Complete and accurate medical documentation and coding are essential to report conditions for which patients are being treated, ensure regulatory compliance, and to foster reimbursement and revenue integrity. The two are intrinsically related, as precise medical documentation is essential to correct coding. Coders directly translate clinicians’ documentation into diagnosis and procedure codes, which describe the patient’s visits clinically and are also used by payors for payment purposes.

In this educational brief, we explore ways that clinical documentation impacts coding and, in turn, reimbursement for hematopoietic cell transplant (HCT). Most of the information will apply to a variety of payors. However, we will spend additional time on requirements specific to Centers for Medicare and Medicaid Services (CMS), as this is an area of frequent concern for many transplant centers.

**Coding Overview**

**Current HCT Coding**

Today, the patient’s diagnoses and the specific treatments provided are reported using ICD-9-CM (*International Classification of Diseases – Ninth Revision - Clinical Modification*) diagnosis and procedure codes in the inpatient setting. In the outpatient setting, ICD-9-CM diagnoses and CPT (Current Procedural Terminology) procedure codes are used to document diagnoses and treatment. Table 1, page 2, contains the current ICD-9-CM procedure codes for HCT.

**ICD-10-PCS: Upcoming Coding and Documentation Changes**

In the near future, health care professionals will face a dual challenge as they strive to maintain sound documentation and coding practices while also planning to implement ICD-10-CM Diagnosis Coding System and ICD-10 Procedure Coding System (PCS) codes. Both are currently slated for implementation in October 2014.

Compared to the ICD-9-CM system, procedure coding under the ICD-10-PCS will require very different—and much more detailed—documentation in order for coders to report complete and accurate procedure codes. Hospitals should begin planning for ICD-10 implementation by considering needed modifications to internal coding and/or charge capture forms to capture the new, required documentation elements. Being proactive will help reduce the number of physician coding queries that occur after ICD-10 is implemented. A draft crosswalk of current transplant codes to ICD-10 codes can be found here.
Procedure Codes

Bone Marrow or Hematopoietic Stem Cell Transplant

Current code assignment for the transplant/infusion procedure is fairly straightforward, but documentation must be present to support the procedure provided. Table 1 shows current procedure codes for HCT.

<table>
<thead>
<tr>
<th>PROCEDURE CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODE</td>
</tr>
<tr>
<td>41.01</td>
</tr>
<tr>
<td>41.04</td>
</tr>
<tr>
<td>41.07</td>
</tr>
<tr>
<td>41.09</td>
</tr>
</tbody>
</table>

Table 2: ICD-9-CM Procedure Code 41 for HCT

<table>
<thead>
<tr>
<th>PROCEDURE CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODE</td>
</tr>
<tr>
<td>41.02</td>
</tr>
<tr>
<td>41.03</td>
</tr>
<tr>
<td>41.05</td>
</tr>
<tr>
<td>41.06</td>
</tr>
<tr>
<td>41.08</td>
</tr>
</tbody>
</table>

Reporting Donor Cell Source to Medicare

In addition to the transplant procedure code, CMS has requested that facilities use ICD-9-CM procedure codes to report the donor cell source on claims for allogeneic transplants to assist them with future data collection. CMS stressed the importance of using ICD-9-CM procedure codes to identify the donor source for allogeneic transplants in the 2011 Final Inpatient Prospective Payment System Rule.[1] Coding staff must be able to locate where your facility’s clinicians document the cell source in the medical record.

Donor source codes:

- 00.91 – Transplant from live related donor.
- 00.92 – Transplant from live non-related donor.
- 00.93 – Transplant from cadaver.

There are currently only two available ICD-9-CM procedure code choices for autologous HCT: 41.01 (without purging), and 41.09 (with purging). Under ICD-9-CM, the correct procedure code for autologous HCT is driven by whether or not purging was performed.

In contrast, the ICD-10-PCS uses a very different procedure code set structure with eight different codes. And, purging does not impact the ICD-10 code selection at all. Instead, the artery or vein utilized during the transfusion process, and whether an open or percutaneous approach was used, directs code selection for autologous HCT under the new system.
Impact of Coding on Medicare Reimbursement

**The Importance of a Secondary Diagnosis**

In coding for Medicare patients, a lot of time and effort is focused on getting the right principle diagnosis and principle procedure recorded on the claim so that the correct Medicare Severity–Diagnosis Related Groups (MS-DRG) can be assigned for inpatient encounters. But, secondary diagnoses are just as important and can have a significant impact on the MS-DRG assignment. Secondary diagnoses are all of the conditions that co-exist at the time of the encounter, develop during the encounter, or affect the treatment received by the patient. Under the MS-DRG reimbursement system, secondary diagnoses are used to assess the severity of the patient’s condition. In addition, payors and health care quality evaluation organizations utilize secondary diagnoses to make assessments of hospital outcomes based on inferred patient acuity.

Taken together, the set of severity levels for a given type of admission is referred to as a MS-DRG “family”; each MS-DRG family is assigned its own relative weights (RW). These relative weights indicate variations in resource consumption between the different conditions, and are a factor in the different Medicare reimbursement rates, with higher-weighted MS-DRGs being reimbursed at a higher level. The relative weight structure is based on CMS’ use of historic provider claims data to set future payment rates. CMS analyzes this same data to also determine if additional MS-DRGs are needed to further differentiate patients, and hence payment rates, based on patient clinical complexity and resource consumption. Having different categories, known as “severity levels,” within an MS-DRG family enables CMS to reimburse encounters appropriately based on expected resource consumption and, in turn, cover more of the hospital’s expected costs of care.

**Severity Levels and HCT**

The severity levels are determined based on conditions that, when reported as a secondary diagnosis code to the principle diagnosis, indicate the patient requires more resources and/or a longer length of stay. This is assessed using a list of conditions organized into two lists, the Major Complication or Comorbidity (MCC) list and the Complication or Comorbidity (CC) list. There are exceptions, which are referred to as being on the “MCC/CC excludes list.” The items on the “excludes” list are associated with a principle diagnosis; when these secondary diagnoses are present, they do not increase the level of severity of the patient’s condition.

When a MCC/CC diagnosis is reported in the secondary diagnosis position—and that specific diagnosis is not included on the MCC/CC excludes list for the principle diagnosis—the admission is eligible to be grouped to the higher-weighted MS-DRG (when one is available).

It is vital that hospitals ensure proper documentation of secondary conditions so that their coders can assign ICD-9-CM codes to these conditions and report them on the UB-04 claim form. This is critical to ensuring that the correct MS-DRG is assigned to the inpatient case, which, in turn, drives the hospital’s reimbursement for its inpatient cases. All secondary diagnoses should be reported within the Uniform Hospital Data Discharge Set (UHDDS) guidelines and ICD-9-CM coding guidelines. Hospitals should monitor their MCC and CC reporting levels on an on-going basis and provide continuous education related to coding and documentation for residents, physicians, and coding professionals. Monitoring reporting of secondary codes on an on-going basis will enable your management team to identify data deviations, investigate them in a timely manner, and provide any needed education to ensure the transplant MS-DRG mix is accurate.

**MCC/CC for Autologous HCT**

Beginning in October 2011, CMS separated autologous transplants (formerly MS-DRG 015) based on severity levels and eliminated MS-DRG 015. The MS-DRG family for autologous transplant now consists of two MS-DRGs, each with its own relative weight that reflects differences in resource consumption:

- **MS-DRG 016**: Autologous transplant with MCC/CC (FY 2013 RW 6.3127)
- **MS-DRG 017**: Autologous transplant without MCC/CC (FY 2013 RW 4.3224)

The higher relative weight for MS-DRG 016 reflects the additional resources required to care for an autologous transplant patient who also has a MCC or CC secondary diagnosis. While all transplant cases are complicated, the MS-DRG family differentiates encounters in which the patient has additional conditions that may require additional resources from encounters in which the patient does not have such conditions.

A review of 2010 Medicare claims data shows that numerous MCC and CC conditions were reported for autologous transplants. The top five diagnoses reported are listed in Table 3 and 4.

**Table 3: Top five CC Codes Reported for Autologous HCT**

<table>
<thead>
<tr>
<th>TOP FIVE CC ICD-9-CM CODES</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>284.1</td>
<td>Pancytopenia</td>
</tr>
<tr>
<td>790.7</td>
<td>Bacteremia</td>
</tr>
<tr>
<td>584.9</td>
<td>Acute renal failure, unspecified</td>
</tr>
<tr>
<td>008.45</td>
<td>Intestinal infection due to Clostridum difficile</td>
</tr>
<tr>
<td>276.1</td>
<td>Hyposmolality and/or hyponatermia</td>
</tr>
</tbody>
</table>

**Table 4: Top five MCC Codes Reported for Autologous HCT**

<table>
<thead>
<tr>
<th>TOP FIVE MCC ICD-9-CM CODES</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>284.89</td>
<td>Other specified aplastic anemias</td>
</tr>
<tr>
<td>Sepsis*</td>
<td>Sepsis or septicemia (all types: bacteria plus sepsis or SIRS and shock if applicable)</td>
</tr>
<tr>
<td>486</td>
<td>Pneumonia, organism unspecified</td>
</tr>
<tr>
<td>518.81</td>
<td>Acute respiratory failure</td>
</tr>
<tr>
<td>585.6</td>
<td>End stage renal disease</td>
</tr>
</tbody>
</table>

*Organism involved (typically a 038.xx code, but there are others such as 112.5) + 995.9x (SIRS code) + Septic shock (if applicable) + any organ failure code (if applicable)
What is Good Documentation?

The primary purpose of documentation is to ensure the continuity of patient care. Documentation fosters communication among all health care providers during and after the patient encounter. Documentation also supports medical necessity and reimbursement.

The ICD-9-CM Official Guidelines for Coding and Reporting states: “A joint effort between the health care provider and the coding professional is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.”[2]

Good documentation consists of a complete, legible, and clear record provided by the clinician about the patient’s clinical condition, treatment, and progress. This documentation is contained in narrative or text form in the patient’s medical record. Documentation must be both complete and legible so coding professionals can translate it into appropriate ICD-9-CM diagnosis and procedure codes. Physician documentation must support the transplant codes through a dictated note, operative report, procedure note, infusion record and/or the Medication Administration Record (MAR), clearance from the lab that the cells were “clean,” and/or certification report.

Documentation Differ by Setting

For inpatient HCT, clinicians must report all diagnosis and procedure codes that occurred in conjunction with the procedure in the inpatient setting, regardless of whether they were associated with the actual “Transplant procedure” or not. Documentation of the infusion procedure must be included in the hospital stay medical record because it serves as verification that the transplant or infusion of cells occurred and allows the facility to report the ICD-9-CM procedure code for HCT. This same documentation also supports the CPT codes, which are required for, and the basis of, physician billing.

For outpatient HCT, the diagnosis code and appropriate CPT codes must both be reported, and are based on medical record documentation.[3] (See the HCT Reimbursement Series document: Medicare Coverage for HCT for more information on specific HCT codes.)

Documentation Impacts Medicare Coverage

Another reason that accurate coding is critical for Medicare patients is because it directly relates to coverage rules that drive the Medicare Code Editor (MCE). The MCE edits HCT ICD-9-CM inpatient procedure codes 41.01, 41.02, 41.03, 41.04, 41.05, 41.07, 41.08, and 41.09 against the diagnosis codes that Medicare does not cover.[4] Claims with non-covered diagnosis will not pass Medicare’s MCE edits for medical necessity; they result in a claim denial and no transplant reimbursement. Claims submitted with diagnoses about which Medicare is silent do not automatically result in a denial, as coverage in these cases occurs at the discretion of the local contractor.

In order for Medicare to cover the transplant procedure for a specific clinical indication, several HCT indications require documentation of information that cannot be coded via ICD-9-CM codes. This must be present in narrative form in the medical record. As a result, someone in your hospital (such as a transplant coordinator or department manager) must be able to access and review specific details about the patient’s condition from the medical record documentation.

Non-Hodgkin Lymphoma Example

Autologous HCT for non-Hodgkin lymphoma is a great example of how documentation impacts coverage. Medicare covers autologous HCT for the following indication: Resistant non-Hodgkin’s lymphoma or those presenting with poor prognostic features following an initial response. The covered diagnosis codes for non-Hodgkin lymphoma are listed in Table 5, below.

Table 5: Covered Diagnoses for Autologous Transplant for Non-Hodgkin Lymphoma

<table>
<thead>
<tr>
<th>NON-HODGKIN LYMPHOMA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>200.00 – 200.08</td>
<td>Reticulosarcoma</td>
</tr>
<tr>
<td>200.10 – 200.18</td>
<td>Lymphosarcoma</td>
</tr>
<tr>
<td>200.20 – 200.28</td>
<td>Burkitt’s tumor or lymphoma</td>
</tr>
<tr>
<td>200.80 – 200.88</td>
<td>Malignant lymphoma and other named variants</td>
</tr>
<tr>
<td>202.00 – 202.08</td>
<td>Nodular lymphoma</td>
</tr>
<tr>
<td>202.80 – 202.88</td>
<td>Other lymphomas</td>
</tr>
<tr>
<td>202.90 – 202.98</td>
<td>Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue</td>
</tr>
</tbody>
</table>

Part of the indication can be coded with these diagnosis codes. But, certain key elements—such as whether the patient’s non-Hodgkin lymphoma is resistant, or that the patient presents with poor prognostic features following an initial response—cannot be coded via the ICD-9-CM codes. Nonetheless, this information is critical to determining whether the coverage indication is met. Hence, a member of the transplant management team must verify this information from the patient’s medical record. For this reason, it is critical for clinicians to document that the patient’s condition is “resistant” or that the patient “presented with poor prognostic features following an initial response.”

If this information is not found in the medical record, the case will not fully meet the coverage indication—if CMS reviews the claim, it is likely to be rejected. Further, if the medical record lacks this documentation, the case may not pass coverage scrutiny in a retrospective audit conducted by external auditors such as the Office of the Inspector General (OIG) or your Fiscal Intermediary/Medicare Administrative Contractor (FI/MAC). Therefore, it is critical for transplant management team and hospital coding staff to work closely with clinicians and fully understand, and comply with, the documentation requirements for meeting Medicare’s HCT coverage criteria.
Creating a Culture of Great Documentation with Clinicians

Educate Clinicians on Documentation Standards
Coding professionals must code using the documentation in the medical record; they are not allowed to make assumptions or inferences about what the physician may have intended to document. For this reason, educating clinicians on what constitutes complete, accurate and consistent documentation is the foundation of a solid revenue cycle. Hospitals should communicate the facility’s gold standard for documentation to all clinicians. Improving internal practices—including creating programs to improve clinical documentation and increase communication across departments—is an important way to establish standards, exchange knowledge, and minimize avoidable coverage errors.

Increase Dialog Across the Team
An effective strategy is for a multidisciplinary team (clinicians, program administrator, coding and billing personnel) to meet and discuss HCT and its coding or coverage requirements so that all team members understand what complete documentation is for these procedures. Such a meeting can help address concerns about clinical questions, documentation, coding, and billing. Physicians may benefit from more information about documentation requirements and how the MCE operates. Coding and billing staff may benefit from physicians explaining the clinical conditions treated with HCT and their current documentation practices. Use a case study and clinical examples from your own institution to highlight how physician notes translate into the codes entered into the patient’s records. Using examples from your own institution is one of the best ways to educate staff on where internal gaps exist and how they can be improved.

Bringing your financial staff and transplant physicians together can be unwieldy at first, but is likely to foster more accurate coding and billing—and fewer claims denials.

Carefully Review Claim Denials
There are several reasons a claim may be denied by a payor. The coder may have misunderstood the physician’s documentation of the patient’s condition and reported an incorrect diagnosis code. Alternatively, the physician may have provided insufficient documentation to enable the coder to report the correct diagnosis code. Or, the patient’s diagnosis may be one that a particular payor does not cover for HCT.

The coding team should carefully review every claim denial. If the team believes the documentation was unclear or incomplete, a physician query should be initiated. If the physician query process results in a change in diagnosis, the hospital should consider re-submitting the claim for processing. Remember that the amended physician documentation must be present in the medical record at the time of re-processing the claim and be added in accordance with your Medical Record Committee’s guidelines. It is helpful to work with your Compliance Department to determine the rules for amending medical records in your facility.

Create a Physician Query Process
Although facility policies vary, physician queries about medical record information are typically performed when the medical record documentation fails to meet one or more of the following five criteria:

1. Legibility
2. Completeness
3. Clarity
4. Consistency
5. Precision

Each hospital should have an active policy about how to compose a clinician query. This policy should specify a list of the data elements to be included in the query, such as: the statement of the issue, the patient’s name, admission date, health record number, the date the query was initiated, and the name and contact information of the individual initiating the query. Of these elements, the statement of the issue is at the heart of the query.

Compose Effective Queries
The query should be written with precise language that identifies the clinical indications from the record and asks the physician to interpret the facts based on his or her professional judgment of the case.

• The query should not appear to be presumptive or directive. It should not prod, probe, or lead the provider to document in a particular way.
• Queries should not include simple “yes/no” answer choices to questions being asked (with the exception of “present on admission” queries).[5] A much safer practice is to ask the physician to document the diagnosis that he or she is agreeing to on the query form.
• Queries should provide diagnosis choices and always include “Other” as one option.
• Queries should not introduce information that is not already documented in the medical record.
• Queries should not use Post-It notes or sticky notes either to transmit queries or to record responses to queries.

The best practice is to require the provider to document the diagnosis in the medical record, rather than on a query form.

EXAMPLE QUERY:
Dr. Jones - The Pathology Report indicates the diagnosis of pancytopenia. If you are in agreement with the report findings, please indicate the type of pancytopenia for this patient or, if the patient does not have pancytopenia, please indicate as such below:

• Antineoplastic chemotherapy induced pancytopenia
• Other drug induced pancytopenia
• Other pancytopenia
• Other __________________________
• Patient does not have pancytopenia
Q How do we code for and report a cancelled transplant?

A If the patient was admitted as an inpatient for the transplant procedure, and the procedure was cancelled, the following V-codes are available to indicate the procedure was not carried out:

- V64.1 (Surgical or other procedure not carried out because of contraindication)
- V64.2 (Surgical or other procedure not carried out because of patient’s decision)
- V64.3 (Procedure not carried out for other reasons)

One of these three codes should be reported as a secondary diagnosis on the claim for the admission during which the procedure was cancelled. The principal diagnosis is still reported as the reason for the admission. The costs associated with the transplant preparations (such as donor search and procurement charges) are reported in your facility’s Cost Report.

Q How do we code Donor Lymphocyte Infusions (DLIs)?

A A DLI procedure is not the same as a full transplant.

- For inpatient DLI, report ICD-9-CM code 99.09 - Transfusion of other substance instead of transplant procedure code 41.05. This occurs because a DLI involves transfusion into the patient of mature donor lymphocytes rather than stem cells or bone marrow.
- For outpatient DLI, report CPT code 38242: Bone marrow or blood-derived peripheral blood stem cell transplantation; allogeneic donor lymphocyte infusions.
- For the DLI products themselves, report CPT code 38205: Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic.

Note that ICD-9-CM procedure code 99.09 does not drive MS-DRG assignment for Medicare cases. A DLI provided to a Medicare beneficiary will not be reimbursed at the same level as a transplant.[6] A DLI can generate a variety of MS-DRGs based on the patient’s diagnoses and/or other procedures reported on the inpatient claim.

Q How do we code for search activity and cell procurement charges?

A Hospitals can use a variety of ways to report search-related charges for HCT, depending on the payor. For Medicare inpatient and outpatient reporting of all donor search and procurement related costs, revenue code 0819 (other organ acquisition) should be billed on the recipient’s transplant bill, as required by the Medicare Claims Processing Manual.

When billing non-Medicare payors, it is advisable to contact your facility’s contracting staff for direction about what your contracts specify. For example, it may allowable to report CPT code 38204 (Management of recipient hematopoietic progenitor cell donor search and cell acquisition) and the appropriate dollar charge using revenue code 0819 and the appropriate dollar charge, or the payor may require the hospital: to submit the NMDP invoice without a CPT code to the payor.

Finally, some hospitals report the unlisted CPT code 38999 (Unlisted procedure, hemic or lymphatic system) to their payors, but be advised that the use of this code will frequently result in an automatic claim hold and need to be manually reviewed by the payor. The NMDP provides a crosswalk of services on the Reimbursement Resource Center – the document is called Vendor CPT Codes.

Q What is sufficient documentation in a medical record of the donor search process, such as HLA typing?

A Physician documentation of the patient’s condition, need for transplant and physician order for the donor search to begin is sufficient documentation for these charges.

Any questions regarding this section should be sent to payorpolicy@nmdp.org
The ASBMT promotes research, education and clinical practice in cellular therapy and blood and marrow transplantation. Its members are physicians, research scientists and allied health professionals in the field of stem cell collection, processing and transplantation.

This educational series was developed jointly by the National Marrow Donor Program (NMDP) and the American Society for Blood and Marrow Transplantation (ASBMT).

The National Marrow Donor Program (NMDP) is the global leader in providing marrow and umbilical cord blood transplants to patients with leukemia, lymphoma and other diseases. The nonprofit organization matches patients with donors, educates health care professionals and conducts research so more lives can be saved. The NMDP also operates Be The Match®, which provides support for patients, and enlists others in the community to join the Be The Match Registry— the world’s largest listing of potential marrow donors and donated cord blood units—contribute financially and volunteer.