

FINAL CHANGES TO THE MEDICARE CODE EDITOR (MCE) FOR FY 2010

The Centers for Medicare and Medicaid Services (CMS) recently published its Final Rule documenting changes to the Inpatient Prospective Payment System (IPPS) for fiscal year FY 2010. Changes are effective on October 1, 2009 and include updates and revisions to ICD-9-CM, the inpatient Medicare Severity Diagnosis Related Groups (MS-DRGs) and the inpatient pricing rules. Also, included are changes to the Medicare Code Editor (MCE), a software program that detects and reports errors in the coding of Medicare claims data. The MCE identifies claims that require further review before classification into a MS-DRG. FY 2010 MCE changes are discussed below. Unless otherwise indicated, all MCE changes discussed are effective October 1, 2009.

1. **NEW ICD-9-CM DIAGNOSIS AND PROCEDURE CODES:** As appropriate, all Medicare code edits are being updated to accommodate FY 2010 diagnosis and procedure code additions and deletions. Ten codes have been added and two removed from newborn only codes. There are two new pediatric codes. Twelve new maternity codes were added and one was removed.
2. **INVALID DIAGNOSIS OR PROCEDURE CODES:** This MCE checks each diagnosis and procedure code against a table of valid ICD-9-CM codes. CMS discovered an error in this edit, code 00.01 (therapeutic ultrasound of vessels of head and neck) was inadvertently left out of the MCE tables. CMS is adding code 00.01 to the table of valid codes in FY 2010.
3. **SEX CONFLICT EDITS:** Procedures allowed for females only. It was brought to CMS' attention that two codes: 75.37 (Amniocentesis) and 75.38 (Fetal pulse oximetry), were also inadvertently omitted from the MCE. CMS is adding these codes to the edit for procedures allowed for females only.
 - **Diagnoses for Females Only:** CMS is updating this edit to include 13 additional diagnoses that are acceptable for women only. They are: 621.34 (benign endometrial hyperplasia), 621.35 (endometrial intraepithelial neoplasia [EIN]), and the (puerperal major infections) 670.1X-670.8X. V65.11 (pediatric pre-birth visit for expectant parent(s)) was removed.
 - **Diagnoses Allowed for Males Only:** CMS acknowledged the omission of four codes in ICD-9-CM subcategory 603 hydrocele. CMS is adding 603.0 (encysted hydrocele), 603.1 (infected hydrocele), 603.8 (other specified types of hydrocele), and 603.9 (hydrocele, unspecified) to diagnoses allowed for males only.
4. **MANIFESTATIONS NOT ALLOWED AS PRINCIPAL DIAGNOSIS:** A manifestation code should NOT be used as a principal diagnosis code. The National Center for Health Statistics (NCHS) removed the "code first associated disorder" from three codes, thus making those codes acceptable as principal diagnosis codes. The following codes were removed from the manifestation code as a principal diagnosis edit:

CODE	DESCRIPTION
365.4	Glaucoma associated with chamber angle anomalies
365.42	Glaucoma associated with anomalies of iris
365.43	Glaucoma associated with other anterior segment anomalies

5. **UNACCEPTABLE PRINCIPAL DIAGNOSES:** Codes that describe a circumstance that influences an individual's health status or codes that do not describe a specific manifestation, but describe an illness due to an underlying cause, fall into the edit for unacceptable principal diagnoses. A series of codes at the subcategory level were created for reporting malignant carcinoid tumors (209.00–209.69). Medicare contractors misinterpreted an instructional note associated with these codes, “code first any associated multiple endocrine neoplasia syndrome,” and designated the codes as unacceptable as principal diagnoses. CMS is removing diagnoses codes 209.00–209.69 from MCE 9. The following four digit codes were removed and replaced with five digits codes noted as added:

REMOVED:

CODE	DESCRIPTION
V10.9	Unspecified personal history of malignant neoplasm
V53.5	Fitting and adjustment of other intestinal appliance
V60.8	Other specified housing or economic circumstances
V72.6	Laboratory examination
V80.0	Special screening for neurological conditions

ADDED:

CODE(S)	DESCRIPTION
V10.90, V10.91, V15.52, V15.80, V15.83	Personal history of specific illnesses
V20.31, V20.32	Health supervision for newborn
V26.42, V26.82	Encounter for fertility preservation
V53.50, V53.51, V53.59	Fitting and adjustment device
V60.81, V60.89	Specified housing or economic circumstances
V61.07, V61.08	Family disruption
V61.23- V61.25	Counseling child problem
V61.42	Substance abuse in family
V72.60-V72.69	Laboratory examinations
V80.01, V80.09	Special screening
V87.32	Contact with and (suspected) exposure to algae bloom
V87.43-V87.46	Personal history of specific therapies
E000.X-E030	Specific activities ranging from various sports to animal care
E830.7, E837.1, E832.7, E833.7, E834.7, E835.7, E836.7, E837.7, E838.7	Accidents involving water craft or transports, but specific to “occupant of military watercraft”
E876.6	Performance of operation (procedure) on patient not scheduled for surgery
E876.7	Performance of correct operation (procedure) on wrong side/body part
E928.7	Environmental and accidental causes, mechanism/component of firearm or air gun
E990.1-E998.9	Injuries due to war operations from various weapons, devices, and craft

6. **BILATERAL PROCEDURES:** The bilateral procedures edit flags check the claim for confirmation of the procedures by the payer. Some codes do not clearly indicate whether the procedures performed in one admission were done on two or more different bilateral joints. A combination of these codes could indicate a bilateral procedure or could indicate procedures performed on a single joint (e.g., duplicate procedures). Diagnoses codes from MDC 8 are used to help identify true bilateral procedures. Codes 274.0 (gouty arthropathy) and 279.4 (autoimmune disease, not elsewhere classified) were removed. The following codes were added:

CODE	DESCRIPTION
209.73	Secondary neuroendocrine tumor of bone
274.00	Gouty arthropathy (unspecified)
274.01	Acute gouty arthropathy
274.02	Chronic gouty arthropathy without mention of tophus (tophi)
274.03	Chronic gouty arthropathy with tophus (tophi)
279.41	Autoimmune lymphoproliferative syndrome
279.49	Autoimmune disease (not elsewhere classified)
813.46	Torus fracture of ulna (alone)
813.47	Torus fracture of radius and ulna
832.2	Nursemaid's elbow

7. **NEW EDIT – WRONG SURGERY:** Two new and one revised external causes of injury and poisoning codes (E-codes) that indicate that a wrong surgery has been performed. Effective January 15, 2009, CMS advised providers that no payment will be made for wrong surgeries or invasive procedures. Hospitals are required to report one of the following E-codes when appropriate:

CODE	DESCRIPTION
E876.5	Performance of wrong operation on correct patient
E876.6	Performance of operation (procedure) on patient not scheduled for
E876.7	Performance of correct operation (procedure) on wrong side/body part

All related services provided during the same hospitalization in which the error occurred are not covered. The type of bill reported should be 0110 which indicates a no-payment claim.

FOR FURTHER INFORMATION

If you have questions regarding the Medicare MCE changes for FY 2010, please contact our Client Services department at 1-800-999-DRGS (3747). For additional information on the IPPS Final Rule, see the following *Industry Insights*:

INSIGHT NO.	TITLE
475	Final Medicare DRG Changes for FY 2010
477	Final Medicare Pricer Changes for FY 2010
478	Final Medicare Quality Changes for FY 2010
479	Final ICD-9-CM Changes for FY 2010

Be sure to check the Ingenix web site for additional Industry Insights on Medicare regulatory issues. You will find Industry Insights under News & Events: <http://www.ingenix.com/News/Industnews/>.