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On the topic:

Avoid ICD-10 Denials for Medical Necessity

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Avoid ICD-10 Denials for Medical Necessity

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Introduction

• Denials for medical necessity can be frustrating to deal with. They can be very time consuming, not to mention costly for your practice.
• Learning to accurately code claims to the highest level of specificity and being knowledgeable about 2017 ICD-10 updates will help keep your Revenue Cycle Management under control.
• Being familiar with your local coverage determinations (LCD’s) can assist in this area.
• Appeal denials if they are received.
What is medical necessity?

• Medicare defines medical necessity as:
  – “Services or supplies that are needed for the diagnosis or treatment of your medical condition, meet the standards of good medical practice in the local area, and aren’t mainly for the convenience of you or your doctor”

Reasons for Denials

• ICD-10 Code Changes
• Documentation guidelines not being met
• Pre-populated Diagnosis Codes
• Specificity
• Lack of Proper Documentation
• Not being familiar with local or national coverage determinations
ICD-10 Code Changes

- The grace period ended October 1, 2016 for Medicare.
- There are 1943 changes to ICD-10-CM codes
- There are a total of 75,625 valid ICD-10-PCS codes for the Fiscal Year 2017.
- Including 3,651 new codes which will be added, and 487 code titles which will be revised.

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- Educate yourself on the ICD-10 updates
- Update your fee tickets/route slips, etc.
- Get new coding books
- Review your common diagnosis codes
- Make your providers aware of any changes
- Ancillary staff need to be education on the changes as well

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ICD-10 Coding Guidelines

• Understanding the coding guidelines given to us will help eliminate some unnecessary denials for medical necessity.
• Often times medical necessity has been met, but it was not coded properly to show that.

Includes Notes

• The word “includes” appears immediately under certain categories to further define, clarify, or give examples of the content of a code category.
Excludes 1

• A “excludes 1” note is a “pure” excludes. It means “NOT CODED HERE!”
• Excludes 1 note indicates mutually exclusive codes: two conditions that cannot be reported together.
• For example, a congenital form of a disease may not be reported with the acquired form of the same condition.

Excludes 2

• An “excludes 2” note means “NOT INCLUDED HERE”.
• An excludes 2 note indicates that although the excluded condition is not part of the condition it is excluded from, a patient may have both conditions at the same time.
• Therefore, when an Excludes 2 notes appears under a code, it may be acceptable to use both the code and the excluded code together if supported by the medical documentation.
Code First

• “Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause
• When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first.

“Code, if applicable, any causal condition first”, notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable.
• A "Code Also" note alerts the coder that more than one code may be required to fully describe the condition. Code sequencing is discretionary. Factors that may determine sequencing include severity and reason for the encounter.
Use Additional Code

• “Use additional code” notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition.

• The sequencing rule is the same as the etiology/manifestation pair, “use additional code” note indicates that a secondary code should be added.

Acute and Chronic Conditions

If the same condition is described as both acute and chronic, code both. The acute is coded first.
Choosing the Correct ICD-10 Code

• Never code from the index
• Follow the instructions
• Choose the highest level of specificity

Example

S23 Dislocation and sprain of joints and ligaments of thorax

INCLUDES: avulsion of joint or ligament of thorax
laceration of cartilage, joint or ligament of thorax
sprain of cartilage, joint or ligament of thorax
traumatic hemorrhosis of joint or ligament of thorax
traumatic rupture of joint or ligament of thorax
traumatic subluxation of joint or ligament of thorax
traumatic tear of joint or ligament of thorax

Code also any associated open wound

INCLUDES: dislocation, sprain of sternoclavicular joint (S43.2, S43.6)
strain of muscle or tendon of thorax (S29.81-)

The appropriate 7th character is to be added to each code from category S23.
A initial encounter
D subsequent encounter
S sequela

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A - Initial encounter

• Used while the patient is receiving active treatment for the condition. Examples of active treatment are:
  1. Surgical treatment
  2. Emergency Department treatment
  3. Evaluation and treatment by a new physician

D – Subsequent encounter

• Used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
Examples

- Cast change or removal
- Removal of external or internal fixation device
- Medication adjustment
- Other Aftercare and follow up visits following treatment of the injury or condition.

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

(Categories for traumatic fractures have additional 7th character values)

• Character “x” is Used as a 5th Character Placeholder in Certain 6 Character Codes to Allow for Future Expansion and to Fill in Other Empty Characters (For Example, Character 5 and/or 6) When a Code That is Less Than 6 Characters in Length Requires a 7th Character
  – Examples:
    • T46.1X5A – Adverse effect of calcium-channel blockers, initial encounter
    • T15.02XD – Foreign body in cornea, left eye, subsequent encounter
**Example**

Correct ICD-10 Code would T17.0XXD
Some new features in ICD-10 CM include:

- **Laterality (Left, Right, Bilateral)**
  
  - Examples:
    - C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast
    - H16.013 – Central corneal ulcer, bilateral
    - L89.012 – Pressure ulcer of right elbow, stage II

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**Laterality**

- **Laterality**
  
  - Code as indicated (Right, Left, Bilateral)
    
    - If no Bilateral code, code both the right AND left
    - If the laterality is not specified in the chart notes, assign the code for the unspecified side.
When a patient has a bilateral condition and each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides), including for the encounter to treat the first side. For the second encounter for treatment after one side has previously been treated and the condition no longer exists on that side, assign the appropriate unilateral code for the side where the condition still exists (e.g., cataract surgery performed on each eye in separate encounters).

The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously-treated site. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.

• Combination Codes For Certain Conditions and Common Associated Symptoms and Manifestations
  – Examples:
    • K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding
    • E11.3411 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
    • I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
Unspecified Codes

• Unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient’s condition at the time of that particular encounter.

• It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

Inclusion of Clinical Concepts That Do Not Exist in ICD-9-CM (For Example, Underdosing, Blood Type, Blood Alcohol Level)

– Examples:
  • T45.526D – Underdosing of antithrombotic drugs, subsequent encounter
  • Z67.40 – Type O blood, Rh positive
  • Y90.6 – Blood alcohol level of 120 – 199 mg/100 ml
• A Number of Codes Are Significantly Expanded (For Example, Injuries, Diabetes, Substance Abuse, Postoperative Complications)
  – Examples:
    • E10.610 – Type 1 diabetes mellitus with diabetic neuropathic arthropathy
    • F10.182 – Alcohol abuse with alcohol-induced sleep disorder
    • T82.02xA – Displacement of heart valve prosthesis, initial encounter

• Codes for Postoperative Complications Are Expanded and a Distinction is Made Between Intraoperative Complications and Postprocedural Disorders
  – Examples:
    • D78.01 – Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen
    • D78.21 – Postprocedural hemorrhage and hematoma of spleen following a procedure on the spleen
And or With

• The word “and” should be interpreted to mean either “and” or “or” when it appears in a title.
• The word “with” should be interpreted to mean “associated with or “due to” when it appears in a code title, the Alphabetic Index or an instructional note in the Tabular List.
• The word “with” in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

External Cause Codes (V00-Y99)

• External cause codes are intended to be secondary codes to codes from other chapters of the classification indicating the nature of the condition. Most often, the condition will be classifiable to Chapter 19, Injury, poisoning and certain other consequences of external causes (S00 – T88).
• There is no national requirement for mandatory ICD-10 external cause code reporting. Unless a provider is subject to a state-based external cause mandate or these codes are required by a particular payer, reporting of ICD-10 codes in Chapter 20, External Causes of Morbidity, is not required.

Example

• Toddler tripped and fell while walking and struck his head on an end table, sustaining a scalp contusion
• S00.03XA – Contusion of scalp, initial encounter
  W01.190A – Fall on same level from slipping, tripping and stumbling with subsequent striking against furniture, initial encounter.
Place of Occurrence Guideline

- Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use AFTER other external cause codes to identify the location of the patient at the time of injury or other condition.
- No 7th characters are used for Y92.
- Do not use place of occurrence code Y92.9 if the place is not stated or is not applicable.

Example

- A farmer was working in his barn and sustained a foot contusion when the horse stepped on his left foot.
- S90.32XA – Contusion of left foot, initial encounter
  - W55.19XA – Other contact with horse, initial encounter
  - Y92.71 – Barn as the place of occurrence of the external cause
Activity Code

• Assign a code from category Y93, Activity Code, to describe the activity of the patient at the time the injury or other health condition occurred.
• An activity code is used only once, at the initial encounter for treatment. Only one code from Y93 should be recorded on a medical record.
• The activity codes are not applicable to poisonings, adverse effects, misadventures or sequela.

Activity Code (cont.)

• Do not assign Y93.9, Unspecified activity, if the activity is not stated.
• A code from category Y93, is appropriate for use with external cause and intent codes if identifying the activity provides additional information about the event.
Example

- Ranch hand who was grooming a horse sustained a foot contusion when the horse stepped on his left foot.
- S90.32XA – Contusion of left foot, initial encounter
- W55.19XA – Other contact with horse, initial encounter
- Y93.K3 – Activity, grooming and shearing an animal

Multiple External Causes

- More than one external cause code is required to fully describe the external cause of an illness or injury. The assignment of external cause codes should be sequenced in the following priority:
- If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
1. External codes for child & adult abuse take priority over ALL other external cause codes
2. Terrorism events take priority over everything else, BUT the above.
3. Cataclysmic events take priority over everything, BUT the above. (1 or 2)
4. Transport events take priority over everything, BUT the above. (1, 2 or 3)

Example

- 30 year-old man accidentally discharged his hunting rifle, sustaining an open gunshot wound to the right thigh, which caused him to fall down the stairs, resulting in closed displaced comminuted fracture of his left radial shaft.
• S71.101A – Unspecified open wound, right thigh, initial encounter
  W33.02XA – Accidental discharge of hunting rifle, initial encounter
• S52.352A – Displaced comminuted fracture of shaft of radius, left arm, initial encounter for closed fracture
• W10.9XXA – Fall (on) (from) unspecified stairs and steps, initial encounter.

Pre-populated Diagnosis Codes

• EHR can save the patient’s initial diagnosis code and insert it automatically into the medical record for each visit.
• While this can be a short-cut (think Physical Therapy pt’s). It can create denials. Often there can be the alpha character at the end that is incorrect:
  – A for Initial Visits
  – D for Subsequent Visits
  – S for Sequale Visits
Proper Documentation

• When discussing specificity it’s important our providers/non-physician extenders understand the changes specificity plays in documentation.
• Laterality, disease process and anatomical specificity are important changes in ICD-10.
• Communication with your providers are a necessary part of ensuring medical necessity requirements have been met.

Clinical Example

• Chief Complaint
  • “Dr. Smith asked that you check my hypertension prior to my surgery.”

• History
  • 81 year old male scheduled for a TURP in 5 days. Dr. Smith requested evaluation for hypertension and cardiac clearance assessment for surgery.¹
  • Inferior wall MI one year ago, received thrombolytic therapy and experienced complete resolution of his symptoms. Last EF (last month) was 50%.
  • Regular physical activity includes walking, swimming, and golfing. He denies SOB with exertion.
  • No history of cerebrovascular disease. No DM, CHF, renal failure, or angina.
  • Has history of essential hypertension and was prescribed metoprolol succinate once daily by PCP, but patient is not taking as he cannot afford it.²

• Exam
Clinical Example cont…

- Patient is an 81 year old male in no acute distress. Height and weight are appropriate for age.
- Vitals taken; BP is elevated at 157/92.
- Chest is clear. Physical exam is normal. No pedal edema.
- EKG shows nonspecific T-wave changes.
- Labs show creatinine at 1.5, a slight increase from his baseline and possibly indicating early renal insufficiency.

Assessment and Plan

- Will have PCP monitor BUN & Creatinine for renal function and nephrology referral if necessary.
- HTN is likely due to patient’s noncompliance with metoprolol succinate. Will coordinate with Dr. Smith as unclear if he was aware of financial situation. Change to propranolol 20 mg, 2 tab PO daily, first dose administered in office. Provided 30 day supply of free propranolol samples.
- Reevaluate HTN in 3 days; if improving then clear for surgery.

Summary of ICD-10 CM Impacts

Clinical Documentation

- Documenting why the encounter is taking place is important, as the coder will assign a different code for a routine visit vs. a surgery clearance vs. an initial visit.
- If known, it is important to document whether or not patients are compliant with their medications. “Underdosing” is a new concept in ICD-10-CM and can be captured along with the diagnoses, such as this case for metoprolol succinate. When an issue with underdosing is noted, document if the matter is new or has been recurrent. The ICD-10-CM terms provide new detail as compared to the ICD-9-CM code V15.81, history of past noncompliance. In this case there was no noted history of noncompliance.
• Documentation indicates that lab results reveal “a slight increase his baseline and possibly indicating early renal insufficiency. Guidelines allow the reporting of additional diagnosis to support the abnormal test result.
• In ICD-10 CM coders are provided the “Use Additional Code” note under the Hypertensive diseases (I10-I15) block. If known, document whether or not the patients have the following: exposure to environmental tobacco smoke, history of tobacco use, occupational exposure to environmental tobacco smoke, tobacco dependence, and or tobacco use. In this case there was no noted history of the above.

Coding

<table>
<thead>
<tr>
<th>ICD-9 CM Diagnosis Codes</th>
<th>ICD-10 CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>401.9 Unsp. essential hypertension</td>
<td>I10 Essential (primary) hypertension</td>
</tr>
<tr>
<td>794.31 Nonspecific abnormal EKG</td>
<td>R94.31 Abnormal EKG</td>
</tr>
<tr>
<td>794.4 Non specific abnormal results of function study of kidney</td>
<td>R94.4 Abnormal results of kidney function study</td>
</tr>
<tr>
<td>412 Old myocardial infarctions</td>
<td>I25.2 Old myocardial infarction</td>
</tr>
<tr>
<td>N/A</td>
<td>T46.5X6A Underdosing of other antihypertensive (Initial encounter)</td>
</tr>
<tr>
<td>N/A</td>
<td>Z91.120 Patient's intentional underdosing of medication due to financial hardship</td>
</tr>
<tr>
<td>V72.81 Pre-operative cardiovascular examination</td>
<td>Z01.810 Encounter for pre-procedural cardiovascular examination</td>
</tr>
</tbody>
</table>
LCD’s and Medical Policies

• Highmark Blue Cross defines medical policies as documents that provide medical necessity and coverage guidelines for all of our medical-surgical products.

• CMS states local coverage determinations (LCDS) are defined in Section 1869(f)(2)(B) of the Social Security Act (the Act). This section states: “For purposes of this section, the term ‘local coverage determination' means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A).”

Locating Medical Policies/LCD’s

• Carriers other than Medicare can most frequently be found on the carriers website

• Local Coverage Determinations can be found on CMS.gov’s Medicare Coverage Database.
Appealing Denials

• Review the documentation and if there is proof of medical necessity begin the appeals process.
• If a denial is received for medical necessity remember that you have a time limit for filing an appeal.
• Each carrier’s appeal process can differ so make sure you have the information for the payer to submit an appeal in the correct manner.
## Appeal Letter

- The appeal letter should be impactful.
- It should include all the pertinent information
  - Patient Name
  - Health Insurance Identification Number
  - Group Number
  - Claim Number
  - The contact name at the carrier

### The reason for the appeal
- Be clear about why you are appealing the denial
- Include the payer’s policy for medical necessity
- Attach documentation showing proof of medical necessity
- State exactly what you would like them to do
- Make sure your contact information is available
Follow Up

– Have a plan for tracking the appeal
– Keep a copy of all documentation
– Know the timeline for when you can expect a response
– Keep a log of medical necessity denials

Resources

• http://www.roadto10.org/specialty-references/clinical-scenarios
Questions?

• Thank you for your attendance!

• Get your questions answered on PMI’s Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp