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March 2016

ICD-10 to Get 5,500 New Codes, including Ones for Face, Hand Transplants, CMS Says

CMS said it plans to add about 1,900 diagnosis codes and 3,651 hospital inpatient procedure codes to the coding system.

By Susan Morse | March 16, 2016

On October 1, the Centers for Medicare and Medicaid Services will add another 5,500 codes to the ICD-10 diagnostic library, officials announced in a March 9 meeting. The addition will come exactly one year after ICD -10, with its nearly 70,000 billable codes, replaced the dated, and much more compact, ICD-9 code set.

CMS said it plans to add about 1,900 diagnosis codes and 3,651 hospital inpatient procedure codes to the ICD-10 coding system for healthcare claims in fiscal year 2017.

Of the 3,651 new hospital inpatient procedure codes, 97 percent will update the cardiovascular and lower joint body systems, CMS said. There will also be new codes for a face transplant, hand transplant and donor organ perfusion, CMS said.

The large number of new codes is due to a partial freeze on updates prior to the original launch on October 1, 2015, according to CMS. The 2016 update will include the backlog of all proposals for changes to the code set.

The new and revised ICD-10-CM (Clinical Modification) and ICD-10 PCS (Procedure Coding System) codes will be included in the hospital inpatient prospective payment system proposed rule for fiscal 2017, which is expected next month. Diagnostic Related Group changes will also launch on October 1, according to CMS.

Written comments on the codes will be accepted until April 8.

Reference: http://www.healthcareitnews.com/news/icd-10-get-5500-new-codes-including-ones-face-hand-transplants-cms-says

Ask the Expert

Coding for Debridement Services in the Wound Care Environment

By Melody Czapski, Auditor

How many of us get dizzy when it comes to understanding the complexity of the documentation requirements and coding guidelines for 'excisional debridement' versus 'selective debridement'? We assign the procedure code based on the supporting documentation, but what are the documentation requirements? How do we determine medical necessity of the service needed to support billing? What are some of the common questions regarding documentation requirements and the medical necessity of service? Let's explore each of these questions in our 3-part series regarding wound care coding.

Wound Care Documentation Guidelines

Wound care involves many parameters, but the following indicators should be included in the continued documentation of healing a wound or ulcer (at minimum):

- Plan of care or order: to include duration, frequency and type of treatment for each specified wound or ulcer
- Clearly define the condition or diagnosis as an ulcer or wound, including pressure ulcer or non-pressure ulcer. ***(NOTE: Physicians use the terms 'wound' and' ulcer' interchangeably; however, they are not synonymous—'ulcer' is typically due to an underlying condition and 'wound' might result from a traumatic injury.)***
- Describe the size (length, width, depth) pre- and post-procedure
- State the stage of pressure ulcers
- Presence of undermining or tracts, decreased circulation, exudate, signs of infection, edges, and presence of foreign bodies, condition of surrounding skin and color—red, yellow, or black

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Ask the Expert *(Continued from page 1)*

- Anatomic location of each wound—often numbered
- Type of tissue removed (viable or nonviable)—subcutaneous, muscle, tendon, bone, necrotic, or slough
- Report only the area actually debrided
- Photography is useful for documenting progress and should include a measuring scale and date
- The progression and response to treatment, in alignment with the plan of care

With the implementation of electronic medical records comes cloning, smart phases, cut/paste, pull-forward—all useful—however, the physician/provider must verify and confirm the accuracy of the documentation for each encounter. Cloned documentation, if not carefully edited, may misrepresent the intensity and severity of service when the changes, new findings and/or responses are not accurately reported or updated in the documentation. Be careful and avoid unintentional mishaps that may cause a payment denial.

Medical Necessity

Medicare will deny surgical (aka "excisional") debridement (CPT 11042 – 11047) if the documentation does not substantiate medical necessity:

- Missing plan of care
- Lacking evidence of progression and response to treatment
- No change in or missing the wound size, depth or volume (dimension and depth) before and after each debridement
- Absence of the description of the necrotic, devitalized or nonviable tissue or slough removed
- The method or technique and types of instruments used
- Excessive number of uses of surgical debridement billed for the same ulcer or wound my result in Medically Unlikely Edits (MUEs)

Medicare and private payers recognize medical necessity as a deciding factor for payment of services. Although each payer may have its own definition, overall, most are similar to that of Medicare.

According to section 1862(a)(1)(A) of the Social Security Act, Medicare will not cover services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

References:

1. Michigan Part A, 3rd Quarter, 2015

2. CPT Assist: June 2014, Vol 24 Issue 6 and Mar 2012, Vol 22 Issue 3; §2o.9

3. Correct Coding Initiative; LCD L28572; CC: Vol 10, #1

4. Ask the Editor #4 and Vol 15, #1, 1st Qtr. 2015.

5. CMS, MLN, 'Global Surgery Fact Sheet' ICN 907166 March 2015;

6. Medicare Physician Fee Schedule; MCPM 100-04, Cpt. 12 §40 and §30.6

7. NCCI, CHAPTER XI pg. 34, #5. Effective 1/1/2016

News & Events

Oxford HIM PTO Benefit

Oxford HIM offers full-time consultants the opportunity to take paid time off! The PTO benefit comes in addition to holiday pay, 401(k) and medical insurance packages, paid travel and other benefits we provide.

If you have any questions, please contact your recruiter or email HIM@oxfordcorp.com.

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Increase your cash flow by referring other HIM professionals to Oxford HIM!

You can earn **$500** for every qualified contract or direct hire candidate. The bonus will be paid to you after the referred contract employee has worked 120 hours or the direct hire employee has completed 90 days.

Please ask your recruiter for more details, or email referrals to lauren_pease@oxfordcorp.com.

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- ◊ Remote Outpatient Coder—Multiple Locations
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Email Lauren_Pease@oxfordcorp.com today to learn more about these opportunities or refer a friend!

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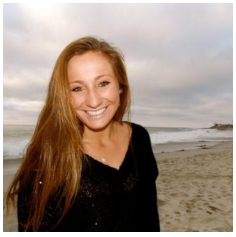
Employee Spotlight



Meagan M., *Associate Recruiter*

I am a San Diego native, born and raised in La Jolla. After graduation, I decided to try the East Coast for a bit, and attended The George Washington University in Washington, DC. There I played water polo for 2 years and studied abroad in London for a semester.

After graduating, I decided I needed to return to the West Coast and moved back to San Diego. Before I started working at Oxford, I did some traveling throughout parts of Europe, New Zealand, and South Africa. It was a great experience that really allowed me to see parts of the world I'd only read about in books.

I truly am glad I found Oxford. Everyone here is so welcoming and working with all the candidates has been an amazing experience. Every day I get to hear about people's different backgrounds and perspectives on the HIM industry. Since starting, I have learned so much and I look forward to recruiting amazing talent in the future!

Who Knows?

What is the osteoinductive protein used as an alternative to bone autografting in spinal fusions, internal fixation of fractures, treatment of bone defects, and reconstruction of maxillofacial defects?

Send your answers to:

Lauren_Pease@oxfordcorp.com

All correct answers will be put into a raffle for a chance to win a $25 gift card.

Last Edition's 'Who Knows' Winner

And the winner is … Krista L.

Answer: Nitrogen gas in the blood

Consultant Spotlight

Andrew L., ***HIM Consultant***

I have been working for Oxford for 6 months but I started coding 14 years ago. I earned my CPC certification, began working in a physician's office and worked there for 2 years. An opportunity arose at the local community hospital for an outpatient coder and I changed jobs to code emergency room records. I worked there for 12 years until the hospital had a drastic change in their healthcare coverage and it became impossible to stay there. Thankfully, in 2008 I was also able to get my CCS credentials which I believe has helped me immensely in my current role.

I began my search for other coding opportunities and eventually landed with Oxford HIM. The first person I had contact with was Kailee Schroeder. She has been, along with my coding manager Michellene Fryson, the reason for my success at Oxford. These ladies have been ultra-professional in their handling of my transition from facility coding to agency coding. They have represented Oxford with integrity and concern and have shown me why my choice to join the Oxford team was a good one.

In my spare time I like to garden and am steward to 75 apple trees in my backyard. They provide a great crop each year which I give away to family and friends. Also, the deer in the area are very healthy and well fed because of the apples, so I have a lot of visitors in my yard.

Living close to Lake Erie also affords trips on the water with my boat. I was a very active sailor and competitively raced for many years in the past, so this pastime is very enjoyable to me.

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Oxford HIM is rated #1 by KLAS!

For the second year in a row we have been rated #1!

Read more on our #1 KLAS rating here:

http://ow.ly/YwMZh

Oxford at HIMSS16!

Oxford had a great time at HIMSS16! Our booth held a hologram and we gave away an Apple Watch!

If we missed connecting with you at the show, please be sure to connect with via Email, Facebook, Twitter or LinkedIn for more information on our staffing solution services.