

UNRAVELING COMPLICATIONS OF RENAL DISEASE AND HYPERTENSION

“Back to the Future”

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INTRODUCTION

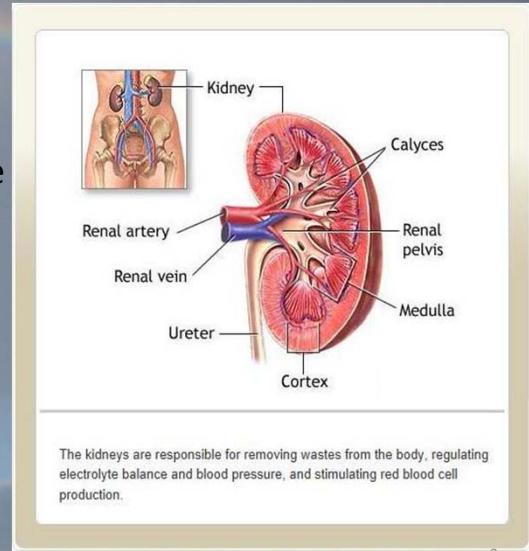
- “The proof is in the detail”
- The medical record is not only a document for billing but also a chronological record of the care that is rendered to the patient
- The medical record protects both the patient and the provider in the event of a malpractice case
- In an audit, the medical record is the only thing an auditor will review



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ANATOMY OF THE KIDNEY

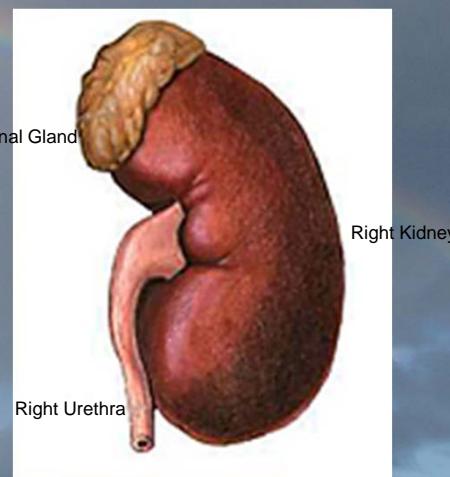
- Calyces (Calyx)
- Renal Pelvis
- Medulla – Inner core
- Cortex – Outer rim
- Ureter
- Renal Vein
- Renal Artery



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Anatomy of the Kidney

- The kidneys filter wastes and excrete fluid when the blood is forced through the internal structures of the kidney
- The healthy kidney keeps the body free of waste and excess fluid



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PHYSIOLOGY OF THE KIDNEY



PHYSIOLOGY OF THE KIDNEY

- The kidney gets its blood supply from the renal artery which gets blood from the abdominal aorta
- Each kidney contains 500,000 glomeruli (in the cortex) which are tiny clusters of capillaries through which the blood is filtered
- In healthy kidneys 1200 ml of blood per minute is typically filtered through the glomeruli and the waste flows into the urinary space



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PHYSIOLOGY OF THE KIDNEY

- The fluid travels thru long tubules where the urine empties into the renal pelvis, ureter and on to the bladder
- 95% of fluid and essential salts are reabsorbed and returned to circulation
- This rate of filtration is called the glomerular filtration rate or GFR
- The GFR is the measure of how well the kidneys are functioning



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GLOMERULAR FILTRATION RATE

- The GFR test that measures how well your kidneys are filtering a waste product called creatinine. Creatinine is generated by the muscles and since people have different amounts of muscle, the GFR allows us to compare kidney function across different People. It accounts for age, race, and gender all factors that impact how much muscle someone has. As kidneys lose function or filtering ability, they do not filter and the creatinine level in the blood start to rise.



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GLOMERULAR FILTRATION RATE

- According to the National Kidney Foundation a normal GFR is a reading between 90-120 mL/min
- Stage 1 Chronic Kidney Disease (CKD) is a GFR > 90
- Chronic Kidney Disease stage 2 is a GFR (60-90) this is **mild** kidney disease
- Chronic Kidney Disease stage 3 is a GFR (30-59) this is **moderate** kidney disease

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GLOMERULAR FILTRATION RATE

- Chronic Kidney Disease stage 4 is a GFR (15-29) this is **severe** kidney damage
- Chronic Kidney Disease stage 5 is a GFR (<15) this is kidney **failure**
- Chronic Kidney Disease coded stage 6 is a GFR (<15) but is on chronic **dialysis**



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DIABETES INSIPIDUS

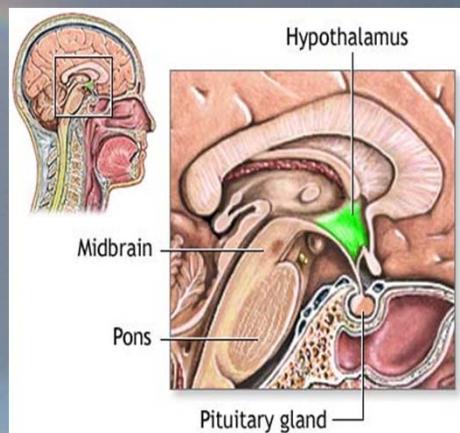
- Diabetes insipidus (DI) is an uncommon condition that occurs when the kidneys are unable to conserve water as they perform their function of filtering blood. The amount of water conserved is controlled by antidiuretic hormone (ADH), also called vasopressin. (ICD-9 253.5)



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DIABETES INSIPIDUS

- ADH is a hormone produced in a region of the brain called the hypothalamus. It is then stored and released from the pituitary gland, a small gland at the base of the brain.
- DI caused by a lack of ADH is called central diabetes insipidus. When DI is caused by a failure of the kidneys to respond to ADH, the condition is called nephrogenic diabetes insipidus. (ICD-9 588.1)



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DIABETES INSIPIDUS

- Nephrogenic DI involves a defect in the parts of the kidneys that reabsorb water back into the bloodstream. It occurs less often than central DI. Nephrogenic DI may occur as an inherited disorder in which male children receive the abnormal gene that causes the disease from their mothers.
- Nephrogenic DI may also be caused by:
 - Certain drugs such as lithium
 - High levels of calcium in the body (hypercalcemia) (275.42)
 - Kidney disease (such as polycystic kidney disease)
- Symptoms
 - Excessive thirst (783.5)
 - May be intense or uncontrollable
 - May involve a craving for ice water
 - Excessive urine volume (788.42)



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SIADH

- Syndrome of Inappropriate Antidiuretic Hormone secretion or SIADH
- The body normally maintains very tight control over its total amount of water and its concentration of sodium
- Certain disease states can upset the delicate balance of water and salt in the body
- If there is too much ADH in the body, or if the kidneys overreact to the ADH they receive, the body retains excess water and the serum sodium concentration becomes diluted and falls to abnormal levels
- Treatment includes water restriction and salt administration and diagnosis of the underlying cause of the SIADH, usually a neoplasm (ICD-9 Code 253.6)



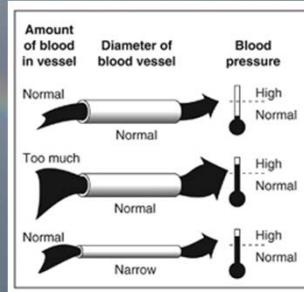
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HYPERTENSION

high blood pressure

Blood pressure measures the force of blood against the walls of the blood vessels. Extra fluid in the body increases the amount of fluid in blood vessels and makes blood pressure higher. Narrow, stiff, or clogged blood vessels raise blood pressure.

- ICD-9 401 – Essential Hypertension
- 401.0 – Malignant Hypertension
- 401.1 – Benign Hypertension
- 401.9 – Unspecified Hypertension



The kidneys play a key role in keeping a person's blood pressure in a healthy range, and blood pressure, in turn, can affect the health of the kidneys. High blood pressure, also called hypertension, can damage the kidneys and lead to chronic kidney disease (CKD).

 People with high blood pressure should see their doctor regularly.

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HIGH BLOOD PRESSURE AND KIDNEY DISEASE

- High blood pressure makes the heart work harder and, over time can damage blood vessels throughout the body. If the blood vessels in the kidneys are damaged, they may stop removing waste and extra fluid from the body. The extra fluid in the blood vessels may then raise blood pressure even more. It's a dangerous cycle.
- High blood pressure is one of the leading causes of kidney failure, also called end-stage renal disease (ESRD ICD-9 585.6). People with kidney failure must either receive a kidney transplant (V42.0) or regular blood-cleansing treatments called dialysis. Yearly high blood pressure causes more than 25,000 new cases of kidney failure in the US.



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HYPERTENSION

- Hypertension Table found under the main term “hypertension” in the index, contains a complete listing of all conditions due to or associated with hypertension and classifies them according to malignant, benign, and unspecified.



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HYPERTENSION

- Hypertension, essential, or NOS
 - Assign hypertension to category code 401 with the appropriate fourth digit to indicate malignant (0), benign (1), or unspecified (9). Do not use either .0 malignant or .1 benign unless the medical record documentation supports such a designation



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HYPERTENSION

- Hypertension with heart disease
 - Heart conditions (425.8, 429.0-429.3) are assigned to a code from category 402 when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code from category 428 to identify the type of heart failure in those patients with heart failure. More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and CHF



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HYPERTENSION

- Hypertension with heart disease (cont.)
 - The same heart conditions with hypertension without a stated causal relationship are coded separately. Sequence according to the circumstances of the encounter



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HYPERTENSION

- Hypertensive chronic kidney disease
 - Assign codes from category 403 when conditions classified in categories 585-587 are present.
Unlike hypertensive heart disease, there is a presumed cause and effect relationship between hypertension and CKD
 - Fourth digit is type of hypertension
 - Fifth digit “0” is stage 1-4
 - Fifth digit “1” is stage 5-6



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HYPERTENSION

- Hypertensive chronic kidney disease
 - If the physician states that the hypertension and CKD are unrelated code the conditions separately sequencing according to the encounter



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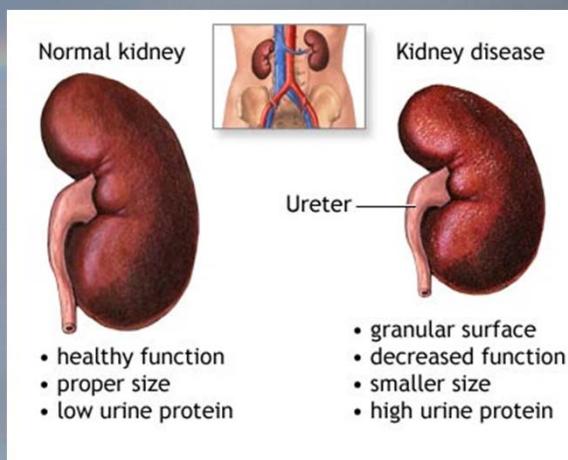
HYPERTENSION

- Hypertension secondary – two codes are required; one to identify the underlying etiology and one from category 405 to identify the hypertension. Sequencing of the codes is determined by the reason for the encounter.
- Elevated blood pressure reading without a diagnosis of hypertension is coded 796.2



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DIABETIC NEPHROPATHY



During diabetic nephropathy the kidney becomes damaged and more protein than normal collects in the urine. As the disease progresses, more of the kidney is destroyed. Over time, the kidney's ability to function starts to decline, which may eventually lead to chronic kidney failure.



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DIABETES MELLITUS

- 250 is the main category for diabetes
- The fourth digit is the manifestation of the diabetes such as 250.4X is diabetes with renal manifestations
- The fifth digit defines the type of diabetes
 - “0” is type II or unspecified not stated as uncontrolled
 - “1” is type I not stated uncontrolled
 - “2” is type II uncontrolled
 - “3” is type I uncontrolled



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DIABETES MELLITUS

- The age of the patient is not the sole determining factor of the type of diabetes
- All type I diabetics must use insulin
- However the use of insulin does not mean the patient is type I
- Add the code V58.67 for long term insulin use



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DIABETES MELLITUS

- Assign and sequence manifestation and association conditions with the 250.XX code before associated codes
- For example: 250.40 is diabetes II with renal manifestations, if the patient has diabetic nephropathy add 583.81 (nephropathy) add the stage of CKD (ie. 585.3) then add V58.67 if there is long term insulin use



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SECONDARY DIABETES MELLITUS

- Used to report diabetes when the disease process is “due to” some other situation such as drug induced or chemical induced
- Code the situation that caused the diabetes
- 249.XX is the series of codes
- Do not use for sequencing diabetes when the primary reason for the encounter was another problem



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SECONDARY DIABETES MELLITUS

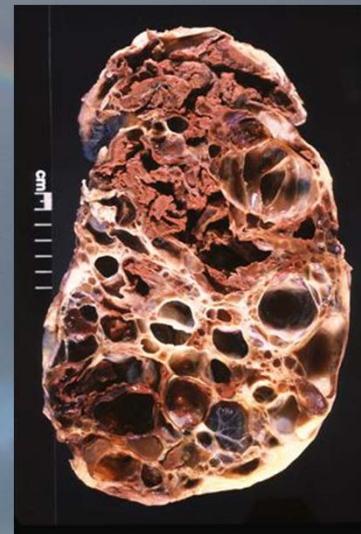
- 249.4X – Secondary diabetes mellitus with renal manifestations
- Fifth digit “0” not stated as uncontrolled or unspecified or “1” uncontrolled
- Use additional code to identify manifestation
 - CKD (585.1-585.9)
 - Diabetic nephropathy (583.81)
 - Intercapillary glomerulosclerosis (581.81)



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POLYCYSTIC KIDNEY DISEASE

- A cyst is a fluid-filled sac. There are two types of kidney cysts.
- Polycystic kidney disease (PKD) runs in families. In PKD, the cysts enlarge and destroy surrounding normal tissue. As the cysts enlarge, the kidneys lose function, leading to progressive kidney failure.



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POLYCYSTIC KIDNEY DISEASE

- PKD can cause kidneys to fail requiring dialysis or transplant
- PKD can cause blood in the urine
- PKD can cause cysts to develop on other organs
- Symptoms of PKD
 - Pain in the back and lower side
 - Headache
 - Urinary tract infections
- Diagnosis is made with imaging and patient history
- Treatments are medication and RRT (renal replacement therapy)

ICD-9 Code 753.12 – Polycystic unspec
 753.13 PKD, autosomal dominant
 753.14 PKD, autosomal recessive (rare disease causing cysts on the kidney & liver causing renal and kidney failure in children and adolescents)



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ACQUIRED CYSTIC KIDNEY DISEASE

- Acquired cystic kidney disease (ACKD) happens when people are on dialysis
- Unlike PKD, patients with ACKD do not develop cysts on other organs
- The kidneys are normal size
- ACKD usually is symptom free
- ACKD is harmless and does not need treatment

ICD-9 Code 593.2



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CHRONIC KIDNEY DISEASE (CKD)

What are the signs of chronic kidney disease (CKD)?

- People in the early stages of CKD usually do not feel sick at all.
- People whose kidney disease has gotten worse may:
 - need to urinate more often or less often
 - feel tired
 - feel itchy or numb
 - lose their appetite or experience nausea and vomiting
 - have swelling in their hands or feet
 - get drowsy or have trouble concentrating
 - have darkened skin
 - have muscle cramps



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WHAT TESTS DETECT CKD?

- The National Kidney Foundations recommend three simple screening tests:
 - a blood pressure measurement,
 - a spot check for protein or albumin in the urine,
 - a calculation of glomerular filtration rate (GFR) based on a serum creatinine measurement
 - Urine albumin 82043
 - Urine creatinine 82570
 - Urine albumin/creatinine ratio 85610
 - Serum creatinine 82565
 - Blood urea nitrogen (BUN) 84520

Measuring urea nitrogen in the blood
may provide additional info

Let's look at these tests



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BLOOD PRESSURE MEASUREMENTS

- High blood pressure can lead to kidney disease, BUT it can also be a sign that the kidneys are already impaired
- People with kidney disease should use whatever therapy is necessary, including lifestyle changes and medicines, to keep their blood pressure below 130/80
- High blood pressure is one of the leading causes of kidney disease



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MICROALBUMINURIA and PROTEINURIA

- Healthy kidneys take wastes out of the blood but leave protein
- Impaired kidneys may fail to separate a blood protein called albumin from the wastes
- At the start of kidney disease, only small amounts of albumin may leak into the urine, a condition known as microalbuminuria, a sign of deteriorating kidney function
- The amount of albumin and other proteins in the urine increases as the kidneys deteriorate. This condition is called proteinuria. (ICD-9 791.0)



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BLOOD UREA NITROGEN (BUN)

- Blood carries protein to cells in the body. After the cells use the protein, the remaining waste is returned to the blood as urea, a compound that contains nitrogen. Healthy kidneys take urea out of the blood and it is in the urine. If the kidneys are not working urea stays in the blood
- If a person's BUN is more than 20 mg/dL, the kidneys may not be working at full strength
- Other causes for elevated BUN are heart disease and dehydration



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OTHER TESTS FOR DIAGNOSIS CKD

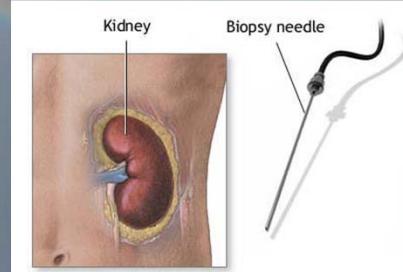
- **Kidney imaging** - Taking pictures of the kidneys including ultrasound, computerized tomography (CT) scan, and magnetic resonance imaging (MRI) are most helpful in finding unusual growths or blockages to the flow of urine.
- **Kidney biopsy** – tiny piece of kidney tissue is obtained through a needle and examined with a microscope (CPT 50200)



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RENAL BIOPSY

- In renal biopsy, a small sample of kidney tissue is removed with a needle. The test is used to evaluate a malfunctioning transplanted kidney. It is also used to evaluate an unexplained decrease in kidney function, persistent blood in the urine (ICD-9 599.70), or protein in the urine (ICD-9 791.0).
- Many glomerular diseases will need a kidney biopsy for definitive diagnosis



CPT Code 50200

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STAGES OF CKD

- eGFR of 90 or above is considered normal
- eGFR stays below 60 for 3 months
- Moderate decrease in eGFR (30 to 59)
- Severe reduction in eGFR (15 to 29)
- Kidney failure (eGFR less than 15)
- Stage 1 (585.1)
- Stage 2 (585.2)
- Stage 3 (585.3)
- Stage 4 (585.4)
- Stage 5 (585.5) or Stage 6 if on dialysis (585.6)



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ACUTE KIDNEY FAILURE

- Acute (sudden) kidney failure is the sudden loss of the ability of the kidneys to remove waste and concentrate urine +/or excrete electrolytes.
- Physician may list as AKI (acute kidney injury)
- May have AKF in the setting of CKD
- Code the AKF primary with the underlying stage of CKD secondary
- Physicians may document: AKI , ARF, renal failure, increased creatinine, prerenal azotemia etc. These are really all the same.



ICD-9 Code 584.9

Acute on Chronic 584.9 followed by the stage of CKD prior to the exacerbation 585.X

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ACUTE TUBULAR NECROSIS

- Acute tubular necrosis (ATN) is damaging and loss of tubular cells usually caused by lack of oxygen and/or chemical insult to the kidney tissues (ischemia of the kidneys). It may also occur if the kidney cells are damaged by a poison or harmful substance.
- Diabetes can make more susceptible
- Common in hospitalized patients
 - Blood transfusions
 - Injury or trauma that damages muscle
 - Hypotension > 30 mins
 - Major surgery
 - Septic Shock
 - Contrast
 - Medication Toxicity
- ATN is often recoverable but may need short term dialysis to support the body while the kidney recovers.



ICD-9 Code 584.5

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ACUTE KIDNEY FAILURE

- Acute Kidney Failure with lesion of renal cortical necrosis (ICD-9 584.6)
- Acute Kidney Failure with lesion of renal Medullary (papillary) necrosis (most often diabetic or associated with NSAID use) (ICD-9 584.7)
- Acute Kidney Failure with other specified pathological lesion in kidney (ICD-9 584.8)
- These lesions may require a biopsy to prove presence of which type lesion



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ANALGESIC NEPHROPATHY

- Caused by use of pain killers such as aspirin, ibuprofen, and naproxen sodium as well as prescription NSAIDs
- Use can be a single dose or more long term
- Can cause acute or chronic kidney disease
- Most frequent in women over 30
- Statistics show that 4 out of every 100,000 people will develop Analgesic Nephropathy
- Blood test should be done frequently to monitor kidney involvement
- A less nephrotoxic substance should be used when possible to avoid damage



ICD-9 Code 583.89

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IgA NEPHROPATHY

- IgA is a protein called an antibody that helps the body fight infections. IgA nephropathy (Berger's disease) occurs when too much of this protein is deposited in the kidneys. IgA builds up inside the small blood vessels of the kidney. Structures in the kidney called glomeruli become inflamed and damaged.
- Risk factors include:
 - A personal or family history of IgA nephropathy or Henoch Schonlein purpura, a form of vasculitis that affects many parts of the body
 - Caucasian or Asian ethnicity
 - IgA nephropathy most often affects males in their teens to late 30s
- Symptoms include:
 - Blood in the urine
 - Repeated blood or dark urine
 - Swelling of hands and feet

ICD-9 Code 583.9

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LUPUS NEPHRITIS

- An inflammation of the kidney caused by systemic lupus erythematosus (SLE) (ICD-9 Code 710.0)
- Lupus can affect the connective tissues of multisystem
- Fever, muscle & joint pain, rash of a butterfly pattern
- Additionally code as a secondary code for the manifestation of the disease
 - Endocarditis (424.91)
 - Nephritis (583.81)
 - Chronic (582.81)
 - Nephrotic Syndrome (581.81)

Coding Note: Watch use of 583.81
This code is a secondary code and cannot be used as a primary code

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FOCAL SEGMENTAL GLOMERULOSCLEROSIS

- Focal Segmental GS is scar tissue that forms in the glomeruli
- Focal means that some of the glomeruli become damaged while others remain normal
- Segmental means that only part of the individual glomeruli becomes damaged
- FSGS affect children and adults but most frequently African-Americans
- Known causes are:
 - Heroin use
 - HIV
 - Inherited genetic problems
 - Obesity
 - Reflux Nephropathy (a condition in which urine flows backward from the bladder to the kidney)
 - Sickle Cell Disease
- Most are unknown etiology

ICD-9 Code 582.1; with
Nephrotic syndrome 581.1

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GOODPASTURE'S SYNDROME

ICD-9 Code 446.21

- Is a rare disease that targets the lungs and kidneys
- Is an autoimmune syndrome where the body's own defense system attacks itself
- Symptoms include
 - Blood in urine (599.70)
 - Protein in urine (791.0)
 - Fatigue and tiredness (780.79)
 - Hemoptysis (786.30)
- Goodpasture's may be diagnosed using blood tests, but biopsy of the lung or kidney may be necessary
- Treatment may be immunosuppressive therapy or plasmapheresis (CPT 36514)
- Patients may need dialysis or kidney transplantation



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SECONDARY HYPERPARATHYROIDISM

- Kidney failure is a common cause of secondary hyperparathyroidism. Kidney failure can interfere with the body's ability to remove phosphate.
- Too much phosphate can cause a change in calcium levels in the body. The calcium needs to be corrected in these patients as well.

ICD-9 Hypocalcemia 275.41

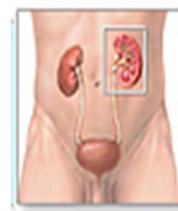
ICD-9 Code for Secondary hyperparathyroidism of Renal origin 588.81

Secondary hyperparathyroidism of non-renal origin
252.02

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NEPHROLITHIASIS (KIDNEY STONE)

A kidney stone is a crystal that forms in the kidney from substances in the urine. It may get stuck in the urinary tract, block the flow of urine and cause great pain +/or kidney failure.



ICD-9 Code 592.0

Uric acid stone 274.11



The most common cause of kidney stones is not drinking enough water

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NEPHROLITHIASIS

- Symptoms and signs of a kidney stone include excruciating, cramping pain in the lower back and/or side, groin, or abdomen as well as blood in the urine
- Kidney stones can be hereditary



One out of every 20 people develop a kidney stone at some time in their life

ICD-9 Uric acid stone 274.11; kidney stone 592.0; stone in ureter 592.1

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LET'S TAKE A "U" TURN

Back to the Basics



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MEDICARE AND ESRD



“A match made in Congress”



N
B
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ESRD DEFINED

- Medicare regulations define ESRD as “that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis treatment or kidney transplantation to survive”.
- 1972, Congress changed the Social Security Act to instruct CMS to pay the cost of treating ESRD via Medicare eligibility



N
B
AND
M
S

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MEDICARE ENTITLEMENT DATE - ESRD

- Entitlement begins after completion of three month waiting period for in-center patients
- Waiting period waived for home dialysis
- Waiting period also waived for transplants



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MEDICARE SECONDARY PAYER (MSP)

- Beneficiary is working
- Beneficiary is disabled
- For ESRD - Completion of coordination period
 - 30 months as Medicare Secondary
 - Primary coverage must be an employer group plan



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MONTHLY CAPITATION PAYMENT

- CMS method to reimburse Nephrologists for all outpatient care of patients with ESRD
- MCP is comprehensive, per patient, per month payment for **all** outpatient renal-related care
- CPT codes 90951 – 90970 are the codes used to bill the MCP and the codes vary by age and the number of face-to-face encounters the provider has with the patient during the month

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MONTHLY CAPITATION PAYMENT

Not included in MCP:

- Non-renal related evaluation and management
- Hospital inpatient services
- All non-renal procedures
- Evaluation for transplant or LRD evaluation
- Training of patients to perform home dialysis

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MONTHLY CAPITATION PAYMENT

Included in the MCP

- All renal-related **outpatient** services rendered to the dialysis patient
- Interpretation of ancillary testing (nerve conduction studies, bone density, doppler studies)
- Services rendered to the dialysis patient while on dialysis
- Physicals required by the dialysis facility for the renal patient



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MONTHLY CAPITATION PAYMENT

Included in the MCP

- Certification of the need for items & services such as DME & home health care
- Care plan oversight services described by CPT code 99375



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MONTHLY CAPITATION PAYMENT

Included in the MCP

- Periodic visits to the patient during dialysis to determine if the dialysis is working well both physiologically & psychologically. During this encounter the physician will determine if any elements of the plan need to be revised to optimize the patient's treatment and/or care.
- Coordination & direction of the multi-disciplinary team involved in the patient's care.



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OUTPATIENT SETTINGS

- The MCP covers all **outpatient** services related to the patient's renal condition
- Services may be rendered in the in-center dialysis unit, patient's home, practitioner's office, outpatient hospital, observation care, emergency room and outpatient surgery
 - **Inpatient services cannot count as MCP encounters**



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PRACTITIONER DEFINITIONS

- MCP physician is the **physician** who performs the “major” (care plan) visit during the month. This physician is the billing physician
- Non-physician practitioner – NP/PA who is employed by the same entity as the physician
 - Must be able under statute to furnish services that would be physician services
- Non-MCP physician – must have a relationship with the MCP physician such as partner



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USE OF NON-PHYSICIAN PRACTITIONERS

- **MCP** physician (billing physician) must provide the visit with the complete assessment of the patient, establish the plan of care, and submit the bill for the monthly service – **Must see the patient at least once a month**
 - Non-physicians can provide some of the visits to equal total # submitted
 - Non MCP physician can provide some of the visits
 - Non-physician must have a relationship with the physician (employee)



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PARTIAL MONTH RULE

- 90967-90970 ESRD related services for dialysis less than a full month of service
- Use limited to:
 - Transient patients
 - Home dialysis patients
 - Patients who have a permanent change in their MCP physician during the month
 - Partial month with one or more face-to-face visits without the complete (care plan) visit but only in patients with
 - Dialysis stopped due to death.
 - Dialysis patient transplanted
 - Dialysis patient hospitalized during the month



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PARTIAL MONTH RULE (cont.)

- Partial month rule **does not** apply to patients who start dialysis during the month
- Without a complete (care plan) visit, these patients cannot be billed for this first month on dialysis
- Cannot bill 90967-90970



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TRANSIENT PATIENTS

- Only one physician can bill for the management of a patient per month
- Bill 90967-90970 for the number of days the patient is under the transient physician's care
- If the transient patient is in the transient dialysis unit for a full month, then the same rules apply as with any other in-center patient. Transient MD becomes MCP physician



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PATIENTS WITH LESS THAN A FULL MONTH MCP

- Bill as if the patient had a full month of dialysis with the appropriate CPT code for the number of encounters if:
 - Dies during the month
 - Transplants during the month
 - Transfers during the month
 - Hospitalized

Patient must have **complete (care plan) visit** to bill using the appropriate CPT code



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HOSPITAL OBSERVATION STATUS

- ESRD-related visits furnished in hospital observation status count as an MCP encounter
- Visit will count towards the total number of encounters submitted (CPT code)
- Describe (document) in the medical record the type of ESRD-related service rendered in observation status



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HOSPITALIZATION & THE MCP IN-CENTER PATIENTS

- ESRD patients, other than home dialysis patients, hospitalized during the month will be billed for the number of face-to-face encounters that occurred when the patient was not in the hospital
- Since the MCP is no longer “time” dependent, but based on encounters face-to-face, the practitioners no longer “carve out” hospital days.
- Bill inpatient care and the CPT code for the number of outpatient face-to-face encounters



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HOME DIALYSIS

- Payment based on 2-3 visit payment level approximately \$221.66
- Monthly visit is the **REQUIRED** in 2011 – bill using full month code 90963-90966 (by age of the patient)
- If patient has less than full month at home– bill using by day code 90967-90970 (by age of the patient)
- Home patients are billed similarly to how MCP was billed historically



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HOME DIALYSIS (cont)

- If the home patient receives in-center dialysis during the month, the provider would still bill the management fee for the month under the home dialysis provision
- The physician cannot bill the in-center CPT code **or** CPT 90935-90937 for the encounters in-center



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HOSPITALIZATION & THE MCP HOME DIALYSIS

- Home patients continue to be billed in a full month or partial month format similar to prior codes
- If the patient is home for the 1st -10th hospitalized from the 11th-20th, then back home from the 21st-30th, you would bill for the 90967-90970 for the 1-10 (10 days), inpatient codes for 11-20, then 90967-90970 for the 21-30 (10 days)

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MODALITY CHANGES

- If a patient switches modalities during the month, bill the entire month using the appropriate **HOME** dialysis code 90963-90966
- If partial month care bill using 90967-90970

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DOCUMENTATION REQUIREMENTS

- CMS stopped short of dictating documentation requirements however were very specific on what was necessary
- With requirements now for verification of physician's face to face visits, documentation of encounters will be necessary
- RPA documentation tool has been revised to meet CMS recommendations



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DOCUMENTATION REQUIREMENTS (cont)

- Document what is clinically relevant including but not limited to:
 - patient's current status and complaints,
 - a clinically appropriate physical examination, assessment of the patient's treatment for ESRD that includes assessment of the adequacy of the dialysis treatment, the status of the patient's vascular access, assessment and treatment of the other conditions associated with ESRD, such as anemia, electrolyte management, and bone density, as well as changes to the patient's management



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ADDITIONAL DOCUMENTATION NEEDED FOR PEDIATRIC PATIENTS

- In addition to the requirements for adult patients, pediatric nephrologists also need to:
 - Monitor the patient for adequacy of nutrition
 - Assess for growth and development
 - Counsel parents

Documentation must show these elements

In addition to the adult documentation requirements



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CHANGES IN DOCUMENTATION REQUIREMENTS (cont)

- Documentation of the complete (care plan) visit is required
- Documentation that the physician performed a service for the patient is required for the other encounters
- Signing a dialysis flow sheet or any other form if not enough...the physician must document they are performing a service at each encounter



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MCP CONCLUSIONS

- Documentation will be key in managing new MCP changes
- Administrative challenges will create additional requirements for excellent record keeping
- Complete visit, including disease appropriate physical exam is necessary to bill the in-center CPT code



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NEPHROLOGY SPECIFIC CPT CODING



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INPATIENT DIALYSIS CODES

- 90935 - Single physician evaluation of hemodialysis
- 90937 - Multiple physician evaluation of hemodialysis
- 90945 - Single physician evaluation of continuous forms of dialysis
- 90947 - Multiple physician evaluation of continuous forms of dialysis

Includes E&M services rendered on the same day



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INPATIENT DIALYSIS CODES

To bill physician must meet the following:

- Be present **during** the dialysis treatment
- Documentation must reflect presence during the treatment
- The need for repeated visit should be noted in the patient's chart. The note should include the problem or anticipated problem which required the physician's repeat evaluation



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INPATIENT DIALYSIS CODES

Four E/M services that can be billed on the same day as dialysis services rendered in the inpatient setting

- Hospital admission
- Hospital discharge
- Inpatient consultation (for commercial payers only)
- Critical Care
 - Most carriers require the use of a “-25” modifier on the E/M code on the same day as a procedure



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IN CONCLUSION

- Unraveling the issues associated with Hypertension and CKD can be confusing
- Read the ICD-9 instructions carefully
- Educate your providers on the importance of specificity of their documentation and coding
 - what is the physician trying to convey and what the coders are to abstract
- Take responsibility to question and not blindly code or enter what is there
- Coding is fundamental.....



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QUESTIONS????



CODE LAS311

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