lesion excision.[3] The code relates to the manner in which the lesion was approached rather than the final pathologic diagnosis since the code should reflect the knowledge skill, time, and effort that the physician invested in the excision.



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## UPCOMING CONFERENCES 2023

JUL 09 **FHIMA** Orlando, FL

FHIMA Florida Health Information Management Association

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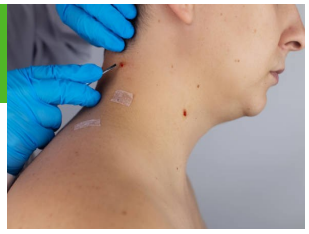
## A BRIEF OVERVIEW OF LESION EXCISIONS (CONT.)

*Author: Rebecca Dyke, CPC, CPMA*



Code selection for skin lesion excisions is driven by histology, method of removal, location, and size. Benign and malignant excisions have the same groups of anatomic locations in their code sets, but benign also has codes for mucous membrane. Destruction methods include laser, chemical and curette (a razor blade) or scalpel.[4] The size of the excision is measured for coding as: *Greatest diameter plus 2 times the narrowest margin.*[2]

**Example:** A lesion 1 cm at its greatest diameter is excised with a margin of 0.5 cm on all sides. The total excised diameter is 1.0 + 2 x 0.5 = 2.0 cm

*If margins aren't included in the documentation, CPT guidelines state to use the widest diameter.*

If millimeters are documented, convert them to centimeters

10 millimeters = 1 centimeter

### CODING

Benign lesions are reported with codes
**11400 – 11471**

*Malignant lesions are reported with codes*
***11600 – 11646***

Codes are grouped by the anatomical locations, then broken down by size:

- Trunk, arms, or legs
- Scalp, neck, hands, feet, genitalia
- Face, ears, eyelids, nose, lips, mucous membrane (benign only)

Simple repair is included in lesion excisions; however, an intermediate or complex repair can be reported separately.

Intermediate repairs are reported with codes
**12031 – 12057**

Complex repairs are reported with codes
**13100 – 13160**

## Medical Terms Word Search

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Z | Y | G | O | M | Y | C | O | S | I | S | A | W | Y | E | M | I | X | R | E |
| U | A | Q | T | T | C | Z | L | N | E | G | T | K | T | Y | C | D | E | S | O |
| W | I | R | C | B | S | S | D | A | E | W | Q | F | N | M | Q | G | Z | T | S |
| Q | G | V | V | V | L | F | Z | N | G | K | Q | Y | F | O | S | E | B | O | T |
| V | E | D | S | X | X | E | E | U | L | C | E | R | A | T | I | O | N | O | E |
| E | L | M | L | E | A | S | P | N | E | S | C | Q | T | S | Z | D | C | P | O |
| A | P | S | T | M | I | G | H | H | L | K | V | Y | G | O | L | I | P | H | M |
| I | I | H | P | S | O | F | N | U | A | X | A | J | T | E | S | A | O | O | Y |
| S | R | B | L | H | T | K | O | F | S | R | G | O | M | L | Y | P | T | R | E |
| P | D | E | F | I | B | R | I | N | A | T | I | O | N | I | M | H | L | E | L |
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| Y | Q | T | I | D | G | K | X | K | S | A | T | E | G | S | C | I | H | O | I |
| L | F | E | D | N | F | J | U | Q | M | M | I | R | J | J | E | S | O | M | S |
| O | H | R | N | G | C | K | L | O | T | O | S | I | U | V | R | M | T | Y | Q |
| P | B | B | U | Q | P | V | B | J | W | C | N | O | A | X | E | H | R | V | M |
| S | P | R | A | I | N | Y | U | W | N | U | S | M | Z | N | H | U | I | G | T |
| U | B | A | J | D | Z | F | S | C | X | A | L | T | A | R | T | G | P | G | G |
| J | U | S | I | V | D | V | F | G | X | L | W | Q | U | N | A | G | S | H | D |
| Q | K | H | Y | Z | O | Y | Q | J | S | G | H | F | H | H | E | G | Y | D | X |

1. agenesis
2. atherectomy
3. blepharitis
4. defibrination
5. diaphysis
6. glaucoma
7. ileostomy
8. jaundice
9. lithotripsy
10. oophorectomy
11. osteomyelitis
12. polydipsia
13. quadriplegia
14. sprain
15. subluxation
16. ulceration
17. vaginitis
18. waterbrash
19. zygomycosis

Sources:

1. https://www.osmosis.org/answers/skin-lesions#:~:text=A%20skin%20lesion%20refers%20to,like%20sunburns%20or%20contact%20dermatitis.
2. https://www.aapc.com/blog/26192-skin-lesion-excision/
3. https://www.aapc.com/blog/85556-coding-uncertain-lesion-excisions-with-certainty/
4. 2023 CPT Guidelines

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## CODING AND SEQUENCING OF COMPLICATIONS ASSOCIATED WITH NEOPLASMS

*Author: Vickie Zaranec, RHIT*

When coding complications associated with neoplasms, it may be helpful to review **Coding Guidelines** as a refresher. Complications can occur due to a malignancy or due to the treatment used for the malignancy. It is important to distinguish between them in order to apply accurate codes that are sequenced correctly. It is also important to read the instructional notes associated with the codes. **Coding Guideline I.C.2.I.4** states that when a patient presents for a complication due to a neoplasm and only the complication is treated, the complication would be sequenced as the primary diagnosis (PDX).

### Examples

* If a patient presented with *hypokalemia* due to a malignancy and the hypokalemia was treated (ex: IV KCL), hypokalemia would be sequenced as the PDX.
* If a patient presented with *dehydration* that was due to the malignancy and only the dehydration was treated (ex: IV fluids), dehydration would be assigned as the PDX.

### However, there is an exception to this guideline

* If a patient is admitted with *anemia associated with a malignancy*, the malignancy would be sequenced as the PDX even when the treatment is directed toward the anemia.
* If a patient presents with *anemia that is due to chemotherapy* and only the anemia is treated, anemia due to antineoplastic chemotherapy and immunosuppressive drugs (adverse effect) would be sequenced as the PDX.

A code for the type of anemia such as *anemia due to neoplastic disease* would be reported as a secondary diagnosis.

Anemia can also be caused by the treatment of the malignancy, such as *chemotherapy, immunotherapy or radiation therapy*. The malignancy code and the adverse effect code would also be added as secondary diagnoses.

For anemia due to *radiotherapy*, the anemia code would be sequenced as the PDX and the *neoplasm* code and the *adverse effect* of radiotherapy codes would be reported as secondary diagnoses.

### When a patient presents with pain related to a neoplasm, the PDX could be the pain or the malignancy

* If the patient is admitted for management of pain due to the malignancy and *treatment is for pain control*, the neoplasm related pain code would be sequenced as the PDX with the code for the malignancy reported as a secondary diagnosis.
* If the patient has neoplasm related pain but is admitted for *treatment towards the malignancy*, the malignancy would be sequenced as the PDX with a code for the neoplasm related pain added as a secondary diagnosis.

### For a patient admitted with symptoms that are associated with a primary or secondary site, the symptom codes would not replace the malignancy as the PDX.

* If a patient is admitted due to *increasing fatigue* that is determined to be due to a malignancy, the malignancy would be reported as the PDX followed by a code for the neoplasm related fatigue. There is a note under neoplastic related fatigue that states "Code first associated neoplasm."
* Patients who are admitted with a *pathologic fracture* due to a neoplasm and the fracture is the focus of care, a code for the pathologic fracture in neoplastic disease would be sequenced as the PDX with an additional code for the neoplasm (sequenced as a secondary diagnosis).

Sources:

1. Official Guidelines for Coding and Reporting, section I.C.2.I.4.
2. Official Guidelines for Coding and Reporting, section I.C.2.I.6
3. Official Guidelines for Coding and Reporting, section I.C.6.b.5
4. ICD-10-CM and ICD-10-PCS Coding Handbook 2023

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# DEFENDING BODY MASS INDEX

*Author: Tonya Shelton, RHIT, CCS, CCDS*

**ICD-10 Coding Clinic 4th Qtr 2018 – *Body Mass Index*** states "obesity and morbid obesity are always clinically significant and reportable when documented by the provider."[1] The CDC (Center for Disease Control and Prevention) states people who are overweight or obese are at increased risks for many serious diseases and health conditions, compared to those with a healthy weight.[2] Coding Clinic 4th Qtr 2011 – *Clinical Significance of Obesity*, reiterates this.

Some conditions noted by the CDC include

- Hypertension
- Type 2 diabetes
- Obstructive sleep apnea
- Hyperlipidemia
- Low quality of life

*When defending the diagnosis of overweight, obesity, and morbid obesity with the assigned BMI code, look for some of these conditions and whether the patient received treatment or monitoring of these during their stay.*

**Case scenario example:** A payer denied code assignment **Z68.41** (Body mass index [BMI] 40.0-44.9, adult), the facility's only CC for the claim, citing lack of clinical evidence in the medical record to support code assignment. They went on to say the BMI is required to be associated with a physician documented weight-related diagnosis and have some bearing or relevance in terms of patient care.

In this case, there was documentation of the patient being

- Morbidly obese at over 300 lbs.
- With a medical history of hypertension
- Type 2 diabetes
- Obstructive sleep apnea and hyperlipidemia

During their hospital stay the patient was continued on

- Home ACE inhibitor
- Accu-Chek with A1C tests
- CPAP
- Atorvastatin

The **Caprini Score** is a risk assessment tool used for occurrence of venous thrombosis and is highly recommended in stroke patients

In addition, **Caprini Risk Scores** were calculated for this patient as they presented with a stroke. In calculating this score, obesity with a **BMI >25** is one of the factors. There was radiologist documentation of the patient's body habitus degrading the diagnostic evaluation, limiting the assessment. The attending physician documented "*obese habitus*" in the progress notes as well as recommended dietician follow-up in the outpatient setting.

Even with all this supportive documentation, the payer denied assignment of this code. We continued our appeal of this decision to the 2nd Level where the **PRO** (Peer Review Organization) eventually overturned the decision. The PRO found the record contained sufficient clinical detail and provider rationale to validate BMI as a clinically relevant secondary diagnosis warranting increased facility DRG reimbursement for the additional services provided. They stated the diagnosis directly affected management of primary and secondary risk factors for stroke including diabetes, use of CPAP for sleep apnea, and management of hypertension.

Sound **Denials?** **Appealing?**

We can **Manage** that!

For more information reach out to your **MARSI** point of contact or **MARSI Denial Management**

Sources:

1. Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2018, pg 77 - Body Mass Index
2. https://www.cdc.gov/obesity/basics/consequences.html

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## DEMYELINATING DISEASES/DISORDERS (CONTINUED FROM ISSUE 25)

## MYASTHENIA GRAVIS

*Author: Amanda Warren, CPC, CRC*

### CODING

Myasthenia Gravis in ICD-10 indexes Myasthenia, Gravis G70.00 (with exacerbation, in crisis G70.01) in Chapter 6 Diseases of Nervous System.

HCC (Hierarchical Condition Category) 75

G70.0 Myasthenia gravis
- G70.00 Myasthenia gravis without (acute) exacerbation[75]
  - Myasthenia gravis NOS
- G70.00 Myasthenia gravis with (acute) exacerbation[75]

**Myasthenia Gravis** (MG) is an autoimmune disease. The body attacks muscular membrane receptors in the central and peripheral nervous system called postsynaptic acetylcholine receptors(AChR)[2]

### CAUSES

Disorders of the *Thymus* and other autoimmune disorders like *Systemic Lupus Erythematosus*, and *Autoimmune Hyperthyroidism* are believed to contribute to the development of the antibodies.[3]

Certain infections can lead to crisis or exacerbation.

### SYMPTOMS

* Myasthenia Gravis affects voluntary muscles
* Double vision and drooping of eyelid
* Choking and struggling with swallowing
* Respiratory/labored breathing (can lead to crisis)

### CLINICAL TYPES

* Ocular-only the extraocular muscles are affected
* Generalized- muscles in various body systems especially respiratory
* Neonatal Myasthenia- IgG antibodies pass by placenta from mother to infant, resolves a few days after birth

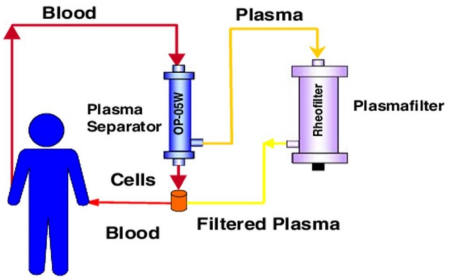
### DIAGNOSIS

* Detailed physical exam, noting symptoms such as drooping eyelids or muscle weakness
* Blood test for presence of antibodies
* Nerve testing Electromyography (EMG)
* Edrophonium test

*Symptoms are common in other diseases and misdiagnosis is common, as diagnosis is difficult and often delayed.*

### TREATMENT

* Drugs to suppress the immune system
* Anticholinesterase medication
* Plasmapheresis, plasma filtering process to remove antibody
* Intravenous Immunoglobulin (IVIg)




*Crisis or exacerbation are life threatening conditions requiring immediate intensive medical care. Presentation of quadriparesis and respiratory insufficiency rapidly progressing to respiratory failure.*

Sources:

1. https://www.webmd.com/brain/understanding-myasthenia-gravis-symptoms
2. https://www.ninds.nih.gov/myasthenia-gravis-fact-sheet
3. https://rarediseases.org/rare-diseases/myasthenia-gravis/
4. https://www.merckmanuals.com/professional/neurologic-disorders/peripheral-nervous-system-and-motor-unit-disorders/myasthenia-gravis
5. https://askhematologist.com/plasmapheresis/