The HIM Times

"Bringing the HIM Experts to You"

Medical Audit Resource Services, Inc.
(352) 385-1881

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To Our Newsletter!

For over two decades, Medical Audit Resource Services, Inc. (MARSI) has been ***"Bringing the HIM Experts to You"***. And now, as an added benefit, we are proud to announce our bimonthly newsletter, offering expertise and advice from leading professional experts in the coding, billing, and compliance fields. MARSI's experts are known nationally and are a trusted resource for our clients, which have driven a high rate of customer retention and an outstanding reputation.

*Our newsletter consists of **HIM Hot Topics** in the following fields:*

General Topics:
- ✓ Yearly and Quarterly Coding Updates
- ✓ Common Coding and Compliance Errors
- ✓ OIG Worklist Items
- ✓ Communicating with Physicians
- ✓ Physician Documentation Guidelines
- ✓ RAC Alerts

Facility Topics (Inpatient/Outpatient):
- ✓ Writing Effective Queries
- ✓ Common PCS Coding Challenges
- ✓ Evaluating Facility Acuity Sheets
- ✓ Coding Injections/Infusions
- ✓ Billable Services in the ED
- ✓ Understanding Clinical Indicators
- ✓ Defensible Principal Diagnosis
- ✓ Effective Surgery Coding Techniques

Risk Adjustment Topics:
- ✓ Writing HCC Queries
- ✓ Late Entries, Addendums, Corrections
- ✓ "MEAT" for Common HCC Conditions
- ✓ HCC Coding Corner

Physician Topics:
- ✓ MDM– Driving Force in E/M Assignment
- ✓ Proper Application of Modifier 25
- ✓ Modifier 59 – Bundled or Not?

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ICD-10-CM/PCS effective October 1, 2017: Have YOU Prepared?

If you have not already reviewed the new ICD-10 guidelines and changes effective 10/01/17, make certain you review as soon as possible. With 71,704 codes in 2018, it is imperative that you review all additions, deletions, and revisions to implement for dates of service October 1, 2017 and forward. There were over 360 additions, 142 deletions, and 250 revisions to codes; some of which will definitely impact your accurate coding for fiscal year 2018!

Check our inpatient section for additional guidance on Coding Clinic, 4th Quarter 2017 regarding: Coding for Documentation Not Meeting Clinical Definition or Diagnostic Criteria including clinical guidance comments from our Medical Director, ***Dr. Todd Husty****.*

Clinical Validation
New Advice from Coding Clinic – and What to Do With It

After the addition of the 'Code Assignment and Clinical Criteria' guideline to Section I.A. of the *ICD-10-CM Official Guidelines for Coding and Reporting* in 2016, much debate surrounded the meaning of this guideline and what it meant for coding and auditing professionals. The guideline very basically states code assignment is based on provider documentation, and not on the clinical criteria the provider used to establish said diagnosis. *Coding Clinic,* Fourth Quarter, 2016, page 147*,* 'Clinical Criteria and Code Assignment', attempted to clarify that facilities "may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis".

What does this mean and how will it affect inpatient coding and auditing?

Fortunately, *Coding Clinic*, Fourth Quarter, 2017, page 110, "Ask the Editor: Omitting ICD-10 Codes", has now clarified that it is not appropriate for a documented diagnosis to be omitted from the record based on not meeting clinical criteria. Basically, it states that a practitioner can make a diagnosis by their own clinical criteria and it should be coded. It goes on to suggest that, if no clinical criteria can be found in the record, we should query the physician. The expectation of the query should be that we obtain clinical rationale for the diagnosis. Dr. Todd Husty, DO, FACEP and MARSI's president, suggests "if a diagnosis is unclear or inconsistently documented while meeting some clinical indicators, then the physician should further clarify his reasoning and what indicators they are using. It's that easy." Additionally, if clinical criteria cannot be found in the record, the physician should be queried. What should be established next is a process for obtaining and documenting the rationale for the diagnosis. Best practice would be to set up a clinical validation review process so the documentation is an accessible part of the medical record. Not only do we need verification of the diagnosis, we must also obtain written documentation regarding the rationale used in making the diagnosis. There are several options for doing this. On the initial clinical validation query form, a section could be added for the physician to provide their rationale in making a diagnosis where clinical criteria doesn't appear to be met. The facility might also establish a requirement that in all such cases the provider is required to document their rationale as an addendum to the record. What's important is that all diagnoses reported are accurately coded and defensible should the condition be challenged at any time.

Dr. Husty further clarifies, "although the question to *Coding Clinic* was about facilities requiring particular clinical definitions or sets of criteria when establishing a diagnosis, it would be logical to believe that the same answer applies to any entity that must follow *ICD-10-CM Official Guidelines for Coding and Reporting* and *Coding Clinic* advice, including all payers. We see innumerable denials from payers based on the diagnosis not having met certain clinical criteria. This *Coding Clinic* negates that reasoning. Payers should not be denying submissions based on diagnoses not meeting their chosen guideline if there is sufficient documentation supporting the physician's rationale."

Facility Modifiers 73, 74, and 52
Oh My!

When it comes to outpatient procedures everyone knows things do not always go as planned. Luckily AMA/CPT has modifiers that help provide additional information to the payers to help them understand the situation better. This article will focus on outpatient facility coding and the modifiers used when procedures are cancelled, discontinued, or not carried out to the full extent of the CPT descriptor; namely modifiers 73, 74 and 52, respectively. It is important to note that if a patient chooses to cancel a surgery prior to the commencement of prepping him or her, no CPT or modifier is to be reported.

AMA/CPT defines modifier 73 as a discontinued outpatient procedure prior to administration of anesthesia. For example, a patient is scheduled for a laparoscopic cholecystectomy; he presents to the surgical department, is prepared for the procedure, taken to the OR room, and then informs the provider that he did not stop taking his Coumadin as instructed. The provider deems it unsafe to continue the procedure and elects to reschedule for a later date pending patient's compliance to pre-op instructions. For this instance you would code the intended procedure of 47562 and add modifier 73. Per CMS MLN Matters MM3507, February 22, 2005, the facility may receive 50% for the OPPS payment amount for this scenario.

Let's take the above example and modify it to say the patient went into the OR, was given general anesthesia, and the physician started to make his incisions and insert the ports for the laparoscopic instrumentation. The patient begins bleeding excessively and begins to experience cardiac manifestations to which the provider deems it unsafe to continue the procedure and stops, closes the patient's incision, and discharges him to the PACU area for observation. You will still code the intended procedure of 47562 and add modifier 74. The AMA/CPT definition of modifier 74 is a discontinued outpatient procedure after anesthesia administration. Per CMS MLN Matters MM3507, February 22, 2005, the facility may receive the full OPPS payment amount for situations such this.

Finally there is modifier 52. AMA/CPT defines 52 as reduced services and CMS further defines to indicate this modifier is used for radiology and other services that do not require anesthesia. (MLN Matters MM3507, February 22, 2005.) There are multiple instances when this modifier would be appropriate – one being multiple attempts at a PICC line insertion. PICC lines do not require anesthesia so it would be appropriate to append modifier 52 to the CPT code to indicate the procedure was attempted but not completed. Additionally, modifier 52 may be used to indicate not all portions of a CPT code description were carried out.

CPT Assistant, July 2015, Volume 25, Issue 7, page 10 provides the following example:

Question:
A patient undergoes revision of the tibial component of the right knee total arthroplasty, but instead of revising the entire component, the orthopedic surgeon only needs to replace the polyethylene liner. The removal of the liner was more complex than simply popping it out and replacing it with a new one. (The physician found that the liner was lodged under the lip of the metal component.) Should this work be reported with code 27486 with modifier 52 appended?

Answer:
Yes, it would be appropriate to report code 27486, *Revision of total knee arthroplasty, with or without allograft; 1 component*, with modifier 52; reduced *services*, appended to indicate that the procedure was reduced as only the tibial polyethylene liner was revised. The finding that the poly liner was lodged under the lip of the metal component does not change the reporting.

Struggling with Modifier 59, X, and 25?
You are Not Alone!

Guidance for proper use of 59 and X modifiers:

Edits are set in place as "*warnings*" to ensure full guidelines are met for the appropriate assignment of modifier 59 and/or X modifiers. Ensure 59 is not applied to simply bypass and edit. Remember, just because it is allowed does not always mean it should be applied!

Consider the following scenarios for proper application of 59 or X modifiers:

- Is this a different session?
- Different procedure or surgery?
- Laterality? Different site or organ system?
- Separate excision or incision?
- Separate lesion or injury? (or area for extensive injuries)
- Is this separate procedure NOT ordinarily performed or encountered on the same date by the same provider of service?
- Was a diagnostic procedure medically necessary on the same date as a therapeutic procedure? Did the diagnostic procedure findings warrant the surgical procedure? If the diagnostic procedure is inherent to the surgical procedure, it should not be separately reportable.
- Injections/Infusions – Ensure injections and/or infusions are performed independently from each other before assigning modifier 59. Know the importance of the hierarchy rules for these code assignments. Most commonly these CPTs are assigned through the CDM by a clinician or department vs coders. Ensure your facility has clear communication between your HIM team and the clinical areas for the appropriate application for these CPT codes. Unfortunately, the error rate is significantly high for these codes and the assumption to apply Modifier 59. In addition, ensure the injections/infusions are not inherent to a surgical procedure, such as a lidocaine injection for a laceration repair and/or injections and infusions inherent to an operating room procedure, as these would be bundled into the surgical procedure. Pre-op and post-op injections may also be part of the surgical procedure performed.

Medical record documentation must support the use of modifier 59, as it provides a clinical story of what was performed and why the modifier was appropriately assigned. Often the documentation lacks evidence/clinical circumstance to warrant its use, resulting in a denial. Ensure your providers are educated on the clinical documentation necessary if the procedures performed together are clearly "distinct procedural services".

Use of Modifier 59 does not require a separate diagnosis for each HCPCS or CPT assigned. Different diagnoses are not adequate for the use of 59.

CMS Modifiers – XE, XS, XP and XU.

XE-Separate Encounter, XS-Separate Structure, XP-Separate Practitioner, XU-Unusual and Non-Overlapping.

CMS implemented new subsets of modifier 59. These are X modifiers and are more selective. Facilities may continue to report 59 until specific instructions are published by CMS. Facilities may decide to utilize the new modifiers. "X" modifiers will be considered the same as modifier 59 until further guidance is published. As of this date, further guidance has not been published. Refer to *Coding Clinic* for HCPCS, 1st Q, 2015, for guidance.

Modifier 25 - For Facility and Physician Evaluation and Management Services

Physician Billing Guidance:

Ensure that a "separately identifiable E&M service" procedure was performed. A separate and identifiable service is defined as a service above and beyond that's associated with another procedure being reported on the same date. The E&M service is generally unrelated to the procedure provided. During the visit, the symptom or condition evaluated may prompt the separate identifiable procedure to be performed. Different diagnoses are not required for the procedure and service reported on the same date of service.

Facility Guidance:

The Outpatient Code Editor only requires modifier 25 to be appended to the E&M Service when it is performed on the same date of service with a procedure code that has a status indicator of "S" or "T". Keep in mind, the application of modifier 25 must be clinically documented in the patient's medical record. Ensure the documentation meets the definition of "significant and separately identifiable E&M Service."

"MEAT" Makes Your Records *NEAT!*

What is MEAT? MEAT is the acronym that will help you in achieving records that have great documentation. Each HCC condition and, for that matter, ALL conditions, should have documentation that support the condition. This is best for the patient and best for your practice. MEAT stands for:

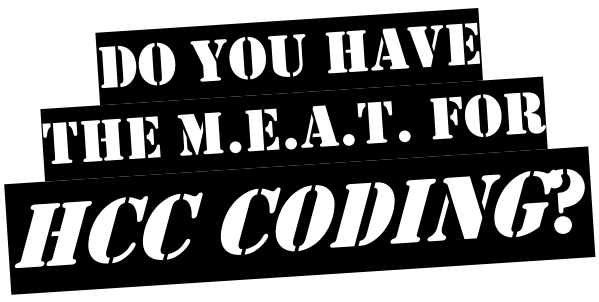
M Manage/Monitoring
E Evaluation
A Assessment and/or
T Treatment

Each condition a provider or coder codes should have at least one element of MEAT; preferably two or more.

Here are some examples of MEAT:

	Monitoring	**Evaluation**	**Assessment**	**Treatment**
Rheumatoid Arthritis	Exam: pain and inflammation in joints	Rheumatoid factor positive, ESR elevated	Worsening	Continue Methotrexate
COPD	Continue to see Pulmonologist	No improvement on prescribed inhalers	Will schedule for PFT when symptoms improve	Medrol dose pack ordered
CHF	Continue to follow with Cardiology, Dr. Smith	No SOB, Mild edema	Stable	Continue Lasix and potassium
Diabetes	Continue home BS monitoring, repeat fasting blood sugar in two weeks. Follow up appointment in 1 month.	HbA1c 7.0, Fasting blood sugar 170.	HbA1c, Fasting BS elevated	Increase Metformin to 1000 mg twice a day

"MEAT" - IT'S NOT JUST FOR DINNER!



HCC

Coding CORNER

Atherosclerosis of Aorta
ICD-10 I70.0
HCC Category 108

Atherosclerosis of Aorta is defined as a process in which blood and fats, such as cholesterol and other substances, build up on your artery walls. Eventually plaque deposits may form. The deposits may narrow, (or block your aorta). These plaques can also rupture, causing a blood clot.
Signs and symptoms, such as chest pain/ pressure and angina, may be noted on exam: A weak or absent pulse below the narrowed area of your artery, decreased blood pressure in an affected limb, and whooshing sounds (bruits) over your arteries (heard using a stethoscope). However, mild Atherosclerosis of Aorta is usually asymptomatic.
This is found on diagnostic testing such as a CXR, Doppler US, ECG, stress test, cardiac catheterization/angiogram, CT, MRI of the chest/abdomen, or an echocardiogram. Look for aortic root dilatation or ectasia (I77.810-I77.819) on the echocardiogram, as well as plaque.
Treatment includes monitoring for the development of an aortic aneurysm, aortic dissection, or aortic rupture. Other treatments include smoking cessation, blood pressure control, lipid control, and glycemic control in patients with Diabetes.

The medications listed below are only examples, not a complete list:

- Cholesterol reducing: Pravastatin (Pravachol), Simvastatin (Zocor), Atorvastatin(Lipitor)
- Beta blockers: Metoprolol (Lopressor, Toprol XL) Nadolol (Corgard)
- Ace Inhibitors: Capoten (captopril) Vasotec (enalapril)
- Anti-platelet: Clopidogrel (Plavix), Ticagrelor (Brilinta)
- Calcium Channel Blocks: Amlodipine (Norvasc) Bepridil (Vascor)
- Diuretics: Lasix (furosemide), bumetanide, Demadex (torsemide)

Remember when collecting for Risk Adjustment that the coder should review all documentation within the medical record. If Atherosclerosis of Aorta is documented without MEAT, or just mentioned as a finding on a diagnostic study, it would be appropriate to initiate a query to the provider to request clarification of the diagnosis or documentation of the diagnosis using **MEAT**.

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Medical Audit Resource Services, Inc.

3040 S. Tuskawilla Rd.
Oviedo, FL 32765

Phone
(352) 385-1881

Fax
(352) 385-1884

E-mail
marsi@himexperts.com

We're on the Web!
See us at:
www.himexperts.com
www.hccexperts.com
www.marsitraining.com

Having trouble with coding, auditing, compliance, denials and/or documentation?

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"We do it the right way."

MARSI's slogan for a decade, and mission statement since inception over 25 years ago.

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