

Questions from Fall 2011 Webinar

<p>1. Will we be required to report place of occurrence codes in ICD-10?</p>	<p>Yes, although we cannot determine the scope and structure of how we will edit for all the external cause codes. The Information Center will continue to share information with submitters throughout 2012.</p>
<p>2. You mentioned situations where a record might have both ICD-9 codes and ICD-10 codes reported, can you explain when that situation might happen?</p>	<p>Because some records are pulled by date of service and some are pulled by discharge date, there may be occasions where the record may span from the 3rd quarter to the 4th quarter of 2013. If this occurs, similar to the CMS requirement, you will need to split the record submitting the dates of service containing ICD-9 codes into 3rd quarter and those that contain ICD-10 codes in the 4th quarter.</p>
<p>3. Should we report ER Procedures such as sutures, etc. that align with the 450 revenue code?</p>	<p>Yes, all significant procedures should be reported, if the services rendered contain a procedure in the range prescribed by WHAIC in Appendix XI, such as a CPT code for sutures, it would be reported as a principal procedure.</p>
<p>4. With regard to the 65+ report, we often find the data on the report accurate in that the patient is still working, covered by another carrier or perhaps a worker's compensation record, the question is, is there a way to reduce the size of the report to not include all the variables mentioned?</p>	<p>The reports query patients over 65 that do not have Medicare as a payer. We realize that some of these are correct, for example, as mentioned; there may be patients that are still working or have a worker's compensation claim. However, we have found that the data is more accurate when we provide the report for facilities to verify assignment of expected source of payment.</p>
<p>5. We are challenged with trying to figure out how to submit the primary CPT code on multi-code claims. We charge the 360 revenue code on each CPT line, but the dollars mainly are on the top code due to the way we charge OR time units. There is not a perfect order to the CPT codes on the claim.</p>	<p>WHAIC follows the guidelines set forth in the Uniform Hospital Discharge Data Set (UHDDS), CMS and the Official Coding Guidelines.</p> <p>In the Wipop manual, WHAIC defines the principal procedure as one performed for definitive treatment (rather than diagnostic or exploratory purposes) or one that is necessary to care for a complication. If two or more procedures appear to meet this definition, the one most related to the principal diagnosis is designated as the principal procedure. If both are equally related to the principal diagnosis, the most resource-intensive or complex procedure is usually designated.</p> <p>If the only clinically significant outpatient</p>

	<p>procedure performed is diagnostic or exploratory in nature (i.e. cardiac cath) it should be reported in the principal procedure field</p> <p>If you're not sure, choose the most significant procedure that was performed for the treatment of the principal diagnosis.</p>
6. Will you offer in-person meetings next year to further discuss Wlpop and ICD-10?	In 2012, we are planning on returning to in-person meetings as we will have a considerable amount of information to cover including updates to Wlpop, ICD-10 and ICD-10 edits, as well as other submission requirements.