2014
ANESTHESIA COMPLIANCE
IN-SERVICE TRAINING
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1. Basics

If you don’t remember anything else, remember this:

- Mantra of the auditor: not documented, not done
- Documentation should support medical necessity
- There’s only one record that matters: the anesthesia record
- There’s only one timepiece that matters: your timepiece
Anesthesia Risk Areas

1. Anesthesia Provider(s)
2. Surgical Procedure Description
3. Diagnosis
4. Mode of Anesthesia
5. Modifiers and Conditional Factors
6. Start time
7. End time
8. Nerve Blocks
9. Invasive Monitoring
10. Follow-up Care
11. Signature
2. Technique

- Technique
- Basics
- Quality of Care
- Time & Medical Direction
- Incidentals
- Post-Op
- NORA
- P4P
- Revenue Enhancement
- Practice Security
The mode of anesthesia is not dependent upon any specific medication but may vary based on dosage, route and timing of administration, the metabolism and interaction with other medications, the clinical status and body habitus of the patient, etc.

- **General Anesthesia** is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. (ASA statement on the Continuum of depth of sedation, Oct 21, 2009)

- **Monitored Anesthesia Care** (MAC) does not describe the continuum of depth of sedation, rather it describes “a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure.”

- **Regional Anesthesia** involves the use of nerve blocks or epidural techniques with sedation. A distinction must always be made between cases in which the nerve block, spinal or epidural is the primary mode of anesthesia versus those for which the intent of the block or epidural is for purposes of post-operative pain management.
Medical Policy for MAC

- CMS, and many other payers, require that cases performed under MAC anesthesia be flagged with a –QS modifier.
- Payment for MAC anesthesia is generally at the same rate as for general anesthesia; however, claims for MAC may be subjected to a higher degree of scrutiny than those for General Anesthesia.
- The MAC service rendered must be reasonable, appropriate and medically necessary, in other words, there must be ample justification for separate payment to an anesthesia provider. The medical condition of the patient must explain the need to provide MAC, e.g. the patient is on medication or is symptomatic, etc. Normal, healthy patients undergoing routine screening procedures would not meet the requirement of medical necessity.
3. Time

- Basics
- Technique
- Time & Medical Direction
- Base Value
- Incidental
- Post-Op
- NORA
- P4P
- Revenue Enhancement
- Practice Security
Anesthesia Start and End Times

- Only the anesthesia provider can accurately confirm the start and end time for each surgical or obstetric procedure.

**Scenario 1:** Anesthesia time starts with provider in-room time and ends when the patient is turned over to PACU staff.

**Scenario 2:** Under certain circumstances, pre-operative time may be included so long as medical necessity requirements are met.

**Scenario 3:** The administration of nerve blocks for post-operative pain or the insertion of catheters for invasive monitoring are typically not included in the anesthesia time, so long as they are performed pre-induction.

**Scenario 4:** Transport time should be included for unstable patients, such as those coming from an ICU.
4. Base Value

- Quality of Care
- Basics
- Technique
- Time & Medical Direction
- Incidentals
- Post-Op
- NORA
- P4P
- Revenue Enhancement
- Practice Security
Procedure Coding

- Coders first establish a CPT surgical code based on the most complicated procedure documented.
- This CPT code is then mapped to a corresponding ASA code to determine the Basic Value.
- There are more than 800 surgical CPT codes that map to multiple ASA codes, many of which have different values.
- Clinician documentation must provide sufficient detail to confirm the appropriate ASA code.
- In most cases only the anesthesia provider will know what is missing, because it is not part of the surgical procedure description.
The following are the five most common integumentary procedures used by anesthesia providers that may refer to multiple ASA codes:

- **10060** – Incision and drainage of skin abscess; simple or single
- **10140** – Incision and drainage of hematoma; seroma or fluid collection
- **11042** – Debridement, subcutaneous tissue; first 20 sq cm or less
- **11400** – Excision of benign lesion including margins, trunk, arms or legs; excised diameter 0.5 cm or less
- **11600** – Excision of malignant lesion including margins, trunk, arms or legs; excised diameter 0.5 cm or less

Each requires a clear indication of the location of the body affected so that the appropriate ASA code can be selected for billing:

- **ASA 00300** (5 base units) For all procedures on the integumentary system, muscles and nerves of head, neck and posterior trunk, not otherwise specified
- **ASA 00400** (3 base units) For procedures on the integumentary system on the extremities, anterior trunk and perineum, not otherwise specified
The following are the five most common abdominal procedures used by anesthesia providers that may refer to multiple ASA codes:

- **44005** – Enterolysis (freeing of intestinal adhesion)
- **44140** – Colectomy, partial; with anastomosis
- **44204** – Laparoscopy, surgical; colectomy, partial, with anastomosis
- **44207** – Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy
- **44620** – Closure of enterostomy, large or small intestine

Each requires a clear indication of the location of the body affected so that the appropriate ASA code can be selected for billing:

- **ASA 00790** (7 base units) For intraperitoneal procedures in the upper abdomen including laparoscopy; not otherwise specified
- **ASA 00840** (6 base units) For intraperitoneal procedures in the lower abdomen including laparoscopy; not otherwise specified
Procedures Involving a One-lung Technique

- The following are the five most common procedures used by anesthesia providers that may involve a one-lung technique:
  - 32110 – Thoracotomy with control of traumatic hemorrhage and/or repair of lung tear
  - 32480 – Removal of lung; other than pneumonectomy; single lobe (lobectomy)
  - 32656 – Thoracoscopy, surgical; with parietal pleurectomy
  - 32663 – Thoracoscopy, surgical; with lobectomy (single lobe)
  - 32666 – Thoracoscopy, surgical; with therapeutic wedge resection, initial unilateral

- Each requires a clear indication whether thoracotomy or thoracoscopy and if one lung ventilation was used.
  - ASA 00541 (15 base units) For thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing 1 lung ventilation
  - ASA 00540 (12 base units) For thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified
Cysto Procedures

- The following are the five most common procedures used by anesthesia providers for cystoscopy procedures
  - 52353 – Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy
  - 52352 – Cystourethroscopy with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus
  - 52354 – Cystourethroscopy with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion
  - 52355 – Cystourethroscopy with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor
- Each requires a clear indication of the location of the body affected so that the appropriate ASA code can be selected for billing
  - ASA 00862 (7 base units) For extraperitoneal procedures in lower abdomen, including urinary tract; renal procedures, including upper one-third of ureter, or donor nephrectomy
  - ASA 00910 (3 base units) Transurethral procedures (including ureteroscopy): not otherwise specified
  - ASA 00918 (5 base units) Transurethral procedures (including urethrocystoscopy; with fragmentation, manipulation and/or removal of ureteral calculus
Femur Procedures

- The following are the five most common procedures used by anesthesia providers for femur procedures
  - 27236 – Open treatment of femur fracture, proximal end, neck, internal fixation or prosthetic replacement
  - 27245 – Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant with or without interlocking screw and/or cerclage
  - 27507 – Open treatment of femoral shaft fracture with plate/screws, with or without cerclage
  - 27506 – Open treatment of femur shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws
  - 27514 – Open treatment of femur fracture, distal end, medial or lateral condyle, includes internal fixation

- Each requires a clear indication of the location of the body affected so that the appropriate ASA code can be selected for billing
  - ASA 01210 (6 base units) Open procedure involving hip joint
  - ASA 01230 (6 base units) Open procedure involving upper 2/3 of femur
  - ASA 01360 (5 base units) Open procedure on lower 1/3 of femur
Spinal Surgery

Documentation of spinal surgery must mention the region of the spine and whether hardware is used as part of the procedure and/or vertebral bodies or interspaces:

- **22554** – Cervical arthrodesis with anterior interbody technique
- **22612** – Lumbar arthrodesis with posterior or posterolateral technique
- **22600** – Cervical arthrodesis with posterior or posterolateral technique
- **22630** – Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy
- **22610** – Thoracic arthrodesis with lateral technique
- **22808** – Anterior arthrodesis for spinal deformity, 2 – 3 vertebral segments

This allows the procedure to be mapped to the appropriate ASA code:

- **00620** (10 units) For thoracic spinal procedures
- **00625** (13 units) For thoracic spinal procedures, anterior approach
- **00626** (15 units) For thoracic spinal procedures with one-lung technique
- **00630** (8 units) For lumbar spinal procedures
- **00670** (13 units) For extensive spine and spinal cord procedures i.e., instrumentation, minimum three vertebral bodies with the two associated interspaces.
- **00600** (10 units) For cervical spinal procedures
- **00604** (13 units) For procedures with patient in the sitting position
5. Incidentals

- P4P
- NORA
- Post-Op
- Incidentals
- Base Value
- Time & Medical Direction
- Technique
- Basics
- Quality of Care
5. Incidentals – Invasive Monitoring

Invasive Monitoring and TEE

- Arterial lines, CVPs and Swan-Ganz catheters are separately billable

- CVPs and Swan-Ganz Together:
  - Separately Payable: If they are two separate lines
  - Not Separately Payable: When the CVP is used to place the Swan-Ganz catheter

- TEE
  - 93312 - Comprehensive diagnostic service, including probe placement, image acquisition, interpretation and report
  - 93313 - Probe placement only
  - 93314 - Interpretation, image acquisition and report only
  - 93318 - Probe placement for intra-operative monitoring
5. Incidentals – Nerve Blocks

Nerve Blocks for Acute Pain Management

- **64415** – Interscalene Block, single
- **64416** – Interscalene Block, continuous
- **64445** – Sciatic Block, single
- **64446** – Sciatic Block, continuous
- **64447** – Femoral Block, single
- **64448** – Femoral Block, continuous
5. Incidentals – Ultrasonic Guidance

Ultrasonic Guidance

- 76937-26 – Ultrasonic guidance for vascular access requiring ultrasound evaluation of potential access sites
- 76942-26 – Ultrasonic guidance for needle placement (acute pain block)
- Brief note of localization process and archived image of ultrasound must be maintained in patient medical record
- Billed “per anatomical region” billable if same anatomical region but different sides of body (bilateral)
- Bilateral blocks considered to be one site only

Please note that payor policies with regard to USG are being constantly revised, the result of which is that USG is becoming bundled into an increasing number of procedures
6. Post-Op

- Quality of Care
- Basics
- Technique
- Time & Medical Direction
- Incidental
- NORA
- P4P
- Post-Op
- Practice Security
- Revenue Enhancement
6. Post-Op

Distinguish Daily Catheter Management from Injection Follow-Up

- Requirements for acute pain follow-up reimbursement
  - Begins post-op day #1 (i.e., the first calendar day after surgery)
  - Round on the patient
  - Progress note
    - Brief history
    - Examination of the site and ask about pain level
7. NORA

- Basics
  - Quality of Care
- Technique
  - Time & Medical Direction
- Incidentals
- Post-Op
- NORA
- P4P
- Revenue Enhancement
- Practice Security
Non-Operating Room Anesthesia (NORA)

- Services provided outside the operating room or delivery suite sometimes get overlooked by either the providers or the billing office.
- We need to make sure we capture all Non-O.R. Anesthesia Services.
- It may be necessary to create a separate form for this.
- Typical Services:
  - Emergency Intubations
  - Blood patches
  - ICU Visits
  - Consults
8. Pay for Performance (P4P)
8. Physician Quality Reporting System

Physician Quality Reporting Measures

- Measure #30 – Antibiotic
- Measure #44 – Beta-Blocker
- Measure #193 – Temperature
- Measure #76 – Central venous access

For 2014, CMS has made a fourth measure, #44 Preoperative Beta-Blocker in Patients with Isolated CABG Surgery

Additional PQRS anesthesia measures are listed in the 2014 CPT Coding Manual; however, CMS has put them on hold for PQRS reporting until 2015
ICD-10-CM
COMING SOON
DATE OF TRANSITION: OCTOBER 1, 2015
ICD-10 Coming Soon - Familiar but Totally Re-Engineered

1964 Mustang 2015 Mustang

Anesthesia Business Consultants, LLC Confidential Presentation Materials
Agenda

- The role of diagnosis in medical billing
- ICD-10 versus ICD-9
- Overall impact of ICD-10 on claims processing
- Expected impact on the specialty of anesthesia
- ICD-10 general documentation requirements
- Specific common documentation scenarios
- ABC plan of action
ICD-10 True or False

- I have to report seemingly irrelevant information like the patient was injured **FALSE**
  - While at the opera: Y92253
  - Stabbed while crocheting: Y93D1
  - Walked into a lamppost: W2202XA
  - Walked into a lamppost, subsequent encounter: W2202XD
  - Submersion due to falling or jumping from crushed water skis: V9037XA
- It requires 25-50 hours to learn how to document ICD-10 **FALSE**
- ABC will make sure a specific code is submitted; so I do not have to make any changes **FALSE**
- My revenue is going to be significantly impacted by ICD-10 **FALSE**
The Role of Diagnosis in Medical Billing

- CPT codes explain **what** was done during the visit, operation, treatment, etc.
- ICD codes explain **why** it was done
- A valid **what** and **why** code that is supported by the anesthesia record documentation (**where**) must be submitted on the claim form for payment
- Medical necessity denials happen when the **what** and **why** are not in agreement with CMS or other payers coverage policies, e.g. National or Local Coverage Determinations (NCD/LCD)
# ICD-10 Versus ICD-9

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
<th>ICD-9-CM (VOLS. 1 &amp; 2)</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Length</td>
<td>3-5 characters</td>
<td>3-7 characters</td>
</tr>
<tr>
<td>Available Codes</td>
<td>Approximately 14,000 codes</td>
<td>Approximately 69,000 codes</td>
</tr>
<tr>
<td>Code Composition (numeric or alpha)</td>
<td>Digit 1 = alpha or numeric &lt;br&gt; Digits 2-5 = numeric</td>
<td>Digit 1 = alpha &lt;br&gt; Digit 2 = numeric &lt;br&gt; Digit 3 = alpha or numeric</td>
</tr>
<tr>
<td>Available Space for New Codes</td>
<td>Limited</td>
<td>Flexible</td>
</tr>
<tr>
<td>Overall Detail Embedded Within Codes</td>
<td>Limited detail in many conditions</td>
<td>Generally more specific (allows description of comorbidities, manifestations, etiology/causation, complications, detailed anatomical location, sequelae)</td>
</tr>
<tr>
<td>Sample Code</td>
<td><strong>813.15</strong>, Open fracture of head of radius</td>
<td><strong>S52.122A</strong>, Displaced fracture of head of left radius, initial encounter for open fracture type IIA, IIB, or IIC</td>
</tr>
</tbody>
</table>
ICD-10 Versus ICD-9

- ICD Codes expanded from approximately 14,000 to 69,000
  - 34,250 (50%) of all ICD-10-CM codes are related to the musculoskeletal system
    - 17,045 (25%) of all ICD-10-CM codes are related to fractures
    - 10,582 (62%) of fracture codes to distinguish ‘right’ vs. ‘left’
  - 25,000 (36%) of all ICD-10-CM codes to distinguish ‘right’ vs. ‘left’
ICD-10 Versus ICD-9

- ICD-10-CM includes a fuller definition of severity, comorbidities, complications, sequelae, manifestations, causes, and a variety of other important parameters that characterize the patient’s condition
  - Thousands of other codes differ only in the way they distinguish among “initial encounter,” versus “subsequent encounter,” versus “sequelae”
  - Note: For anesthesia, 95% of your claims will be for initial encounter for active treatment
ICD-10 Versus ICD-9

- Who is going to determine the final ICD-10 code?
  - CPT surgical codes crosswalk to ASA codes
    - Utilize as a guide
    - Not all CPT codes have a 1:1 match between systems
  - There is a CMS crosswalk for ICD-9 to ICD-10
    - Utilize as a guide
    - Not all ICD-9 codes have a 1:1 match between diagnoses
  - Many providers say that since anesthesia has been utilizing crosswalks for many years that ICD-10 will be just utilizing a different crosswalk
  - Can we piggyback on someone else’s work?
    - The answer is no
Overall Impact of ICD-10 on Claims Processing

- The potential impact of ICD-10 is not known
  - Due to different payer environments
  - Due to different levels of implementation

- Claims issues
  - Payer claims processing challenges
  - Coding issues
    - Documentation insufficiencies
    - Default to unspecified

- Payer issues
  - Each payer will implement differently
    - National payers have a plan
    - Local payers may not have a plan
    - WC and Auto Liability not subject to HIPAA rules
Expected Impact on the Specialty of Anesthesia

- Anticipation of productivity and revenue decreases
  - Good clinical documentation and teamwork will minimize the effect
- Documentation scrutiny
  - Medical necessity issues
  - Unspecified issues
  - Orthopedics largest impact
- Communication with surgical colleagues
  - Break down the barriers
  - Looking through the surgical lens
  - Encourage team approach to coding and documentation
Expected Impact on the Specialty of Anesthesia

- In the past, anesthesia claims were seldom denied as long as a valid code was submitted.
- Now the code must be valid and you must answer some detailed questions:
  - Laterality, obstruction, recurrent.
- ICD-10 will impact timeliness of claims processing if the questions are not answered the first time:
  - Clients will be contacted.
  - Operative reports researched.
  - All of this slows down getting the claim to the payer and consequently slows down your revenue.
Anesthesia record presents with the verbiage: “Fracture radius shaft”

- ICD-9: Without any further detail this can be coded as 813.21 for fracture of radius and ulna, shaft closed, radius alone
- ICD-10: Cannot be coded without more information

No code is ever considered valid or complete unless it’s coded to the highest level of specificity in its category.
# ICD-10 Documentation Requirements

## Fracture Care

1. **Anatomic site on bone**
   - Proximal
   - Shaft
   - Distal

2. **Laterality**
   - Right
   - Left

3. **Fracture Type**
   - Displaced
   - Non-displaced
   - Open
     - 3 or more subsets
   - Closed

4. **Episode of Care**
   - Initial
   - Subsequent
   - Sequelae
How the coder will arrive at the correct code:

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S52.3</td>
<td>Fracture shaft of radius</td>
</tr>
<tr>
<td>S52.32</td>
<td>Transverse fracture of radius</td>
</tr>
<tr>
<td>S52.324</td>
<td>Non-displaced transverse fracture of shaft or right radius</td>
</tr>
<tr>
<td>S52.324A</td>
<td>Non-displaced transverse fracture of right radius, initial</td>
</tr>
<tr>
<td></td>
<td>encounter for closed fracture</td>
</tr>
</tbody>
</table>
ICD-10 Documentation Requirements
Inguinal Hernia

Anesthesia record presents with the verbiage: “Inguinal Hernia”

- **ICD-9**: Without any further detail this can be coded as 550.9 for Inguinal hernia without mention of obstruction or gangrene
- **ICD-10**: Cannot be coded without more information

No code is ever considered valid or complete unless it’s coded to the highest level of specificity in its category.
ICD-10 Documentation Requirements
Inguinal Hernia

1. Laterality
   - Bilateral
   - Unilateral
2. Obstruction
3. Gangrene
4. Recurrent

*Hernia with both gangrene and obstruction is classified to hernia with gangrene
   - Includes
     - Bubonocele
     - Direct inguinal hernia
     - Double inguinal hernia
     - Indirect inguinal hernia
     - Inguinal hernia NOS
     - Oblique inguinal hernia
     - Scrotal hernia
### ICD-10 Documentation Requirements

#### Inguinal Hernia

*How the coder will arrive at the correct code:*

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K40</td>
<td>Inguinal Hernia</td>
</tr>
<tr>
<td>K40.1</td>
<td>Bilateral Inguinal Hernia with gangrene</td>
</tr>
<tr>
<td>K40.11</td>
<td>Bilateral Inguinal Hernia with gangrene recurrent</td>
</tr>
</tbody>
</table>
## Colonoscopy

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>45378</td>
<td>Colonoscopy</td>
<td>57.04%</td>
</tr>
<tr>
<td>45385</td>
<td>Colonoscopy for removal of tumor</td>
<td>23.66%</td>
</tr>
<tr>
<td>45380</td>
<td>Colonoscopy with biopsy</td>
<td>18.35%</td>
</tr>
<tr>
<td>45382</td>
<td>Colonoscopy for control of bleeding</td>
<td>0.80%</td>
</tr>
<tr>
<td>45383</td>
<td>Colonoscopy with ablation of tumor</td>
<td>0.10%</td>
</tr>
<tr>
<td>45381</td>
<td>Colonoscopy with submucosal injection</td>
<td>0.05%</td>
</tr>
</tbody>
</table>
## Most Common ICD-9 Diagnoses

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>V58.83</td>
<td>Encounter for unspecified procedure or aftercare</td>
<td>28.60%</td>
</tr>
<tr>
<td>V76.51</td>
<td>Screening for malignant neoplasm</td>
<td>13.90%</td>
</tr>
<tr>
<td>562.1</td>
<td>Diverticulosis</td>
<td>7.50%</td>
</tr>
<tr>
<td>211.3</td>
<td>Benign neoplasm of large intestine</td>
<td>6.50%</td>
</tr>
</tbody>
</table>
### Screening Codes

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>V58.83</strong></td>
<td><strong>Z51.81</strong></td>
</tr>
<tr>
<td>- Encounter for other or</td>
<td>- Encounter for other</td>
</tr>
<tr>
<td>unspecified procedures</td>
<td>aftercare</td>
</tr>
<tr>
<td>and aftercare</td>
<td></td>
</tr>
<tr>
<td><strong>V76.51</strong></td>
<td><strong>Z12.11</strong></td>
</tr>
<tr>
<td>- Special screening for</td>
<td>- Encounter for screening</td>
</tr>
<tr>
<td>malignant neoplasms;</td>
<td>for malignant neoplasm;</td>
</tr>
<tr>
<td>colon</td>
<td>colon</td>
</tr>
</tbody>
</table>
# Diverticulosis

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10 Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>562.10</td>
<td>Location?</td>
</tr>
</tbody>
</table>
| o Diverticulosis of colon (without mention of hemorrhage) | o Large intestine  
| | o Large and small intestine  
| | o Unspecified  
| | Perforation and abscess?  
| | Bleeding? |
# Benign Neoplasm

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10 Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>211.3</td>
<td><strong>Location?</strong></td>
</tr>
<tr>
<td></td>
<td>- Cecum</td>
</tr>
<tr>
<td></td>
<td>- Ascending colon</td>
</tr>
<tr>
<td></td>
<td>- Transverse colon</td>
</tr>
<tr>
<td></td>
<td>- Descending colon</td>
</tr>
<tr>
<td></td>
<td>- Sigmoid colon</td>
</tr>
<tr>
<td></td>
<td>- Other</td>
</tr>
</tbody>
</table>

- Benign neoplasm of other parts of the digestive system
# Knee Arthroscopy

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>29881</td>
<td>Arthroscopy of the knee with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartments, when performed</td>
</tr>
</tbody>
</table>
# Most Common ICD-9 Diagnoses

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>836.0</td>
<td>Tear medical cartilage or meniscus knee current</td>
<td>37.80%</td>
</tr>
<tr>
<td>836.2</td>
<td>Other tear cartilage or meniscus knee current</td>
<td>24.31%</td>
</tr>
<tr>
<td>836.1</td>
<td>Tear lateral cartilage or meniscus knee current</td>
<td>10.78%</td>
</tr>
<tr>
<td>719.46</td>
<td>Pain in joint, lower leg</td>
<td>9.81%</td>
</tr>
</tbody>
</table>
## Tear Medial Cartilage or Meniscus Knee Current

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10 Criteria</th>
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<tbody>
<tr>
<td>836.0</td>
<td>- Current injury</td>
</tr>
<tr>
<td></td>
<td>- Tear of medial cartilage or</td>
</tr>
<tr>
<td></td>
<td>meniscus of knee, current</td>
</tr>
<tr>
<td>836.2</td>
<td>- Current injury</td>
</tr>
<tr>
<td></td>
<td>- Other tear of cartilage or</td>
</tr>
<tr>
<td></td>
<td>meniscus of knee, current</td>
</tr>
<tr>
<td>836.1</td>
<td>- Current injury</td>
</tr>
<tr>
<td></td>
<td>- Tear of lateral cartilage or</td>
</tr>
<tr>
<td></td>
<td>meniscus of knee, current</td>
</tr>
<tr>
<td></td>
<td>- Type of meniscus</td>
</tr>
<tr>
<td></td>
<td>- Type of tear</td>
</tr>
<tr>
<td></td>
<td>- Laterality</td>
</tr>
<tr>
<td></td>
<td>- Episode of care</td>
</tr>
<tr>
<td></td>
<td>- Initial</td>
</tr>
<tr>
<td></td>
<td>- Subsequent</td>
</tr>
<tr>
<td></td>
<td>- Sequela</td>
</tr>
<tr>
<td>ICD-9</td>
<td>ICD-10 Criteria</td>
</tr>
<tr>
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<td>-------------------------------</td>
</tr>
<tr>
<td>719.46</td>
<td>• Location</td>
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<tr>
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<td>• Laterality</td>
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<td>o Pain in joint, lower leg</td>
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# ABC Plan of Action

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Phase I (Q1)</td>
<td>Client Feedback Gathering</td>
</tr>
<tr>
<td>Phase II (Q2 and Q3)</td>
<td>Client Feedback and Training</td>
</tr>
<tr>
<td>Phase III (Q4)</td>
<td>Implementation – Contingency Plan Roll Out</td>
</tr>
<tr>
<td>Phase IV (Q1 2016)</td>
<td>Post Implementation – Provider Re-Education</td>
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