Webinar Q&A

ICD-10-CM Update: Are you ready for the Code Set Updates and the end of the CMS Flexibility Period?

The following questions were submitted following the webinar above. Below are responses to provide additional details on these matters. As with the webinar, please note that the answers below are merely intended as general guidance that may not be suitable for certain specific situations, and should not be understood to supersede any policies or procedures at your facility; please consult official documents, your Medicare Administrative Contractor, or a qualified attorney for any specific legal guidance.

Question 1: Did you state that "evaluate for" is NOT a billable reason for exam?

Answer: That is correct.

The phrase and clinical indication "evaluate for" fits the definition of a *probable or uncertain condition* ("evaluate for" a condition and "rule out" a condition essentially mean the same thing).

ICD-10-CM Official Guidelines for Coding and Reporting FY 2017 state:

> **Section II. Selection of Principal Diagnosis**
>
> **H. Uncertain Diagnosis**
>
> If the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.
>
> **Note:** This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Radiologists are considered ancillary service providers for coding purposes. They rarely if ever have any direct physical contact with their patients. Additionally, our services do not fit into any of the categories listed above "inpatient admissions to short-term, acute, long-term care and psychiatric hospitals". Finally, our services are not billed under Part A Medicare. As such, we are providing ancillary Medicare Part B services to our patients and CMS requires us to follow the ICD-10 Guidelines for Outpatient Services.

According to these guidelines in an outpatient setting, terms that fit the definition of "probable or suspected conditions" (e.g., probable, suspected, questionable, rule out, working diagnosis, etc.) are not codeable for Part B providers. If there are no diagnostic findings gleaned from the documentation, then we must go back to the clinical history (signs, symptoms, lab results, etc.) that prompted the radiology exam to be ordered.

Question 2: We have adjusted to not using rule out, but have not been told evaluate is not acceptable.

Answer: Please, refer to the response for Question 1. Really, the key here is whether or not the term or phrase that is being used *fits the **definition** of a "probable or uncertain condition"*. The logic is nearly the same for both "rule out" and "evaluate for", therefore they both meet the criteria and neither should be coded in the outpatient Medicare Part B billing. Remember, any term that fits the definition of a *probable or uncertain condition* needs to be included in this coding guidance.

Question 3: At the AHIMA convention, it was mentioned that the provider must use the word "crisis," etc. in order to code the new HTN codes. Are you stating that the values listed can be used by coder to assign these new HTN codes?

Answer: The resource documented in this presentation is the 2017 ICD-10-CM Official Guidelines for Coding and Reporting.

Chapter 9: Diseases of the Circulatory System (I00-I99) states:

> **10) Hypertensive Crisis**
>
> Assign a code from category I16, Hypertensive crisis, for documented hypertensive urgency, hypertensive emergency or unspecified hypertensive crisis. Code also any identified hypertensive disease (I10-I15). The sequencing is based on the reason for the encounter.

Based upon that specific guidance available at the time of this presentation, you would be correct to code the new I16 Hypertensive Crisis Codes if the provider's documentation contains any of the following terms:

1. Hypertensive Crisis
2. Hypertensive Urgency
3. Unspecified Hypertensive Crisis

Please continue to monitor changes to this guidance periodically. The official title of this reference is listed below (you can obtain updated information by searching for it online):

> *ICD-10-CM Official Guidelines for Coding and Reporting FY 2017*; October 1, 2016 – September 30, 2017; published by Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS)

Question 4: At this point, where's the highest rate of denial/declination specific to radiology procedures?

Answer: The medical industry was fortunate that CMS provided that grace period between October 1, 2015 and October 1, 2016 allowing for use of less specific and unspecific ICD-10 CM codes. Most providers have not even had a full month of claims sent to their payers. We will not really be able to see any trends or patterns in payments and denials for at least a couple/few months. Once we have collected and analyzed that data, we intend to provide guidance and education to those facilities and providers that are not meeting the required documentation standards that ICD-10 CM demands.