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JULY BIRTHDAYS
ERIKA JACOBO | JULY 2ND
JAMIE HINSCHBERGER | JULY 5TH
CINDY FALER | JULY 8TH
CARRIE JENNINGS | JULY 8TH
STACEY SCHROPP | JULY 8TH
CHRISTINA BIRD | JULY 10TH
HEATHER CARRIZALES | JULY 10TH
MARY GATES | JULY 11TH
STACEY STOWERS | JULY 13TH
JILLIAN TUTTLE | JULY 17TH
AMANDA MEDRANO | JULY 17TH
SHONNA NOGGLE | JULY 24TH
MELISSA MCINTOSH | JULY 28TH
ALYSA COPPINGER | JULY 30TH

HAPPY FOURTH OF JULY

Created and edited by Ashley Holmes
**DIABETIC RETINOPATHY**

Diabetic Retinopathy is the result of elevated blood sugar causing damage to the blood vessels of the retina. Some of the early symptoms of diabetic retinopathy include: floaters, blurred vision, impaired color vision, and vision loss. Diabetic retinopathy is the leading cause of vision loss and visual impairment in young adults.

There are two main types of diabetic retinopathy, non-proliferative and proliferative. When an individual has non-proliferative diabetic retinopathy he or she will first develop microaneurysms in the blood vessels of the retina. These microaneurysms leak fluid into the retina distorting vision. As non-proliferative retinopathy progresses, the blood vessels that nourish the retina will swell, causing the blood flow to the retina to be disrupted. In the most severe stage, the blood vessels are completely blocked.

The vessels respond to this by secreting growth factors that cause new vessels to form which marks the beginning of proliferative diabetic retinopathy. These new vessels are fragile in comparison to the normal blood vessels and are more susceptible to swelling and leaking. Scar tissue begins to form due to the fragile nature of these vessels which makes the retina prone to detachment.

Macular edema is another common condition that occurs with diabetic retinopathy. The macula is a portion of the retina that is responsible for being able to clearly see the details of objects. About half of people with diabetic retinopathy develop diabetic macular edema. Furthermore, diabetic macular edema can occur at any stage of retinopathy, so early treatment is essential to prevent vision loss.

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**CODING TRANSPLANT COMPLICATIONS**

Category T86, Complications of transplanted organs and tissue, is reserved for transplant complications such as failure, infection, rejection, or malignancy associated with organ transplant, with the fourth, fifth, or sixth character indicating the organ involved.

A transplant complication code is assigned only if the complication affects the function of the transplanted organ. Additional codes are assigned to identify other transplant complications, such as acute graft-versus-host disease (D89.810), malignancy associated with organ transplant (C80.2), or post-transplant lymphoproliferative disorders (D47.21).

Two codes are required to fully describe a transplant complication: the appropriate code from category T86- and a secondary code that identifies the complication.

Pre-existing conditions or conditions that develop after the transplant are not coded as complications unless they affect the function of the transplanted organs. Post-transplant surgical complications that do not relate to the function of the transplanted organ are classified to the specific complication. For example, a postsurgical infection is coded as a postoperative wound infection, not as a transplant complication.

Post-transplant patients who are seen for treatment unrelated to the transplanted organ are assigned a code from category Z94. Transplanted organ and tissue status, to capture the transplant status of the patient. A code from category Z94 should never be used with a code from category T86 for the same organ.

**OVARIAN CANCER AND DEBULKING**

Ovarian cancer is the deadliest of the gynecological cancers. Unfortunately a Papanicolaou test (Pap smear) does not check for ovarian cancer. Ovarian cancer begins in the ovaries and is often undetected until it has spread. After the cancer has spread it is a more advanced stage, which makes it harder to treat. The standard treatment begins with a debulking process. The purpose of the debulking process is to remove as much of the tumor(s) as possible, which often includes removing the organs as well.

The CPT codes for debulking surgery are 58953 and 58954. CPT 58953 is used when a bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy, and radical dissection for debulking. The CPT 58954 is used when there is also a pelvic lymphadenectomy and limited para-aortic lymphadenectomy done.
According to the **ICD-10-CM 2018 guidelines**:

When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicated the former site of the malignancy. How do we use the documentation to apply these guidelines?

Cancer is coded as **CURRENT** if the record states that:

- Active treatment is for the purpose of curing or palliating care.
- Cancer is present but unresponsive to treatment.
- The current treatment plan is observation, expectant management, or watchful waiting.
- The patient refused treatment.

Cancer is coded as **HISTORY OF** if the record states that:

The current status of cancer is “cancer free,” “no evidence of disease,” “NED,” or any other verbiage that indicates cancer is not current.

**What if cancer is documented as “in remission”?**

The **National Cancer Institute** defines ‘in-remission’ as:

“A decrease in or disappearance of signs or symptoms of cancer. Partial remission, some but not all signs and symptoms of cancer have disappeared. Complete remission, all signs and symptoms of cancer have disappeared, although cancer still may be in the body.”

Some forms of cancer (i.e. leukemias, myelomas) do have options in ICD-10 to specify, “in remission.” For those that do not, it is important to look at the documentation to determine if cancer is still present but the patient is symptom free versus the cancer being completely gone from the body.

**Helpful terminology to help determine:**

**Neoadjuvant chemotherapy**: Medicine administered before surgery to reduce the size of a tumor, and possibly provide more treatment options.

**Adjuvant**: “in addition to”, refers to medicine administered after surgery for treatment of cancer. This may be chemo, radiation, or hormonal therapy. The purpose may be:

- **Curative**: to treat cancer
- **Palliative**: to relieve symptoms caused by cancer without effecting a cure
- **Preventative/Prophylactic**: to keep cancer from reoccurring after treatment or keep cancer from occurring in a person who has never had cancer but has increased risk factors (family history, carcinoma in situ)

**Example 1**: Patient has breast cancer status post bilateral mastectomy/chemo/radiation. Patient is now on tamoxifen for five years.

Code this case as current. The record states that the patient is on adjuvant therapy for breast cancer (tamoxifen), but doesn’t note the purpose of the drug (curative, palliative, preventative). It also doesn’t say “cancer free” or “NED.”

**Example 2**: Patient has history of breast cancer, status post bilateral mastectomy/chemo/radiation. She is on prophylactic tamoxifen for five years. No evidence of disease.

Code this case as “history of.” The documentation notes “history of” and “no evidence of disease,” and describes the purpose of the adjuvant therapy is “prophylactic.”

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**PFSAs: What They Are and How to Review Them**

Patient Financial Services Announcements (PFSAs) are sent to PFS staff when a new process is implemented, or when a process has changed or been updated. CID has begun to use these as a method of communication to staff.

Staff should make sure to review the PFSAs when they are received. The subject line for these communications will begin with ‘PFSA,’ followed by the title of the document. Each e-mail contains a link to the document. To see all active PFSAs, you can search the PH-ARM Manual using the steps below:

1. Go to the PFS SharePoint.
2. Go the CID link at the top of the page.
3. In the top right-hand corner, click on PH-ARM Training Manual Search.
4. In the search bar, type “PFSA”, and do not hit enter*.
5. Click Patient Financial Services Announcements (PFSAs) to review all current PFSAs.
6. In the next window, search the title of the PFSA you are looking for. Once found, double click the title to open and review the document.
Procedures can’t be shared. When documentation indicates that an ARNP or PA performs a procedure(s) and staff appends a presence statement the procedure should be billed as IND under the ARNP or PA. The staff who signs the procedure would be listed as the billing provider within the charge session. Per CMS.

“The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non-facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to critical care services or procedures.”

Apply this guidance to minor procedures. If the procedure if performed in the OR and there is appropriate documentation that an ARNP or PA assisted with the procedure, review the CPT for approval of an AS modifier and bill accordingly. In that scenario, we would bill the CPT code under the provider with no modifier and then the same code again with AS and IND under the ARNP or PA.

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AAPC/AHIMA Local Chapter Meetings:

**AAPC Local Chapter Meetings:**

**Quad Cities Chapter** (formerly Bettendorf) Chapter President: Kathryn Joyce Phillis @ 515-313-7247 or email at kathryn.phillis@yahoo.com

Chapter Meeting to be held July 24th, 2018 at 6:00 p.m. 6600 - 34th Ave. Moline, Illinois

Speaker: Kim Karndstedt, ARNP-C

Topic: Cardiac Procedural Coding

**Cedar Rapids Chapter** Chapter President: Penelope Allen @ 319-247-3126 or email at pallen@pcofiowa.com

**Burlington Chapter** Chapter President: Tammara Mason @ 319-768-3475 or email at tmason@grhs.net

**Iowa City Chapter** Chapter President: Bridget Toomey @ 319-530-8168 or email at bridget-toomey@uiowa.edu

**AHIMA Local Chapter Meetings:**

District G Contact Information: Carrie A Jackson, RHIA @ 563-508-1014 or email at cjison14389@live.eicc.edu

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**JUNE**

**PFSA**

- ABN Modifiers
- Account Note Query
- Filter Option Added to Prof. Inquiry Screen
- Redacting PHI in Greenshot and Adobe

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**SHARED PROCEDURES**

By DJ Borkovec

- ABN Modifiers
- Account Note Query
- Filter Option Added to Prof. Inquiry Screen
- Redacting PHI in Greenshot and Adobe

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**Awards**

- Amanda Miller
  - SPOT Award
- Erika Jacobo
  - SPOT Award
- Christy Ragav
  - SPOT Award
- Donna Wong-Gibbons
  - SPOT Award
- Ashley Graham
  - SPOT Award
- Emyr McCallister
  - SPOT Award
- Brooke Roley
  - SPOT Award
- Porsche Mulherin
  - SPOT Award
- Lindsey Cagley
  - SPOT Award
- Sara Mury
  - SPOT Award
- Ashley Holmes
  - SPOT Award
- Kim Bekker
  - SPOT Award
- Rachel Simon
  - SPOT Award
- Emily Dore
  - SPOT Award

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**Shannon Delin**

5 Years of Service
CID Team Spotlight

**OPHTHALMOLOGY**

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**Emmy McCallister**
Revenue Cycle Manager

Year the department was formed: 1925
Patient visits annually: 65,000
Specialty areas: 15
Total coding staff: 6

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“**I have been the manager over the Ophthalmology Coding team for close to two years. What I love about the Ophthalmology department is that they are a true team. The coders work side by side with the providers and are an essential part of the resident documentation training. I appreciate this team’s ability to see past what training on documentation will do for our institution but the important role it will have in the future of each provider’s career. When you visit the hospital you will see how creative and fun the group has made getting to know the providers and developing strong working relationships with them. Department leadership also has an active, hands-on approach to working with the coders, which further supports the success of our piece in operations. The team is very self-sufficient, realizing their role in the patient experience and working to make the coding piece of that experience as hassle free as possible. I have enjoyed very much working with this group and am lucky to work with such experienced coders! 82 years of combined coding experience speaks for itself.**”

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**Gail Jons**
Coding Coordinator

“**The Ophthalmology coders are smart, humorous, and self-motivated. Despite the constant changes in coding, technology, and policies, they always approach their work with respect and grace. This year one of our coders transitioned to another department. The remaining coders did a fabulous job learning complex surgical coding and the subtle nuances of services that they were assigned to. They are always quick to reach out to each other or to me when they come upon a challenging coding situation and need to brainstorm. We have had a few occasions when coders were off for an extended time, and the other coders are always quick to jump in and help keep everything moving along in a timely and efficient manner. This work is not just a job to them; they are truly invested in Ophthalmology, and they are seen as an integral part of a top rated department.**”

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**OPHTHALMOLOGY CODERS**

Jennifer Juba
Kristi Howsare
Alysa Coppinger
Kirsten Jensen