The HIM Times

"Bringing the HIM Experts to You"

Medical Audit Resource Services, Inc.
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News Flash!

MARSI/AHIMA Announce HCC Curriculum Affiliation

MARSI is pleased to announce our recent affiliation with the American Health Information Management Association (AHIMA) as we join together to offer an online HCC curriculum. This Risk Adjustment Coding/Auditing course prepares professionals for risk adjustment coding while going a step further to address the necessary tools and skills required for precise chart auditing. The course offers a methodology for logically categorizing findings and helping ensure that these findings are appropriately addressed. It is worth 40 CEUs! If interested, please visit the AHIMA website for additional information (link provided below) and enjoy a 15% discount with code **HCCCA18**

https://my.ahima.org/search/all?q=%22risk%20adjustment%2Fhcc%20coder%2Fauditor%20training%22

CPT Updates for 2018!

Major CPT Updates for 2018:

172 Additions:	
Evaluation & Management	5
Anesthesia	5
Surgery	42
Radiology	7
Pathology	57
Medicine	13
Category III	41
TOTAL:	**170**
Revisions:	60
Deletions:	82

Evaluation & Management:

Cognitive Assessment/Care Plan Services: 99483 - Replace G0505 developed by CMS in 2017;

Psychiatric Collaborative Care Management: 99492-99494 - Behavioral Health Manager & psychiatry consultant working w/PCP or qualified health care professional;

General Behavioral Health Integration Care Management: 99484 - Assessment, monitoring, and management w/20 minute threshold to report directed clinical staff time for oversight;

Observation Care Services had outpatient hospital terminology added: 99217-99220

Contents

Surgery Section:

Integumentary: 15730, 15733 (Additional flap codes); 19294 (Prep tumor cavity for radiation applicator)
Musculoskeletal: 20939 (Bone marrow aspiration for spinal surgery bone grafting)
Respiratory: Sinus Endoscopy: 31241, 31253, 31257, 31259, 31298 (Additional codes to encompass total [anterior/posterior] and w/wout removal of tissue)
Lungs/Pleura: 32994 (Cryoablation of pulmonary tumor)
Vascular Injection: 36465, 36466, 36482, 36483
Hemic/Lymphatic: 38573
Endovascular Repair: 34701-34713, 34714-37416 (Additional codes for endovascular repair abdominal aorta/iliac arteries; Code descriptor changes now based on "treatment zones"; Adjunctive outside the treatment zone may be separately reported)
Digestive: 43286, 43287, 43288 (Additional of Esophagectomy codes)
Male Genital: 55874 (Transperineal placement biodegradable material peri-prostatic)
Female Genital: 58575 (Laparoscopic TAH w/omentectomy for tumor debulking)
Nervous: 64912-64913 (Additional nerve repair codes)

Radiology/Pathology Sections:

Radiology: Chest x-ray codes – four only number of views (9 view-specific deleted); Abdominal X-ray - 3 additional
Pathology: Molecular Pathology – 39 new codes; Addition Proprietary Laboratory Analysis Section (17 new codes);

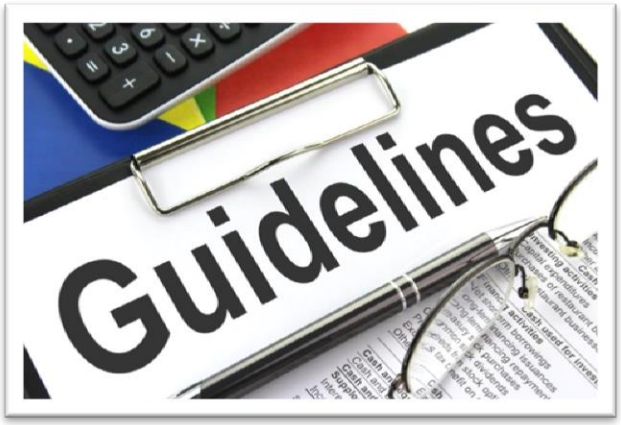
Medicine Section:

Vaccines: 90587, 90750, 90756, 90682 (Additional vaccine supply for Dengue, Shingles, & Influenza)
New Subsection: Home & Outpatient Internatl. Normalized Ratio (INR) Services 93792-93793;
Pulmonary: 94617 Exercise Testing for Bronchospasm; 94618 Pulmonary Stress Testing;
Ophthalmology: 0469T
Endocrinology: 95249 (Additional ambulatory continuous glucose monitoring w/ patient provided equipment)
Photodynamic Therapy: 96573-96574 (Additional Codes)
Orthotic Therapy: 97763 (Addition of prosthetic/orthotic management code)

Modifier Additions:

96 - Habilitative Services (to learn new skills)
97 - Rehabilitative Services (to restore or improve skills)

** This update is intended to be a summary only of the additional codes for CPT for 2018. Further explanation or investigation should be taken if these codes are applicable to your practice or facility.



Inpatient 2018 Coding Guideline Update: "With"

The 2018 *ICD-10-CM Official Guidelines for Coding and Reporting* adds under the term "**with**" the word "**in**" and further clarifies "when another guideline exists that specifically requires a documented linkage between two conditions," (e.g. sepsis guideline for "acute organ dysfunction that is not clearly associated with sepsis") and "when a guideline requires that a linkage between two conditions be explicitly documented."

Like many coding professionals, you might be wondering:

'What does that mean?'

First, let's take a look at the "**With**" guideline: **"With"**

The word "**with**" or "**in**" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or **when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis.")**

For conditions not specifically linked by these relational terms in the classification or **when a guideline requires that a linkage between two conditions be explicitly documented,** provider documentation must link the conditions in order to code them as related. The word "**with**" in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

Next, let's take a look at the portion of the Sepsis and Severe Sepsis guidelines that talk about organ failure:

Sepsis, Severe Sepsis, and Septic Shock:

1. **Sepsis:** For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, sepsis, unspecified organism.

2. **Severe Sepsis:** A code from subcategory R65.2, severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

3. **Sepsis with organ dysfunction:** If a patient has sepsis and associated acute organ dysfunction or multiple organ dysfunction (MOD), follow the instructions for coding severe sepsis.

4. **Acute organ dysfunction that is not clearly associated with the sepsis:** If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign a code from subcategory R65.2, severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

So… What does it all mean?

If a patient has **sepsis with an acute organ dysfunction or sepsis with multiple organ dysfunction,** such as acute kidney injury and/or acute respiratory failure, the provider ***must*** link the organ failure to the sepsis. This applies even though the code has additional information where the term **with** is used.

If the provider does not say the organ(s) dysfunction is due to the sepsis, then code R65.2X should ***not*** be assigned without first querying the provider to clarify whether the sepsis was, in fact, the cause of the organ dysfunction.

Medical Necessity Denials?

Understanding Medical Necessity & the Utilization of Resources for Coders for Surgical Procedures

Start with the basics by understanding the following terms:

What is **Medical Necessity**? According to Medicare.gov, "medically necessary" is defined as "health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine."

What is an **MUE**? The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. A MUE for a HCPCS/CPT code is the "maximum units of service" that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have a MUE.

What is an **ABN**? An ABN is an "Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131. The ABN is a written notice you must issue to a Fee-For-Service beneficiary before furnishing items or services that are usually covered by Medicare but are not expected to be paid in a specific instance for certain reasons, such as lack of medical necessity as defined by the following MLN article published by CMS.

Further advice may found in the complete article at:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf.

Ensure your coders are utilizing all available resources such as:

- NCCI Annual Policy Manual (National Correct Coding Initiative Policy Manual)
- LCDs (Local Coverage Determination)
- NCD (National Coverage Determination)
- ICD-10-CM Guidelines (Updated Annually on October 1st)
- Coding Clinics for HCPCS and CPT Assistants
- CPT Guidelines

Prior to the day of surgery, ensure your staff has reviewed the medical necessity of the upcoming scheduled surgery. In some cases, an ABN (Advance Beneficiary Notice) may be necessary. If medical necessity is not present for the upcoming surgery, query to the ordering provider to correlate the clinical diagnosis warranting the non-covered procedure.

A few example(s) of common denials are as follows:

Are your Vertebral Augumentation Procedures (AKA Kyphoplasty) Commonly Denied?
For example let us review CPT 22514: Diagnosis per order states "Fracture Lumbar L-4" procedure ordered "Kyphoplasty L4 Vertebra." To ensure medical necessity, a review of all documentation is needed and/or possibly an inquiry to the ordering physician for higher specificity for the fracture for the procedure requested.

Refer to the following guidance for this example:

- LCD Policy ID L34048B, Vertebroplasty and Vertebral Augumentation (Percutaneous), MAC=15-CGS Administrators, LLC.
- Covered Diagnosis = Covered: C41.2, C79.51 - C79.52, C90.00 - C90.02, C96.5 - C96.6, D16.6, D18.09, D47.Z9, D48.0, D49.2, E71.39, E80.3, E88.89, M48.31 - M48.38, M48.51XA, M48.52XA, M48.53XA, M48.54XA, M48.55XA, M48.56XA, M48.57XA, M48.58XA, M80.08XA, M80.88XA, M80.88XG, M81.0 - M81.8, M84.58XA, M84.68XA, M85.80, M85.9, M87.00, M87.10, M87.20, M87.30, M87.80, M89.9 or M94.9.
- Note the limited covered diagnosis for this procedure. Unspecified fracture of the L-4 would assume traumatic with ICD-10-CM assignment S32.049A. S32.049A is **not** a covered diagnosis for CPT 22514 per the above mentioned LCD. Educate your staff to determine if an ABN should be presented to the patient prior to the procedure. Communication with the ordering provider is the key to ensuring a stress free day for your patient before he or she arrives at the facility.

Ensure your coders are reviewing the surgeons H&P and operative report for code assignments. Here you may find the specificity of the fracture (pathological vs traumatic) as well as the type of vertebroplasty performed. Was augmentation truly performed? Ensure you are coding any identifiable diagnoses from the physicians' operative report as well; However, do not add any diagnosis codes from the LCD if not present or documented by the provider.

Use CPT Assistant for accurate code assignment.
Our example above for 22514 has an abundance of coding references to assist your coder, for example, **CPT Assist Coding Update – Percutaneous Vertebroplasty and Vertebral Augmentation: CPT-Assistant, January 2015, Volume 25, Issue 1, page 8.**

Use the Coder's Desk Reference - Coders are not surgeons - Utilize the CDR to assist in accurate coding.
The Coder's Desk Reference is a valuable tool, giving insight to the coder with a brief description of the procedure(s) performed. If in question, coders should consult the CDR for assistance. Here is a quick glimpse of our example CPT 22514 in the CDR: 22513-22515 - The physician performs a minimally invasive percutaneous kyphoplasty, a modification of the percutaneous vertebroplasty, to reduce the pain associated with osteoporotic vertebral compression fractures…**Refer to your Coder's Desk Reference for the entire article.**

Please keep in mind that this is ***only*** an aid to correct coding and ***not*** a definitive source. It should only be utilized for a brief description of what is usually included in the procedure.

Another example: Consider complex coding for cataract extractions. **Receiving denials?** The patient may present to the facility for a non-complex procedure; however, the surgeon may perform a complex procedure due to unusual findings. Example: Surgeon documents the following in the operative report for the cataract extraction: *"due to the poor pupil dilation, the Malyugin ring was placed."* The malyugin ring would warrant a complex repair vs non-complex. Cataract surgery with a small pupil poses a challenge for the procedure. The Malyugin pupil expander is used to dilate the pupil to perform safe cataract surgery. Assign CPT 66982 (appending appropriate RT/LT or 50 modifier) and ICD-10-CM H57.03 for the complex cataract procedure with use of malyugin ring due to small pupil. H57.03 defines the diagnosis of "Miosis" (excessive constriction of the pupil of the eye). Referring to the following LCD L33558, you will find the H57.03 warrants medical necessity for the complex extraction CPT 66982; however, again, only assign the diagnosis if documented by your provider.

Refer to the following CPT Assistant for guidance on the above scenario. Surgery: Eye and Ocular Adnexa *CPT Assistant*, March 2016, Volume 26, Issue 3, page 10.

Download a current annual version of the NCCI Annual Policy Manual (National Correct Coding Initiative Policy Manual) for Medicare to assist you in understanding why an edit may be put in place. Most encoders are developed with NCCI edits as warnings; however, ensure you are not bypassing an edit based solely on your encoder edit. Referring to the NCCI Policy will explain in detail why you are receiving this warning.

OT/PT: All About Time!

Physical therapy and occupational therapy billing and coding can be very confusing to many coders. There are so many things to take into consideration, such as time - **what counts and how do I count it? -** And, of course, **proper documentation**. This article will focus on aspects of time.

Time - What ***does*** count? Many EMR's have a place in their system that will indicate "time in and time out," and that is essentially what it says - the time the patient entered the PT department and the time they left. This time is ***NOT*** the time coders should use when calculating billable time for physical therapy. They should only be using time documented for each modality. Time begins when the physical therapist is directly delivering treatment services - the time spent before and after treatment is not counted when adding billable timed units. When billing for procedures that are billed based on time, it is important to note that in order to use the code, the time documented must equal more than half the time described by the code.

Most of the physical therapy codes are described as being per every 15 minutes. CMS has developed a "rule of 8's" to help coders count billable units of each modality. Per Medicare Claims Processing Manual, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services, when only 1 service is provided in a day, providers should not bill for services performed for less than 8 minutes. They have included a table in the manual that helps break down the "rule of 8's" and assist coders and billers in calculating billable units. For the complete table please see the Medicare Claims Processing Manual, Chapter 5.

- **1 unit ≥ 8 minutes through 22 minutes**
- **2 unit ≥ 23 minutes through 37 minutes**

As you see from the partial table above, in order to bill for more than one unit, the time must exceed the first 15 minutes by at least 8 minutes to count the additional unit. A common practice in billing for physical therapy is to add up all the time for all the time based modalities to determine your units and then apply the CPT codes accordingly. Be sure not to count time for modalities that are not billed by timed units, such hot/cold packs.

For example: (taken from Medicare Claims Processing Manual, Chapter 5)

- **33 minutes of therapeutic exercise (97110)**
- **7 minutes of manual therapy (97140)**
- **40 Total timed minutes.**

Per the 8 minute rule, 40 minutes is billed at 3 units. Since the therapeutic exercise was performed for 2 full units, you would bill 97110x2 and 97140x1.

Time is just a small piece of the puzzle when billing for physical and occupational therapy. Please see the Medicare Claims Processing Manual, Chapter 5, for complete details and instructions on how to bill for physical therapy, to include all applicable modifiers.

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