Although ICD-10 codes may look very different upon first glance, the guidelines for assigning those codes are not much different from those you are using right now, says Jackie Miller, RHIA, CCS-P, CPC, PCS, Vice President of Product Development at Coding StrategiesSM.

Principles Won’t Change

“First of all, don’t panic!” Miller says. “If you’re like most of us, you’ve spent years building up your coding knowledge, and that knowledge is not going to suddenly become useless on Oct. 1, 2013,” when ICD-10 becomes effective.

For instance, you likely will code the same primary diagnosis with ICD-10, but you will only be assigning a different code. In the radiology setting, for example, if a patient has a chest x-ray because of congestive heart failure (CHF), you will still code the CHF, but you will report it as I50.9 under ICD-10 rather than 428.0 under ICD-9.

There Are Some Challenges

On the other hand, some codes will change more than others. “For example, the trauma codes are very different in ICD-10, and most people who use them will need a good deal of practice to get comfortable with the code numbers, their arrangement in the book, and the use of seventh-digit extensions,” Miller points out.

In addition, the coding process likely will be much slower at first because you will need to use the ICD-10 Index to look up many codes that you currently have memorized or can find directly in the Tabular List.

4 Steps to Take Now

Based on her experience, Miller suggests taking four steps now to make the transition to ICD-10 smoother:

1. Read up on the ICD-10 classification — particularly the components and code structure.
2. Download the ICD-10 files for free on the National Center for Health Statistics (NCHS) Web site (http://www.cdc.gov/nchs/icd/icd10cm.htm), and try looking up a few of your more common diagnoses.
3. Make a to-do list of all the tasks you need to complete by the go-live date (Oct. 13, 2013), including software updates, form revisions, etc.
4. Begin educating coders regarding the basic information about ICD-10, although you should not begin full ICD-10 training until the implementation date draws closer.

“The unknown is almost always scarier than the known,” Miller says. “And remember that Coding Strategies and Coding Metrix will be with you every step of the way from now until 2013 and beyond. We’ll give you all the information and tools that you need to succeed with ICD-10.”

Look Inside

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Reporting smoking cessation counseling services to Medicare is not as simple as assigning the correct CPT® codes. There are several limitations you have to be aware of if you expect to receive payment.

Medicare Lays Down the Rules

Medicare began paying for smoking cessation counseling in 2005. And for Medicare to cover the service, the patient must use tobacco, must be competent and alert, and must fall into one of the following two categories:

1. The patient has a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use.
2. The patient is taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use based on FDA-approved information.

In addition to the cardiovascular and respiratory diseases linked to smoking, the U.S. Surgeon General has also confirmed links between smoking and decreased bone mineral deposits, osteoporosis, fracture risk and delayed postoperative healing.

Medicare covers two cessation attempts each year. Each attempt may include a maximum of four sessions. This means that Medicare covers no more than eight counseling sessions per year.

Examine the Codes

CPT® provides two codes for smoking cessation counseling sessions based on the length of the session:

- 99406 — intermediate intensity counseling visit lasting 3-10 minutes
- 99407 — intensive counseling visit lasting more than 10 minutes

Note that you should not separately report counseling lasting three minutes or less because discussing and counseling a patient regarding smoking cessation and tobacco use for less than three minutes is included in the counseling component of the evaluation and management services codes.

And you can assign 99406-99407 in addition to an E/M service or other service performed on the same day. If you are reporting 99406-99407 in addition to an E/M service, you should append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code to indicate that it is a separate and distinct service from the smoking cessation counseling.

What’s Included

To properly report 99406-99407 to Medicare, the physician must provide actual counseling and not just review the patient’s smoking history. The Centers for Medicare and Medicaid Services (CMS) recommends that the physician use its printed materials as part of the counseling effort, which you can find at www.smokefree.gov.

You should bill the counseling linked to the diagnosis code for the condition the patient has that is adversely affected by the tobacco use or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by using the tobacco.

For additional information regarding reporting smoking cessation counseling and other E/M services, sign up for the Coding Metrix Evaluation and Management curriculum at www.codingmetrix.com.
Ready … Set … Code!

Now, it’s your turn. Try your hand at coding the following real-world case. When you feel you have the answer, turn to page 4.

Scenario: A patient undergoes ultrasound examination because of blood in the urine. The radiologist documents her impressions of both the right and left kidneys, as well as for the bladder. The physician notes abnormalities in the right kidney and recommends further examination by computed tomography.

Keep in mind that if the pro-time test is performed in an office lab as a CLIA-waived test, you should apply modifier QW to the test code — that is, 85610-QW.

The Centers for Medicare and Medicaid Services (CMS) has issued a national coverage determination (NCD) for pro-time testing (www.cms.gov/mcd/index_section.asp?ncd_sections=40), which states that in a patient on stable warfarin therapy, repeat testing is ordinarily not necessary more than every two or three weeks. Within the NCD, you will also find a link to the covered ICD-9-CM diagnosis codes for this test that is updated quarterly.

For a more thorough discussion regarding how to report Coumadin clinic services, including anticoagulant therapy management and specific Medicare reporting rules, please see the upcoming issue of Cardiology Coding & Compliance Expert.

Cardiology Coding and Compliance Information Direct From the Experts

Get the latest information that you need. In this month’s issue of Cardiology Coding & Compliance Expert, you’ll find the following articles:

• Your Diagnostic Heart Cath Coding May Look Significantly Different in 2011
• There’s More to the Coronary Arteries Than RC, LC and LD … And Your Coding Depends on What You Know
• Count All 3 Elements Before Assigning Comprehensive EP Study Code
• CMS Says ICD-10 Is on the Way, Make Sure You’re Ready for the 2013 Deadline
• Effective Immediately, Self-Referral Rules Change Under New Health Care Reform Law
• Many Payors Say Stick With Modifiers 76/77 Rather Than 59 for Repeat EKGs
• Medicare Updates List of ICD-9 Codes Not Requiring Q0 for Clinical Trial ICD Services

Subscribe today by calling 1-877-6-CODING or go online at www.codingstrategies.com.
CSI Speaks Out

If you’re traveling to or live near an upcoming conference, Coding Strategies may be there, too. CSI staff frequently offer coding and reimbursement presentations at different locations and events around the country. Here are a few of the speaking engagements that are coming up for our staff, so be sure to sign up:

Oncology

CSI Staff: Cindy Parman
Event: Iowa Oncology Society Spring Conference
Location: Sheraton West Des Moines, Des Moines, Iowa
Date: May 14, 2010
Topic: Oncology Coding Tips & Traps

CSI Staff: Cindy Parman
Event: Association of Community Cancer Centers (ACCC) Regional Oncology Symposium
Location: Hilton Kansas City Airport, Kansas City, Mo.
Date: May 27, 2010
Topic: Oncology Coding Tips & Traps

CSI Staff: Cindy Parman
Event: ACCC Regional Oncology Symposium
Location: The Westin Richmond, Richmond, Va.
Date: June 17, 2010
Topic: Oncology Coding Tips & Traps

CSI Staff: Cindy Parman
Event: ACCC Regional Oncology Symposium
Location: Sheraton Seattle Hotel, Seattle, Wash.
Date: June 24, 2010
Topic: Oncology Coding Tips & Traps

CSI Staff: Cindy Parman
Event: Southern Oncology Association of Practices (SOAP) Fall Meeting
Location: Phoenix, Ariz.
Date: Oct. 8, 2010
Topic: Medicare/RAC Audits, ICD-10-CM

Radiology

CSI Staff: Melody Mulaik
Event: Association for Medical Imaging Management (AHRA) 2010 Annual Meeting and Exposition
Location: Gaylord National Hotel and Convention Center, National Harbor, Md.

Ready ... Set ... Code!

Scenario: A patient undergoes ultrasound examination because of blood in the urine. The radiologist documents her impressions of both the right and left kidneys, as well as for the bladder. The physician notes abnormalities in the right kidney and recommends further examination by computed tomography.

Answer: For this case, you should report the radiologist’s services as 76770 (Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; complete). According to the CPT® manual, a complete retroperitoneal ultrasound examination consists of real-time scans of the kidneys, abdominal aorta, common iliac artery origins and inferior vena cava.

“Alternatively, if clinical history suggests urinary tract pathology, complete evaluation of the kidneys and urinary bladder also comprises a complete retroperitoneal ultrasound,” the manual states. Therefore, the radiologist’s documentation supports reporting 76770.

CMS Updates Conversion Factor

The Centers for Medicare and Medicaid Services (CMS) updated the current 2010 conversion factor to $36.0791 from Jan. 1-May 31, 2010, the agency announced in the May 11 Federal Register. Keep in mind that if Congress does not act, the conversion factor will drop to $28.3868 effective for all dates of services from June 1-Dec. 31, 2010.
How Do You Stack Up?
Take the Coding Metrix Challenge and Find Out!

If you are responsible for radiology coding or administration, then don’t miss this FREE self-assessment! This 15-question quiz will test your skills when it comes to radiology coding and compliance.

FREE Assessment & 25% Discount!
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CSI’s monthly eNewsletter subscriptions provide detailed information regarding the medical coding and compliance concerns of hospitals, physician practices, IDTFs and other organizations that provide or bill for services to ensure that everyone is aware of the reporting requirements when submitting claims. Each issue will contain articles that focus on:

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