Focus on Ophthalmology

Sue Vicchrilli, COT, OCS, Salt Lake City, Utah (left)
Kim Ross, CPC, OCS, Novato, Calif. (right)

Plus: Liver Transplants • Modifier 25 • 2009 OIG Hospital Plan • HIEs • Professional Tune-ups
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- Detailed Pre-/Intra-/Post-service information for understanding the correct application of CPT codes
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Members of the American Academy of Professional Coders (AAPC) shall be dedicated to providing the highest standard of professional coding and billing services to employers, clients, and patients. Professional and personal behavior of AAPC members must be exemplary.

- AAPC members shall maintain the highest standard of personal and professional conduct. Members shall respect the rights of patients, clients, employers, and all other colleagues.
- Members shall use only legal and ethical means in all professional dealings, and shall refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive, or illegal acts.
- Members shall respect and adhere to the laws and regulations of the land, and uphold the mission statement of the AAPC.
- Members shall pursue excellence through continuing education in all areas applicable to their profession.
- Members shall strive to maintain and enhance the dignity, status, competence, and standards of coding for professional services.
- Members shall not exploit professional relationships with patients, employees, clients, or employers for personal gain.

This code of ethical standards for members of the AAPC strives to promote and maintain the highest standard of professional service and conduct among its members. Adherence to these standards assures public confidence in the integrity and service of professional coders who are members of the AAPC.

Failure to adhere to these standards, as determined by AAPC, will result in the loss of credentials and membership with the American Academy of Professional Coders.
Choose CEUs to Stretch Skill Levels

In 2007, AAPC made it easier to report CEUs by requiring documentation every 24 months instead of every 12 months. We also doubled the number of free CEUs available to members.

In 2008, we made it easier to record CEUs by activating our online reporting system, CEU Tracker.

But to hear at least one vendor tell it, for 2009 we’ve made CEUs much harder to obtain: “Attention Certified Coders: CEU Rules get stricter in 2009. It won’t be as easy to earn CEUs for your CPC certification this year…” blazed across the bottom of some Coder’s Pink Sheets earlier this year.

The note caught us by surprise; but then we realized it is at least partly true. AAPC has modified its CEU policy a bit, and has implemented a mission statement for CEUs. This statement holds us to a standard that may, in fact, make it “harder” for some who haven’t focused on continuing education.

AAPC CEU Mission

All members and business associates of AAPC must “Uphold a Higher Standard” in education. AAPC certified coders must choose continuing education that stretches their skill levels. Vendors and local chapters must provide quality in curriculum. AAPC’s national office must develop a comprehensive list of CEU opportunities and provide vendors and local chapters with timely and consistent CEU approvals.

For members, this means opportunities to earn 5 CEUs in 60 minutes should be a thing of the past. Members instead “must stretch their skill levels” — meaning we must choose CEUs that truly enhance our professional knowledge and keep us up-to-date with changes in the medical marketplace. Plan ahead and expect to expend an hour for each CEU earned.

For vendors and local chapters, this means focusing on what to teach, building it, and then seeking CEUs is the new standard. Don’t begin a project by determining its CEU count. That’s the tail wagging the dog. If the education is there, the CEUs will be there, too. AAPC products must meet the same standards as our vendors’ products.

For AAPC’s CEU analysts, this means more scrutiny to ensure certified members are getting an hour’s worth of curriculum with each CEU granted. It also means analysts must be diligent so vendors receive quick responses and members have a wide variety of CEUs from which to choose. It’s a tough job, which is why AAPC’s vendor analysts are all certified coders.

CEUs awarded by AAPC analysts can be as little as 0.5 or as much as 40. The CEUs can be free to members or pricey. It’s important for members to seek out CEUs that match their needs and pocketbooks.

One of the best CEU values members will find in 2009 is the AAPC National Conference in Las Vegas, April 5-8. The curriculum has something for everyone; and this year, an eight-station anatomy lab staffed by physicians provides a unique, hands-on experience. Some of the best parts of the conference are not tied to CEUs: discussing specific coding issues, face-to-face encounters with expert faculty; networking with coders in your specialty from all over the country; and witnessing just how diverse and professional the many faces of AAPC are. We hope to see you at the Rio! ■

Sincerely,

Sheri Poe Bernard, CPC, CPC-H, CPC-P
Vice President of Clinical Coding Content
Are you where you want to be?
Make sure you have the right tools to reach your destination.
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Radiology | Cardiology | Radiation Oncology
Medical Oncology | E/M | And More!
Have you ever thought about how many people and resources it takes to build a bridge? There are more than half a million bridges in the United States today, and we rely on them to cross obstacles, such as rivers, oceans, railroad tracks, and canyons. When engineers design bridges, they consider many factors that influence the design. For example, the spanning distance and available materials must be considered before determining the size, shape, and appearance. A bridge is typically constructed with beams supported at the end by piers. The weight of the beams pushes straight down on the piers. The farther apart the piers, the weaker the beams become. It can take years to build a bridge strong enough to withstand the test of time.

Physicians and medical coders also need to build a bridge strong enough to last a lifetime. The spanning distance may seem great, but the only materials required are respect and understanding. These materials are the foundation for binding together solid teams, partnerships, and managing relationships.

**Bridge the Gap**

The first step in building a strong bridge is identifying areas of contention. Many people see things as right or wrong—they’re right and you’re wrong. When a situation is viewed through this lens, a power struggle ensues. When an opposing situation is seen as simply opinion and not fact, however, cooperation is possible. Identifying and understanding our differences allows for compromise and negotiation.

**A Team Approach**

The AAPC has concentrated efforts for the past couple of years on building a strong bridge between the professional coding community and medical societies. The Academy has reached out and supported numerous medical societies and in turn has obtained support from the provider community. The positive strides made over just the past few months have developed a team approach for specialty credentials and exams. Various specialty societies have partnered with AAPC to ensure our specialty credentials remain the gold standard for certification. Many organizations have specialty credentials, but AAPC has taken them a step further by making certain our specialty coders are the best in the industry.

Developing strong relationships with the medical societies has strengthened the bridge between physicians and other AAPC members and enabled the AAPC to reinvent specialty exams. Specialty committees were formed with members and society experts to develop specialty examinations that incorporate real-world cases. This takes our organization and credentials to the next level of expertise. By certifying multi-specialty coders, the new credentials give other specialty coders skill validation. This does not devalue the core CPC® credential—it strengthens it.

Not only will our specialty credentials become an industry force, but the AAPC and specialty societies’ collaboration will achieve a level of mutual respect that fosters education and sharing. This affords us the opportunity to learn from physicians and their societies. We can provide physicians with a path to follow that partners with and employs qualified certified coders working together to make the health care industry stronger. Keeping good relationships intact will position the AAPC for future success. Remember that when our organization wins, we all win. Lend a hand in building the bridge. We can assist and encourage health care industry professionals to get involved and form partnerships to build a strong and long-lasting bridge.

“Teamwork is the ability to work together toward a common vision. The ability to direct individual accomplishments toward organizational objectives. It is the fuel that allows common people to attain uncommon results.” *Andrew Carnegie*

Until next month… ■
Over the past year, we have been asking you to get to know us by a new name, Contexo Media. Our customers and students have relied on us for over 20 years to provide elegant solutions for coding, reimbursement and compliance. While our name has changed, we haven’t changed our core belief that medical professionals need affordable and easy-to-use tools to do their jobs more effectively.

This year, we are building on our strong tradition by publishing several best-in-class tools for coding reference, including the all-new 2009 Procedural Coding Professional. We are also committed to delivering our unique blend of tools and training through new technology, including E-learning, webinars, and other distance learning platforms. This will allow us to deliver more timely and relevant information than ever before.

Plus, we will continue to partner with the American Medical Association to bring you the hugely popular regional CPT® Changes seminars.

Our books, software and online education offerings are all designed with input from medical professionals from across the nation, and offer a trustworthy, independent source of information and insight. This helps us ensure our products meet vigorous expectations – yours.
Spring time is upon us. After such a cold winter with more rain and snow than we care to remember, it’s time to look at the new beginnings, new codes, new ways to keep ourselves educated, and our local chapters in a new light.

Many of us are so busy coding and billing, educating on coding, and working full time we forget one of the best resources for this is our local chapters. Our local chapters can provide the professional tune-up we need to remind us why we love what we do. Local chapter meetings can involve education, networking, and an opportunity to make great new friends. It can be a place to network, to find employment opportunities, and to share experiences in your specialty with fellow coders. For most of us, our families aren’t excited to hear about how something is coded or about a success story in coding education when we get home from work or a seminar. When we attend local chapter meetings, we can share these stories, ask for expertise on other specialties, or offer expertise to fellow local chapter members. This can turn into a great networking forum and also a great education session.

As many of us plan for our personal tune-up—for example, going to a movie, attending a church service, having dinner with friends, or traveling on vacation—we forget that we should also treat ourselves to professional tune-ups. Reflect on how contributing to the AAPC and what attending a local chapter meeting can mean for you personally and professionally.

Attending a local chapter meeting can be the most rewarding and affordable way to listen to quality speakers and receive CEUs at a minimal cost. Networking opportunities are in abundance. The best way to talk about coding solutions, to look for CPCs to hire, to obtain those last few CEUs, and to learn of code changes in a timely fashion is to attend your next local chapter meeting.

**For most of us, our families aren’t excited to hear about how something is coded or about a success story in coding education when we get home from work or a seminar. When we attend local chapter meetings, we can share these stories, ask for expertise on other specialties, or offer expertise to fellow local chapter members.**

**AAPCCA Gears Up for Vegas**

Next month we are gearing up for the National Conference in Las Vegas, and the AAPCCA is very excited. We currently have 16 members on our board who have served you and your local chapters diligently over the past two years. As in the last two national conferences, the AAPCCA will be very visible. We will attend Sunday’s local chapter events, as well as the “Get to Know Your Local Chapter” booths.

**Changing of the Guard**

On a sad note, we have eight current AAPCCA members who will be rotating off the board come conference. We appreciate their hard work and time put into our board over the past two years. The good news is that we have eight new members rotating on the board. On behalf of the entire Board of Directors, we could not be more excited about our local chapters’ future and how the new board will continue to assist them in their success. We will be wearing our purple AAPCCA board of directors’ shirts at conference. Please make sure you stop one of us and say “Hi!” We may have a treat for you!

I want to take this opportunity to thank all of the local chapters and local chapter officers who email us personally to let us know you appreciate what we are doing for our local chapters. We thank you for your hard work and effort to make local chapters a success. See you in Vegas!

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Need a Professional Tune-up?
Local chapters provide resources for jump-starting your career.

By Terry A. Fletcher, CPC, CCC, CEMS, CCS-P, CCS, CMSCS, CMC

Terry A. Fletcher, AAPCCA Executive Chair, CPC, CCC, CEMS, CCS, CCS-P, CMSCS, CMC

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www.aapc.com March 2009 9
Letters to the Editor

One Digit Makes a Difference

Dear Coding Edge,

In the January 2009 issue of Coding Edge, I noticed an incorrect code in the article “Road Map to ICD-10-CM.” It is on page 23 at the top-left for History of tobacco use. For the ICD-9-CM code, the article has V15.52, but the code should be V15.82.

Thanks,

Kathy Giem, CPC, CASCC
Grand Valley Surgical Center

Dear Kathy,

Thanks for catching our typo. It’s nice to know nothing gets past a coding professional’s radar.

Sincerely,

Coding Edge

Do Not Report Surgical Aftercare with an Acute Injury Code

Dear Coding Edge,

I have a comment regarding the article “Reporting the Surgical Relay” in the January issue (pages 26-27) with respect to the use of modifiers 54, 55, and 56. Under the sub-heading Consider Low-Level E/M, the author states that as an alternative to modifier 55 Postoperative management only, an office could use procedure code 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family. For the primary diagnosis, use V58.3x Encounter for other and unspecified procedures and aftercare; attention to surgical dressings and sutures, with a secondary diagnosis of 884.0 Multiple and unspecified open wound of upper limb, without mention of complication.

Code 884.0 is not appropriate for this scenario as this is no longer an open wound, and the correct coding guidelines specify that after the wound has been treated/healed, we do not report the surgical aftercare with an acute injury code. The correct way to report suture removal would be with V58.43 Aftercare following surgery for injury and trauma and V58.32 Encounter for removal of sutures.

Thank you,

Debra A. Mitchell, MSPH, CPC-H

Dear Debra,

You’re right. The better code choice would be V58.43, along with the V code for suture removal (V58.32).

Many thanks for your help with this!

Coding Edge
CCI Edits V.14.3 Exclude New Drug Admin Codes

In case you haven’t noticed, the National Correct Coding Initiatives (CCI) edits, Version 14.3, effective Jan. 1 through March 30, includes the 2008 CPT® codes for drug administration, not the 2009 CPT® codes. Hospital CCI edits lag one quarter behind physician CCI edits. The new CPT® codes for drug administration services won’t be available in CCI edits until Version 15.0, which will be released April 1.

To ensure reliable claims submission, carefully review 2009 first quarter Medicare outpatient claims containing drug administration codes for any bundling policies that apply but aren’t included in the CCI edits.

New Nuclear Medicine Category II Codes

New for 2009, nuclear medicine professionals have nuclear medicine specific Category II codes available; however, you won’t find these codes listed in the 2009 CPT® book. The following quality measures became effective Oct. 1, 2008.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Long Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3570F</td>
<td>Patient considered to be potentially at risk for fracture in a weight-bearing site (NUC_MED)</td>
</tr>
<tr>
<td>3572F</td>
<td>Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (eg, X-ray, MRI, CT) corresponding to the same anatomical region in question (NUC_MED)</td>
</tr>
<tr>
<td>3573F</td>
<td>Patient not considered to be potentially at risk for fracture in a weight-bearing site (NUC_MED)</td>
</tr>
</tbody>
</table>

Insurers Overcharge Beneficiaries Billions for Drugs

Since the Medicare Part D prescription program began in 2006, private health insurers with plans under the Medicare prescription drug benefit have overcharged beneficiaries and the program by billions of dollars. Because of required audit failure, according to a Department of Health and Human Services (HHS) Office of Inspector General (OIG) report, the Centers for Medicare & Medicaid Services (CMS) will not know the total impact. In 2006, 80 percent of health insurers with Medicare prescription drug benefit operating plans overcharged the program by about $4.4 billion. The report found CMS should have conducted 165 audits for 2006, instead it has begun seven as of April 2007 and CMS probably won’t address the 2006 audit problems before 2010. ☐
St. Patrick’s Day became a custom in America in 1737, the first year that St. Patrick’s Day was publically celebrated in Boston. Today, people celebrate the day watching parades, wearing green clothes, and drinking beer. Drinking beer or any alcoholic beverage in moderation is acceptable to most, but for others it is an addiction that, over time, can result in severe liver disease, most notably cirrhosis. Even for people who stop drinking alcohol, the effects are still evident in the body many years later.

Alcoholic cirrhosis is the most serious type of alcohol-induced liver disease. Cirrhosis is the replacement of normal liver tissue with scar tissue. According to the American Liver Foundation, www.liverfoundation.org, between 10 and 20 percent of heavy drinkers develop cirrhosis, usually after 10 or more years of drinking. The damage from cirrhosis is not reversible, and it is a life-threatening disease. The risk is particularly high for people who drink heavily and have another chronic liver disease, such as viral hepatitis C.

Liver transplantation is a common treatment for patients with alcoholic liver disease diagnoses in North America and Europe. The criterion for selecting a patient for liver transplantation with alcoholic cirrhosis is the patient must abstain from alcohol for six months. This has been referred to as the six month rule, and is used to predict future abstinence. An optimistic view about the salutary effects of transplantation on alcoholic relapse came from Thomas Starzl, who coined the aphorism, “liver transplantation was the ultimate sobering experience.”

All prospective liver recipients have the same consultation process and multi-disciplinary team conferences regardless of the patient’s diagnosis. As a transplant coder, the initial patient consultation is the first coding assignment. After the patient is placed on the transplant list with the United Network for Organ Sharing (UNOS), the search and the wait begins to find an appropriate donor organ for the recipient.

**The Procurement Process**

The organ placement process is outlined on the UNOS Web site (www.unos.org) as a complex organ matching process for potential recipients based on ranking, policy criteria, and organ offers. Calls are made in succession to multiple recipients transplant centers to expedite the placement process. When the organ is accepted for a recipient, the donor is taken to the operating room (OR) for organ harvest.

The procedure begins with donor brain death declaration, which is noted in the chart along with consent from an appropriate family member. The Ingenix Coders’ Desk Reference for Procedures 2009 outlines the procurement process with code 47133 Donor hepatectomy (including cold preservation), from cadaver donor as:

The physician performs a donor hepatectomy by removing the liver from a cadaver donor for transplantation into another recipient. The physician accesses the liver, which is mobilized from its attachments. The blood supply and bile ducts to the liver are dissected free and isolated. The liver is removed with its attached blood vessels and bile ducts and perfused with a cold preservation solution and removed from the operative field. The liver is preserved for transplantation into the recipient. The organ remains under refrigeration, specially packed in a sealable container with some preserving solution and kept on ice in a suitable carrier.

This code includes the graft, harvesting, and the cold preservation. When billing for the procurement, most guidelines state that documentation must include what

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**CODE FOR SUCCESS**

When a Damaged Liver Needs Transplantation

By Shelly Bauguss, CPC, CGSC, CANPC, CGIC
type of organ preservation solution was used, e.g. custodial histidine-tryptophan-ketoglutarate (HTK). After the organ is procured, it is sent to the recipient’s surgical facility for the transplant.

Transplantation Process

The recipient’s transplantation process begins after the organ is accepted from the transplant center. The patient is brought to the OR and all standard practices of prepping, draping, and placing lines are performed.

The liver graft is brought to the operating room and the backbench procedures begin. The CPT® manual has six standard backbench codes for this portion of the transplantation process. These codes are:

47140 Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)

47141 Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV)

47142 Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)

47143 Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe split

47144 Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into two partial liver grafts (ie, left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII)).

47145 Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into two partial liver grafts (ie, left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII)).

The main differences in these codes are whether the liver graft was obtained from a living or cadaver donor, and if the liver is split or not. It is important to make sure that the physician’s documentation indicates what form of backbench was performed. There are two backbench reconstruction codes to use when the liver graft requires venous or arterial reconstruction. Previously procured iliac veins from the donor are anastomosed to the veins or arteries of the donor liver graft. These codes are:

47146 Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each

47147 Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each

Use these codes for each anastomosis performed during donor vessel reconstruction.

Aortic conduit creation is another reconstruction that can be performed and is used for extremely complex cases where the recipient’s vascular anatomy would not support liver graft placement or if the graft does not lend itself to standard transplantation placement. The procedure is performed by using the iliac artery procured from the donor, which consists of a common iliac artery, an external iliac artery, and an internal iliac artery. To join the vessels together to make the graft longer the physician uses anastomoses.

As a solution to this coding challenge it was determined in our facility that to bill appropriately for this procedure, the unlisted code 37799 Unlisted procedure, vascular surgery is reported and compared to the code 47147, and assigning one unit per anastomosis required to create the graft. The rationale for coding this way is because the procedure is performed on the backbench and separate from the donor graft itself, so the standard reconstruction codes do not apply for this procedure.

Prior to the donor graft placement, the recipient’s liver must be removed and the abdomen prepared for graft placement. In preparing the abdomen, a temporary portacaval shunt is performed by partially occluding the
vena cava and performing an end to side portacaval shunt using sutures. Even though this is a temporary shunt, the full procedure is performed per the CPT® definition of code 37140 Venous anastomosis, open; portocaval. It is billable in addition to the transplant codes themselves.

The standard liver transplantation codes are:

- **47135** Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
- **47136** Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age

Orthotopic is graft placement in the same anatomical location as the original organ. Heterotopic is graft placement in an abnormal anatomical location. Since it is most common for the liver graft to be placed in the normal anatomic location in the recipient, code 47135 is the most commonly used code. Due to the history of poor outcomes with heterotopic placement the practice has all but been abandoned. The transplant surgeon should indicate which type of transplant occurs, if the information is not clearly indicated in the documentation of the anatomic position the liver graft was placed, for example, in the abdomen or the pelvis, then clarification is needed from the surgeon. Codes 47135 and 47136 include the partial or whole recipient hepatectomy, partial or whole transplantation of the allograft and the recipient care.

**Additional Procedures**

During transplantation, additional procedures maybe performed. For example, a Roux-en-Y procedure may be performed due to anatomic variances in the graft, the recipient, or both. The procedure can be of the extrahepatic biliary ducts or of the intrahepatic biliary ducts. The CPT® codes available for these procedures are:

- **47780** Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract
- **47785** Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract

If an aortic conduit is created and placed in the patient (an additional procedure as well), this may be billed with the code 37799, depending on where the conduit was placed and what vessels were attached to the conduit. If there is, a code for the anastomosis performed with the conduit the code range will be 35631–35636 because the graft is created using arteries from the donor and not from the recipient.

These codes, in addition to the code 37140, would have a modifier 51 Multiple procedures added to indicate these are multiple procedures in addition to the base transplant codes depending on the payer. Most payers have software to recognize these instances automatically and would not require the coder to apply modifier 51.

**Immunosuppression Therapy**

After the procedure is complete, the patient will need to be monitored and immunosuppression therapeutic medications will be adjusted by the transplant surgeon throughout the patient’s stay. These subsequent hospital visits are billable per CMS guidelines as long as they are truly significantly, separately-identifiable from a standard postoperative visit and indicated by the use of modifier 24. To know if the visit would be billable under this guideline, for example, check if the documentation outlines the immunosuppression drugs used, any side-effects caused by the therapy, and/or if any modifications are required. The note should not include any references to wound checks or other standard post-operative care plans. For the best outcome, the coder might suggest using two notes, one for the immunosuppression and a separate note for the post-operative follow-up note.

**Liver Transplant Awareness**

There are currently 100,665 people on the waiting list for organ transplant; every 11 minutes a name is added to the national transplant waiting list. To learn more about organ donation or to sign up to become a donor please visit [www.donatelife.net](http://www.donatelife.net).

**Sources:**

- American Liver Foundation ([www.liverfoundation.org/education/info/alcohol/](http://www.liverfoundation.org/education/info/alcohol/))
- United Network for Organ Sharing ([http://unos.org/whatWeDo/organCenter.asp](http://unos.org/whatWeDo/organCenter.asp))
- Coders’ Desk Reference for Procedures; 2009; published by Ingenix

Special thanks for clinical assistance to: William Chapman, MD, professor of surgery in the Division of General Surgery, and chief of the Abdominal Transplantation Section for Washington University Medical School in St. Louis, Mo. and also to Christopher Anderson, MD, assistant professor of the Surgery Division of General Surgery Section of Transplant Surgery for Washington University Medical School in St. Louis, Mo.
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Health Information Exchanges (HIEs)—and their larger counterparts, regional health information organizations (RHIOs)—allow payer, provider, and patient to retrieve, view, and enter information on conditions, encounters, payments, etc. This vital data exchange with increased security and robust viability is a health IT dream.

HIEs are focused on building and maintaining electronic information architecture. The design of these electronic record “warehouses” allows users (patients) and participants (hospitals, providers, and payers) various access and control over patient medical record content.

Immediate Access
An insurance company must request copies of a medical record when reviewing treatment necessity. Very soon, access to that same record may be available as soon as the provider completes, enters, and authenticates the note. If this same visit requires consultation elsewhere, little or no paperwork would be required for the consultant to access a comprehensive patient history.

For patients, transferring records easily, maintaining a personal health transcript, and granting access improves the customer service experience. For providers and hospitals, HIEs solve workflow and broken information trail problems; clinical benefits result from care delivery and continuity. Payers must find opportunities to connect fragmented patient data and draw upon a full range of clinical opinions.

The revenue cycle also gains from HIE’s mediation of health data needs by driving down the moving information costs between one another, permitting quicker turnaround times with denial management, claims submission, and payment. Automation allows re-routing staff time from return on investment (ROI) and claims submission to other areas in the revenue cycle. HIEs empower patients to readily participate in the revenue cycle process and encourage practices to excel in collection efforts.

Opportunities Abound
In the framework of HIEs, coders will likely see duties take place in real time. Revenue cycle functions will move forward, making us pioneers in this process. In that leadership role, coders become responsible for developing HIEs’ usefulness in mining data and querying for information in that network system. This role will encourage coders to become data quality experts for their employers. Others’ roles, including QA management, and quality control, will emerge.

Ideally, HIEs would permit end users to tap into embedded knowledge resources and share clinical, coding, and billing related tools, information, and products. This host of information would improve daily coding processes and allow smaller practices to access resources that might otherwise be off limits due to expense.

Staff in coding areas, especially, will become experts on key points of the HIE adoption. Foremost, our understanding of sharing information related to billing will give us a strong foothold over the HIE. Our current understanding of medical records easily translates into working the HIE as a research tool for the practice—not only on coding-related issues, but in sharing patient data or information within our organizations. Coders should also have a keen understanding of HIE privacy and security issues in the ever-changing health care business.

HIEs also promise to make strides in the accuracy of diagnostic coding for provider-based services. With clinical laboratory results and documentation available shortly after completion of a test, coders may be able to...
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Kevin Shields is HIMS supervisor at the VA Medical Center in Louisville, Ky. and a member of the Ingenix Coding & Referential Advisory Board Network and the AHIMA Action Community for e-HIM Excellence (ACE). He has also participated in stakeholder focus groups for a local HIE and is studying health information technology at Weber State University. Kevin may be reached at kevbshields@yahoo.com.
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Correctly Code Patient Counseling

Use sign, symptom, or condition to prevent confusion with Preventive Medicine Counseling codes (99401-99404).

A patient’s status—new, established, or consultation—isn’t the only element you should consider when coding an evaluation and management (E/M) office or other outpatient service. You also need to match the usual time associated with the E/M codes with the documented time spent counseling the patient for her sign, symptom, or condition.

The usual time associated with E/M office or other outpatient clinic visit codes are shown in Table A.

**Table A.** When choosing an E/M code, consider the time element in addition to the patient’s status.

<table>
<thead>
<tr>
<th>New Patients</th>
<th>Established Patients</th>
<th>Consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201–10 minutes</td>
<td>99211–5 minutes</td>
<td>99241–15 minutes</td>
</tr>
<tr>
<td>99202–20 minutes</td>
<td>99212–10 minutes</td>
<td>99242–30 minutes</td>
</tr>
<tr>
<td>99203–30 minutes</td>
<td>99213–15 minutes</td>
<td>99243–40 minutes</td>
</tr>
<tr>
<td>99204–45 minutes</td>
<td>99214–25 minutes</td>
<td>99244–60 minutes</td>
</tr>
<tr>
<td>99205–60 minutes</td>
<td>99215–40 minutes</td>
<td>99245–80 minutes</td>
</tr>
</tbody>
</table>

**CPT® 2009** states, “When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** may be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.”

For example, Monday, an established patient with diabetes Type 2 (ICD-9-CM: 250.00 Diabetes mellitus without mention of complication; type II or unspecified type, not stated as uncontrolled) presents for a follow-up visit. The provider performs and documents a detailed history, detailed exam and moderate medical decision-making (MDM).

Using history, exam and MDM as the key components, the CPT® code selection should be 99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

As part of the MDM, the provider instructs the patient to go to the lab for an A1C, CPT® 83036 Hemoglobin; glycosylated (A1C) blood (except reagent strip). The patient complies and goes to the lab on Wednesday for the blood work. When the results come back, the provider reviews the results and schedules a face-to-face visit with the patient to discuss the results and to set a course of action for treating the patient’s medical condition.

**Note:** Lab results and counseling via phone does not constitute the use of telephone E/M codes because the phone call is the result of a sign, symptom, or condition addressed within the last seven days of an E/M visit.

Friday, the established patient returns. Because the patient was just seen Monday, only a problem focused history, problem focused exam, and moderate MDM are performed and documented. In the progress note’s documentation, the provider states, “Spent approximately 25 minutes, of which 50 percent of the time was spent counseling (describe the counseling or coordination of care) the patient on the risks of diabetes, how to eat healthy, the use of home glucose testing, how to begin or expand on a exercise regiment, and prescription drug management if needed, etc.”

Using history, exam and MDM as the key components for this E/M visit, the CPT® code selection should be 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

If you use time (25 minutes) as the key controlling factor for this E/M visit, however, your code selection could be 99214 for this visit as well.
Five steps is all you need for modifier 25 claim success.

*Misuse of modifier 25* Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service is among the most common coding mistakes, costing medical practices millions each year in missed reimbursement opportunities and costing insurers millions each year in improper payments. You can improve your chances for modifier 25 success if your claims meet the following five criteria.

1. **The physician must provide an evaluation and management (E/M) service and a separate procedure or service for the same patient on the same day.**

Do not apply modifier 25 if the physician performs an E/M service only.

For example, a neurologist examines a patient experiencing upper-extremity weakness and pain. After a thorough examination, the physician schedules the patient for a diagnostic electromyography (EMG) exam to follow several days later.

In this case, you would report an appropriate outpatient E/M code, such as 99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family, depending on the documented service level.

Because the neurologist provided only the E/M service on the initial service date, modifier 25 is not appropriate.

For electrodiagnostic testing on a later service date, you would report the appropriate EMG code, such as 95861 Needle electromyography; two extremities with or without related paraspinal areas. Unless the patient experiences a significant worsening of symptoms or a new complaint requiring a separate evaluation, you would not report another E/M service for this later encounter.

Note that all physicians who bill under the same National Provider Number (NPI) (such as physicians sharing an NPI in group practice) are considered, from a coding perspective, the same provider.

2. **The same-day E/M service must be significant and separately identifiable.**

According to CPT® and the Centers for Medicare & Medicaid Services (CMS) guidelines, all procedures and services—no matter how minor—include an inherent E/M component. Any E/M service you report separately must exceed the minimal evaluation that normally accompanies any other same day service(s) or procedure(s).

CMS Transmittal 954 (Medlearn Matters MM5025, Change Request 5025, May 19, 2006) states specifically you should apply modifier 25 only for “a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work for the service.”

A significant, separately identifiable E/M service might occur on the same day as another procedure or service when:

1. The provider sees a new patient, or
2. The provider sees an established patient with a new complaint or a change in status.

In either case, a separate E/M service is essential to determine the need for any same-day procedure(s) or service(s) that follow.

For example, an orthopedist sees a new patient for knee pain evaluation. The orthopedist diagnoses the patient with osteoarthritis of the knee and discusses options for management, then injects a steroid such as Depo-Medrol (J1020 Injection, methylprednisolone acetate, 20 mg or J1030 Injection, methylprednisolone acetate, 40 mg) to provide patient relief.
Physicians can help highlight a separate E/M service by separating the E/M service documentation from any other same-day procedure(s) or service(s) documentation. That is, the provider should document the history, exam, and MDM in the patient’s chart, and record the procedure notes on a different sheet attached to the chart or in a different section within the electronic medical record.

You may report both the aspiration and the same-day E/M in this case using 90772 Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular and 99201-99205, as appropriate to the documented E/M service level, with modifier 25 appended. You may also report the drug supply. Only after completing an E/M service would the surgeon make a decision to perform an additional procedure (the injection).

In a second example, a consult patient visits a cardiologist complaining of palpitations (785.1 Symptoms involving cardiovascular system; palpitations) and light-headedness (780.4 General symptoms; dizziness and giddiness). The physician performs a complete cardiac workup (for example, 99243 Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family) and orders a same-day, in-office echocardiogram.

You may report both the echocardiogram and the same-day E/M in this case, using 93307 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete and 99243-25. You might also report additional codes, such as +93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete (list separately in addition to codes for echocardiographic imaging) or +93325 Doppler echocardiography color flow velocity mapping (list separately in addition to codes for echocardiography), depending on the equipment and the images the physician obtained. Only after completing an E/M service would the physician make a decision to perform additional procedures (in this case, the echocardiography).

If the provider sees the patient for a previously-scheduled procedure or service, you would not normally report a separate, same-day E/M service. “Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed,” confirms the Medicare Claims Processing Manual (Chapter 12, Section 40.1).

In our first example, the orthopedist would not claim an E/M service on the same day as the previously-scheduled injection. Remember: The physician has already evaluated the patient for the same problem during the earlier E/M visit. The orthopedist may provide a cursory exam immediately prior to the injection, but such an evaluation is neither significant nor separately identifiable. Rather, it is an inherent component of the injection itself.

Even if the physician provides an assessment and plan, you probably should not report a separate E/M service unless the patient has a new, unrelated complaint, or has experienced a worsening of symptoms that prompt a new history, exam, and medical decision-making (MDM).

Documentation should support unambiguously any separately-reported E/M service. Explanatory text for modifier 25 in the CPT® manual stresses “a significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service” you choose to report. CMS rules also stress that the provider must “appropriately and sufficiently” document medical necessity for both the E/M service and the other service or procedure. Although you don’t need to submit this documentation with the claim, it must be available upon payer request.

Physicians can help highlight a separate E/M service by separating the E/M service documentation from any other same-day procedure(s) or service(s) documentation. That is, the provider should document the history, exam, and MDM in the patient’s chart, and record the procedure notes on a different sheet attached to the chart or in a different section within the electronic medical record. This demonstrates to the payer and the coding staff the distinct nature of the E/M service.

At a minimum, providers should document same-day E/M services as well as if they had not provided any other procedure(s) or service(s).

3. The E/M service doesn’t take place during a global period.

All related, follow-up examinations by the same physician during a previous procedure’s global period—such as those to evaluate the patient’s recovery—are included in the global surgical package of the previous procedure.
For an unrelated E/M service during a previous procedure’s global period, you may report an appropriate E/M code with modifier 24 Unrelated evaluation and management service by the same physician during a postoperative period appended. This would require that the E/M service is for a new problem not connected to the patient’s previous complaint or procedure.

4. The same-day procedure(s) or service(s) does not have a 90-day global period.

You should append modifier 57 Decision for surgery—not modifier 25—to a separately identifiable E/M service occurring on the same day, or on the day before a major surgical procedure, and resulting in the physician’s decision to perform the surgery, according to the Medicare Claims Processing Manual, section 40.2.

A major surgical procedure is any procedure or service with a 90-day global period. Note that the global period for a major surgical procedure begins one day prior to the actual procedure.

For example, a neurosurgeon in the ED examines a patient with a closed-in head injury due to a fall. Upon full evaluation, the surgeon admits the patient and immediately operates to evacuate a subdural hematoma (61108 Twist drill hole for subdural or ventricular puncture; for evacuation and/or drainage of subdural hematoma).

In this case, you should report both the surgical procedure (61108) and the examination that led to the decision to perform the surgery (such as 99284, Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.).

Because the evacuation is a major procedure (it has a 90-day global period), you should append modifier 57 to 61108. The available documentation should note specifically that the E/M service resulted in the decision for surgery.

You can find global periods for all CPT® procedure codes by consulting Medicare’s Physician Fee Schedule relative value file (MPFS RVU), which you may download from the CMS Web site at www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage. Be sure to select the most recent file for download as it is updated quarterly.

To determine the global period for a particular procedure, simply look to the fee schedule’s “GLOB DAYS” column. You will find several categories, including 000 (zero), 010, 090, XXX, ZZZ, YYY, and MMM (for maternity codes).

Note that carriers may classify as “major” some procedures with a “YYY” global period. Check with your carrier before reporting an E/M service modifier with these procedures.

5. Provide a diagnosis for the E/M

You do not need a separate diagnosis to justify a same-day E/M service with modifier 25. CPT® specifically states, “The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.” CMS guidelines, as articulated by Transmittal 954, uphold this instruction.

For example, a new consult patient visits a general surgeon with a complaint of intense heartburn and abdominal pain. The surgeon takes a complete history and performs an extensive exam. She then performs diagnostic endoscopy to check for reflux disease.

In this case, you will report the endoscopy with 43200 Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure). Separate documentation will also support a level-three outpatient consult, with modifier 25 appended (99243-25).

You should link the signs and symptoms that prompted the exam (787.1 Heartburn and 789.00 Abdominal pain; unspecified site) to the E/M code. You can link the same signs-and-symptoms diagnoses to the endoscopy. Or, if the surgeon finds verifiable evidence of reflux disease (530.xx), you would report that diagnosis as primary.

If you can cite a different diagnosis for the E/M service, such as when a patient arrives for a scheduled procedure but the physician must provide E/M for a new, unrelated problem, be sure to link a separate diagnosis to the E/M service, to show it is an independent service.

G. John Verhovshek, MA, CPC, is AAPC’s director of clinical coding communications.
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Focus on Ophthalmology Coding

From A-scans to YAG.

By Kim Ross, CPC, OCS, and Sue Vicchrilli, COT, OCS

Remember the pirate’s often-lost wooden eye in “Pirates of the Caribbean?” Or Tom Cruise’s eye transplant in “Minority Report?” Movies showing eye injuries intrigue us. Although it is a challenge to code these incidents, an even greater challenge is correctly coding the ophthalmic procedures we see daily. Our focus is to highlight key points in coding the services most frequently performed in ophthalmology.

A-scan Ultrasound for Intraocular Lens Calculations

CPT® codes 76519 Ophthalmic biometry by ultrasound echography A-scan; with intraocular lens power calculation and CPT® code 92136 Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation

Report this code for use of the IOL Master, which allow measurements of eye length and surface curvature, necessary for cataract surgery.

Medicare rules differ from non-Medicare payers. For Medicare, these codes have one global technical component (modifier TC) and a professional component (modifier 26) for each eye. Because non-Medicare payers typically do not recognize these modifiers, only the RT Right side or LT Left side modifiers should be appended to 76519 or 92136.

Argon Laser Trabeculoplasty (ALT)

CPT® code 65855 Trabeculoplasty by laser surgery, 1 or more sessions (defined treatment series).

Medicare has assigned a 10-day global period to this code selective laser trabeculoplasty (SLT). This means that when a separately identifiable exam is performed the same day, modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service should be appended to the appropriate level of exam. Because some non-Medicare payers recognize a 90-day global period for 65855, modifier 57 Decision for surgery should be appended to the evaluation and management (E/M) code describing the exam that determines the need for surgery when the laser is performed on the same day. Beginning January 2008, this procedure became payable in an ambulatory surgical center (ASC).

Benign Skin Lesions

Medicare and non-Medicare payers will cover benign skin lesion removal with appropriate documentation. The chief complaint should contain words such as red, increasing in size, oozing, and/or itching. A photo for documentation purposes is helpful. As with any procedure that may be considered cosmetic, it is best to obtain an Advance Beneficiary Notice (ABN) from the patient. Append modifier GA
Waiver of liability statement on file to the claim indicating an ABN is on file.

**Blepharoplasty**

CPT® code 15822 *Blepharoplasty, upper eyelid* and
CPT® code 15823 *Blepharoplasty, upper eyelid, with excessive skin weighting down lid*

Most Medicare payers have a Local Coverage Determination (LCD) indicating specific preoperative documentation requirements to distinguish cosmetic vs. functional blepharoplasty. CPT® code 15822 is typically considered cosmetic. By appending modifier GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit, offices indicate as such.

CPT® code 15823 is typically submitted for functional claims. One key component often missing in chart documentation for functional claims is the lack of a visual complaint from the patient. Too often the chart might state, “Patient complains of excessive baggy upper lid skin,” which does not provide medical justification for a functional claim.

**Cataract Extraction**

CPT® code 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)*

Extracapsular cataract removal is the number one procedure performed in ASCs. Contrary to what many physicians and coders think, there isn’t a national policy with a visual acuity requirement. Coverage varies by payer. The best documentation indicates the impact the reduced vision has on the patient’s daily living activities.

**Complex Cataract Extraction**

CPT® code 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage*

It’s important to note that this CPT® code is not for:

- Complications that occur during surgery
- Vitrectomy performed at the time of surgery
- Piggyback or multi-focal IOLs
- Specific viscoelastic like Healon 5 or Healon GV
- Complex cases that take longer than usual
- Diagnosis of floppy iris syndrome or use of Sugarcaine intraoperatively
- Extraordinary services performed in routine cataract surgery

**Fluorescein Angiography**

CPT® code 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report*

This test has unilateral payment, which means 100 percent of the allowable fee is payable per eye when medically indicated. It is inappropriate to submit a claim for the eye that does not have pathology. Claims may be submitted as a single line item (eg, 92235-50) or a two-line item with the RT and LT modifiers (eg, 92235-RT, 92235-LT), depending on payer preference. Cost of the dye is not separately payable.

**Fundus Photography**

CPT® code 92250 *Fundus photography with interpretation and report*

Cost of the dye is not separately payable.
Foreign Body
CPT® code 65222 Removal of foreign body, external eye; corneal, with slit lamp
This code has a zero-day global period, which means when the physician sees the patient a few days later, it is a billable exam. The procedure is payable per eye, not per foreign body. And in the event a rust ring develops, 65222 is the appropriate code to use again.

Keratoplasty
Since Jan. 1, there are four options for transplanted cornea. A ▲ indicates a change in the CPT® description. A ● indicates a new CPT® code. The following new procedures have already received ASC approval:
▲ 65710 Keratoplasty (corneal transplant); anterior lamellar
▲ 65730 Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)
65750 Keratoplasty (corneal transplant); penetrating (in aphakia)

Lacrimial Punctal Plugs
CPT® code 68761 Closure of the lacrimal punctum; by plug, each
This is the only lacrimal procedure where payment is per puncta, not per eye. The code is the same whether using temporary (collagen) or permanent (silicone) plugs. Typically, it is not necessary to distinguish the difference to the payer. In 2002, Medicare bundled the supply of the plug(s) with the insertion. Non-Medicare payers may pay separately for the supply of the plug with HCPCS Level II codes A4262 Temporary, absorbable lacrimal duct implant, each for collagen, A4263 Permanent, long term, non-dissolvable lacrimal duct implant, each for silicone, or CPT® code 99070 Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (List drugs, trays, supplies, or materials provided).

Patient complaint should document dryness, burning, itching, excessive tears, and/or photophobia. Documentation should indicate other methods of treatment have been tried and proven unsuccessful before plug insertion. This could include artificial tears, ointments, humidifier, etc.

Optic Nerve Scan
CPT® code 92135 Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral
In 2006, this service was billed more than five million times to Medicare. One hundred percent of the allowable is paid per eye when medical necessity exists. Contact your intermediary to confirm medical necessity.

Ophthalmoscopy
CPT® codes 92225 Ophthalmoscopy, extended with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial and 92226 Ophthalmoscopy, extended with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent
As with other procedures that have unilateral payment, 100 percent of the allowable is paid per eye
when medical necessity exists. Payment is for the detailed drawing, not for viewing. The drawing should be detailed, but payers no longer require a colored drawing.

**Pachymetry**

CPT® code 76514 Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)

Payment for 76514 is the same whether testing one or both eyes. This procedure is covered by Medicare as a one-time basis for glaucoma usually, but also as indicated in the progression of corneal disease.

**Pterygium**

CPT® codes 65420 Excision or transposition of pterygium; without graft and 65426 Excision or transposition of pterygium; with graft

No matter the source of the graft, it is bundled with the surgical code (65426). Amniotic membrane transplant is not separately billable per CCI.

**Suture Removal**

CPT® codes 15850 Removal of sutures under anesthesia (other than local), same surgeon and 15851 Removal of sutures under anesthesia (other than local), other surgeon.

Aside from these two codes, suture removal is never separately payable. It is part of the global surgical fee or any E/M or eye code billed if you were not the surgeon or if the patient is out of the global period. Never report suture removal as a corneal foreign body. Laser suture lysis is considered suture removal. It is inappropriate to code 66250 Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure for this service.

**Topography**

CPT® code 92025 Computerized corneal topography, unilateral or bilateral, with interpretation and report

This was a new code in 2007. Payment is the same whether one or both eyes are tested. Do not report 92025 with any corneal transplant code after the decision for surgery has been made, and until the end of the global period. This helps to maintain the value of the surgical code.

**Visual Fields**

CPT® code 92081 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent), 92082 Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33), and 92083 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2).

Payment for these codes is the same whether one or both eyes are tested. CPT® code 92081 or 92082 is appropriate for documentation prior to blepharoplasty.

**YAG Laser Capsulotomy**

CPT® code 66821 Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)

Typical LCD indicates documentation should reflect:

- Vision loss due to decreased light transmission (visual acuity of 20/30 or worse after other acuity loss causes have been ruled out).
- Increased glare. Test results must show decrease in two lines of visual acuity in glare tester.
- Indication of the impact the reduced vision has on the patient’s daily activities.

Medicare payers do not expect to see this procedure performed regularly within the cataract global period, and may request documentation.

---

Sue Vicchrilli, COT, OCS, is an American Academy of Ophthalmology coding executive. Sue’s 26-year ophthalmic background includes all aspects of coding, reimbursement, practice management, and clinic and surgical assistance. Sue is the Academy’s coding executive, the author of EyeNet’s Savvy Coder, AAOE’s Coding Bulletin, the Ophthalmic Coding Coach, Ophthalmic Coding Module Series, and “Code This Case.”

Kim Ross, OCS, CPC, is an American Academy of Ophthalmology coding specialist. Kim has been in the field of ophthalmology since 1975. The past 13 years were in a multi-specialty academic setting at the University of California, San Francisco (UCSF). Since 2004, she managed departmental revenue and compliance, coding and reimbursement, as well as OR utilization for the 20-surgeon faculty at UCSF.
Hospitals would do well to monitor their plan using the 2009 OIG Work Plan.

In the January issue of Coding Edge, we looked at the 2009 Office of Inspector General (OIG) Work Plan as it pertains to physician practices. We would be remiss, however, if we didn’t look at the items relating to hospitals, and how hospitals can best use this information to create a compliance work plan.

Each October, the Department of Health and Human Services (DHHS) OIG gives us a bit of insight into what the upcoming year will bring. Their annual Work Plan describes the activities within each office of the OIG for the upcoming federal fiscal year. Some items are added, some are removed, and some carry on. By examining this plan, you can see what the federal government feels are hospital sector concerns and use this information to devise an auditing and monitoring plan for the year.

The Hospital Work Plan

Additional Part A Medicare Capital Payments for Extraordinary Circumstances

The Centers for Medicare & Medicaid Services (CMS) has a program where hospitals can request additional capital payments be made to them under extraordinary circumstances. Eligibility for additional capital payments requires unanticipated capital expenditures in excess of $5 million for circumstances beyond the facility’s control, such as floods, fires, and earthquakes. Certain criteria must be met and reviewed to determine whether a facility should receive these payments. You are at a risk for not meeting the criteria, for example, if the unanticipated expenditure doesn’t exceed $5 million after net proceeds from any other payment sources, such as, insurance, or local, state or federal government funding programs. If you are a recipient of such a payment, take a look at your replacement capital funding to be sure you still meet the federal criteria following receipt of all other payment sources.

Provider-Based Status for Inpatient and Outpatient Facilities

For several years, a provider-based status item has appeared on the OIG’s Work Plan. This item is slightly different than in past years, and should be noted as such. Hospitals with provider-based facilities can receive enhanced reimbursement, and are often a target of government inquiry. This review is aimed at facilities with cost reports claiming provider-based status to determine the potential impact on the Medicare program for those facilities that improperly claim provider-based status. If you are a facility claiming provider-based status for any of your sites, check that you meet all criteria laid out in the guidelines originally set in 2001 and revised in 2005.

Hospital Ownership of Physician Practices

In a different approach to a provider-based status review, the OIG will look at Medicare reimbursement appropriateness for hospital-owned physician practices with the provider-based designation. Hospital requirements to obtain provider-based status for purchased physician practices were revised by CMS in 2005. The revisions address issues like patient population served, practice location, and the hospital’s control level and governance over the physician practice. If your hospital-owned physician practices are operated as provider-based clinics, now is a great time to determine if you meet the criteria to attain the provider-based designation.

Reliability of Hospital-Reported Quality Measure Data

Within the last few years, quality data reporting has gone from simply a statistical task to one that can effect reimbursement. The advent of consumer tools like the Hospital Compare Web site (www.hospitalcompare.hhs.gov) make it more important for quality data submitted to CMS to be accurate and complete. This year, the OIG...
will look at the quality data submitted by hospitals to ensure they have implemented sufficient controls for creating a valid data set.

Who submits quality data for your facility? Review the process for putting this data together, and verify if appropriate quality assurance checks are occurring on this data prior to submission. Also, do you have similar submissions due for other entities, such as State Health Departments or benchmark projects you are involved in? If so, maximize your efforts toward gathering by creating efficiencies in data collections for all quality measures.

Coding and Documentation Changes Under Medicare Severity Diagnosis Related Group (MS-DRG) System

In October of 2007, MS-DRGs were implemented to help recognize illness severity in the Medicare inpatient reimbursement system. The OIG has quickly decided to review this new system through coding trends and patterns to determine its vulnerability to potential upcoding. The key to accuracy in coding under MS-DRGs is high-quality clinical documentation. To review your compliance with this new system, a three part review is essential:

1. Look at your clinical documentation process. Have you implemented a documentation improvement team, or concurrent coding processes?
2. Have your finance department review the financial impact of MS-DRGs. Are there any areas of increased reimbursement that will serve as red flags for government reviewers? If so, take the time to review those claims.
3. Provide continuing education for coders on MS-DRGs, inpatient coding, and improving clinical documentation for the new system’s coding side.

Serious Medical Errors (Never Events)

CMS issued a rule in 2007 aligning patient safety, quality, and payment methodology aimed at denying payment for certain hospital acquired conditions through coding of present on admission (POA) indicators. At the same time, legislation was passed requiring the OIG to study serious medical errors known as Never Events, examining the types of events and what payments are being made by any party in these instances. The review that appears in the Work Plan this year pertains to this legislation, as well as a review of hospitals’ compliance with the new Present on Admission coding requirements. Some state governments are also moving forward with mandated never event and hospital acquired condition (HAC) denials. Now is the time to examine your adverse event reporting process, and get finance, risk management, quality assurance, HIM, coding, and administration all on the same page with regard to billing and coding for both serious medical errors and hospital acquired conditions.

Many of this year’s OIG Work Plan items continue from the previous year’s plan. Some of these items include:

- Part A Hospital Capital Payments
- Part A Inpatient Prospective Payment System Wage Indices
- Payments to Organ Procurement Organizations
- Inpatient Hospital Payments for New Technologies
- Critical Access Hospitals
- Medicare Disproportionate Share Payments
- Inpatient Psychiatric Facility Emergency Department Adjustments
- Provider Bad Debts
- Medicare Secondary Payer
- Payments for Diagnostic X-rays in Hospital Emergency Departments

Eligibility for additional capital payments requires unanticipated capital expenditures in excess of $5 million for circumstances beyond the facility’s control, such as floods, fires, and earthquakes. Certain criteria must be met and reviewed to determine whether a facility should receive these payments.

Jillian Harrington, MHA, CPC, CPC-I, CCS-P, is the president/CEO of ComplyCode, a healthcare compliance consulting and education firm in upstate New York. She holds a Masters in Health Administration from the Rochester Institute of Technology, and is a former member of the AAPC National Advisory Board.
Spinal fusion involves multiple steps beyond those described by arthrodesis codes 22532-22632, including bone grafting (20930-20938) and instrumentation placement (22840-22851). For complete coding, you should report these additional procedures separately. When extensive decompression accompanies arthrodesis, you may report the procedures independently.

**Three Questions Discern Spinal Bone Graft Codes**

To select an appropriate spinal bone graft code, the available documentation must allow you to answer at most three questions:

1. Was the graft taken from the patient’s body (an autograft) or from another source (allograft)? If documentation includes bone harvesting, an autograft code is appropriate. Allografts include all prepared grafts, such as Cornerstone or Medtronic Verte-Stack, or tissue taken from a bone bank.

2. If the graft was taken from the patient’s body, did the surgeon have to create a new incision to remove the donor tissue? Bone tissue taken from the ribs, spinous process, or laminar fragments is “local.”

3. Was the graft a single piece of bone (structural), or did it consist of several—or many—smaller pieces (morselized)? For example, along with posterior cervical laminectomy, the surgeon may pack morselized bone in open areas on either side of the spine and in the facet joint spaces to promote new bone growth.

These three questions help you easily discern among the spinal bone graft codes.

<table>
<thead>
<tr>
<th>Spinal Bone Grafts</th>
<th>Auto or Allo graft</th>
<th>local or separate incision</th>
<th>structural/morselized</th>
<th>code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autograft</td>
<td>local</td>
<td>unspecified</td>
<td></td>
<td>20936</td>
</tr>
<tr>
<td></td>
<td>separate incision</td>
<td>structural</td>
<td></td>
<td>20938</td>
</tr>
<tr>
<td></td>
<td></td>
<td>morselized</td>
<td></td>
<td>20937</td>
</tr>
<tr>
<td>Allograft</td>
<td>N/A (surgeon does not harvest graft)</td>
<td>structural</td>
<td></td>
<td>20931</td>
</tr>
<tr>
<td></td>
<td></td>
<td>morselized</td>
<td></td>
<td>20930</td>
</tr>
<tr>
<td>Threaded bone dowel (allograft)</td>
<td>N/A (surgeon does not harvest graft)</td>
<td>N/A</td>
<td></td>
<td>22851</td>
</tr>
</tbody>
</table>

For example, suppose the surgeon performs a posterior lumbar interbody fusion (PLIF) for stenosis (724.02 Spinal stenosis; lumbar region) and spondylolisthesis (738.4 Acquired spondylolisthesis) at L1-L2 and L2-L3. She harvests bone from the iliac crest, via a separate incision, to prepare and place a morselized graft at each interspace.

You would report 22630 Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar for arthrodesis at the first interspace, and +22632 Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure) for the additional interspace.

You would report +20937 Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure) for the har-
vest, preparation, and placement of the morselized graft. You should report any spinal graft code only once per procedure, regardless of how many areas the surgeon treats with that same type of graft.

Note that all spinal bone grafting codes 20930-20938 include graft shaping or preparation, when required, and all autograft codes include graft harvesting. You would not code separately for either of these services.

According to the 2009 National Physician Fee Schedule Relative Value File, you may not append modifier 50 Bilateral procedure, or modifiers 62 Two surgeons, 80 Assistant surgeon, 81 Minimum assistant surgeon or 82 Assistant surgeon (when qualified resident surgeon not available) to spinal graft codes 20930-20938.

CPT® designates spinal bone graft codes as modifier 51 Multiple procedures exempt, meaning they should be paid at the full fee schedule amount when reported as additional procedures. Be aware, however, that Medicare designates graft procedures +20930 Allograft for spine surgery only; morselized (List separately in addition to code for primary procedure and +20936 Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure) as status “B” codes. As such, Medicare payers will always bundle these codes into payment for other services. Third party insurers do not necessarily follow this convention.

Look to Surgical Approach When Reporting Spinal Instrumentation
As with bone grafts, separately billable instrumentation placement generally accompanies arthrodesis. For instance, in the aforementioned PLIF with morselized autograft example, the surgeon may also have fixed pedicle screws at two points to stabilize the spine further.

If the surgeon places a metal cage or other prosthetic device, such as a threaded bone dowel, in the intervertebral space, you will report +22851 Application of intervertebral biomechanical device(s) (e.g., synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure).

You should report only a single unit of 22851, regardless of how many devices the surgeon places at a single level. If the surgeon places devices on multiple spinal levels, however, you may report multiple units of 22851 (one unit for each individual spinal level).

When coding for instrumentation that spans across several vertebral segments using rods, cages, plates, wires and/or other mechanical devices, you must determine whether the device is anterior (attached to the front of the spine or vertebral segment, facing the front of the body) or posterior (attached to the back of the spine or vertebral segment, facing the back of the body). Anterior instrumentation usually involves application of plates screwed directly onto the vertebral bodies, whereas posterior instrumentation involves placement of rods or other apparatus that grip the lamina or are screwed into the pedicles. Generally, the type of instrumentation will correspond to the surgical approach (anterior or posterior) the surgeon selects.

You will claim placement of anterior instrumentation using +22845 Anterior instrumentation; 2 to 3 vertebral segments, 22846 Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure) and +22847 Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure), depending on the number of vertebral segments spanned.

If the surgeon places posterior instrumentation, you must further determine whether the device is segmental (22842-22844) or nonsegmental (+22840 Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)).

Nonsegmental posterior instrumentation attaches to the spine at two points only—the proximal and distal portions (top and bottom) of the rod or other device. You may report placement of nonsegmental posterior instrumentation using +22840.

Segmental posterior instrumentation attaches to the spine at three or more points, including the proximal and distal portions of the rod or other device. You may describe placement of segmental posterior instrumentation using +22842 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple books and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure), +22843 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple books and sublaminar wires); 7 to 12 vertebral segments) (List separately in addition to code for primary procedure), or
+22844 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure), according to the number of vertebral segments spanned.

Be cautious when counting vertebral segments, keeping in mind that a single interspace lies between two vertebral segments. For instance, the span C6-T2 contains four vertebral segments (C6, C7, T1, and T2) and three vertebral interspaces (C6/C7/C7/T1, and T1/T2). To report anterior instrumentation across this span, you would choose 22846, which describes four to seven vertebral segments, rather than 22845, which describes two to three vertebral segments.

CPT® defines spinal instrumentation procedures as inherently bilateral, so you should not apply modifier 50 to any spinal instrumentation codes. As with spinal bone grafts, all codes describing instrumentation placement are exempt from multiple-procedure (modifier 51) adjustments, according to CPT®.

For example, a complete spinal fusion might include:

- L4/L5 Discectomy
- L5/S1 Discectomy
- L4/L5 Transforaminal interbody fusion, posterior interbody technique
- L5/S1 Transforaminal interbody fusion, posterior interbody technique
- Morselized autograft, obtained from local incision
- L4/L5 Interbody cage placement
- L5/S1 Interbody cage placement
- L4, L5, S1 Bilateral pedicle screw instrumentation

You would report the arthrodesis at two interspaces using 22630 Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar and +22652 Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure).

In this case, the discectomy to prepare the interspaces at L4/L5 and L5/S1 is included in the arthrodesis, although a more extensive discectomy could be separately coded, when justified (see below for more information).

For the morselized autograft, you would report 20937.

For placement of the interbody cage at the first level, you would report 22851. Because cage placement occurs at a second level, you may also report a second unit of 22851 with modifier 59 Distinct procedural service appended. Modifier 59 shows the payer that you addressed separate levels.

For the pedicle screw instrumentation, you should report 22842. Remember, even though the instrumentation was bilateral, you would not append modifier 50.

### Code Separately More Than Minimal Decompression Services

Arthrodesis may include related procedures such as minimal laminectomy and/or discectomy to prepare the interspace, as indicated in the individual arthrodesis code descriptors. Codes 22554-22585 and 22630-22632 describe scrapping away of the disk just enough to make room for graft material.

In some cases, the surgeon may perform a more than minimal (more extensive than usually associated with arthrodesis) discectomy or laminectomy. In these cases, separate coding for the decompression (for instance, 63047, Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s) (spinal or lateral recess stenosis)), single vertebral segment; lumbar) with modifier 59 may be justified.

To support a separate service, the surgeon’s documentation should highlight decompression of neural elements and removal of fibrovascular scar tissue over the dura (for instance, the posterior longitudinal ligament), removal of disc material on the far lateral sides, with foraminotomy, and/or necessary removal of osteophytes (bone spurs).

G. John Verhovshek, MA, CPC, is AAPC’s director of clinical coding communications.
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CEU costs got you down? While there are low or no cost opportunities available, CEUs and the valuable education they represent still can cost money. Employers are finding that helping coders with their continuing education is paying off with money-saving accurate, compliant coding.

Kreeta Haffner, business office manager, Boulder Medical Center, said when asked why she pays for her employee's, clinic coder Lisa Curtis', CPC, CPC-E/M, CEUs, “It is a win-win for the clinic.” Haffner added, “We pay $150 annually towards membership costs.” Although both Boulder Medical Center and Lisa benefit from the decision to pay for CEUs, Haffner said, “I cannot dictate what other clinics’ employee benefits should be, but providing additional education helps our clinic.”

When Curtis was hired she inquired if Boulder Medical Center paid for CEUs and was told that they did. “It is not something I had to request,” Curtis said. “Each year we figure out a budget for this. They haven’t told me ‘No’ yet.”

Because Boulder Medical Center pays for Curtis to attend workshops and conferences, she said, “I find there is a lot more to learn by attending workshops than just reading and doing (free) tests, although those are useful too; reading and doing the tests doesn’t always mean the information will stick. Interaction with other coders is very important. It’s an opportunity to meet and network with other coders in person that you wouldn’t normally meet, and learn about their experiences. I’m looking forward to going to the conference in Las Vegas!”

Billing Manager Jennifer L. Sprague, CPC, of Nephrology Associates of Syracuse, P.C. is also an employee who has her CEUs paid by her employer. When asked about it, she said, “I do work for an organization that pays for CEUs. It’s wonderful! Our practice, Nephrology Associates of Syracuse, P.C. believes in educating staff and managers to keep up with the ever-changing health care community. Our practice recently paid for me to take my CPC® exam. Not only did they pay for the exam, they also paid for a Boot Camp in Boston, Mass. to prepare me for the exam. They are an excellent company to work for.”

Lahey Clinic in Burlington, Mass. also pays for employees’ CEUs. Robin M. Serrentino, professional coding department administrative assistant at Lahey said, “My department pays for our coder’s membership, all audio conferences and seminars. This way they are able to earn their CEUs. We believe in educating the coders who work in this department. It takes a lot of pressure off the coder to know that they can receive education merely at

When Employers Pay for CEUs, Everyone Wins

By Michelle A. Dick, senior editor
the tip of there fingers. As long as they work at Lahey their memberships are paid for by Lahey. You would say it's one of Lahey's perks.”

How to Convince Your Employer

It’s not only the coding professional who benefits when CEUs are paid for. Many employers reimburse coders for their continuing education expenses because they know it will pay off in the long run with accurate coding, ensuring proper reimbursement for medical services. Curtis said, “It’s a tremendous benefit to the employers to keep their coders up-to-date. The providers have a lot on their plates focusing on patient care. Someone needs to keep up with the ever-changing coding world.” What better way to ensure current coding practices than providing the means for continuing education.

By paying for employees’ CEUs the employer also helps to safeguard their practice from potentially damaging liability by proving they took measures to stay up-to-date with compliant coding practices. According to Julie E. Chicoine, Esq., RN, CPC, of the AAPC’s Legal Advisory Board, if false claim litigation arises, “paying for coders’ CEUs can help prove that the provider took steps to stay current and on top of federal health care program requirements.” Legal Advisory Board member Michael Miscoe, Esq., CPC, CHCC, agrees. “Doctors are ultimately responsible for the accuracy of their claims. Whether trained in coding or not, they are expected to report services accurately. Taking affirmative steps, such as hiring certified coders as well as providing appropriate ongoing continuing education, demonstrates a commitment to compliance, which is essential to avoiding allegations of gross negligence—a key factor in civil false claims act liability.”

Free CEU Options

If you aren’t fortunate enough to have CEUs paid for you, please take advantage of AAPC’s free or low cost CEU options. To find out more about these options, see the accompanying sidebar “Earn CEUs in an Economy Slump.”

Hang This Up

If you need more CEUs than our free options offer, approach your employer to help compensate for the expenses. If you aren’t comfortable with that, hang this article on your wall where it can be seen and possibly provoke a conversation about the benefits of employers supporting CEU costs. ■

Michelle Dick is senior editor of Coding Edge

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Earn CEUs in an Economy Slump

Both student members and newly certified members always ask me how to earn CEUs for free or at a very low cost. I am always taken aback by this question because seasoned members know the answer to this question and it is in the student member’s best interest to know the answer also.

Attend Local Chapter Meetings

A free or low cost CEU option is to attend local chapter meetings. At recent chapter meetings, there was concern about the economy and how members will continue to pay to keep memberships current and obtain CEUs during a time when many employers don’t pay to send employees to conferences and workshops.

I feel now is the perfect time to remind everyone that we can earn CEUs for free by supporting our local chapters. Most local chapter meetings offer one or two CEUs per meeting and most meetings are free to members. Although members are assigned to a specific local chapter, you are welcome and encouraged to network with and attend other local chapters, allowing you the opportunity to earn additional CEUs.

Chapters offering exam reviews may also offer CEUs to both non-certified and certified members. If you are a certified member and want to attend a review, you may earn CEUs for free or at little cost.

Members can also offer presentations to fellow chapter members during local chapter meetings and earn CEUs for their time. Presenting at a local chapter is a wonderful way to earn additional CEUs while helping others obtain CEUs as well.

There is no better time than now to come out and support the AAPC and your local chapter! It can be fun, informative, free-of-charge and you are afforded the opportunity to network with your peers. New chapters are popping up all the time—look for a location near you.

AAPC News Sources Earn You Free CEUs

The AAPC’s monthly Coding Edge magazine and the electronically sent bi-monthly EdgeBlast allow you to earn additional CEUs at no cost. You can earn CEUs by taking the Coding Edge Test Yourself quizzes at www.aapc.com/MemberArea/resources/coding-edge/index.aspx and the EdgeBlast quizzes at www.aapc.com/memberarea/resources/EdgeBlast_Archive.aspx.

We all have the opportunity to obtain the minimum requirement of 18 CEUs per year simply by participating in local chapter meetings, learning in exam reviews, and completing the questionnaires in Coding Edge and EdgeBlast.

I assure you that I have never paid to obtain CEUs as I take full advantage of the benefits afforded to me as part of my AAPC membership. ■

By Trina Cuppett, CPC, CPC-H
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nationally recognized physician experts on IR and Cardiology coding
Coding Edge (CE): Tell us a little bit about your career—how you got into coding, what you’ve done during your coding career, what you’re doing now, etc.?
Trina: My first job was at the age of 18 in a medical office working as an administrative assistant to the clinical director. One of my duties was filing worker’s compensation claims. I have also worked as a practice coordinator in a family practice and psychiatric practice. Another medical job I had was filing UB-92s for a hospital billing office and conducting chart audits for outpatient hospital services. Currently, I teach billing and reimbursement issues and medical terminology and anatomy at a local community college.
CE: What is your involvement level with your local AAPC chapter?
Trina: I started with the Hickory Chapter at its inception in 2004 and I am the president. In the past, I have networked with the Statesville Coding Chapter and started the Mooresville Coding Chapter in Mooresville, N.C. I have also mentored two previous chapter presidents; and I am currently working with Mooresville chapter President Marcia Kraus to promote networking among our local chapters.
CE: What has been your biggest challenge as a coder?
Trina: My biggest challenge as a coder has probably been implementing “mentoring” in our area for students and new members. Most of us forget that when we first got into the field someone, somewhere helped us along the way. I’m a firm believer in paying it forward. Recently, I had some seasoned members come into the classroom for mentoring with students and the students really appreciated our members giving them an hour of their time. The mentors explained their ideas on breaking into the coding field, landing a first job in the medical field, and studying tips for their upcoming CPC® exams.
CE: What do you advise other coders to do if they disagree with the way a physician has coded his chart? Do you approach the physician, or have a monthly meeting?
Trina: I have always approached the physician directly. In some environments it is difficult to have regular monthly meetings due to patient scheduling, rounds, and call duties. I have found that most physicians are extremely receptive to being approached about coding issues. Compliance is such an important issue that physicians want to make sure they are aware of possible discrepancies.
CE: If you could have any other job, what would it be?
Trina: I am blessed to be doing it. Teaching has afforded me the opportunity to help implement classes, to be proactive for change, and to help our local coding students in school and through the chapter. I feel very blessed to be doing what I enjoy.
CE: How do you spend your spare time? Tell us about your hobbies, family, etc.
Trina: I am a student with a double major in paralegal technology and middle grade education, so I don’t have a lot of spare time. I love to read, garden, and travel with my family as much as we can. My children love going to zoos, aquariums, water parks, the mountains, and the beach.
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The Case of the Alphabetic Bowel

A double loop (Maydl) hernia, although rare, isn't necessarily twice as difficult to code as a more typical hernia.

In this case, a 40-year-old male presented with a 48-hour history of colicky pain in the abdomen and pain in the left inguinal region with vomiting and progressive abdominal distension. He had a lump in the left inguinal region that had not been tender and easily reducible for 20 years.

During surgery, the hernial sac was found to have 250 ml of foul-smelling brownish fluids, which were removed. Exploration of the sac revealed the hernia contained a segment of small bowel, the cecum, and the appendix, all of which were gangrenous. The intra-abdominal section of small bowel was 1.5 meters long and also gangrenous. The physician performed a massive small bowel resection and excision of the cecum and appendix, along with an ileocolic anastomosis.

In this case, ICD-9-CM coding is fairly straightforward, in spite of the uncommon nature of the patient's condition. Code 550.0x Inguinal hernia; with gangrene defines an inguinal hernia with gangrene, as is documented in this case, and includes obstruction. The hernia is a double loop, but that does not mean it is bilateral. The hernia is not specified as recurrent (although the patient has exhibited an easily-reducible lump in the left inguinal region for many years). As such, a fifth digit of “0” unilateral or unspecified (not specified as recurrent) is appropriate.

The primary procedure (the procedure with the highest number of relative value units) in this case is the excision and anastomosis of the small bowel, 44120 Enterectomy, resection of small intestine; single resection and anastomosis.

The operative report defines the anastomosis as massive, but there is only one resection and anastomosis. Add-on code +44121 Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure) is not appropriate. The documentation does not contain specific information (such as the time required to perform this particular procedure vs. the time required for a more typical case) necessary to append modifier 22 Unusual procedural services to 44120.

Code 44960 Appendectomy; for ruptured appendix with abscess or generalized peritonitis describes removal of the gangrenous appendix, and should be reported separately in this case. Note that the National Correct Coding Initiative (CCI) bundles a standard appendectomy (44950 Appendectomy) into the small bowel resection (44120). In the absence of evidence for abscess or generalized peritonitis, you would not report the appendectomy separately.

The final (lowest-valued) code in this case is for the hernia repair: 49507 Repair initial inguinal hernia, age 5 years or older, incarcerated or strangulated. The patient’s age (40), location of the hernia (inguinal), initial vs. recurrent (initial), and clinical presentation (strangulated) all factor in the code choice. Note that CPT® instructions preceding hernia repair codes 49491-49590 specify, “the excision/repair of strangulated organs or structures such as testicle(s), intestine, ovaries are reported by using the appropriate code for the excision/repair.” This is why we would report the enterectomy, 44120, separately.
MALT Lymphoma Confined to Colon

Primary malignant lymphoma of the large intestine is rather rare, accounting for only 0.2 percent of primary neoplasms of the large intestine. Intestinal marginal zone B-Cell lymphoma (MZL) of mucosa-associated lymphoid tissue (MALT) type is equally rare. Here, the patient has a MALT lymphoma involving only the colon, with no other evidence of Non-Hodgkin’s lymphoma (NHL). Can you code this?

Indications: An asymptomatic, 52-year-old female presented to her primary care physician’s office for a routine health exam. Review of systems was negative for weight loss, fatigue, chills, night sweats, hematochezia, or alteration in bowel function. Physical exam was remarkable for a rectal polyp palpable on digital rectal exam. Stool was hemoccult negative, and lab studies revealed normal CBC, creatinine, calcium, and hepatic function.

Procedure: The patient underwent a routine colonoscopy that revealed a 0.5-cm rectal polyp and a 4 cm frond-like villous mass at 60 cm. The rectal polyp was hyperplastic, and the mass histologically demonstrated lymphoma features. A subsequent hemicolectomy was performed. The surgical specimen was consistent with extranodal marginal zone B-Cell lymphoma of MALT type.

The patient recovers well after the resection and has finished conjunctive chemotherapy successfully. A repeat CT scans shows no evidence of NHL.

Have You Gone to Extremes?

Have you got a challenging scenario you’d like to see discussed in this forum? Send your op report to extreme.coding@aapc.com. Before forwarding it to us, please safeguard the patient’s personal information by changing dates and removing unique identifiers.
Our journey using the ICD-10-CM roadmap leads us to draft guidelines and coding issues focusing on “Understanding the ICD-10-CM Draft Guidelines for the Skin and Subcutaneous Tissue.” Consider the codes for the Skin and Subcutaneous Tissue located in chapter 12 of ICD-10-CM.

In ICD-9-CM there are three subchapters in chapter 12:
- 680–686 Infections of skin and subcutaneous tissue
- 690–698 Other inflammatory conditions of skin and subcutaneous tissue
- 700–709 Other diseases of skin and subcutaneous tissue

These three subchapters were expanded in ICD-10-CM chapter 12 to include blocks L00-L99, as follows:
- L00–L08 Infections of the skin and subcutaneous tissue
- L10–L14 Bullous disorders
- L20–L30 Dermatitis and eczema
- L40–L45 Papulosquamous disorders
- L50–L54 Urticaria and erythema
- L55–L59 Radiation-related disorders of the skin and subcutaneous tissue
- L60–L75 Disorders of skin appendages
- L76 Intraoperative and postprocedural complications of dermatologic procedures
- L80–L99 Other disorders of the skin and subcutaneous tissue

Chapter 12 in ICD-10-CM was restructured to bring together related disease groups. Nearly all of the categories and subcategories in ICD-10-CM were expanded to either the fourth- or fifth-character level in this chapter. ICD-10-CM includes a number of category and/or subcategory title changes to adequately reflect the content. Diseases were grouped in either their own blocks or new categories to identify specific disease types.

Codes in ICD-9-CM moved to chapter 12 in ICD-10-CM:

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>704.1 Hirsutism</td>
<td>L68 Hypertrichosis</td>
</tr>
<tr>
<td>039.0 Erythrasma</td>
<td>L08.1 Erythrasma</td>
</tr>
<tr>
<td>136.0 Ainhum</td>
<td>L94.6 Ainhum</td>
</tr>
</tbody>
</table>

Decubitus Ulcers and Non-decubitus Ulcers of Lower Limbs

Decubitus ulcers were also expanded in ICD-10-CM. In ICD-9-CM, two codes are used to identify the decubitus ulcer and a secondary code is assigned to identify the pressure ulcer stage. In ICD-10-CM, only one code is needed to adequately describe the condition and the ulcer’s stage.

Using ICD-9-CM, two codes are necessary. The first listed diagnosis identifies the decubitus ulcer’s location and the secondary code describes the ulcer’s stage. In ICD-10-CM, only one code is necessary to describe both the pressure ulcer site and the ulcer’s stage. Notice the level of specificity in ICD-10-CM.
When assigning a code for these ulcers using ICD-10-CM, review the record thoroughly to verify both the ulcer's site and severity. For multiple ulcers of the same site, it is only necessary to assign a code for the most severe ulcer.

Any condition reducing blood flow to the legs may cause a lower limb ulcer. The same condition may also prevent an ulcer from healing, even with aggressive treatment. When the underlying condition is known, it should be sequenced before the ulcer.

Atherosclerosis of the lower extremities and diabetes mellitus are common underlying conditions. Combination codes for atherosclerosis of the lower extremities and diabetes mellitus include lower extremity ulcers. The sequencing instructions at categories L89 and L97 differ slightly from the standard conventions, however.

A serious decubitus ulcer that does not respond to treatment may be a reason for hospital admission. If decubitus ulcer is the reason for admission, it should be the principal, first-listed diagnosis. Secondary codes for the other decubitus ulcer-associated health problems should also be assigned. Generally, an underlying condition is responsible for a non-decubitus ulcer of the lower limb (L97).

An L97 code should be used with the combination code for the underlying condition to specify the ulcer's site and depth. In some cases, no underlying cause for the ulcer is documented. In such cases, a code from L97 may be listed first.

The instructional note at L97 indicates the “code first” note is applicable only when an underlying condition is documented.

For example: A patient is treated in the outpatient hospital wound care clinic for a severe non-healing ulcer of the right midfoot and heel with bone necrosis due to diabetes mellitus.

Both decubitus and non-decubitus ulcers may become so severe that gangrene (necrosis of the tissue) sets in at the ulcer’s site. For gangrene cases resulting from a skin ulcer, the gangrene should be sequenced first, followed by the code for the ulcer.

When gangrene is present, the primary focus of treatment is to remove the gangrene, usually with debridement or amputation of the affected area. The “code first” note at categories L89 and L97 instructs that gangrene should be sequenced before the ulcer. This note applies only if gangrene is present.

For example: A patient with a gangrenous pressure ulcer of the right ankle, with necrosis of the muscle and bone is treated for debridement of the area.

Review the comparison:

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<tr>
<td>707.02</td>
<td>L89.322</td>
</tr>
<tr>
<td>707.22</td>
<td>Pressure ulcer of left buttock stage II</td>
</tr>
</tbody>
</table>

Using ICD-9-CM, gangrene of the lower extremities instructional notes state to code first any associated condition. In the example above, the pressure ulcer and the ulcer’s stage are coded first and second, with the gangrene as a tertiary diagnosis. In ICD-10-CM, the instructional notes identifies that gangrene is coded first, followed by the pressure ulcer. This differs from ICD-9-CM instructions.

A secondary external cause code identifying the exposure’s source should be used when reporting categories L56 Other acute skin changes due to ultraviolet radiation and L57 Skin changes due to chronic exposure to non-ionizing radiation.

For example: A female patient who uses a tanning bed in her apartment daily is treated by a dermatologist for multiple solar keratoses on her face due to overexposure in the tanning bed.

Compare ICD-9-CM and ICD-10-CM:

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<tr>
<td>707.06</td>
<td>I96</td>
</tr>
<tr>
<td>707.24</td>
<td>Gangrene, not elsewhere classified</td>
</tr>
<tr>
<td>785.4</td>
<td>L89.514</td>
</tr>
<tr>
<td></td>
<td>Pressure ulcer of right ankle, stage IV</td>
</tr>
</tbody>
</table>

With both ICD-9-CM and ICD-10-CM, the condition followed by the external cause code is reported. Because the location of the overexposure is known, it can be reported as well. Notice in ICD-10-CM, the place of occurrence states “apartment.”

Compare ICD-9-CM and ICD-10-CM codes:

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<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.81 Diabetes with other specified manifestations, type I (juvenile type), not stated as uncontrolled</td>
<td>E086.621 Diabetes mellitus due to underlying condition with foot ulcer</td>
</tr>
<tr>
<td>707.14 Ulcer of heel and midfoot</td>
<td>L97.413 Non-pressure chronic ulcer of right heel and midfoot with necrosis of bone</td>
</tr>
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With both ICD-9-CM and ICD-10-CM, the condition followed by the external cause code is reported. Because the location of the overexposure is known, it can be reported as well. Notice in ICD-10-CM, the place of occurrence states “apartment.”
The place of occurrence codes for home is sub-divided to include apartment, boarding home, single family residence, institution, nursing home, prison, reform school dormitory, and mobile home. These categories are further divided to include areas of the home including, bathroom, bedroom, driveway, garden, kitchen, swimming pool, etc.

Compare ICD-9-CM and ICD-10-CM place of occurrence residential codes for an apartment and a single family home:

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y92.00</td>
<td>Y92.00</td>
</tr>
<tr>
<td>00</td>
<td>residence (non-institutional) (private)</td>
</tr>
<tr>
<td>Y92.039</td>
<td>Y92.019</td>
</tr>
<tr>
<td>apartment</td>
<td>house, single family</td>
</tr>
<tr>
<td>Y92.031</td>
<td>Y92.010</td>
</tr>
<tr>
<td>bathroom</td>
<td>kitchen</td>
</tr>
<tr>
<td>Y92.032</td>
<td>Y92.011</td>
</tr>
<tr>
<td>bedroom</td>
<td>dining room</td>
</tr>
<tr>
<td>Y92.030</td>
<td>Y92.012</td>
</tr>
<tr>
<td>kitchen</td>
<td>bathroom</td>
</tr>
<tr>
<td>Y92.038</td>
<td>Y92.013</td>
</tr>
<tr>
<td>specified NEC</td>
<td>bedroom</td>
</tr>
<tr>
<td>Y92.016</td>
<td>Y92.014</td>
</tr>
<tr>
<td>swimming pool</td>
<td>driveway</td>
</tr>
<tr>
<td>Y92.017</td>
<td>Y92.015</td>
</tr>
<tr>
<td>garden or yard</td>
<td>garage</td>
</tr>
<tr>
<td>Y92.018</td>
<td>Y92.016</td>
</tr>
<tr>
<td>specified NEC</td>
<td>swimming pool</td>
</tr>
</tbody>
</table>

ICD-10-CM category L76 "Intraoperative and postprocedural complications of dermatologic procedures" is a new subsection found in chapter 12 that is divided into fourth and fifth characters:

- Fourth character describes complications and conditions following surgery, such as hemorrhage and hematoma
- Fifth character further specifies the complication

Examples of postprocedural complications in ICD-10-CM include:

L76.11 Accidental puncture and laceration of skin and subcutaneous tissue during a dermatologic procedure
L76.12 Accidental puncture and laceration of skin and subcutaneous tissue during other procedure
L76.2 Postprocedural hemorrhage and hematoma of skin and subcutaneous tissue following a procedure
L76.21 Postprocedural hemorrhage and hematoma of skin and subcutaneous tissue following a dermatologic procedure
L76.22 Postprocedural hemorrhage and hematoma of skin and subcutaneous tissue following other procedure
L76.8 Other intraoperative and postprocedural complications of skin and subcutaneous tissue

Use additional code, if applicable to further specify disorder
L76.81 Other intraoperative complications of skin and subcutaneous tissue
L76.82 Other postprocedural complications of skin and subcutaneous tissue

Some of the codes in chapter 12 of ICD-10-CM have been expanded further to include notes directing the coder to use an additional code:

- Use additional code (B95–B97) to identify organism
- Code first (T36–T65) to identify drug or substance
- Code first underlying disease
- Code first any associated

For example:
L00–L08 Infections of the skin and subcutaneous tissue

Use additional code (B95–B97) to identify infectious agent
L02 Cutaneous abscess, furuncle and carbuncle
Use additional code to identify organism (B95–B96)
L23 Allergic contact dermatitis
Code first (T36–T65) to identify drug or substance

Because ICD-10-CM codes are expansive compared to ICD-9-CM codes, coding skin and subcutaneous tissue will be challenging. Detail and specificity in documentation are the key ingredients to successfully coding ICD-10-CM skin and subcutaneous tissue.

Next up is “Diseases of the Musculoskeletal System and Connective Tissue.”

Deborah Grider, CPC, CPC-H, CPC-P, CEMC, CPC-I, CCS, CCS-P, is the president of the AAPC’s National Advisory Board. She is also writing the ICD-10-CM Implementation Guide, which will be released in 2009.
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<tbody>
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<td>1</td>
<td>Choice of oval chain, mug or license plate from AAPC merchandise store</td>
</tr>
<tr>
<td>2</td>
<td>Credential frame from AAPC merchandise store</td>
</tr>
<tr>
<td>5</td>
<td>NEXT membership dues waived</td>
</tr>
<tr>
<td>10</td>
<td>NEXT membership dues waived + Free 2010 Code Books</td>
</tr>
</tbody>
</table>
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1. The physician sees an established patient with a new diagnosis of diabetes. If the total visit lasts 25 minutes, what is the minimum number of minutes the physician must spend on counseling and/or coordination and care to code the visit using time—rather than history, exam, and medical decision-making—as the controlling factor in selecting an E/M level?
   a. 12 minutes
   b. 13 minutes
   c. 25 minutes
   d. There is no minimum time requirement.

2. The physician sees a new patient in consultation for a total of 35 minutes. Using time as the key factor, what is the correct code for this visit if 20 minutes are spent in counseling and coordination and care?
   a. 99202
   b. 99203
   c. 99242
   d. 99243

3. Under ICD-9-CM, you must use a minimum of two separate codes to describe what characteristics of a pressure ulcer?
   a. location and depth
   b. location and any associated diabetes
   c. location and any associated gangrene
   d. location and stage

4. ICD-10-CM category L76 describes intraoperative and postprocedural complications of dermatologic procedures. Which of the choices below best describes the information conveyed by the forth digit in this category?
   a. complications and conditions following surgery
   b. intra-operative hemorrhage and/or hematoma
   c. post-operative hemorrhage and/or hematoma
   d. accidental puncture and laceration of skin and subcutaneous tissue

5. Which modifier applies when the same physician performs an unrelated E/M service that occurs during the global period of a previous procedure?
   a. modifier 24
   b. modifier 25
   c. modifier 57
   d. The same physician may never bill for an E/M service during another procedure’s global period.

6. Which of the choices below best describes the difference between modifiers 25 and 57?
   a. Modifier 25 applies only to E/M services; modifier 57 applies only to surgical services.
   b. Modifier 25 applies to E/M services separately provided with minor procedures (those with 0-day, 10-day, or no global period); modifier 57 applies to E/M services that prompt a major (90 day global) procedure.
   c. Modifier 25 applies only to a separate, distinct E/M service; modifier 57 applies to any E/M service provided immediately prior to surgery.
   d. Modifier 25 requires a separate diagnosis for the E/M and same-day procedure; modifier 57 does not require separate diagnoses for the E/M service and same-day procedure.

7. How would you indicate a bilateral procedure for Fluorescein angiography, 92235?
   a. 92235 x 2
   b. 92235-50
   c. 92235-LT, 92235-RT
   d. Coding varies by payer preference.

8. In the office, the same ophthalmologist removes sutures during the global period of a previous surgery. How would you report this service?
   a. using an appropriate E/M code
   b. 66250
   c. The service is not separately billable.
   d. 15850

9. Which code would you choose for backbench preparation of a liver for transplant taken from a cadaver, with trisegment split of whole liver graft?
   a. 47140
   b. 47143
   c. 47144
   d. 47145

10. A CVA patient receives skilled treatment consisting of 20 minutes of therapeutic exercise (CPT® 97110) and 25 minutes of gait training (CPT® 97116). The total “Timed Code Treatment Minutes” documented will be 45 minutes. What is the proper coding?
    a. 97110, 97116
    b. 97110, 97116 x 2
    c. 97110 x 2, 97116
    d. 97110 x 2, 97116 x 2
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<tr>
<th></th>
<th>Regular Price</th>
<th>Early Bird Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single attendee</td>
<td>$775</td>
<td>$625</td>
</tr>
<tr>
<td>Two attendees</td>
<td>$725 each</td>
<td>$575 each</td>
</tr>
<tr>
<td>Three attendees</td>
<td>$700 each</td>
<td>$550 each</td>
</tr>
<tr>
<td>Four or more attendees</td>
<td>$525 each</td>
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