

ICD-10: Lingering Issues

The #1 standout question involves the 7th character.

BY HARRY GOLDSMITH, DPM

Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

As noted previously, ICD-10 implementation happened without catastrophic consequences. That is not to say there weren't (and aren't) some glitches or issues. One standout glitch was the failure on the part of several MACs (Medicare Administrative Contractors aka Medicare carriers) to appropriately convert approved ICD-9 codes to ICD-10 codes within some LCD (Local Coverage Determination) policies. In particular, routine foot care claims were/are being denied because diagnoses historically included as "at risk" systemic conditions were absent when the October 1, 2015 LCD was implemented.

Consequently, doctors who accurately coded ICD-10 on claims found that the contractor's software edits didn't contain the same codes...leading to denials. To their credit, most involved MACs worked with their podiatric Contractor Advisor Committee (CAC) representatives to begin the process to supplementing their policies and edits. Unfortunately, as of this writing, some of the MACs are still having problems implementing the correct edits. Many practitioners who perform palliative care are still waiting to get paid.

The #1 standout issue associated with ICD-10 implementation is confusion over the 7th character—when

is it "A", when is it "D", why bother recognizing "S"? (we'll save that for another time).

Let's briefly clarify 7th character use:

7th Character "A"

"A" is for active treatment. Some of you were thinking, wait a minute, "A" is used during an initial encounter, but you would be so wrong. When a valid code requires a 7th character (for foot and ankle specialists that would typically be fractures and other injuries, and your encounter involves active treatment, you would apply an "A" in the 7th character position.

- Performing surgery to repair an injury;
- Seeing a patient in your office, sent to you by a primary care physician, to treat [active treatment] a stress fracture;
- Continuing active treatment of an injury—distinguished from any follow-up care of an original injury.

Hint: If it's follow-up care of an original injury, it's not active treatment. If it's not active treatment, you can't use the "A" character in the 7th position.

Hint: Debridement of ulcers is not active treatment UNLESS you are debriding a wound resulting from an

"A" is for active treatment.
"D" is for follow-up treatment.

There will be times that you see a patient and perform active treatment of an injury during more than one encounter, and you will code a 7th character "A" each time you perform active treatment (not follow-up care) on a patient. It sort of makes the "initial encounter" description, at best, meaningless; at worst, confusing.

What are examples of an encounter involving active treatment?

- Seeing a patient in the emergency department [not a typical place for follow-up care] for an injury and ordering an x-ray;
- Seeing a patient with an injury, working the patient up for the injury, and booking surgery for the injury;

injury. [NOTE: diabetic ulcers do not take a 7th character]

Hint: If your ICD-10 reference (example, APMA Coding Resource Center) does not indicate that a 7th character is required to complete a valid code, then a 7th character is not to be added.

Hint: If you are following up care (e.g., debriding an injury site after your initial active treatment), it isn't active treatment.

7th Character "D"

"D" is for follow-up treatment. The "subsequent encounter" description given it by CMS/CDC should

Continued on page 68

Lingering Issues (from page 67)

have been “follow-up encounter & care.” The common examples are return visit to check status; return visit to clean up (debride/clear) the wound site; patient seen in your office from an emergency department or physician’s office asking you to follow-up this patient’s injury; an encounter where x-rays are taken to check the status of the injured site; follow-up, follow-up, follow-up.

If you have a patient who was taken to the operating room for a fractured phalanx and metatarsal, and that patient has a K-wire sticking out the end of his/her toe, and you remove it...it’s a 7th character “D”. Why? Because the initial active treatment was performed in the operating room. The removal of the K-wire was follow-up to the initial active treatment. It was not a new active treatment.

Hint: If the patient in front of you is there for an injury follow-up, regardless of who the original treater of the injury was, it is a follow-up (“D”) encounter.

Hint: If what you are doing is not the initial active treatment, it’s a follow-up.

Hint: It is you who decides if you are actively treating the patient or following up. When the issue is on the fence, ultimately you have to make (and document) the call.

Just remember, “A” does not have to be an initial encounter; “D” (subsequent encounter) may be assigned a new patient (never seen before) if you are merely following up someone else’s active treatment; “A” can happen more than once on the same patient for the same condition if you are actively treating the patient’s injury; and “D” does not mean done.

The Wisdom of CMS

While there are things CMS does well, there are times when they don’t do things well. Let’s take:

The “X” Modifiers

In August 2014, CMS unilaterally announced that “The-59 modifier is the most widely used HCPCS modifier. Modifier-59 can be broadly applied. Some providers incorrectly consider it to be the “modifier to use

to bypass (NCCI). This modifier is associated with considerable abuse and high levels of manual audit activity, leading to reviews, appeals and even civil fraud and abuse cases.”

This is amazing. When I ask my audiences in my coding seminars about the NCCI (CCI, Correct Coding Initiative), 70% have no idea what I’m talking about. What they do know is that 1) specialties like podiatry, orthopedics, and dermatology deal in multiple procedures, as a rule, not as an exception and 2) the “-59” modi-

to see the examples of considerable abuse and “even civil fraud” cases they claim to exist.

So, how do you check the considerable abuse in the use of the “-59” modifier? You introduce/substitute specific “-59” modifier subsets (i.e., you unbundle the “-59” modifier) without taking away any of the CPT “-59” modifier definition:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,
- XS Separate Structure, A Ser-

**The “-59” modifier is used
when you perform two procedures and they are
wholly independent of each other.**

er means “distinct procedure”, a term that is hardly confusing.

The “-59” modifier is used when you perform two procedures and they are wholly independent of each other (“this procedure has nothing to do with that procedure, and I would like to get paid for both, please”). The NCCI edits, as it happens for Medicare, get unbundled when a “-59” modifier is applied to a component procedure that is distinct from the comprehensive procedure—example, a matrixectomy (believe it or not) is a distinct procedure from a bunionectomy with osteotomy. Now, you may argue that “oh, no, matrixectomies are always included in bunionectomy procedures and to want to get paid for both is abusive”... but you would be wrong. Who in NCCI land linked the two and felt it was important enough to require the surgeon to add a “-59” modifier to distinguish the two? Back to the “-59” modifier and the need for “X” modifiers...

“This modifier is associated with considerable abuse and high levels of manual audit activity, leading to reviews, appeals and even civil fraud and abuse cases.”

You know CMS never once offered facts to back up the “considerable” abuse claim. The high levels of manual audit activity is a thing they decided to engage. It would be nice

vice That Is Distinct Because It Was Performed On A Separate Organ/Structure,

- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

[For your reference, the CPT “-59” modifier definition: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.”

The only thing that substituting the “X” modifiers did was make the components of the “-59” modifier confusing. For example, what do you

Continued on page 70

Lingering Issues (from page 68)

mean by separate organ (e.g., the skin is an organ; does that mean you can only perform a single procedure on the skin?); what is a separate structure (how does one define “structure”—a metatarsal, a foot, a leg, an extremity?); what do you mean by “does not overlap usual components of the main service (does that mean it is a “distinct procedure”—the “-59” modifier term)? Despite a year and a half of requests for clarification from CMS on the use of the “X” modifiers and the continued use of the “-59” modifier (things like, now that you have 4 subsets of the “-59” modifier, how exactly will that stem the tide of the alleged “considerable” abuse versus allow you 4 subsets to abuse?), CMS has been silent to everyone’s delight. Rumor has it that Novitas Medicare will venture into the self-interpretation arena when it comes to the “X” modifiers. We shall see.

PQRS

Let’s preface this by reminding everyone that CMS (as well as other payers) requires providers to perform services that are medically necessary, within the standard of care, and subject to evidence-based medicine. The future compensation

by payers be required to meet similar evidence-based requirements?

Let’s take the case of imposition of the goal of interoperability requirements on separate EHR software programs to ultimately meet meaningful use goals. A great idea. Unfortunately, the requirement came before the technical ability to achieve the goal. Bad timing.

Then there is my favorite PQRS. Have you been around for 5-6 (or

in progressive improvement in long-term outcomes. Average blood glucose over a three-month time period is measured by A1C percentage. People without diabetes have A1C values in the 4.5% to 6% range. One PQRS benchmark measures the percentage of a physician’s diabetes patients whose A1C values are below 7.0%, thereby incentivizing aggressive use of medication in this population.

However, recent studies have

When treating a patient with diabetes, the physician must decide between attempting to lower A1C below 7.0% as incentivized by PQRS, or doing what is in the patient’s best interest by taking a more conservative approach.

more?) years? We’ve gone from incentives to penalties. Many practices were happy to get the incentives, especially when their software did most of the work for them. “Do you smoke?” “Yes.” “Stop” [check that one off]. “Do you fall?” “Nope.” “Try not to” [check that one off]. “As a foot doctor, I am going to examine your feet.” “Good, I was wonder if

contradicted the assumption that achieving A1C values below 7% is beneficial—and in fact provide evidence that doing so causes harm. Lowering average blood glucose to this range is associated with an increased risk of all-cause mortality, cardiovascular mortality, and episodes of dangerously low blood glucose (hypoglycemic episodes), according to recent studies.

Also, there appears to be no reduction in risk of stroke, vision loss, nerve damage, kidney damage, or limb amputation. So when treating a patient with diabetes, the physician must decide between attempting to lower A1C below 7.0% as incentivized by PQRS, or doing what is in the patient’s best interest by taking a more conservative approach.

Meanwhile, patients—unaware of these conflicting goals—assume that their health is the only consideration influencing the physician’s treatment recommendations. [check that one off]

“Continuing along the path of obsolete guidelines, we encounter PQRS benchmarks regarding “target” low density lipoprotein (LDL) cholesterol in the diabetic population. Here, CMS wants us to show that a sufficient percentage of the physician’s diabetic

Continued on page 72

Fee for service is being pushed out for grander plans of reimbursement... like capitation and other risk-based systems.

system proposed to be implemented in the next few years depends on quality care and lower costs. Fee for service is being pushed out for grander plans of reimbursement... like capitation and other risk-based systems. Regardless, if you listen, you will hear payers demanding evidence-based medicine qualifiers to significantly improve outcomes and reduce waste. Okay, I’ll buy that. By the way, if evidence-based medicine is good enough for providers, shouldn’t rules, guidelines, additional regulations, and bureaucratic hoops, as well as limit of services imposed

you, the foot specialist would get around to examining my feet instead of typing in your laptop.” “No problem” [check that one off]. I think my internist summed it up best: “Hell, I don’t have the time to waste on this ___.”

It’s not just me who has strong feelings about PQRS. Take these snippets quoted from an article written by Peter C. Cook, MD, MPH in Medical Economics (November 15, 2015): “Under PQRS guidelines, it is assumed that progressive lowering of average blood glucose in Type 2 diabetes mellitus (Type II DM) results

Lingering Issues (from page 70)

patients have LDL cholesterol values of 100 milligrams per deciliter (mg/dL) or less.

Based on evidence compiled after CMS introduced this PQRS “quality” measure, we know that attaining LDL values below 100 mg/dL—or any other target value—is unimportant. Rather, the evidence suggests that nearly all patients with diabetes should be prescribed a relatively high dose of medication from the statin class of cholesterol-lowering agents, regardless of their baseline LDL cholesterol.” Emphasis added. [check that one off]

MU

“MU [Meaningful Use] has turned the physician-patient encounter into a mechanistic and scripted experience that takes a one-size-fits-all approach to patient care, leaving the physician with little time or discretion to address patients’ actual health needs and concerns.”

You are encouraged to read his entire article. What I especially enjoyed were the comments posted in regard to the article: “...I, too, was driven from practice partly by the massive burden of data entry required by these preposterous new Medicare regulations. You are correct that Medicare’s micro-management of physician behavior by means of ill-informed payment incen-

tives is literally killing patients...”

“Dr. Cook’s comments are further testimony to how federal bureaucratic governmental meddling, while often good-intentioned, more often than not results in no benefit (at best) or making things worse (at worst), and at what cost.”

I asked CMS this last year and never received a reply. Does CMS have after all these years of quality incentivization ANY peer-reviewed published studies—produced at the same level of quality they expect physicians to validate services—that validate ANY of the quality measures making significant impacts on quality of outcomes since the introduction of PQRS? Shouldn’t they?

The Codingline-NYSPMA 2016 Coding Seminar

(January 21, 2016—The Day Before the Clinical Conference—Marriott Marquis, New York, New York). Topics will include “What’s New in Coding for 2016”; “ICD-10: Troubleshooting & Issues”; “DME Update”; “Legally Yours”; PQRS, Meaningful Use, and Value-Based Payment Modifier”; “E/M Coding”; Q/As. Go to www.codingline.com and click on the “Events—New York Coding” tab for more information; or go to http://www.nyspma.org/aws/NYSPMA/pt/sp/conference_home_page

The Ultimate Value: Codingline Gold (\$529/year)

Gold is Codingline’s premium service that bundles a number of unique benefits to assist you in achieving coding accuracy, reimbursement effectiveness, practice efficiencies, and practice profitability. Codingline Gold is designed to provide coding and reimbursement information for today’s foot and ankle specialists. What does Gold offer? “Direct to Expert” Hotline (confidential interactive Q/A service); both Codingline Silver and CodinglinePRINT access and benefits; discounts to Codingline seminars and workshops; access to The Library; access to Reference Desk; and access to the Forum. Doctors, staff, and coders, go to www.codingline.com/gold.htm for more information. At \$529/year, this is an ultimate value. If you have any questions, email hgoldsmith@codingline.com (Harry Goldsmith, DPM). **PM**

Disclaimer: The information offered by CodinglinePARTICULARS is provided in good faith for purposes of communication and discussion, and is strictly the opinion of the editor, Harry Goldsmith, DPM, or the listed authors. Neither Codingline nor Podiatry Management represents that any such opinion is either accurate or complete, and should not be relied upon as such. The reader is responsible for ensuring correct applicability of any information, opinion, or statements written in by CodinglinePARTICULARS. Specific payer reimbursement information should be obtained from the specific payer in question.



Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.