April, 2016

TCMA Billing Department

Billing Buzz

Choosing Current Condition vs Personal History Diagnosis Codes

Knowing whether to choose a diagnosis code for personal history of a condition or the code for the actual condition can be confusing. This is especially true when dealing with cancer diagnoses.

The general rule regarding cancer diagnoses is:

- It is appropriate to use the active cancer diagnosis code when cancer is present or when the patient is undergoing treatment (e.g. surgery, chemotherapy, radiation, hormone therapy, etc).
- It is appropriate to code for history of cancer when a primary malignancy has been excised or eradicated with no further treatment required. According to ICD-10 guidelines, "Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment but has the potential for recurrence and therefore may require continued monitoring."

As stated in the 2016 ICD-10-CM Official Guidelines for Coding and Reporting:

"When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed. When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy."

The issue has also been addressed directly by some payers. The June 10, 2014 edition of BCBSMA Provider Central stated the following:

"There is often confusion around when to code for "active cancer" vs. "history of cancer." Improper use of the copy and paste function within electronic medical records can further complicate this issue.

To accurately code a cancer diagnosis, the medical documentation must clearly state whether the cancer is a current and active condition *or* a past condition that has been excised or eradicated with no further treatment needed. The office note must clearly indicate:

- If the cancer is present and being actively managed or treated
- If the cancer has been eradicated or excised
- If there is evidence of recurrence
  What treatment is being used to manage the active cancer

CMS audits follow ICD-9 coding guidelines which state that it is appropriate to use "history of" when the condition is resolved, cured, and gone. "

The table below contains some frequently used Cancer and Personal History of Cancer Codes

Type	Current condition code	Personal History code
Breast (female)	Right - C50.911 / Left - C50.912	Z85.3
Prostate	C61	Z85.46
Skin	C44.90	Z85.828
Lung	C34.90	Z85.118
Liver	C22.8	Z85.05
Thyroid	C73	Z85.850
Bladder	C67.9	Z85.51
Colon	C18.9	Z85.038
Cervix	C53.9	Z85.41
Uterus	C54.9	Z85.42

Coding for Tick Bites

When a patient is seen for initial evaluation and management of a tick bite on the right upper arm the following codes should be reported in the order shown:

S40.861A: Insect bite (nonvenomous) of right upper arm, initial encounter

W57.XXXA: Bitten or stung by nonvenomous insect and other nonvenomous arthropods; initial encounter

Note that the primary code, S40.8 61A, describes an insect bite and is not specific to ticks. However, it is appropriate in this case as there is not a code that is specific to tick bites. Also note that the code is specific to the site of the bite. There are separate codes for bites on the head, neck, abdomen, lower arm, chest, upper back, lower back, thigh, lower leg, foot and so on. There is no code for an unspecified site.

The tick bite codes can be found in the Internal Medicine, Family Medicine, and Pediatrics ICD-10 Custom Lists by searching 'tick or 'bite'. If the affected body part is entered in the search box along with 'tick' or 'bite' the returned results will be more specific.

New Problem

Search

Search for: tick arm

Using:

Problem De

Searching: ICD-10 Family Medicine	ICD-9	ICD-10
Tick bite, upper arm, left, initial encounter		S40.862A
Tick bite, upper arm, left, subs encounter		S40.862D
Tick bite, upper arm, right, initial encounter		S40.861A
Tick bite, upper arm, right, subs encounter		S40.861D

Note that searching 'tick arm' will return upper arm codes. For forearm search 'tick forearm. Searching 'tick leg' will return lower leg codes. For a bite on the thigh search 'tick thigh'.

Here is one more example:

New Problem

Search

Search for: tick sc

Using:

Searching: ICD-10 Pediatrics	ICD-9	ICD-10
Tick bite, scalp, initial encounter		S00.06xA
Tick bite, scalp, subs encounter		S00.06xD

The secondary code, W57.XXXA, is an 'external cause of morbidity' code. It can never be used as a primary diagnosis. Its purpose is to provide additional information describing the circumstances of an injury or health condition. According to ICD-10 guidelines, there is no mandatory requirement for reporting the external cause codes.

Pregnant State Incidental?

When a pregnant patient is seen for a routine prenatal visit, a condition related to pregnancy, or a condition affecting pregnancy, diagnosis *Z33.1 – Pregnant state, incidental* should not be reported by the OB or any other provider.

ICD-10-CM instructions or Chapter 15: Pregnancy, Childbirth and the Puerperium state:

- Obstetric cases require codes from *Chapter 15, Pregnancy, Childbirth, and the Puerperium*.
- Chapter 15 codes are in the range **O00-O9A** and have sequencing priority over codes from other chapters.
- Should the provider document that the pregnancy is incidental to the encounter, then code *Z33.1, Pregnant state, incidental*, should be used *in place of any Chapter 15 codes*.
- It is the provider's responsibility to state that the condition being treated is not affecting the pregnancy.
- *Z33.1, pregnant state, incidental* should not be reported with codes from chapter 15.

The only time *Z33.1, pregnant state, incidental*, should be reported is when a pregnant patient presents with a separately identifiable diagnosis and the provider documents that the condition is unrelated to and not affecting the pregnancy.

Example: Pregnant patient with cough and fever is diagnosed with upper respiratory infection. Documentation states that patient is 25 weeks pregnant, and URI is unrelated to and not affecting pregnancy. The visit should be reported with the diagnosis codes below in the order shown

- J06.9 – acute URI, unspecified
- Z33.1 – pregnant state, incidental

It is never correct to assign Z33.1 to a prenatal visit, an OB ultrasound, or an NST.

Audit Statistics

Below are the Audit Statistics comparing 2015 to 2014

	Met Criteria	Under Coded	Over Coded	Category Change	Missing Billing	NP/PA Issue	No Attestation	Insufficient Documentation	Procedure Only	Service Not Billable
2014	68.75	17.78	9.51	2.55	.62	.61	.44	.26	.44	.09
2015	66.87	19.26	8.58	3.19	1.84	.26	.49	0	.49	.36

Findings:

Down in Met Criteria
Up in Under Coded
Down in Over Coded
Up in Category Change (new to established and vice versa)
Up in Missing Billing
Down in NP/PA issues
All others had a minimal change

Conclusion—The detail of the statistics was reviewed. Due to our growth one might expect the decrease in the Met Criteria category was due to new providers having to learn a new EMR along with all the other challenges of joining a new group. Unfortunately that is not the case. All the providers who had 4 or more records under coded have been with Tri-County for a while. That being said, please let us know what tools you would find helpful to assist you with choosing the correct level of service.

We have good news on the level 5 audits. In 2015 92.06% of records reviewed met the criteria for level 5 service. This was an improvement from 89.13% in 2014. The number of records recoded to a level 4 service decreased from 8.94% to 6.40%.

	Total # of Level 5 Records Reviewed	# of Supported Level 5 Service	# Recoded to Level 4 Service	# Number Recoded to Level 3 Service	# Recoded to Level 2 Service
2014 Totals	727	648	65	12	2
Percentage		89.13%	8.94%	1.65%	0.28%
2015 Totals	781	719	50	8	0
Percentage		92.06%	6.40%	1.02%	0.00%

What's the Difference Between "Other Specified" Diagnosis Code and "Unspecified" Diagnosis Code?

'**Other specified' Codes** are for use when the information in the medical record provides detail for which a specific code does not exit

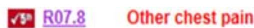
<u>Example – 'Other Specified':</u>

62 Year old woman presents with intermittent left sided chest pain. Severity is variable, worse with deep inspiration. Patient denies other pain and associated symptoms.

On physical exam, tenderness over her left anterior chest wall was reported to be the same pain she experienced at home. Breath and heart sounds are normal.

EKG shows NSR at 75 BPM with abnormal T-waves in the V-leads.

Below is an excerpt from the ICD-10 manual that defines anterior chest wall pain as R07.89.



R07.8	Other chest pain
R07.81	Pleurodynia
	Pleurodynia NOS
	EXCLUDES1 epidemic pleurodynia (B33.0) (B33.0)
R07.82	Intercostal pain
R07.89	Other chest pain
	Anterior chest-wall pain NOS
R07.9	Chest pain, unspecified

Therefore, the diagnosis codes for this visit are:

R07.89 – Other chest pain
R94.31- Abnormal EKG

'Unspecified' Codes are for use when the information in the medical record is insufficient to assign a more specific code

<u>Example – 'Unspecified':</u>

62 Year old woman presents with chest pain.

Physical exam is normal

EKG shows NSR at 75 BPM with abnormal T-waves in the V-leads.

R07.8	Other chest pain
R07.81	Pleurodynia
	Pleurodynia NOS
	EXCLUDES1 epidemic pleurodynia (B33.0) (B33.0)
R07.82	Intercostal pain
R07.89	Other chest pain
	Anterior chest-wall pain NOS
R07.9	Chest pain, unspecified

Therefore, diagnosis codes for this visit are:

R07.9 – Chest pain, unspecified
R94.31- Abnormal EKG

R07.9 is chosen because the medical record does not specify additional information