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ADDRESSING THE NEEDS OF HEALTHCARE CODING PROFESSIONALS

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coding focus

ACMCA Notes

New Downloadable CEUs.

In these challenging times, every hard earned dollar is important. With that in mind, the ACMCA has reinvented itself to bring to you, cost effective, downloadable continuing education unit (CEU) courses. Each course is composed of an eBook of 100+ pages, 1-3 Lectures related to the eBook or specialty eBook to emphasize the key points, relevant appendices and a CEU exam.

The new process is simple, after study, you simply take the CEU exam; submit it to info.acmca.info and your CEUs will be awarded. Your CEU documentation record will be on file for employers and associations to verify when necessary.

By simplifying the CEU process, we are able to offer high quality training at very cost effective prices that you may do on your own time at your convenience.



Editor's Note: The *coding focus*, is a free quarterly informational newsletter published through the Academy of Certified Medical Coding Auditors (ACMCA). We welcome your input and educational articles relevant to our mission and patrons. Submit articles to info@acmca.info.

Certification before ICD-10 implementation!

The ACMCA concurs with most authorities that if you are in medical insurance, billing or coding (MIBC), and are not certified, but you wish to be, now are the time to do it!

Getting certified now, allows you an opportunity to really establish yourself with the medical codes, which as we know, drive the bottom line of healthcare, before the number of codes in diagnostic coding and hospital procedural coding and the processes of coding change significantly.

Certifying now, means continuing education later with ICD-10. Procrastinating certification means certifying down the road with ICD-10. The ICD-9 is approximately 13,500 diagnostic codes compared to 120,000 in ICD-10 CM. In regard to inpatient procedures, ICD-10 PCS is a little less than 200,000 procedure codes, versus ICD-9's 4,000 codes.

The Best Investment to make is in YOU!

Career paths in MIBC and HIM



Economies go up and down. Houses, cars and other materials things come and go. But the one thing that you can never lose is what you invest in yourself in education, continuing education and certification. This has never been more apparent than today with the world and US economies in the fight of their life.

What makes medical insurance, billing and coding (MIBC) and health information management (HIM) critically important and unique in the Health Care Industry Today?

According to the American Health Information Management Association (AHIMA), those who enter the world of HIMS today have many new job opportunities in both the general practice of HIM, and in other unique, related jobs. These are important, because all of these unique jobs are integrated with one common thread: "**health information**". In order to get to the information, the HIM professional must know how to abstract (define, identify, and utilize) data and systems, both organizational processes and computer technology, in order to turn the data into valuable, useable information. Similarly, the MIBC professional today has become a commodity with the payer and regulatory complexities with which they must work with on a daily basis. As the MIBC and HIM professionals grow, they often specialized in new areas of practice.

Some of the newer, unique and evolving health care information specialists' roles in HIM include some of those listed below. It is important to remember that job descriptions in MIBC and HIM are not written in stone. Health care facilities will have many variations on these positions based on their size and needs of each facility. Also, it is somewhat contingent on the organizational structure, infrastructure of computer and communication systems and talent within the organization. In some organizations, the HIM professional or managers will wear many hats. In larger facilities, they may have a more focused and highly specialized job. Example roles now include:

Internal Medical Record or Coding Reviewer

This is an experienced MIBC or HIM professional that performs internal auditing for their organization as required under the Federal U.S. Sentencing Guidelines (self-monitoring requirements) for organizations that accept government reimbursement or funding. The position requires knowledge of medical documentation, coding, billing and how HIM systems work within the organization.

OPPS and IPPS Coordinators

The outpatient perspective payment systems and inpatient perspective payment systems are complex. How does a facility know they are being paid correctly and timely? The OP

and IPPS coordinators have the important job of analyzing the revenue streams, what is going out the door in the way of coding and billing, and the reimbursement streams, what is being received from the payers in the way of payment and denials. They work closely with coding and billing departments and assist when needed on the reimbursement and claims appeal processes.

Healthcare Financial or Clinical Analyst

This important position abstracts clinical, financial, and operational data from medical systems, documents, and other clinical and financial computer databases to create valuable reports, which assists the management teams with organizational decision making. Information may relate to utilization and productivity, to the design of more appropriate workflows; or it may be more clinical, to improve patient care, and to improve systems and processes.

Clinical Applications Coordinator

With the implementation of electronic medical records, which include every department from pharmacy to the nursing stations, the Clinical Applications Coordinator is critically important to patient care and workflow analysis. The coordinator often analyzes everything from patient schedule to software application integration between departments, and even training of clinical staff.

Clinical Project Manager, Senior Project Manager

This is an advanced position. The Project Manager has responsibility for both department budgets (financial and time management) and results, (for example, meeting the organizational goals specific to HIM). The Project Manager helps to set project or work objectives, delegates to the appropriate staff, performs risk management, does follow up evaluations, and resets objectives as needed.

Clinical Research Associate

Many clinics and hospitals today do clinical trials, or drug and medical equipment studies in partnership with other organizations. This requires HIM specialists who managed the administrative processes of the clinical research. They are generally responsible for the quality assurance for providers' clinical documentation, adhering to standard operating procedures, and the overall study protocols. They often interface between the provider and the medical companies who are requesting the clinical research trials. A big part of the clinical research associate's job is going to be education of patients, staff in matters of patient privacy, confidentiality, obtaining informed consent and maintaining the overall integrity of the research project(s).

Clinical Vocabulary Manager

The components of HIPAA have created the need for the Clinical Vocabulary Manager. This HIM professional may be a role in the HIMS department, or the information technology department (IT). The role ensures that both legislative requirements and system

requirements are met in order to facilitate medical communications related to the quality clinical record documentation and also be in compliance with the law. In addition, under the Administrative Simplification Compliance Act, medical information management systems must use standardized vocabularies, code sets and formats used in electronic data interchange (EDI), electronic claims submission (ECS) (billing), and any other electronic transmission of private health information (PHI).

For more information regarding the many new roles for MIBC and HIM professionals, see the Department of Labor's Occupational Handbook 2008-2009 (Index: A-B) at: <http://www.bls.gov/oco/ocoiab.htm>



The Coding & Reimbursement toolbox

3 Keys for Coding Hypertension

by Michael Alan Meyer, DO, CCS, CPC, CPCI



3 Keys to Coding Hypertension

Key #1: Is the hypertension primary, or secondary to another condition?

Hypertension may be primary, or secondary to another condition. If secondary, the physician should also list the cause of the hypertension. The coder must then abstract from the PHR both the primary diagnoses and the manifestations in order to code correctly. Hypertension is generally related and documented to cardiac disease, renal disease or both cardiac and renal diseases.

Key #2: Is the hypertension documented as benign or malignant?

Physicians do not always document benign versus malignant in the PHR, which means the coder has two choices; either query the physician, if readily available and practical, or code unspecified. Malignant, benign or unspecified is determined by the fourth digit of the diagnosis code. Benign hypertension is also known as essential hypertension. It is more common than malignant hypertension and runs a relatively long and symptomless course. Malignant hypertension is "a form of hypertension that progresses rapidly, accompanied by severe vascular damage," (Tabers) This type of hypertension may be life-threatening and lead to stroke. Malignant hypertension can be life threatening and may cause a stroke, but again, is much less common than benign hypertension.

Key #3: What is the other disease process they hypertension is related to?

If the hypertension is primary, then the hypertension diagnosis code is sequenced first and we list the manifestation codes as secondary. For example, category 402 is hypertensive heart disease, 403 is hypertensive chronic kidney disease, and category, 404 is hypertensive heart and chronic kidney disease. The rules of coding hypertension are:

- ✓ Hypertension + Heart Disease – never assume that it is cardiac hypertension, unless clearly stated by the physician in the PHR.
- ✓ Hypertension + Renal Disease – is assumed by the coder to be related in all cases and the coder will chose from the category 403.
- ✓ Hypertension + Renal and Heart Disease, again, you may assume renal hypertension, but do not assume cardiac hypertension unless clearly stated by the physician in the PHR.

Coding Primary Hypertension:

- **Case 1:** The PHR indicates end-stage renal disease with benign hypertension: Code: **403.11**, Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease, 585.5 or 585.6 should also be coded with this hypertensive code. **Note:** Only one code is required to communicate both conditions.
- **Case 2:** The PHR indicates benign hypertensive heart disease with congestive heart failure. Code: **402.11**, Benign hypertensive heart disease with heart failure and **428.0**, Congestive heart failure (CHF), unspecified. **Note:** Since the physician documentation links the hypertension to the heart disease, you may use the 402 code. You would also need to report the type of heart failure, CHF.

Coding Secondary hypertension:

- **Case 1:** The PHR indicates that the patient has a pheochromocytoma, with high arterial blood pressure. **Code: 255.6**, Medulloadrenal hyperfunction (due to pheochromocytoma), **405.99**, Other secondary hypertension, unspecified. **Note:** The primary “cause” or condition is the tumor, and the hypertension is the manifestation. Since the documentation did not state malignant or benign, the coder must indicate secondary hypertension, unspecified.
- **Case 2:** The PHR indicates benign hypertension due to aldosteronism. **Code: 255.10**, Hyperaldosteronism, unspecified, and **405.19** Other secondary hypertension, benign. **Note:** The hypertension is secondary to aldosteronism. Therefore, the coder must report the causal condition as primary with the hypertension as the secondary diagnosis. See: Hypertension (HTN) Chart in the CMS Official Coding and Reporting Guidelines at:
<http://www.cdc.gov/nchs/datawh/ftp/ftpICD9/icdguide08.pdf>

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