Hello and Thank You!
The response to our first issue of the Coding Link was overwhelming and we are excited to provide you with yet another information-packed issue. Many questions have been brought to the forefront and many more are left to be answered. We look forward to your continued participation and sharing of information as we assist others in the network.

If you are interested in reading about a particular topic or would like to author a brief article, do not hesitate to contact our department!

Thank you and enjoy!
Lynn Wall – walll@slhn.org
X3642

Anemia Documentation Tips

Did you know that coding guidelines differentiate between the types of anemia AND there are distinct ICD-9 codes for the above? Avoid a query from the Coding Documentation Specialists by following any of the following:

1. If blood products are ordered, remember to document the reason for the transfusion.
2. Document any intra-operative blood loss as less than expected, expected, or greater than expected.
3. Document if the anemia is due to a disease process, hematological problem, or use of anticoagulants.
4. Per a physician on staff, a 2gm/dl drop in Hgb is considered anemia, and therefore, this is what we base our queries, if needed, on.

REMEMBER: A Complication code for blood loss anemia will only be assigned if the physician indicates that the blood loss was excessive or due to a complication of a procedure. Simply documenting blood loss anemia following a procedure DOES NOT constitute a complication, but will create a higher level of severity for the patient stay.

General Documentation Corner

There is a myriad of documentation suggestions to assure the condition and case severity of your patient is coded correctly. Listed below are just a few:

1. Note potential underlying cause, if known (eg. diabetes, hypertension, trauma, etc.)
2. Specify severity – acute vs. chronic
3. Diseases and test results MUST be documented by a physician and should be linked to a specific condition.
4. Coders can NOT decipher the use of symbols and therefore, when documenting lab values for a diagnosis i.e. instead of low NA+, hyponatremia should be spelled out in full, at least once in that patient’s hospital stay.
5. Document PMH, PSH, and PFM as this helps the coders with E&M level of service codes and history codes.
6. Remember never to write –see previous record- for any information as coders can not look at previous stays for any information…this also includes any information from a patient transferred from another facility.
7. List diagnoses in admitting orders to help justify patient’s admission.

For further information or clarification, do not hesitate to contact Cindi, Michele or Lynn Wall.

Getting to the Principal Diagnosis While Slimming Down on the DDR’s

When making your final diagnosis, please keep in mind the definition—“the condition established after study to be chiefly responsible for occasioning the admission to the hospital”. Try not to use symptoms such as pain, syncope, shortness of breath, chest pain, etc. When an etiology is found after physical exam, studies, and tests, according to the definition, the etiology of the symptom(s) would be the diagnosis.

Of course for some admissions an etiology is not or cannot be determined – in those cases it would be appropriate to use a symptom as the final diagnosis. When the etiology of the symptom or that the etiology is undetermined/unknown at the time of discharge is documented in the chart – this can eliminate a DDR being sent to you.

Regulatory Update

Elimination of 90-day Grace Period for HCPCS Level I (CPT) & Level II (DME, Therapy, Drugs) codes//ICD-9 Update Changes

CMS had permitted a 90-day grace period for the use of discontinued codes for dates of service January through March 31 that were submitted to Medicare contractors by April 1 of the current year.

As a result of the Health Insurance Portability & Accountability Act (HIPAA), codes sets must now be date of service compliant. HCPCS is a code set and therefore, beginning January 1, 2005 it will eliminate the usual three month grace period altogether.

In addition, with the recent passage of the Medicare Modernization Act (MMA), not only was there a big impact on drug use and how it is reported, ICD-9-CM code updates were also impacted. Previously, ICD-9-CM codes were update annually every October 1st – the beginning of the Federal fiscal year.

The MMA now mandates that updates to ICD-9-CM codes will occur annually on April 1st and October 1st of every year.
What does this mean to you? Whether a physician office practice or hospital service, all resources and tools utilized for coding services rendered must be up-to-date and ready for use on the day the new codes become effective.

What can you do now? Stay on top of coding changes, keep in contact with payors, and routinely review superbills if used.

For more information, access CMS website at http://www.cms.hhs.gov/providers/pufdownload/anhcpedl.asp

Or contact a member of the Coding Department.

New Charting Tool to be Put Into effect

Soon, a new “Non-Cardiac Chest Pain” charting tool will be put into affect. This tool is designed to be used only as a reference when cardiac diagnoses have been ruled out. Please consider other possible causes of chest pain and document them as such as the diagnosis rather then using simply “chest pain” as this gives the coders another avenue to use in assigning an ICD-9 code. If, during testing, the possible diagnosis has been ruled out, also document this.

Differentiating the causes of Syncope

The etiology of syncope is often difficult to determine. It is equally as difficult to code. The term ‘vasovagal’ in ICD-9-CM coding is the same as syncope – no distinction or differentiation is made. If there are other causes (or potential causes) of syncope, such as bradycardia or other arrhythmias, Parkinson’s Disease, TIA’s, CVA’s, etc., please document these as part of your differential diagnoses.

How to Avoid the DDR’s from Outpatient Charts

Too much information is never enough, but too little can be nerve racking to a coder. This is when you as physicians, in turn, get a DDR sent to you. The following are a few tips on how to avoid receiving any further DDR’s in the future. Remember, it is all up to you, and how much information you are willing to tell us.

1. Document the type of polyp removal, for i.e. cautery, snare, biopsy, etc.
2. Document the type of dilation performed, i.e. dilation with insertion of a guide wire, balloon dilation, etc.
3. Document if a splint was applied, not just that the person was sent home with one.
4. Document the type of CMG and/or uroflowometry performed, i.e. simple, complex.
5. Document the size of a wound and if it was surgically debrided.
6. Document the type of biopsy performed, i.e. core needle, fine needle, incisional, excisional, etc.

Seeking Physicians to provide In-services on the following topics:

► Septicemia
► Pain Management
► Renal Failure

If interested, please contact:
Cindi Callantine at x4741 or via email at callanc@slhn.org
Michele Ortiz at x4747 or via email at ortizm@slhn.org
Lynn Wall at x3642 or via email at walll@slhn.org