NDHIMA

Prairie Record News

June 2017

President's Message

Kim Thompson, MS, RHIA
NDHIMA President 2016-2017

President's Report

The official kick off to summer is almost here. As we wind up for summer vacations and celebrations, the NDHIMA Board is welcoming new members to the group. The results from the recent election are in and we are excited to have Laurie Peters as President Elect and Shawna Zastoupil as Membership Director joining our board starting July 1. We also have several returning board members: Kathy Haaland -Treasurer, Reanna Leier - Education Director 2 year term and Hope Friesen - Education Director 1 year term. Please join me in welcoming all new and returning members to the board!

The AHIMA task forces and councils have been busy at work. Updates were provided on a recent House Leadership call which I have summarized below.

The 2017 House Meeting Task Force is working on developing the draft agenda for the house meeting at the National Convention in October 2017. There will be two sets of breakout sessions that delegates can attend. One breakout session will be on HIM Reimagined (HIMR) and the other is still being decided on. Larissa Stein and Laurie Peters will be attending the national convention this year and will bring back information to share regarding the house meeting.

The CDI Task Force has created a Query Toolkit which is now available on the AHIMA website. The CDI Summit Program Committee will be hosting the Clinical Documentation Improvement Summit in Washington DC July 31-August 1, 2017. There will be keynote addresses from nationally recognized industry experts on CDI best practices. Click on the link for more information about this summit. http://www.ahima.org/events/2017jul-cdisummit-dc

The Privacy and Security Practice Council will be participating in an upcoming webinar titled: Hidden Pieces of Privacy & Security in 21st Century Cures on May 25th. AHIMA will be celebrating the Privacy & Security Institute's 11th anniversary at the national convention in Los Angeles October 7-8, 2017. Click on the link for more information about this summit. http://www.ahima.org/events/2017Oct-PS-Institute-LA

In my last newsletter report, I provided you with a timeline for the HIMR Task

Force. This task force is comprised of 81 members with representation from all geographic areas, education and industry, with a diversity of credentials (AHIMA and otherwise). The task force has been working on a proviso recommendation which was submitted to CCHIIM for their vote. This proviso, if approved, would allow for someone with a bachelor's degree and an RHIT to be able to sit for the RHIA exam up to a certain point before the curriculum moves in a different direction. The task force has posted the final white paper at http://www.ahima.org/about/him-reimagined. The market assessment team has been tasked to look at content specific areas such as the impact of technology, alternative delivery systems and demographic characteristics. A research firm has been engaged and the pilot survey is to be tested 5/18-5/19 with the full survey being conducted 5/22 – 6/2 with initial results available in July 2017. The group will use the results to determine what areas of specialization they need to focus on and what curricular competencies they need to include at the various levels of education. The core competencies will then be identified and will be ready for comment in December 2017.

As always, there are lots of exciting things going on in our profession. I hope you found the information and updates helpful in keeping up with what is happening through AHIMA. If you have any questions about the information contained within my report, please contact me.

Have a wonderful summer!

Thank you,

Kim Thompson

Past President/Chair Nominating Committee's Message

Becky DeSautel, RHIT, CCS
NDHIMA Past President/Nominating Chair 2016-2017

Election: May 1-15, 2017

The 2017 Nominating Committee (Becky DeSautel, Ashley Brusseau and Carol Arthaud), is pleased to announce the results of the recent electronic election.

President Elect: Laurie Peters, RHIA, CCS

Treasurer: Kathleen Haaland, RHIT

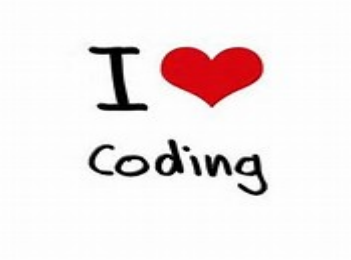
Membership Director: Shawna Zastoupil, RHIT

Education Director – 1 Year Team: Hope Friesen, RHIT

Education Director – 2 Year Term: Reanna Leier, RHIT

There are 219 NDHIMA eligible voters and out of these eligible voters 39 voted resulting in an 18% voter response rate. This was a decrease of 13% compared to last year. Thank you to everyone who voted! The newly elected board officers and directors will assume their elected positions July 1, 2017 and will be recognized at our annual business meeting on September 14th during the Fall Conference in Fargo.

The Nominating Committee joins all NDHIMA members in congratulating those elected, and we thank all of those who placed their names on the ballot.



DVAC Meeting Summary January 2017:

DRG Validation Advisory Committee (DVAC)
Workforce Safety Offices
Bismarck, ND
January 20, 2017 Minutes

Members Present: Deb Selland, Michelle Coalwell (phone), Susan Weidler, Joy Krush, Sue Roehl, Vicki Martel, Julie Thrailkill (phone), and Kari Buchholz (phone), and Laura Jassek. Shauna Vistad (North Dakota Blue Cross, was also present.)

Meeting opened by Deb Selland. Agenda for current meeting and minutes from October 7, 2016 were reviewed and approved.

Susan Weidler requested Sepsis with RSV be deleted from the Agenda.

Old Business:

Bibliography review – Vicki handed out the Mater Bibliography index. .
Membership – Cheryl Nelson has resigned from DVAC. She recommend Jackie Molfino fill her position. Jacki Molfino was approved as a new DVAC member.
Bronchoscopy with washing – a question was previously posed to Coding Clinic by Michelle. There has still been no response.
We reviewed Coding Clinic 1Q 2016 which discusses the differences between:
Brushings – (excision)
Lavage – drainage, unless it meets the definition of irrigation (substance). No root operation of extraction is available, so they recommend excision. Michelle will bring this back to the next meeting.

COPD exacerbation with pneumonia – Previously discussed. Michelle is still waiting for a response from Coding Clinic. Per Coding Clinic, 3Q 2016, COPD with pneumonia is assigned J44.10 – COPD with acute lower respiratory infection; "use additional code to identify infection". The question raised to coding clinic is in regards to aspiration pneumonia – is it considered an infection? We will carry this over awaiting response from Coding Clinic, however, it was the consensus that even though aspiration pneumonia is not specifically address in 3Q Coding Clinic, it is still a pneumonia.

ST myocardial infarction, status post stent, readmitted less than 4 weeks out from MI.

Assign for 4 weeks. Does affect Quality reporting. We discussed the issue of meeting the UHDDS criteria for reporting. There is current no guidance re: the assignment of the code only if related to subsequent admissions with cardiac symptoms/work-up, etc.

From Coding Clinic 4Q 2012:

Question:
When a patient is transferred from a hospital to a nursing home for continued recovery following an acute inferior wall myocardial infarction, what is the principal diagnosis at the nursing home? Would this be considered a "subsequent episode of care?"

Answer:
In this case, if the patient is in the recovery phase equal to, or less than, the four-week time frame for the acute myocardial infarction (AMI), continue to use code I21.19, ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall. Please note that for encounters occurring while the myocardial infarction is equal to, or less than, four weeks old, including transfers to another acute setting or a postacute setting, and the patient requires continued care for the myocardial infarction, codes from category I21 may continue to be reported. However, if the AMI occurred more than four weeks before, assign code Z51.89, Encounter for other specified aftercare.

Peri-prosthetic fractures – We reviewed the updated information in Coding Clinic 4Q 2016. New codes have been created in chapter 13. We note that the 7th character assignment does affect the APR-DRG.

Periprosthetic fractures
ICD-10-CM/PCS Coding Clinic, ***Fourth Quarter ICD-10 2016*** *Pages: 42-43*
Effective with discharges: October 1, 2016
New codes have been created to identify periprosthetic fractures. A new category (M97) has been created in Chapter 13, Diseases of the musculoskeletal system and connective tissue. Periprosthetic fractures were previously classified in the complication section of ICD-10-CM at subsubcategory T84.04, Periprosthetic

fracture around internal prosthetic joint. However, the American Academy of Orthopaedic Surgeons (AAOS) clarified that periprosthetic fractures are not complications of the prosthesis (the prosthesis itself is not fractured, the area around the prosthesis is fractured). For breakage (fracture) of prosthetic joints, assign codes from subcategory T84.01, Broken internal joint prosthesis. Periprosthetic fractures occur as a result of trauma or pathological conditions. A code for any underlying condition as well as a code for the specific type of fracture (traumatic or pathological) should also be assigned. If the reason for admission/encounter is the fracture, the specific type of fracture (traumatic or pathological) should be sequenced first and the periprosthetic fracture code should be sequenced as a secondary diagnosis code. These fractures can occur around any prosthesis, but the most common sites are the hip ***(M97.0)****, knee* ***(M97.1),*** *ankle* ***(M97.2),*** *shoulder* ***(M97.3),*** *elbow* ***(M97.4).*** *Subcategory* ***M97.8*** *identifies "other" sites of periprosthetic fractures. These codes require a fifth character to specify laterality for each joint and also require a 7th character to indicate: initial encounter (A), subsequent encounter (D) or sequela (S).*

Question:

A 64-year-old female patient with history of bilateral hip replacement presented to the hospital after having tripped and fallen sustaining a traumatic periprosthetic fracture of the lower end of the right femur. She had no symptoms of loosening of the prosthesis prior to this fall. How is this coded?

Answer:

Assign code S72.401A, Unspecified fracture of lower end of right femur, initial encounter for closed fracture, and code M97.01XA, Periprosthetic fracture around internal prosthetic right hip joint, initial encounter, along with the appropriate external cause code for the fall.

Question:

A patient, who is status post right total hip replacement, presents with a periprosthetic fracture. Patient states he stepped off of a curb, and immediately felt pain in the hip. After study**,** it was determined that the patient had a pathological fracture of the pelvis. How is this coded?

Answer:

Assign code M84.454A, Pathological fracture of pelvis, initial encounter, and code M97.01XA, Periprosthetic fracture around internal prosthetic right hip joint, initial encounter

7th Character for Coding for Injuries

We reviewed various scenarios for 7th character assignments:

Current treatment – A

Pelvic fracture going to Swing Bed or SNF – initial (A) or subsequent with routine healing (D) – will depend on the documentation.

Active treatment of wounds in Therapy or Rehab – may still be initial

treatment. The setting does not drive the 7th character assignment. Typically, Rehab, Therapy, or SNF will be subsequent treatment, but not always. Active does not equal "Acute".

New Business:

RAC/MIC updates (standing item) – Currently members report RAC requests are quiet, but there have been a few requests received. MIC reviews – Julie reported the MIS system is up and working. 670 requests for records were sent last month. Review requests include 3 day or less stays, certain DRGs, and readmissions within 7 days.

AHIMA/NDHIMA (Standing Item)

3Q Coding Clinic Review

Ileostomy takedown: Anastomosis in inherent in the procedure; not coded separately. If no removal takes place, then assign a repair code.

Hartmann procedure: Root operation of "Repositioning" is appropriate for the procedure to takedown a Hartmann.

Parastomal hernia repair – Assign a code for Repair, abdominal wall, in addition to the stoma takedown Even though the entry Takedown leaders the coder to repair, there are various options. Do not rely just on the Index. Review documentation carefully.

Viral Sepsis: Assign A41.89 (other specified sepsis). No specific code to indicate "viral" or for virus specificity are available. Assign B97.89 – other viral agents as the cause of diseases elsewhere. A code from subcategory R65.2, Severe sepsis, would not be assigned unless severe viral sepsis or an associated acute organ dysfunction is documented

Audiology: - Newborn screening – the audiologist would report Z13.5 for their services. No code for facility

PICC line removal: no procedure code assigned.

Excisional debridement of sacral muscle: Assign to hip muscle. If laterality is not specified, code both.

VersaJet non-excisional debridement: Code to the closest body part available. Code to extraction.

Calculus: Code to where the calculus start, even if they are removed from another site

Gunshot wound: Is a puncture wound. "Laceration" implies a cut.

Pathology Report: Do not code directly from Path report. Discussion was had regarding the interpretation for "admissions for diagnostic tests" in which coders are allowed to assign codes from a physician interpretation.

Past History: Be very careful assigning codes from Past History. Is it the patient's relating their Past History? The provider documenting the patient history from previous experience and/or records?

AHIMA Guideline re: coding validation: We believe the intent was to take the onus off of the coders, but not off the documentation requirements. It opens another dilemma of code assignments when the documentation to support the diagnosis is not present in the record. Coder versus CDI situations can occur. Questionable cases should be discussed prior to billing. UHDDS does, in a way, place responsibility of clinical determination in the coder's lap. The underlying guideline to follow should be "is it a reportable diagnosis". We should continue to monitor discussions.

Other Discussion:

Total Knee Arthroplasty: Does it include patella, lower bone – replacement? (Patella is rarely replaced). There is a separate code available for a replacement of the patella (0QRF0JZ).

Follow Up: From 4Q 2016 Coding Clinic:

Partial (unicondylar) knee replacement

ICD-10-CM/PCS Coding Clinic, ***Fourth Quarter ICD-10 2016*** *Pages: 109-110*
Effective with discharges: October 1, 2016

Related Information
A new device value was added to differentiate unicondylar knee replacement from other knee replacement procedures. In addition, body part values C-Knee Joint, Right and D-Knee Joint, Left, were moved into their own rows to enable this.

Device
L Synthetic Substitute, Unicondylar
This change impacts just one table:

oSR *Replacement of Lower Joints*

The articular surfaces in the knee are the condyles. In the medial compartment of the knee, the medial condyle of the femur articulates with the medial condyle of the tibia. In the lateral compartment of the knee, the lateral condyle of the femur articulates with the lateral condyle of the tibia.

In a total knee replacement, the condyles of the femur and tibia are replaced in both the medial compartment and the lateral compartment of the knee. In a partial knee replacement, the condyles of only one compartment are replaced. In other words, either the medial condyles of the femur and tibia are replaced, or the lateral condyles of the femur and tibia are replaced. Because only one set of condyles are replaced, this type of partial knee replacement is also known as unicondylar replacement.

Question:
The patient had severe arthritis of the left knee and underwent total knee replacement. How is this procedure coded?

Answer:
Assign the following ICD-10-PCS procedure code:

oSRDoJZ *of left knee joint with unicondylar synthetic substitute, open approach*

Question:
The patient had severe arthritis in the lateral compartment of the left knee and underwent a partial knee replacement. The lateral condyles of the femur and tibia were replaced using an open approach. How is this procedure coded?
Answer:
Assign the following ICD-10-PCS procedure code:
oSRDoLZ *of left knee joint with unicondylar synthetic substitute, open approach*

Kidney failure due to dehydration in a transplant patient: is this a transplant complication?
Kari – assignment – transplant complication research

Uncontrolled diabetes mellitus: Index of code book – Uncontrolled diabetes – options for hypoglycemia or hyperglycemia.
Poor control - - with hyperglycemia
Out of control – - With hyperglycemia.

Discussion to follow the Index.

Parking Lot:

Joy will highlight 4Q 2016 Coding Clinic at the next meeting.

Chronic Conditions

Meeting adjourned at 2:10 PM.

Geralyn Matejcek, Health Information Department Chair at NDSCS would like to recognize and thank all members serving on the NDSCS Advisory Committee.

NDSCS HEALTH INFORMATION DEPARTMENT ADVISORY COMMITTEE MEMBERSHIP 2016-2017

Sue Roehl, RHIT, CCS 2000- Chair of Committee
Manager-Health Care Services
EideBailly
Fargo, ND

Jolisa Jenstead, RHIT 2005-
Hospital Coding- Manager
Sanford Health-Fargo, ND

Denise Andersen, CCA, RHIT 2014-
Coding Review Analyst
Lake Region Healthcare
Fergus Falls, MN

Dyan Torgerson, RHIT 2006-
Healthcare Consulting Senior Associate,
EideBailly
Wahpeton, ND

Brenda Huston, CPC 2016-
HIM Manager & NDSCS Student-2016-
Confer Health Solutions, CHI St. Joseph's Health
Dickinson, ND

Michelle Rietschel, RHIT2016-
Enterprise Clinic Coding Director
Sanford Health-Fargo, ND

Van Gill, RHIA, CHPS 2016-
HIM Director, Privacy Officer
Jamestown Regional Medical Center
Jamestown, ND

Leslie Wendland, MS, RHIA
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Kim Thompson, MS, RHIA 2010-2017
Senior Revenue Cycle Administrator &
NDHIMA President
Sanford Health – Fargo, ND

Jan Anderson, RHIT 2016-
Manager of HIM
Altru Health System
Grand Forks, ND

Student Representatives:

Brenda Huston 2016-2017
Matty Wynn 2015-16 & 2016-2017
Laura Anderson 2016-2017

NDSCS Representatives:

Harvey Link, VP Academic & Student Affairs
Ken Kompelien, Dean ASB Division
Geralyn Matejcek, MBA, RHIA, HI Dept. Chair
Ashley Brusseau, RHIT, Instructor
Trese Saar, Administrative Assistant

Membership Update

Sue Hanna, RHIT, CPC
Membership Director

As of May 15, 2017 the membership numbers for NDHIMA are:
208 Active Members
138 Certified Members
2 Emeritus Members
10 New Graduate Members
5 New to AHIMA Members
58 Student Members

This compares to the February 10, 2017 membership numbers:
210 Active Members
130 Certified Members
2 Emeritus Members
9 New Graduate Members
1 New to AHIMA Members
60 Student Members

NDHIMA Fall Conference

Reminder that the Fall Conference will be held in Fargo September 14 -15. This will be at the Hilton Garden Inn.

Some of the topics that are being considered (dependent upon availability of speakers) include:

1. Endocrinology Diabetes
2. Compliance
3. Vendor Hour
4. Possible panel on drugs
5. Data Integrity
6. CAH and RHC topic
7. Chiropractor
8. Coding Roundtable- 2 hours
9. AHIMA Membership Presentation
10. CSA message
11. Revenue Cycle Management
12. RAC
13. Generation Gaps

If you or someone you know is available to speak on any of these topics, please contact the Education Co-Directors, Reanna Leier: reannaleier@gmail.com or Hope Friesen: hope.friesen@sanfordhealth.org

Information will be coming out later this summer. Save this date and we hope to see you there!