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I would like to say “THANK YOU” for everyone’s patience and knowledge sharing over these last several months. There is so much to learn, but we have wonderful volunteers and leaders that have guided me, and shared from their own experiences.

The Annual Meeting is quickly approaching. The Annual Meeting Committee has a wonderful event planned full of wonderful speakers, delicious food, plenty of coffee and Duluth Adventures. I hope to see everyone there and enjoying being in a new location for our annual meeting.

Lastly, we are rounding up the fiscal year and I look forward to the next chapter in this awesome journey with our next Board of Directors.

Thank you for everyone’s support, encouragement and patience.

Joy Schmitt, RHIT, CHIMA
Executive Director
Minnesota Health Information Management Association

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**ELECTION RESULTS**

The 2018 - 2019 MHIMA Nominating Committee is pleased to announce the results of our recent electronic ballot:

- President-Elect: Mary Juenemann, MS, RHIA, CCS
- Delegate Directors: Neysa Noreen, MS, RHIA & Lisa Schultz, MAOL, RHIA
- Secretary: Stephanie Peterson, RHIA
- Treasurer: Lorna Clodfelder, RHIT
- Audit Committee: Christina Nelson, RHIT, CPMA

We had a 7.6% voter response this year. Thank you to everyone who voted! The newly elected officers, board members and audit committee members will be recognized at our annual business meeting on May 2nd, 2019, and will assume their elected positions on July 1st, 2019.

The Nominating Committee joins all MHIMA members in congratulating those elected, and we thank all those who placed their names on the ballot and were not elected this year.
Hello everyone!

We are getting very excited for our upcoming “Up North” MHIMA Annual Meeting Conference - #MHIMAUKNORTH19.

This year it is being held at the Duluth Entertainment Convention Center (DECC) in Duluth, MN on May 1-3, 2019. Our theme this year ties in well with northern Minnesota: “Set up Camp for S'More HIM Updates!”.

We have fun and exciting things planned: a S’mores bar, roof deck pictures, Canal Park scavenger hunt, and Visit Duluth to name a few. The Annual Meeting Planning Committee has been hard at work making sure things are in place and ready to go.

We have a jam-packed agenda full of local speakers and emerging hot topics in healthcare and we couldn’t be more excited! Registration is open on the MHIMA website as well as a link to the hotel block at the Holiday Inn, which is connected to the DECC via skywalk.

Can’t wait to see everyone in May!

Heather Feltus and Lisa Schultz
2018-2019 MHIMA Annual Meeting Co-Chairs
The Distinguished Member award identifies and honors outstanding members of the Minnesota Health Information Management Association (MHIMA) whose record of contributions to our field is truly exceptional. Candidates must have been an active member for five (5) years or longer and have made an outstanding contribution to the profession. The MHIMA Nominating Committee and the Board of Directors are pleased to announce the 2019 MHIMA Distinguished Member:

Diana M. Warner, MS, RHIA, CHPS, CPHI, FAHIMA

Diana has contributed prolifically to the profession for 29 years and counting, sharing both her lived experience and knowledge with HIM professionals in Illinois and Minnesota, nationally and internationally through her writing, presentations, and mentorship of HIM professionals. She holds a Bachelor of Science in Health Information Administration from the University of Alabama and a Master of Science in Public Administration from Columbus State University. Diana’s past professional positions include Director of Health Information Management at the University of Minnesota Physicians, AHIMA’s Director of Standards, and AHIMA’s Director of Informatics/Information Governance & Standards. She currently serves as the Director of Client Relations and Account Management for MRO.

Prior to her employment at AHIMA, Diana was already serving, writing and presenting about the topics that form the backbone of health information management: how to manage it, how to protect it, how to secure it, and how to lay the foundation for an interoperable paradigm. In 2010, she was granted fellowship to AHIMA, in recognition of her “significant and sustained contribution to the advancement of the health information management (HIM) discipline, through service, excellence in professional practice and advancement of the profession through innovation and knowledge sharing.” (AHIMA 2018)
Besides serving as President and Director for ILHIMA while a resident there, Diana has also previously served on the MHIMA Board of Directors as a Secretary, President-Elect, President, and Past President, as well as volunteered her time on a number of MHIMA committees throughout the years.

Diana is a truly distinguished member within our Association. The passion she carries for the HIM profession and her dedication to advancing the national vision for healthcare information standards and interoperability makes her an exceptional recipient. She exemplifies many of the characteristics that make one a natural born leader and that represent the hallmark of what it means to be distinguished. She has been an exceptional leader for nearly three decades and is a resounding voice for the future of the profession.

In recognition of this and all she has given to our Association, MHIMA proudly confers on Diana Warner its 2019 Distinguished Member award. Please join us in celebrating the recognition of this outstanding HIM professional at our 2019 Annual Meeting. Diana will be honored on Thursday, May 2nd, 2019.

Warm regards,

Christina Snaza, MS, RHIA
Past President, MHIMA
OUTSTANDING STUDENT

The MHIMA Nominating Committee and the Board of Directors are pleased to announce the 2019 recipient of its Outstanding Student Award!

This Achievement Award seeks to honor students who have demonstrated excellence, leadership, and commitment to the future of the HIM profession and their future career.

Our recipient this year is Emma Peters-Axtell.

Emma is a senior at the College of St. Scholastica (CSS) and will graduate in May with a Bachelor of Science degree in HIM. Her nominator said, “In addition to being a high achiever academically with a 3.96 GPA, Emma is a well-rounded, enthusiastic, hard-working and motivated student at CSS. She asks appropriate questions, collaborates well with her classmates and faculty, has exceptional problem-solving and critical thinking skills, and she not only participates in but seeks out opportunities where she can learn practical HIM skills, gain HIM experience, and network with HIM professionals.”

In 2018, Emma was the General Chair for planning the MHIMA Region B annual meeting and was active as Vice President of the Student HIM Association (SHIMA). She is a 2018 recipient of the MHIMA Scholarship program, the 2018 recipient of the CSS HIM Department’s Sr. Loretta Scholarship, and was nominated by her classmates for the prestigious 2019 Sr. Loretta Leadership award.

One of Emma’s most impressive traits is her desire and motivation to learn more about the HIM profession through practical experience. In an effort to learn more about the HIM profession, she sought out and received an HIM internship at Just Associates in Denver, CO, in the summer of 2018. In the fall of 2018, she applied for and received another internship position as a Physician Quality HIM Intern at Essentia Health in Duluth. She is also honing her data management skills as a Data Management volunteer for the Lake Superior Youth Chorus.

Emma is an outstanding role model for HIM students at all levels and she is respected and recognized as such by her classmates and faculty.

Please join us in congratulating Emma at our Annual Meeting, on Thursday, May 2nd, 2019!

Christina, MS, RHIA
Past President, MHIMA
Nominating Committee Chairperson
The MHIMA Nominating Committee and the Board of Directors are pleased to announce the 2019 recipient of its Rising Star Award!

This Achievement Award seeks to recognize individuals who have demonstrated progressive leadership in and commitment to the future of the HIM profession through excellence in the workplace and/or participation in local, regional, state, or national related HIM activities.

Our recipient this year is **Nick Procaccini**.

Nick obtained his Associate of Arts and Sciences (AAS) degree in Health Information Technology from Anoka Technical College in 2013 and successfully received certification as a Registered Health Information Technician (RHIT) the following year. He made the Dean's list during his time at Charter Oak State College and in December 2018 graduated with a Bachelor of Science degree in Health Information Management. Nick is currently preparing to sit for the Registered Health Information Administrator (RHIA) exam.

Since 2014, Nick has worked in the Document Management department at Allina Health. He has progressed from an eHIM Specialist I (document prepper(scanner), to an eHIM Lead, and is now an eHIM Supervisor that supports a team of 25 onsite and remote employees. Described as a “quiet leader,” Nick leads by example and word, and diligently works side by side with his staff until a comfort level is achieved and they can successfully work independently. He has effectively taken on tasks with increasing scope and responsibility while simultaneously managing a warehouse of pre-EMR/paper medical records. Nick also works cohesively with his immediate manager to assure consistency with Allina Health's retention and disposition standards, inventory management, and execution of special projects.

Nick’s dedication to the profession is also evident through his continued involvement with MHIMA. He has volunteered on the Annual Meeting Planning Committee as well as the Marketing & Communications Committee. Last year he was elected to MHIMA's Audit Committee and is currently serving in this role through June 2020.

Please join us in congratulating Nick at our Annual Meeting, on Thursday, May 2nd, 2019!

Christina, MS, RHIA
Past President, MHIMA
Nominating Committee Chairperson
Donations Needed for Annual Meeting Silent Auction

The MHIMA Annual Meeting is almost here!

On behalf of our Scholarship Committee, we are asking for donations for the 2019 Annual Meeting Silent Auction Donations.

Not sure what to donate?
The sky is the limit with the Silent Auction...any item big or small is accepted! Bring your favorite bottle(s) of wine, mugs, tumblers, k-cups, beans, and Starbucks/Caribou gift cards, relaxation baskets, jewelry, purses, or any other item. We appreciate and accept all donations.

Please complete the donor sheet (found on website) and bring to meeting with your item.

All funds generated go towards the scholarships given annually.
The College of St. Scholastica

The MHIMA Annual Conference stands out as a highlight on the calendar for The College of St. Scholastica each and every year. We find that it is a wonderful opportunity to network with alumni of the programs and hear about their journey, as well as connecting with industry partners, and introducing our current students to the professional organization. This year brings a special edition and we feel very fortunate to have the meeting in our backyard as MHIMA members from across the state travel to our beautiful city. We feel a strong sense of place and purpose here, as our presence in Duluth dates to the establishment of the St. Scholastica Monastery in 1892. The sisters quickly became active in the healthcare field, and the College continues to build on that history today.

While Duluth has a strong industrial background, we see the expansion of healthcare in the city and region as a continuing driver for growth, as local systems are looking to innovate and expand. The same growth is occurring in parallel with the renewal of the city itself. You'll find new breweries, cideries, restaurants, and other craft stores to compliment the many outdoor activities that can be found on our rugged hillside views and along the majestic shores of Lake Superior.

In the Benedictine tradition of hospitality, you'll find our alumni, faculty, and students volunteering in many roles during the meeting. Be sure to stop by our S'Mores booth during the break on Thursday and keep an eye out for us in our proud blue flannels. Stop by our exhibitor booth to say hello as well, and we'll share the inside scoop on our favorite to-dos around town.

Our warmest welcome to all attendees!
Cheryl Zupec
On March 25 and 26, 2019, Ryan Johns, Jeri Romano, and myself had the privilege of representing MHIMA in Washington, DC at the annual AHIMA Advocacy Summit and Hill Day. In addition, we were joined by Gina Sanvik, AHIMA staff member and MHIMA Past President. We had a very full schedule in Washington this year.

On Monday, the members of the AHIMA Advocacy team had an outstanding line up of presentations for us! The day was spent with presentations by leaders of healthcare leaders to include Timothy Noonan, Deputy Director from the Office for Civil Rights, Dr. Andrew Gettinger, Chief Clinical Officer for the Office of the National Coordinator for Health IT, and Donna Pickert, Chief, Classification and Public Health Data Standards for the Centers for Disease Control and Prevention. Items discussed by the presenters included:

1. Priorities of the Office for Civil Rights and the modernization of HIPAA to drive value-based healthcare.
2. Priorities of the Office of the National Coordinator and their work on securing access, exchange and use of electronic health information.
3. ICD-11 update and implementation considerations.

The attending members also had the opportunity to meet AHIMA’s new Chief Knowledge Officer and get her know her better.

Finally, at the end of the day, Lauren Riplinger, AHIMA’s Federal Relations, Senior Director introduced the items that the members would be reviewing with our legislative representatives. We received a folder containing information regarding four items that we brought to the table to discuss with the Minnesota congressional teams. During this discussion, it was noted AHIMA and AMIA partnered together on several of the items proposed.

Our first ask was regarding “Patient Matching”. Since 1999, Congress has prohibited the use of appropriated funds to working on creating a unique patient identifier. Due to being unable to potentially correctly identify patients, health leaders recognize this as an increasingly serious patient safety issue. AHIMA has been asking for the language in the Appropriations Bill to be removed since 2001. We will continue asking for this change in the Appropriations Bill until we get this legislation corrected. The second ask was regarding “Extending the HIPAA Individual Right of Access to Non-Covered Entities”. We discussed with our legislative representatives the challenges created by mobile applications and
health social media applications that retain patient data, but are not covered by HIPAA’s right of access. These entities are not bound by or required to abide by HIPAA regulations. These groups include companies such as Apple, Amazon, and 23 and me. Third, we discussed the fundamental disconnect between what the HIPAA right of access requires and what Certified Health IT can deliver pertaining to the Designated Record Set. We asked our lawmakers to revise the definition of the Designated Record Set and require certified Health IT to provide the amended Designated Record Set electronically. Our fourth ask was regarding, “Encourage Note Sharing with Patients in Real Time”. The recommendation was to promote the use of Open Notes through the Medicare and Medicaid payment programs, including MIPS and other payment models.

So bright and early on Tuesday morning, Ryan, Jeri, Gina, and I headed for the Hill to meet with our Minnesota Representatives and Senators. The four of us had the opportunity to meet with staff members working with Senators Amy Klobuchar and Tina Smith. Then Jeri met with Representative Emmer’s legislative staff, while the rest of the group met personally with Representative Pete Stauber and his Legislative Director, Jeff Bishop. It was an informative meeting and while there, we learned that Representative Stauber’s mother is a St. Scholastic Health Information Management alumna. It was a great connection and lead to a wonderful discussion with him. We look forward to continuing our connections with our Minnesota Legislative lawmakers and their staff members.

If you have any questions or would like additional information regarding the information above, please feel free to contact Ryan Johns, Jeri Romano or myself and we will gladly assist you.

Sue Nathe, RHIT
MN KFA Advocacy/Legal Manual Chair
MHIMA LEGISLATIVE UPDATE

MHIMA supports the passage of House File (HF) 831 and Senate File (SF) 1575 “Health records released without patient consent circumstances modified”

For all Bills to become law, there must be two bills created and passed through the Legislature, one through the House of Representatives and another through the Senate. The two bills are then combined into one bill and sent to the Governor to be either signed into law or vetoed.

On February 20, 2019 a hearing was held at the Minnesota Legislative House by the Health and Human Services Committee regarding HF 831. HF 831 is a Bill that was introduced to bring the Minnesota Health Records Act in alignment with the Federal HIPAA law. HF 831 was introduced by Representative Laurie Halverson, District 51B. As Representative Halverson stated at the hearing, this revision will update and modernize the Minnesota Medical Records Act. This Bill has support, as well as opposition, throughout the House of Representatives and the State of Minnesota.

HF 831 was passed in the Committee and has been referred to the Judiciary Committee for review. Please see the link below for the actual language which is proposed. In addition, the hearing from Wednesday can also be accessed via the Internet and that link is attached below.

UPDATE: HF 831

There has been no movement within the House at this time. On 02/20/2019, HF 831 was adopted by the Health and Human Services Policy Committee and referred to the Judiciary Finance and Civil Law Division.

Secondly, on February 21, 2019, a companion Bill, SF 1575 was introduced to the Minnesota Senate. This Bill has the same language as HF 831. SF 1575 has been referred to the Senate Health and Human Services Finance and Policy Committee for review.

UPDATE: SF 1575

There was a hearing on March 12, 2019 to discuss SF 1575 in the Health and Human Services Finance and Policy Committee. After that hearing, SF 1575 has been tabled and there has been no additional movement. If you are interested in listening to the audio link from that Committee hearing, it is available on the website for the MN Senate.

I am asking all MHIMA members to take action and contact their Minnesota House Representatives and Senators to show support for...
and encourage the passage of HF 831 and SF 1575.

If you do not know who your Minnesota House and Senate Representatives are, I have attached a link below, which will assist you with finding this information.

How to find your Legislators:  https://www.leg.state.mn.us/

House File:  HF 831
Wednesday House video:  https://www.youtube.com/watch?v=fL2wKW-niT4
(Start at 37 minutes)
Senate File:  SF 1575

If you have any questions, please feel free to reach out to Sue Nathe, MHIMA Advocacy Chair at sue.nathe@tchc.org.
### CALENDAR OF EVENTS

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<td>Apr. 30, 2019</td>
<td>MHIMA Board of Directors and Key Volunteers Meeting</td>
<td>The MHIMA Board of Directors and Key Volunteers will meet on April 30, 2019, prior to the 2019 MHIMA Annual Meeting and Educational Conference. Location: Duluth Entertainment and Convention Center, Duluth, MN</td>
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<tr>
<td>8:00 AM</td>
<td>2019 MHIMA Annual Meeting</td>
<td>The 2019 MHIMA Annual Meeting is scheduled for May 1 - 3, 2019. Location: Duluth Entertainment and Convention Center, Duluth, Minnesota</td>
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<td>Sept. 14, 2019 to</td>
<td>AHIMA Health Data and Information Conference</td>
<td>The AHIMA National Convention will be held September 14 -19, 2019. Location: McCormick Place, Chicago, Illinois</td>
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Each quarter a sample OP report will be presented with suggested ICD-10-PCS code(s) and rationale(s). Suggested codes are based upon the information in the most current form of ICD-10-PCS and the Official Coding Guidelines.

PREOPERATIVE DIAGNOSIS:
1. Infrarenal abdominal aortic aneurysm.

POSTOPERATIVE DIAGNOSES:
1. Infrarenal abdominal aortic aneurysm.
2. Bilateral iliac stenoses.

OPERATIONS PERFORMED:
1. Endovascular abdominal aortic aneurysm repair.
2. Bilateral common iliac artery angioplasties.

ANESTHESIA: Spinal

OPERATIVE FINDINGS:
1. Primary device deployed via the left common femoral artery was a 23 mm x 12 mm x 16 cm Excluder bifurcated endoprosthesis.
2. Right contralateral limb was a 14 mm x 12 cm Excluder endoprosthesis.
3. After placement, high-grade bilateral common iliac artery stenoses remained. Angioplasty performed using 14 mm x 4 cm kissing balloons with 0% residual stenosis.
4. Completion angiogram revealed no evidence of endoleak with excellent proximal and distal seal.

PROCEDURE: The patient was brought to the interventional radiology suite. Support lines were placed. The patient had an arterial line, Foley catheter and intravenous lines placed preoperatively. He received 1 gram of Ancef. A spinal anesthetic was then secured. The patient was then placed in the supine position, and his abdomen and groins were prepped and steriley draped. The surgeon then performed bilateral common femoral artery cut-downs through oblique incisions down to the common femoral artery. The common femoral artery was isolated proximally and distally and encircled using vessel loops. Then, 5000 units of heparin was given intravenously. On the right, the surgeon then cannulated the right common femoral artery and under fluoroscopic guidance advanced the wire into the suprarenal aorta. An 8 French sheath was then placed into the right groin.
On the left, the assistant then cannulated the left common femoral artery and advanced a wire into the suprarenal aorta. An 8 French sheath was placed into the left groin as well. The decision was made to deploy the right via the left femoral artery. Therefore, a pigtail catheter was placed over the wire into the left common femoral artery. The patient had a previous renal artery stent in the right renal artery and this was used as a marker. The patient had chronic renal insufficiency, and therefore, minimal contrast was used. Visipaque contrast was used during the procedure. An angiogram was performed which isolated the level of the renal arteries. Amplatz Super Stiff wires were then placed bilaterally. On the left, the assistant exchanged the sheath for an 18 French sheath. She advanced this up to the level of the renal arteries over the wire. The primary device, which was a 23 x 14 x 16 device, was chosen and it was advanced up to the level of the renal arteries. The sheath was withdrawn. Multiple angiograms were performed to reveal the appropriate position. The assistant then deployed the device. A 27 mm balloon was then placed into the proximal area and inflated gently to create a proximal seal.

The surgeon then exchanged over an Amplatz wire for a 12 French sheath in the right groin. The sheath was pulled back into the sac and the contralateral limb was cannulated in a barber pole fashion. The catheter was advanced and dye was injected, as well as the balloon inflated to confirm that we were within the contralateral limb. An Amplatz Super Stiff device was then placed. The sheath was advanced up to the contralateral gate and measurements were performed. A 14 x 12 contralateral limb was chosen, and the surgeon then passed this over the wire up to the appropriate position. The sheath was withdrawn and the device was deployed; 14 mm kissing balloons were then placed into the gate area and inflated to create a good seal. Angiogram revealed a high-grade stenosis in both the right and the left common iliac arteries that had been diagnosed preoperatively as well. The 14 mm balloons were then placed in a kissing fashion and inflated to perform angioplasty of the common iliac arteries. There was 0% residual stenosis.

The catheters were removed and a pigtail catheter was then reinserted above the renal arteries. A completion angiogram was performed, which revealed good flow through the graft. There was excellent position below the renal arteries and filling of the renal arteries. There were good proximal and distal seals without any evidence of endoleak. The small atretic left internal iliac artery did not have any flow, but this was of no clinical consequence.

At this point, the procedure was concluded. The wires and catheters were removed. The sheaths were removed from the groins and vascular clamps were placed on the femoral arteries. The surgeon then repaired the arteriotomies using 5-0 Prolene suture. The clamps were released, restoring blood flow to the legs. There were excellent pulses after the procedure. Then, 50 mg of protamine was administered. Both femoral incisions were then closed in multiple layers using Vicryl suture. Sterile dressings were placed. The patient tolerated the procedure well and was transferred to the recovery room postoperatively.
On March 25 and 26, 2019, Ryan Johns, Jeri Romano, and myself had the privilege of representing MHIMA in Washington, DC at the annual AHIMA Advocacy Summit and Hill Day. In addition, we were joined by Gina Sanvik, AHIMA staff member and MHIMA Past President. We had a very full schedule in Washington this year.

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### Advanced ICD-10 PCS Coding Corner

**ICD-10-PCS Code Suggestions:**

- 04V03DZ, Restrict of Abd Aorta with Intraluminal Dev, Perc Approach
- 047D3ZZ, Dilation of Left Common Iliac Artery, Percutaneous Approach
- 047C3ZZ, Dilation of Right Common Iliac Artery, Percutaneous Approach

**Rationale for Endovascular Abdominal Aortic Aneurysm Repair:**

An abdominal aortic aneurysm (AAA) results when the aortic wall weakens and bulges. A common descriptor for abdominal aortic aneurysms is based on its relation to the renal arteries. An ‘infrarenal’ AAA is located below the level of the renal arteries. In this case, an endovascular aneurysm repair (EVAR) is performed. In an EVAR, a percutaneous incision is utilized for deployment of a tubular device or stent-graft into the lumen, or the inside of the aneurysmal vessel.

**INDEX:**

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**Let’s look at the code in table 04V.**

**Section:**

Medical and Surgical, Value 0

**Body System:**

Lower Arteries, Value 4

**Root Operation:**

Restriction, Value V

The intent or objective in an EVAR is to “restrict” the aneurysmal section of the aorta by “partially closing the lumen of a tubular body part.” As stated in the coding handbook, “the stent graft restricts the aneurysm from circulating blood, thus preventing its expansion and rupture.”

Coding Clinic for ICD-10-CM/PCS First Quarter 2014 clarifies that an endovascular aneurysm repair is coded to the root operation “Restriction” when the aneurysm is repaired by putting a synthetic graft, stent, or other device into the lumen of the artery.

**Body Part:**

Abdominal Aorta, Value 0

Two values exist in ICD-10-PCS for the aorta. Thoracic aorta, ascending/arch, for parts of the aorta located above the diaphragm and “abdominal aorta” for parts of the aorta located below the diaphragm.
**Approach:**
Percutaneous, Value 3

The femoral arteries are accessed “percutaneously” using fluoroscopic guidance. A guide wire is passed across the dilated portion of the aorta. An introducer sheath is inserted over the primary access guidewire. The body portion of the stent graft is advanced over the wire followed by placement of the contralateral extension limb of the endograft.

**Device:**
Intraluminal Device, Value D

An Excluder bifurcated endoprosthesis (or graft) was deployed via the left common femoral artery into the body of the abdominal aorta and advanced up to the level of the renal arteries. A balloon was then placed into the proximal area and inflated gently to create a proximal seal. A contralateral Excluder limb is then deployed. Kissing balloons were then placed into the gate area and inflated to create a good seal.

A bifurcated endograft, like a bifurcated vessel, divides into two branches. Bifurcated aortic endografts have distal docking limbs and/or extensions that reach into the left and right common iliac arteries. Branched endografts are not the same as bifurcated endografts. Branched refers to the nubs designed to treat branch vessels off the abdominal aorta, such as the renal arteries. Bifurcated refers to an endograft that divides into the right and left iliac arteries. In our case, the bifurcated graft was advanced up to the level of the renal arteries; documentation does not support the need for, nor the placement of a branched or fenestrated graft to keep the visceral arteries (renal arteries) open.

Coding Clinic, Third Quarter 2016 addresses procedural coding for endovascular repair of an Infrarenal AAA with deployment of an Iliac Graft Extension. Advice directs us to assign the device value, “intraluminal” for insertion of the Gore® Excluder® graft being used to treat the infrarenal abdominal aortic aneurysm. A separate code is not assigned for deployment of the iliac extension component.

Angioplasty is performed at the attachment sites and junction points to maintain the position of the grafts and create a good seal.

PCS Guideline B3.1 states that “Components of a procedure specified in the root operation definition and explanation are not coded separately.” Therefore, the angioplasties which are an integral part of the endograft placements are not coded separately.

In addition, Coding Clinic 4th Quarter 2016 also addresses the “landing zone” or “seal zone” for endograft procedures. The “landing zone” or “seal zone” is a
segment of healthy tissue into which the endograft extends so it can form a healthy or satisfactory seal. In certain instances, the “landing zone” or “seal zone” may involve boundaries in another body part. Advice provided clarifies that a separate code is not assigned for the “landing zone” or “seal zone” even if it’s in a different body part.

Qualifier:
No Qualifier, Value Z

The qualifier value “Bifurcation” is only used to describe bifurcated vessels, not to identify a bifurcated endograft. While a “bifurcated” endograft is placed, the aneurysm does not involve the bifurcation; therefore, the qualifier value for “Bifurcation” is not assigned.

Rationale for Bilateral Common Iliac Artery Angioplasties:
Following EVAR treatment of the AAA, bilateral common iliac artery stenoses are treated with angioplasty.

INDEX:
Angioplasty
- See Dilation, Lower Arteries 047

Let’s look at the code in table 047.

Section:
Medical and Surgical, Value 0

Body System:
Lower Arteries, Value 4

Root Operation:
Dilation, Value 7

While the intent of the EVAR is to make the lumen of the tubular body part smaller, the intent of the angioplasties performed in the bilateral common iliac arteries is to expand the lumen of the tubular body parts. “Dilation” is the correct root operation.

Body Part(s):
Common Iliac Artery, Right, Value C
Common Iliac Artery, Left, Value D

Two distinct sites were dilated, the right common iliac artery and the left common
iliac artery. PCS multiple procedures guideline, B3.2a states that “multiple procedures” are coded if during the same operative episode, the same root operation is performed on “different body parts as defined by distinct values of the body part character.”

**Approach:**
Percutaneous, Value 3

The right and left common iliac arteries were accessed “percutaneously” following the EVAR using fluoroscopic guidance.

**Device:**
No Qualifier, Value Z

Angioplasties were performed on the stenotic portion of the native common iliac arteries “without insertion of stents.”

**Qualifier:**
No Qualifier, Value Z

Procedural documentation does not support use of a “drug-coated balloon.” In addition, the coding handbook states that “the bifurcation qualifier captures procedural differences between interventional procedures performed on a straight vessel versus a vessel bifurcation.” Since treatment of the right and left common iliac arteries does not involve the vessel bifurcation, the qualifier value for “Bifurcation” is not assigned.

**References:**


*AHA ICD-10-CM and ICD-10-PCS Coding Handbook 2019, Nelly Leon-Chisen, RHIA*

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Thank you for your article submissions!

We would like to give our great appreciation for everyone who helped with this newsletter. Special thanks to those who solicited or submitted content: Joy Schmitt, Heather Feltus, Lisa Schultz, Christina Snaza, Sue Nathe, Anne Pavlik, Cheryl Zupec and Kate Haffner.

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