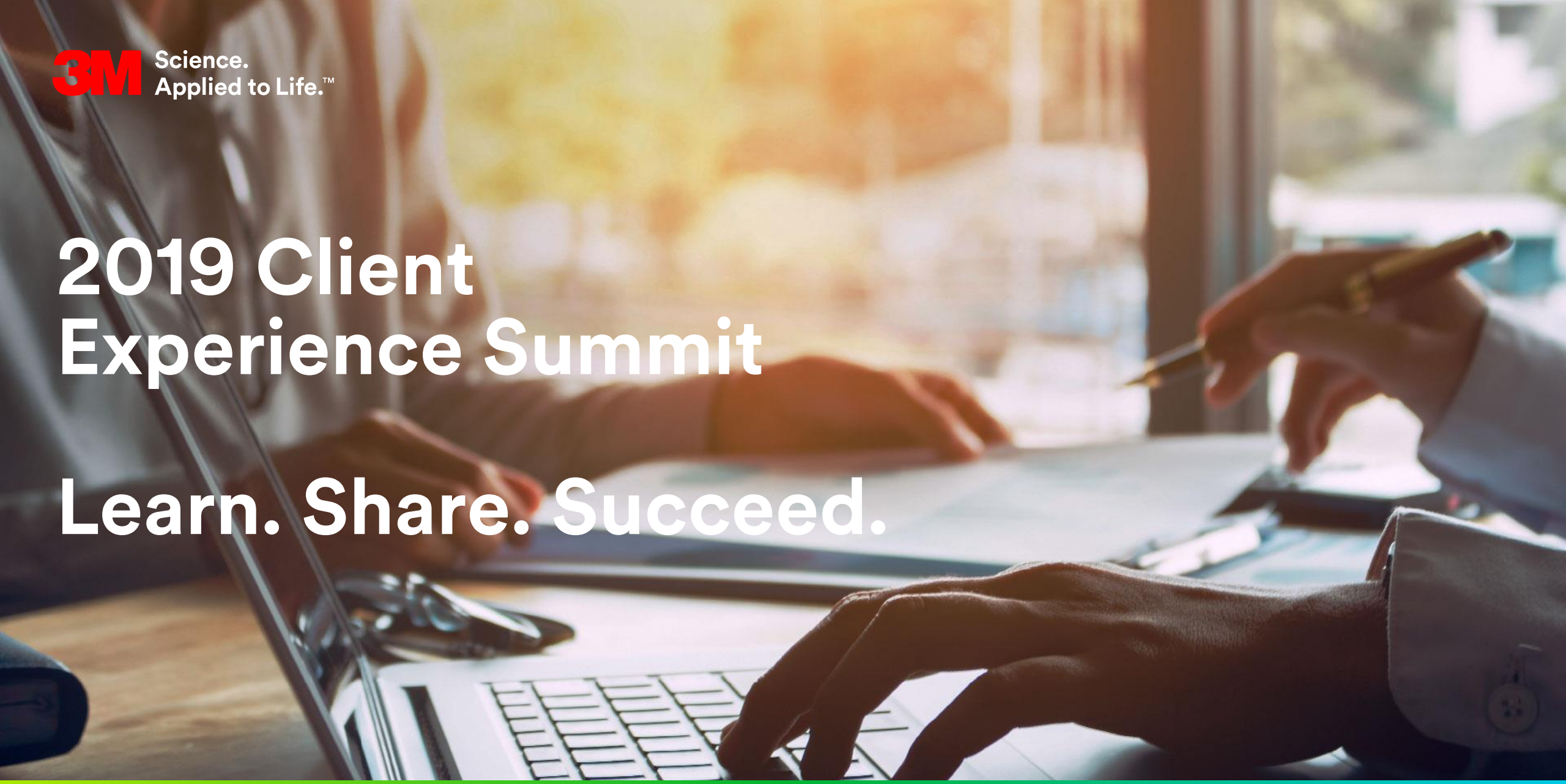
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Nosology Nuggets

Michele Taylor RHIT, CCS
Rauna Gale RHIA

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3M HIS Nosology Teams

Nosology Support Team

- 18 team members
  - RHIA, RHIT, CCS, CPC, CIRCC

Nosology Development Team

- 28 team members
- RHIA, RHIT, CCS, CPC, RN, CDIP CCDS

Nosology CAC Development Teams

- 35 team members
- RHIA, RHIT, CCS, CPC-H, CDIP, IR

High-Volume Nosology Topics - Agenda

- Sepsis Sequencing
- Rehabilitation
- Bronchoscopy PCS
- CHF grouping
- NCCI and Other Edits with CMS website tips and tricks
- Separate Procedure Designation
- Podiatry
- LINX

Sepsis Sequencing

Sepsis Sequencing

- *If the reason for admission is both sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code(s) for the underlying systemic infection (A41.9) should be assigned first and the code for the localized infection should be assigned as a secondary diagnosis.*

- *If sepsis or severe sepsis is documented as associated with a noninfectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the noninfectious condition should be sequenced first, followed by the code for the resulting infection.*

- ***If the infection (sepsis) meets the definition of principal diagnosis, it should be sequenced before the non-infectious condition.*** *When both the associated non-infectious condition and the infection meet the definition of principal diagnosis, either may be assigned as principal diagnosis.*

Source: ICD-10-CM Official Guidelines for Coding and Reporting FY 2019 Page 25-27

Sepsis Sequencing

Scenario:

Patient is admitted with left diabetic foot ulcer with cellulitis and gangrene. Patient had fever and tachycardia with blood cultures taken. Sepsis was confirmed. Sepsis due to cellulitis with gangrene. The patient had excisional debridement of left diabetic foot ulcer and placed on IV antibiotics.

Discharge summary:

- *Diabetic peripheral angiopathy with gangrene*
- *Diabetic left foot ulcer with cellulitis*
- *Sepsis.*

Sepsis Sequencing

Is this sepsis due to an infection or is it sepsis due to noninfectious process?

Diagnosis for review:

- *Diabetic left foot ulcer*
- *Cellulitis*
- *peripheral angiopathy*
- *Gangrene*
- *Sepsis*

Sepsis Sequencing

Scenario:

- Sepsis with localized infection; cellulitis. Sepsis would be sequenced as principal
- Sepsis and Infectious Gangrene; Sepsis would be principal
- Sepsis and Diabetes with ulcer, without cellulitis; either sepsis or diabetes could be sequenced as principal.

Sepsis

- Coding must be based on provider documentation.
- Although ultimately related to the accuracy of the coding, clinical validation is a separate function from the coding process and clinical skill.

"Code assignment should be based on provider documentation. As has been repeatedly stated in Coding Clinic over the years, diagnosing a patient's condition is solely the responsibility of the provider. Only the physician, or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis, can "diagnose" the patient. As also stated in Coding Clinic in the past, clinical information published in Coding Clinic does not constitute clinical criteria for establishing a diagnosis, substitute for the provider's clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of a patient's medical condition."

Source: ICD-10-CM/PCS Coding Clinic®, ***Fourth Quarter ICD-10 2016*** *Pages: 147-149*

Rehabilitation: Debility

The diagnosis of debility

Chief complaint:

>Debility, acute encephalopathy.

Pt is post recent hospitalization for CVA with left hemiparesis and dysarthria. Presented now with altered mental status and inability to get out of bed. Had extensive acute care workup. Ultimately felt to be multifactorial, primarily staph urinary tract infection.

- *Debility, acute encephalopathy –multifactorial due to staph with UTI on septra.*
- *acute/chronic Diastolic CHF.*
- *A.fib*

The diagnosis of debility

Would the code R53.81 for debility be the principal diagnosis?

Rehab diagnosis:

- Debility due to acute encephalopathy still treating with antibiotics and IV hydration.
- Hemiparesis.
- dysarthria.
- *acute/chronic Diastolic CHF.*
- *A.fib*

The diagnosis of debility

- When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed.
- In this case, the underlying reason for the debility and deconditioning is coded as the principal diagnosis.

Source: ICD-10-CM Official Guidelines for Coding and Reporting FY 2019 Page 109

The diagnosis of debility

Diagnosis: debility due to cholelithiasis. Cholecystectomy was performed.

If the reason for the debility no longer exists: surgery took care of the problem like cholelithiasis, etc. Then a code like Z48.815 would be reported.

Z48.815 Encounter for surgical aftercare following surgery on the digestive system.

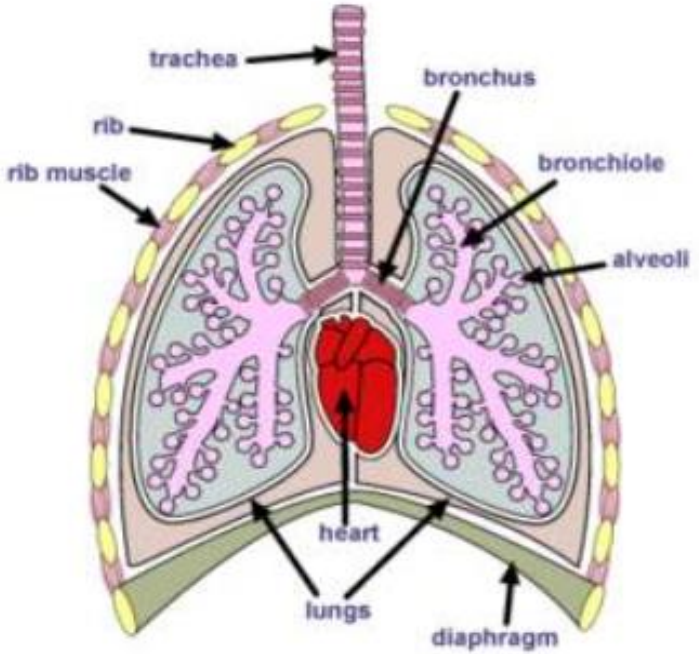
R53.81 for debility would **not** be used as the principal diagnosis.

Source: ICD-10-CM/PCS Coding Clinic, Fourth Quarter 2013 Page: 129

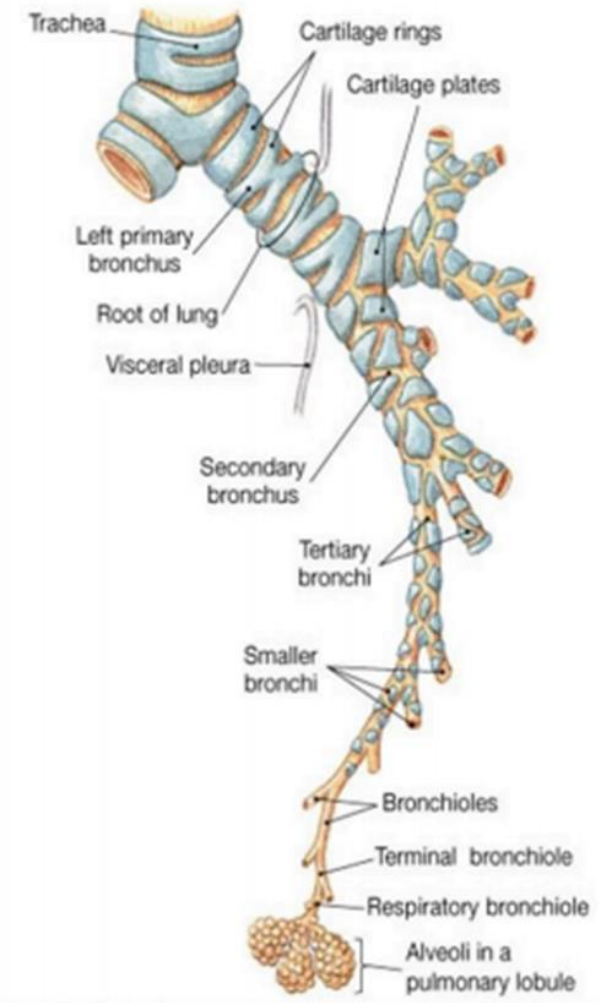
Rehabilitation

Nosology can not provide advice regarding etiological diagnosis for IRF-PAI.

Please see Coding Clinic® third quarter ICD 10 2015 page: 36.



Bronchoscopy PCS



Bronchoscopy drainage versus irrigation.

- The bronchioles are considered bronchus while the alveoli are considered lung tissue.

Bronchoscopy

Bronchoalveolar lavage (BAL): It consists of washing out the peripheral airways and alveoli tissue with a rinsing (sampling) solution. Saline may be introduced into a subsegment of the lung and then gentle suction is used to retrieve the saline along with cells for cytology. This is a "liquid biopsy" and is not the same as a whole lung lavage therapy. Lavage is coded to the root operation drainage. The lung body part value more accurately captures the objective of BAL.

"BAL is performed in the left lower lobe" The correct code:

0B9J8ZX Drainage of left lower lung lobe, via natural or artificial opening endoscopic, diagnostic

Source:

- *ICD-10-CM/PCS Coding Clinic,* ***First Quarter ICD-10 2017*** *Page: 51*
- *ICD-10-CM/PCS Coding Clinic,* ***First Quarter ICD-10 2016*** *Pages: 26-27*
- *ICD-9-CM Coding Clinic,* ***Third Quarter 2002*** *Page: 16 to 17*

Bronchoscopy

Washings without brush biopsy:

> *"Flexible bronchoscope is introduced in the oral cavity. Vocal cords were visualized. Carina is visualized. Bronchial tree was inspected thoroughly. No evidence of endobronchial lesions, alveolar hemorrhage, mucopurulent secretions. There are mild inflammatory changes and worsening interstitial infiltrates and hypoxia. Bilateral lung washings were performed. Patient tolerated the procedure well."*

- There is no official guidance on how to code washings when washings are the only procedure performed with diagnostic bronchoscopy.
- The ICD-10-PCS Index directs you to "see Irrigation" for Washing.
- Since the documentation does not specify whether the washings are performed for diagnostic or biopsy purposes best practice would be to clarify.
- We suggest writing a letter to the AHA regarding Washings without any other procedures including a brushing.

Bronchoscopy

Washings performed with other procedures such as aspiration of mucus plugs or endobronchial/transbronchial biopsies are not separately reported.

Source:

- *ICD-10-CM/PCS Coding Clinic, **Third Quarter ICD-10 2017** Pages: 14-15*
- *ICD-10-CM/PCS Coding Clinic, **First Quarter ICD-10 2016** Pages: 26-27.*

Bronchoscopy

Transbronchial is defined as through, beyond or across the bronchus. To report transbronchial biopsy, the operative report would need to support the intent of biopsy of lung tissue.

Per ICD-10-CM/PCS Coding Clinic, **First Quarter ICD-10 2016** Pages: 26-27, the lung lobe body part is reported when the documentation specifies the lung lobe.

If you are not sure we highly suggest you query for the appropriate documentation.

Bronchoscopy

Brush biopsy is coded to the root op extraction.

ICD-10-CM/PCS Coding Clinic, **Fourth Quarter ICD-10 2017** PageS: 41-42.

Endobronchial biopsy is coded to the root op excision

ICD-10-CM/PCS Coding Clinic®, **First Quarter ICD-10 2016** Pages: 26-27 advises root operation “excision” for endobronchial biopsy.

Bronchoscopy

Sample operative report:

Extrinsic compression was found in the superior segment of the left lower lobe (B6). The airway lumen is nearly occluded with irregular mucosa. Washings were obtained in the superior segment of the left lower lobe and sent for bacterial culture and cytology. The return was cloudy. Guided brushings were obtained in the superior segment of the left lower lobe with a cytology brush and sent for routine cytology. Endobronchial biopsies were performed in the superior segment of the left lower lobe using forceps and sent for histopathology examination. Transbronchial biopsies were performed and sent for routine cytology. The sampling device penetrated the full thickness of the bronchial wall to reach the sampling site in the left lower lung lobe. Three biopsy samples were obtained.

Bronchoscopy

- 0BDB8ZX, extraction of left lower lobe bronchus, via natural or artificial opening endoscopic, diagnostic for the brushings from the left lower lobe bronchus
- 0BBB8ZX, Excision of left lower lobe Bronchus, via natural artificial opening endoscopic, diagnostic for endobronchial biopsy
- 0BBJ8ZX, excision of left lower lung lobe, via natural or artificial opening endoscopic, diagnostic for the transbronchial biopsy documented from the left lower lung lobe
- No PCS code is assigned for the washings when performed with brushings

CHF Grouping

CHF with DRG grouping

"We have a chart using I110 HTN w/heart failure, as primary diagnosis and I50.21 acute systolic heart failure as a secondary.

Acute or acute on chronic with hypertensive heart failure has not been an MCC in this scenario. Today, acute systolic CHF (I50.21) is an MCC where acute on chronic systolic CHF (I50.23) is not. WHY?"

CHF with DRG grouping

Codes I50.31 and I50.21 **are NOT excluded** as MCC with PDx I11.0. When these codes are assigned as secondary codes, you will group to DRG 291.

Codes I50.33 and I50.23 **ARE excluded** as MCC with PDx I11.0 and you will group to DRG 293 for these secondary codes.

Review Appendix C for each of these codes. Appendix C in the MS-DRG definitions manual which lists CC/MCC exclusions

CHF with DRG grouping

As an example, find the following:

https://www.cms.gov/ICD10Manual/version36-fullcode-cms/fullcode_cms/P0031.html v36

Appendix C > Part 1 > find code I50.23 > blue hyperlink for 0682:30 codes

I5023 MCC 0682:30 codes Acute on chronic systolic (congestive) heart failure

PDX Collection 0682

I0981 Rheumatic heart failure

I110 Hypertensive heart disease with heart failure

When I11.0 is the PDX, code I50.23 is excluded as a CC/MCC.

NCCI and other edits

Tips and tricks for navigating the CMS website

Outpatient Software Edits in 3M™ Coding and Reimbursement System (CRS)

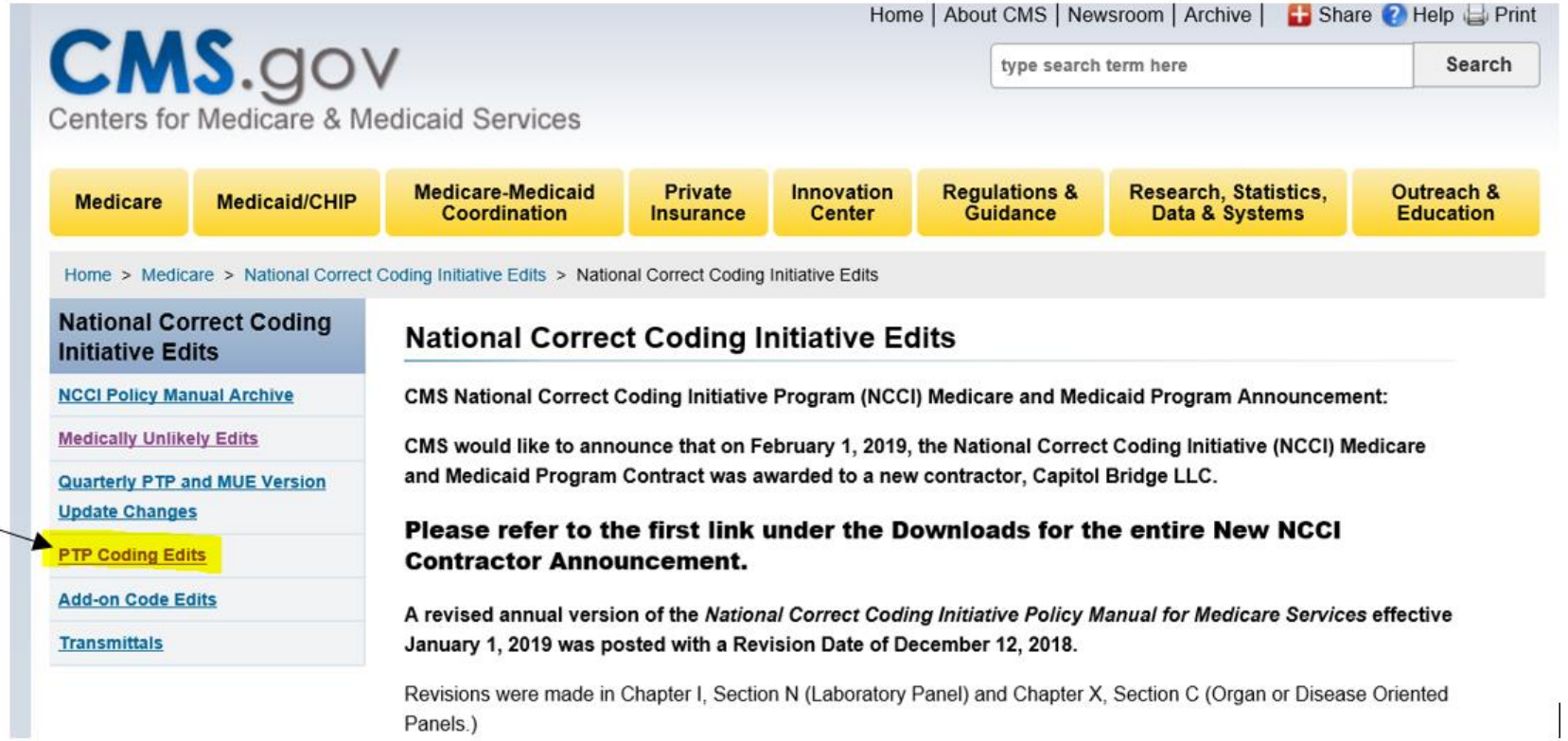
Let's review NCCI edits which include PTP edits and MUE edits

Also, 3M proprietary edits and what they mean

PTP Coding Edits (Procedure to Procedure)

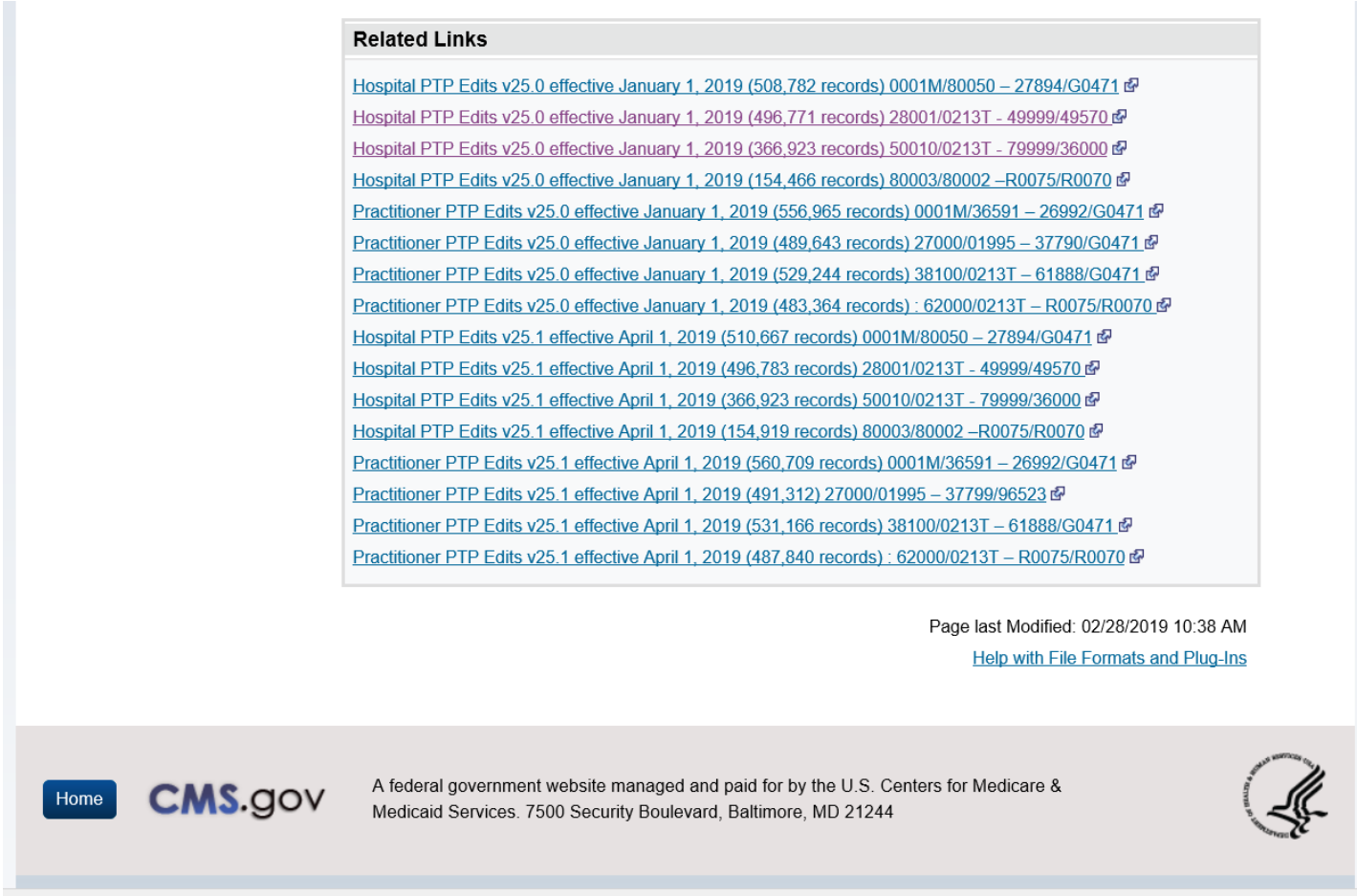
Many of the NCCI edits are based on the standards of medical/surgical practice. Services that are integral to another service are component parts of the more comprehensive service. CMS has listed these in a Column 1/Column 2 format.

CMS Home page link to PTP Coding Edits



Link to directly go to the PTP Coding Edits

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html



Related Links

Hospital PTP Edits v25.0 effective January 1, 2019 (508,782 records) 0001M/80050 – 27894/G0471
Hospital PTP Edits v25.0 effective January 1, 2019 (496,771 records) 28001/0213T - 49999/49570
Hospital PTP Edits v25.0 effective January 1, 2019 (366,923 records) 50010/0213T - 79999/36000
Hospital PTP Edits v25.0 effective January 1, 2019 (154,466 records) 80003/80002 –R0075/R0070
Practitioner PTP Edits v25.0 effective January 1, 2019 (556,965 records) 0001M/36591 – 26992/G0471
Practitioner PTP Edits v25.0 effective January 1, 2019 (489,643 records) 27000/01995 – 37790/G0471
Practitioner PTP Edits v25.0 effective January 1, 2019 (529,244 records) 38100/0213T – 61888/G0471
Practitioner PTP Edits v25.0 effective January 1, 2019 (483,364 records) : 62000/0213T – R0075/R0070
Hospital PTP Edits v25.1 effective April 1, 2019 (510,667 records) 0001M/80050 – 27894/G0471
Hospital PTP Edits v25.1 effective April 1, 2019 (496,783 records) 28001/0213T - 49999/49570
Hospital PTP Edits v25.1 effective April 1, 2019 (366,923 records) 50010/0213T - 79999/36000
Hospital PTP Edits v25.1 effective April 1, 2019 (154,919 records) 80003/80002 –R0075/R0070
Practitioner PTP Edits v25.1 effective April 1, 2019 (560,709 records) 0001M/36591 – 26992/G0471
Practitioner PTP Edits v25.1 effective April 1, 2019 (491,312) 27000/01995 – 37799/96523
Practitioner PTP Edits v25.1 effective April 1, 2019 (531,166 records) 38100/0213T – 61888/G0471
Practitioner PTP Edits v25.1 effective April 1, 2019 (487,840 records) : 62000/0213T – R0075/R0070

Page last Modified: 02/28/2019 10:38 AM

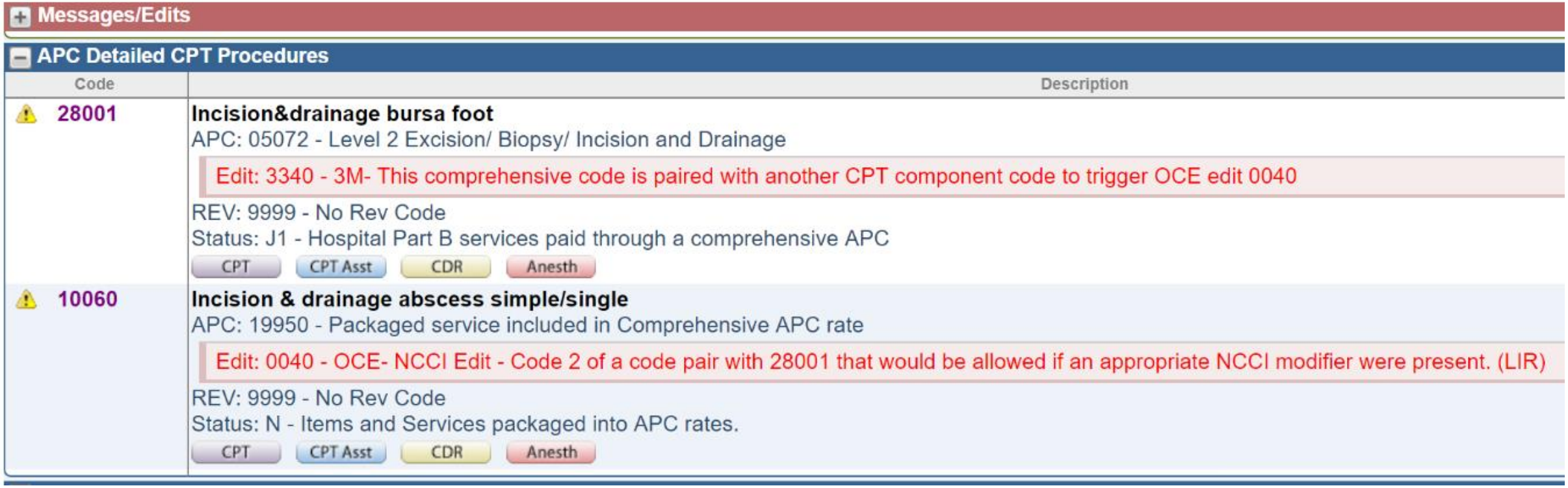
Help with File Formats and Plug-Ins

Home CMS.gov A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services. 7500 Security Boulevard, Baltimore, MD 21244

PTP Spreadsheet

	A	B	C	D	E	F	G	H	I	J	K
1	CPT only copyright 2017 American Medical Association. All rights reserved.										
2	Column1/Column 2 Edits										
3	Column 1	Column 2	*=in existence	Effective	Deletion	Modifier	PTP Edit Rationale				
4			prior to 1996	Date	Date	0=not allowed					
5					*=no data	1=allowed					
6						9=not applicable					
7	28001	0213T		20100701	*	1	Misuse of column two code with column one code				
8	28001	0216T		20100701	*	1	Misuse of column two code with column one code				
9	28001	0228T		20101001	*	1	Standards of medical / surgical practice				
10	28001	0230T		20101001	*	1	Standards of medical / surgical practice				
11	28001	0490T		20180101	*	1	Misuse of column two code with column one code				
12	28001	10030		20140101	*	1	More extensive procedure				
13	28001	10060		19960101	*	1	More extensive procedure				
14	28001	10140		19960101	*	1	Standards of medical / surgical practice				
15	28001	10160		19960101	*	1	Standards of medical / surgical practice				

NCCI edit in 3M CRS



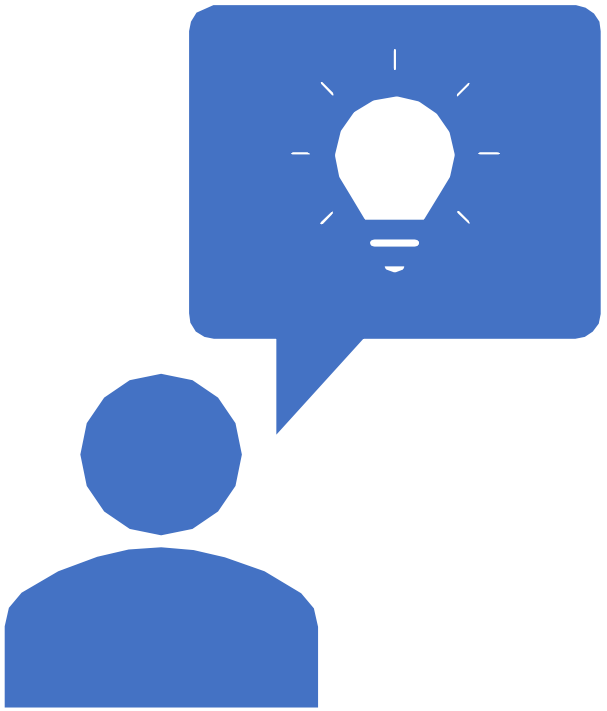
CMS Modifier Update July 1, 2019

Background: Modifiers 59, XE, XS, XP and XU are included among the NCCI-associated modifiers. CMS has required that these modifiers be appended to the column 2 code of a PTP edit in order to bypass the edit.

Modifier Policy Update

Policy: CMS now allows the modifier 59, XE, XS, SP, or XU on column one and two codes. This change will be effective on or after July 1, 2019.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R2259OTN.pdf



3M™ APCfinder™ Software already has this logic incorporated into its software. 3M edit 3171 alerts the coder that a modifier appended to the column 1 code is suppressing the NCCI edit.

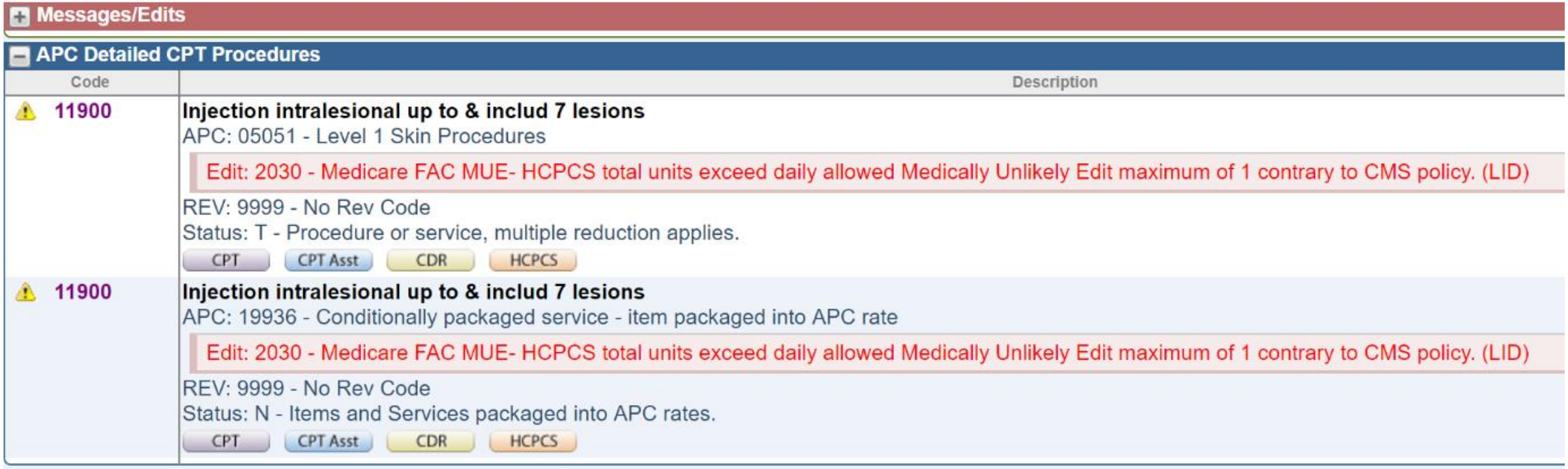
MUE Edits

A MUE is a Medically Unlikely Edit and is the maximum number of units of service that are allowed under most circumstances, by the same provider for the same patient on the same date of service.

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

HCPCS/ CPT Code	Outpatient Hospital Services MUE Values	MUE Adjudication Indicator	MUE Rationale
11770	1	3 Date of Service Edit: Clinical	Anatomic Consideration
11771	1	3 Date of Service Edit: Clinical	Anatomic Consideration
11772	1	3 Date of Service Edit: Clinical	Anatomic Consideration
11900	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
11901	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
11920	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction

MUE edit in 3M CRS

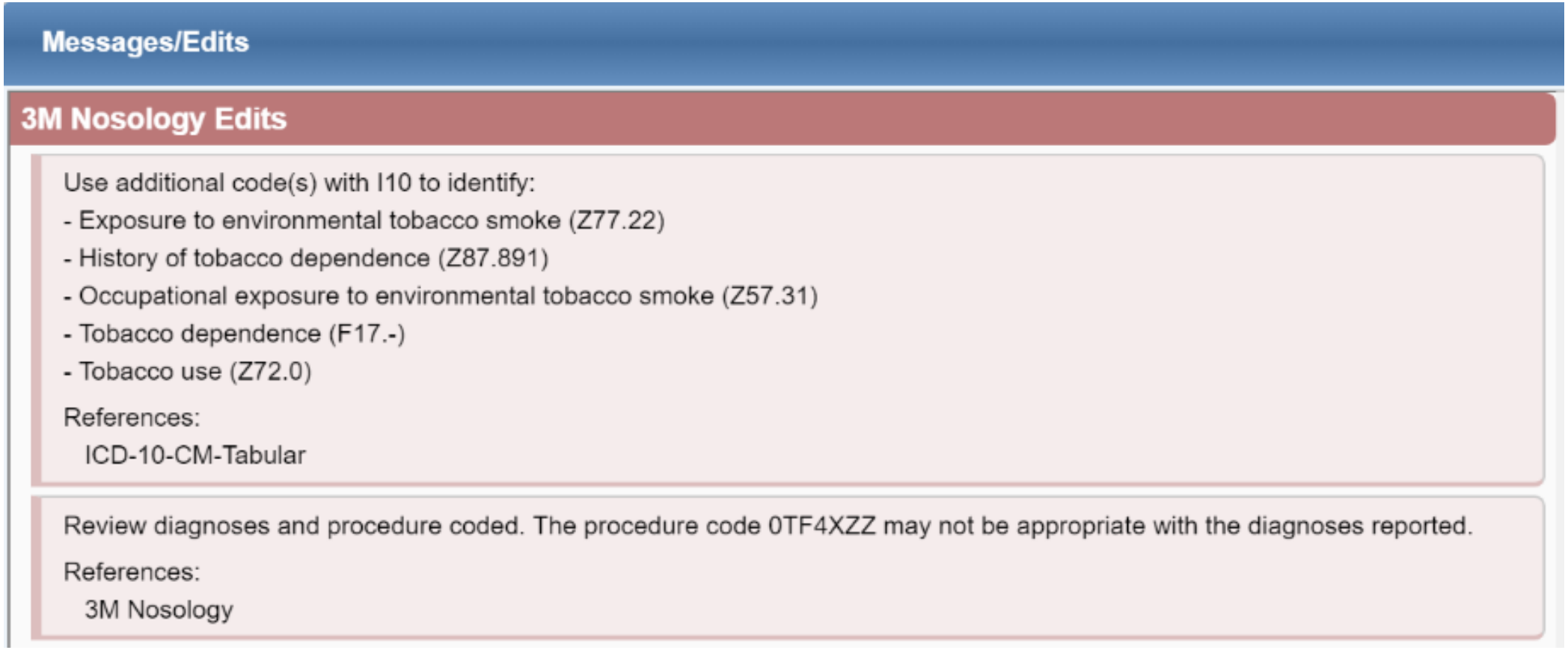


3M Messages/Edits

The 3M™ APCFinder™ product includes the Medicare APC HOPD grouper logic. This grouper will display all OPPS OCE edits, including NCCI/PTP/MUE.

This software also includes 3M nosology edits and 3M proprietary informational edits. Nosology edits display helpful information based on coding conventions such as guidelines, tabular and index directives, and excludes notes. 3M proprietary edits provide additional information to help coders find and fix problems before claims are submitted.

Nosology Message/Edit Example



Nosology Proprietary Edit

Messages/Edits

APC Detailed CPT Procedures

Code	Description
28285	**Correction hammertoe** APC: 05113 - Level 3 Musculoskeletal Procedures Edit: 3129 - 3M- Presence of an anatomic site modifier on this or code(s) 28270 is suppressing NCCI edit. Check documentation to determine whether both codes pair(s) can be billed or an additional site modifier added. REV: 9999 - No Rev Code Status: J1 - Hospital Part B services paid through a comprehensive APC CPT CPT Asst CDR HCPCS Anesth
28270-T2	**Capsul mttarphlngl jt +-tenorrhaphy ea jt spx; (-T2 Left foot, third digit)** APC: 19950 - Packaged service included in Comprehensive APC rate Edit: 3129 - 3M- Presence of an anatomic site modifier on this or code(s) 28285 is suppressing NCCI edit. Check documentation to determine whether both codes pair(s) can be billed or an additional site modifier added. REV: 9999 - No Rev Code Status: N - Items and Services packaged into APC rates. CPT CPT Asst CDR Anesth

Outpatient Software Edit Listing

Link to support website. This contains spreadsheets and gives an explanation of each OP edit.

https://support.3mhis.com/app/answers/detail/a_id/3763/kw/OP%20software%20edits

Separate Procedure Designation

Separate Procedure Designation

2019 NCCI Manual Chapter I, letter J **CPT "Separate Procedure"** Definition from the CMS website

https://www.cms.gov/Medicare/Coding/Nationalcorrectcodinited/index.html.

If a CPT code descriptor includes the term “separate procedure”, the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a “separate procedure” when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.

A CPT code with the “separate procedure” designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach. Modifier 59 or a more specific modifier (e.g., anatomic modifier) may be appended to the “separate procedure” CPT code to indicate that it qualifies as a separately reportable service".

Coding Clinic for HCPCS® Fourth Quarter 2009 Page: 3-6

"There are some CPT codes that the American Medical Association designates as "separate procedures." This designation is given to certain codes to identify services that are commonly carried out as a component of a more comprehensive procedure or service. An NCCI edit may or may not exist for a "separate procedure" code reported with a more comprehensive procedure code. Therefore, when coding for outpatient services, it is important to follow not only the NCCI edits but to also follow CPT and CMS NCCI edit guidelines for the appropriate reporting of "separate procedure" codes." This reference further states, "CMS interprets this designation to prohibit the separate reporting of a "separate procedure" when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach."

Example of Separate Procedure in NCCI Manual Chapter 6

9. Injection of air into the abdominal or pelvic cavity is integral to many laparoscopic procedure… shall not separately report CPT code 49400 (injection of air or contrast into peritoneal cavity (separate procedure)) for this service.

Podiatry

Podiatry Case

The patient has hammertoes of second and third toes along with medially subluxed third metatarsophalangeal (MTP) joint. Arthrodesis is performed of the second and third interphalangeal joints along with repair of the subluxed third metatarsophalangeal joint.

The MTP subluxation repair of third MTP would be reported with 28270

See CPT Assistant®, **September 2014** Page: 13 which states, "It would not be appropriate to report code 28645 for an MTP joint subluxation. CPT code *28270, Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)*, may be reported for the subluxation repair. Because a subluxation is not a complete dislocation of the joint, a dorsally subluxated joint repair is reported with code 28270."

The Hammertoe procedures would be reported with 28285

Coding Clinic for HCPCS® - **Third Quarter 2010** Page: 3 states, “CPT code *28285, Correction, hammertoe,* is appropriately reported for all hammertoe corrections. The code descriptor for CPT code 28285 intentionally does not specify which interphalangeal joint is involved in the correction (i.e., distal, proximal, middle) procedure. Therefore, CPT code 28285 is reported to represent the repair of several deformities that are referred to as "hammertoes". The name is derived from the way the toe hits or hammers onto the walking surface with each step. Located at the proximal interphalangeal joint the hammertoe can occur in addition to other specific deformities of the lesser toes simultaneously.”

NCCI edit

When 28270 for capsular work is reported with 28285 for Hammertoe, an NCCI edit is triggered. The edit indicates that 28285 is the comprehensive code in this case.

You can find the PTP edit in the spreadsheet on the CMS website

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

8366	28285	28232		20160101	*	1	CPT "separate procedure" definition
8367	28285	28234		19960101	*	1	Standards of medical / surgical practice
8368	28285	28270		20171001	*	1	CPT "separate procedure" definition
8369	28285	28272		19971001	*	1	CPT "separate procedure" definition
8370	28285	28310		20181001	*	1	CPT "separate procedure" definition

Separate Procedure Designation

Code 28270 also has separate procedure designation. CPT codes with a separate procedure designation should not be separately reported when performed with another procedure in an **anatomically related area**. Procedures designated as a separate procedure are considered an integral component of another procedure or service.

Hammertoe with Capsulotomy

CPT Assistant®, **December 1996** Page: 7 and CPT Assistant®, **September 2011** Page: 11 recommend reporting 28270 for MTP capsular work in addition to hammertoe repair. However, CPT Assistant is advice given by the AMA and it doesn't always agree with CMS which is Medicare guidelines. Coding Clinic for HCPCS advice is given by the AHA.

The 3M Nosology advice is based on CMS/Medicare guidelines.

LINX

LINX Procedure

The LINX® Reflex Management System by Torax® Medical, Inc provides an alternative to acid-suppressing drugs for patients with frequent gastroesophageal reflux and regurgitation. These patients will often also have a hiatal hernia.

http://www.toraxmedical.com/linx/

- The LINX® System is designed to augment the weak Lower Esophageal Sphincter (LES) and prevent reflux from the stomach into the esophagus. The small flexible band of interlinked titanium beads which contain magnetic cores is placed around the esophagus just above the stomach by laparoscopy. The magnetic attraction between the beads closes the LES immediately after swallowing.

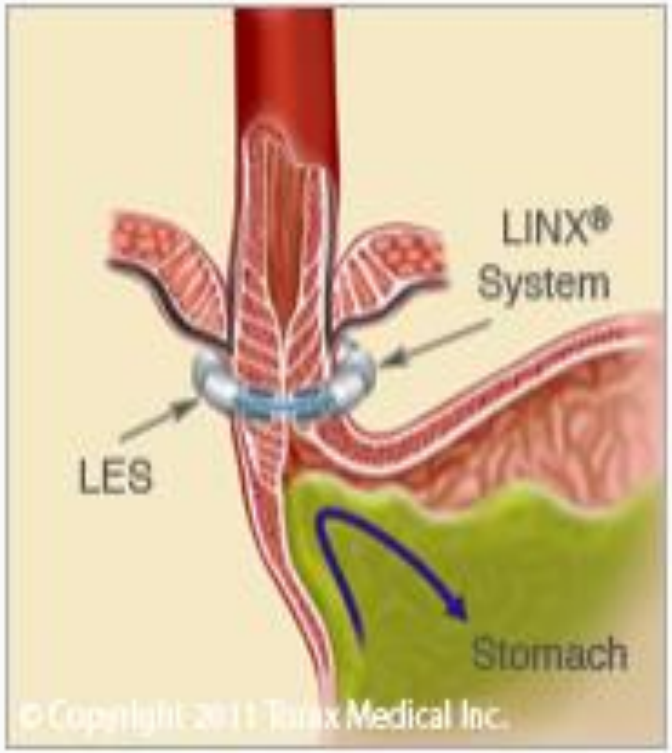


Figure 1: The LINX System is designed to help the LES resist opening to gastric pressures.

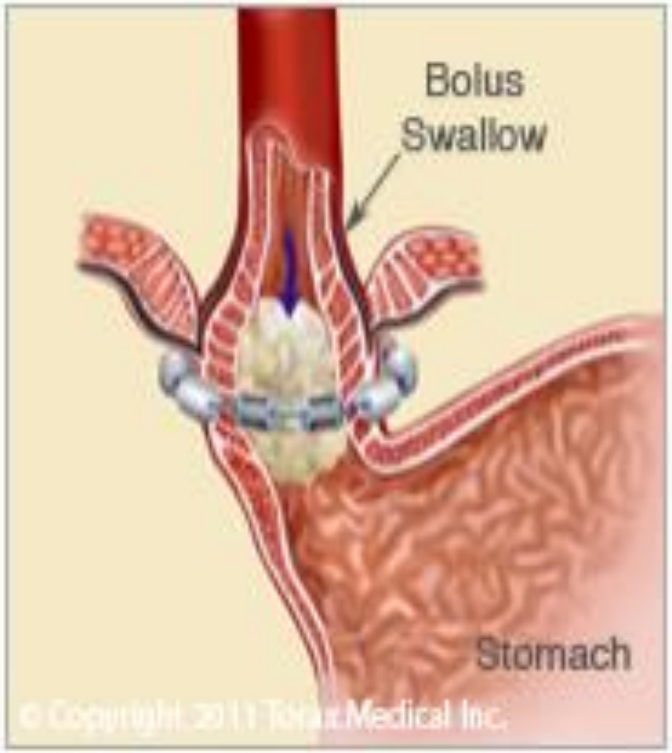


Figure 2: The LINX System is designed to expand to allow for normal swallowing.

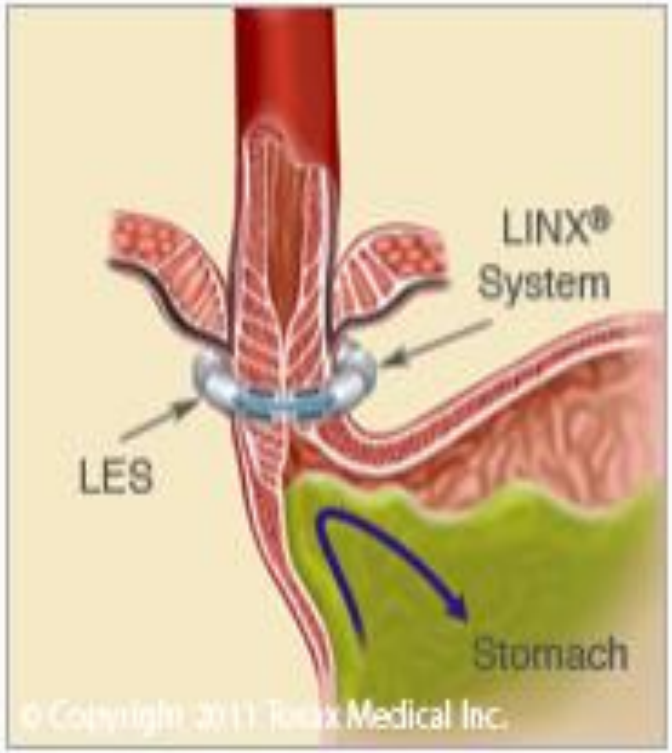


Figure 3: Magnetic attraction of the device is designed to close the LES immediately after swallowing.

Coding Clinic for HCPCS® Third Quarter 2018, page 6 advises only one code for both procedures: 43284. Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e. , magnetic band), including cruroplasty, when performed.

Clarification effective June 28, 2019

Coding Clinic for HCPCS® Second Quarter 2019 Page 10-11 states to assign CPT code 43284 for the LINX implantation and also for the hernia repair performed. The laparoscopic cruroplasty is also known as a laparoscopic hiatal hernia repair. Therefore, CPT code 43284 includes both the hernia repair and the implantation of the LINX device.

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Report code 43284, *Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed*, for the entirety of the work described. When CPT code 43284 was created, the procedure was described for use only in patients with small hiatal hernias less than 3 cm because the literature supported the use of the device only in these circumstances. As a result, the work of cruroplasty (for small hiatal hernias) was included in the code descriptor.

Questions?

Thank you for attending!

Have a fabulous day!