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

May 1, 2018: Issue 4

The HIM Times

"Bringing the HIM Experts to You"

Please stop by and see us at these upcoming events!

- ✓ **FHIMA Convention 2018: July 29-Aug. 1, Booth 404**
  7/30 - 4:35 pm – 5:35 pm "HCC, DRGs All Over Again" – Dr. Todd Husty
- ✓ **AHIMA Convention 2018: Sep. 22-26, Booth 1045**

Contents

Outpatient Corner

Ditch the Confusion on Injections and Infusions

By: Theresa Rosa, AAS, CCS, CPC

A common treatment used by physicians to treat an abundance of illnesses and ailments is with the use of intravenous medications. The coding/sequencing of these codes can be tricky for many HIM professionals due to the specific set of guidelines put forth by the AMA in the CPT book. These guidelines cover chemotherapy services as well as therapeutic services. CPT outlines two hierarchies to follow, depending on whether you are coding for a facility or physician's office. When reporting for the physician's office, the initial code is based off the treatment diagnosis. For facility reporting, however, there is a structured algorithm that coders must follow when selecting the initial services code. This article focuses on **facility reporting**.

There are many variables to take into consideration when coding for injection and infusion services. The coder must know the difference between infusion, injection, and hydration. He or she must then answer three important questions:

1) What was received?
2) How was it administered?
3) How long did it take?

As always, accurate and complete documentation is essential in answering these questions.

For facility reporting, all infusion services are coded based on a hierarchy. The guidelines instruct that only one initial treatment code may be reported per encounter and should be selected based on the hierarchy. There are also a few key documentation requirements for reporting of these services. These requirements are consistent regardless of whether they are at the top or bottom of the hierarchy. The hierarchy for facility reporting lists chemotherapy first, followed by diagnostic/prophylactic services, and then hydration services.

For ALL injection/infusion services there must be medical necessity documented in the chart. Each service must have the following present in the record: the start and stop time of the injection/infusion, the route, the medication administered, and the dosage amount. The only exception to this rule is if an infusion (not hydration) does not have a STOP time it can be billed/coded as an Intravenous Push (IVP). The importance of the start/stop time comes into play for billing/coding the services because the codes for each service are selected based on the length of time the drug/substance is administered.

An infusion, whether it is chemotherapy or a diagnostic/prophylactic substance, can only be reported as such when it runs for 16 minutes or longer. It is then reported with codes 96413, 96415, 96416, 96417, 96365, 96366, 96367, and 96368.

An IVP may only be reported as such when it runs for 15 minutes or less. It is reported with codes 96409, 96411, 96374, 96375, and 96376.

Hydration may only be reported if it runs for a minimum of 31 minutes or more. It is reported with codes 96360 and 96361. It is important to note that fluids running to facilitate the administration of other drugs/biologicals are not separately reported as hydration.

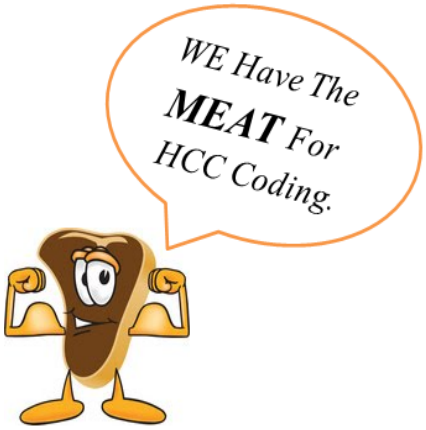
For success in coding for these services the coder must thoroughly understand the CPT guidelines summarized above. To eliminate infusion confusion just remember to never stop *infusing* yourself with coding guidelines!

HCC Corner

Pulmonary Hypertension

By: Nancy Keenan, CPC, CCS, CHCCS, RN

- Primary Pulmonary HTN, Primary Group 1 Pulmonary HTN (I27.0)
- Secondary Pulmonary HTN (I27.20-I27.29)
- Pulmonary HTN, unspecified (I27.20)
- Secondary Pulmonary Arterial HTN, Group 1 Pulmonary HTN (I27.21)
- Pulmonary HTN due to left heart disease, Group 2 Pulmonary HTN (I27.22)
- Pulmonary HTN due to lung disease and Hypoxia, Group 3 Pulmonary HTN (I27.23)
- Chronic thromboembolic Pulmonary HTN, Group 4 Pulmonary HTN (I27.24)
- Other Secondary Pulmonary HTN, Group 5 Pulmonary HTN (I27.29)



Monitor – Signs, symptoms, disease progression, disease regression

Evaluate – Test results, medication effectiveness, and response to treatment

Assess – Ordering tests, discussion, review records, counseling

Treat – Medications, therapies, other modalities

Definition: Is defined as increased pressure in the pulmonary arteries (which are the arteries that carry blood from your heart to your lungs). As a result of increased pressure in the pulmonary arteries, the right side of the heart works harder to push the blood to the lungs. This increased pressure over time can cause changes in the right ventricle which can lead to right sided heart failure.

Groups/Types of Pulmonary HTN (New codes as of 10/1/17)

- Primary Group 1 Pulmonary HTN (I27.0)-this type may have no known cause (idiopathic) or may be inherited
- Group 1 Pulmonary HTN-this type is caused by drugs or toxins or other systemic diseases (HIV, connective tissue diseases, portal hypertension, and congenital heart disease)
- Group 2 Pulmonary HTN-this type is caused by left heart disease (valvular heart disease, left ventricular systolic/diastolic dysfunction, and left heart inflow and outflow obstructions)
- Group 3 Pulmonary HTN-this type is caused by lung disease and hypoxia (bronchiectasis, cystic fibrosis, interstitial lung disease, pleural effusion, sleep apnea, and COPD)
- Group 4 Pulmonary HTN-caused by pulmonary embolism
- Group 5 Pulmonary HTN-caused by unclear or multifactorial mechanisms such as sarcoidosis, hematologic disorders, thyroid disorders (hyper or hypothyroidism), etc.

Diagnosis of Pulmonary HTN: Can be diagnosed by right heart catheterization or echocardiogram.

Signs and Symptoms: Shortness of breath, fatigue, dizziness, etc.

Treatment: Is directed at the cause of the pulmonary hypertension and cure depends on the cause and if the type of treatment is successful. An atrial septostomy (procedure in which an opening is made between the right and left atria of the heart to reduce pressure in the right side of the heart) and lung transplantation are potential treatments as well as medication.

Medications for Pulmonary HTN

- **Synthetic prostacyclin's:** Epoprostenol (Flolan, Veletri), Iloprost (Ventavis), and Treprostinil (Tyvaso, Remodulin, Orenitram)
- **Endothelin receptor antagonists:** Bosentan (Tracleer), Macitentan (Opsumit), Ambrisentan (Letairis)
- **Phosphodiesterase-5 inhibitors:** Sildenafil (Revatio) and Tadalafil (Adcirca)
- **High-dose calcium channel blockers:** Amlodipine (Norvasc), diltiazem (Cardizem, Tiazac, others) and nifedipine (Procardia)
- **Soluble guanylate cyclase (SGC) stimulator:** Adempas (Riociguat)
- **Anticoagulants:** Warfarin (Coumadin, Jantoven)
- **Digoxin (Lanoxin)**
- **Diuretics:** Furosemide (Lasix), Bumetanide (Bumex), Spironolactone (Aldactone), etc.
- **Oxygen:** Oxygen therapy might be used to help treat pulmonary hypertension. Some people who have pulmonary hypertension eventually require continuous oxygen therapy.

Documentation for HCC: Review the alphabetic index and inclusion terms in the tabular list to ensure the correct code is chosen depending on the cause documented in the medical record. The etiology of the pulmonary hypertension as well as any complications may also Risk Adjust. Review the chart note for the presence of "MEAT" and for documentation on specialists' notes (cardiologist and pulmonologist). Opportunities for queries may be found on tests performed such as an echocardiogram or right heart catheterization.

HCC and Risk Adjustment Payment Methodology

By: Nancy Keenan, CPC, CCS, CHCCS, RN

HCC stands for *Hierarchical Condition Category* and is the basis of the Risk Adjustment Payment Methodology for Medicare Advantage plans (Part C of Medicare). The Risk Adjustment Payment Methodology for MA plans is based on the member's health status (HCC's) and certain demographic characteristics (age, gender, disabled status, original reason for entitlement, etc.). It is a prospective payment system in that it predicts the cost of the member from data collected in the prior year. For example, data collected from 2018 predicts the cost to take care of the member in 2019.

There are 79 Hierarchical Condition Categories which include certain ICD-10 codes that are clinically related. Each HCC category has a weight and all weights are added together to determine the patient's risk score. To find out if a diagnosis belongs to a HCC category (Risk Adjusts), a HCC Mapping spreadsheet is provided on the following CMS website: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html.

Separate models exist for PACE/ESRD, CMS-HCC, and RX (which is the prescription drug benefit that some MA plans provide to their members). It is important that diagnoses are documented correctly in the medical record in order to provide the necessary funds to the health plan to care for their members.

The HCC coder/auditor reviews medical record documentation to ensure that ICD-10 diagnoses are documented correctly. Diagnoses are documented correctly when the following rules are followed:

- Documentation of diagnoses must be from a face-to-face visit from an acceptable provider specialty and data source.
- The required clerical information must be found on the DOS being submitted to CMS (Patient name, DOS, patient identifier, and signature with credential).
- The appropriate guidelines must be followed: ICD-10 Coding Guidelines, AHA Coding Clinic, and Risk Adjustment Participant Guide.

Any updates to the above mentioned guidelines are the responsibility of the coder/auditor. Any changes in the HCC Models mentioned above (including weights, disease interactions, etc.) can be found on the CMS website in the following link under the most recent Advance Notice and Announcement: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html#

Physician Corner

Clarification on Physician Use of Modifier 25

By: Marsha Diamond, CPC, COC, CCS, CPMA, AAPC Fellow

We continue to see the misuse of Modifier 25 for physician services. We have several clients who have either received RAC letters, or are currently under CIA (Corporate Integrity Agreements) under the OIG (Office of Inspector General) as a result of their misuse of this modifier.

Some of this misuse may be the result of past practices, and, the fact that many of the carriers allowed an E/M (Evaluation and Management) service along with a service/procedure in the past. However, in March, 2012, CPT published a clarification in *CPT Assistant* (March, 2012, Volume 22, Issue 3, Page 4) that clarified the use of modifier 25 for "significantly, separately identifiable E/M services".

CPT indicates that there are common "overlapping services" that, when performed as part of the E/M and the service/procedure, do NOT constitute justification for billing an Evaluation and Management service. This includes a review of the medical chart, reviewing results of progress (or lack thereof) since last visit, physician orders, completion of chart documentation and any follow-up instructions to the patient for the service/procedure performed.

The CPT Assistant article contains the following "Modifier 25 Usage Checklist" to assist the physician office in making the appropriate determination whether an E/M service with modifier 25 is appropriate:

- Was the physician's evaluation and management of the problem significant and beyond the normal preoperative and postoperative work?
- Was the procedure or service scheduled before the patient encounter?[1]

If the physician's E/M was documented as beyond the normal preoperative and postoperative work, then an E/M-25 would be appropriate. If the procedure or service was scheduled before the patient encounter, and, there were no additional problems/complaints addressed during the encounter, an E/M-25 would not be appropriate.

Take a look at this very thorough CPT Assistant article – it will perhaps shed some clarification on this very confusing aspect of E/M coding.

REFERENCES:

[1]CPT Assistant (2012). Modifiers 25 and 59. *CPT Assistant*, March 2012, Volume 22, Issue 3, Page 4.

In other MARSI news…

We enjoyed chatting with everyone that stopped by our booth at the AAPC Healthcon 2018 in Orlando, FL. We appreciate your visit and hope to see you again at the upcoming AHIMA 2018 and FHIMA 2018 conferences! Congratulations to our drawing winner, Ann D. Linton, CPC, CEMC, CUC, AAPC Fellow!

(AAPC HealthCon April 8-11 2018, pictured – Molly Snowberger, Shanon Kole, Kyle Sheldon, Marsha Diamond)

Upcoming MARSI Events!

- ✓ FHIMA Convention 2018: July 29-Aug. 1, Booth 404
  MARSI's President and Chief Medical Officer, Dr. Todd M. Husty, will be speaking July 30th from 4:35 pm – 5:35 pm on "HCC, DRGs All Over Again"
- ✓ AHIMA Convention 2018: Sep. 22-26, Booth 1045

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

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Bye; see you later.

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