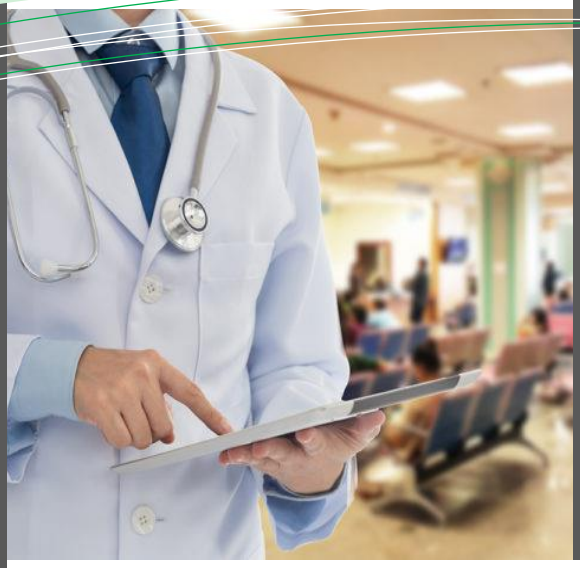
ISSUE
08
JANUARY 2019

BRINGING THE HIM EXPERTS TO YOU!

The HIM Times



this issue

Welcome Back!

CPT Updates 2019

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

Perhaps the most significant changes in CPT for 2019, are changes in the CMS interpretation of documentation requirements. Effective January 1, 2019, CMS has revised their documentation requirements to reflect that providers will only be required to focus on changes since the last visit, rather than redocumenting for the purpose of meeting a required number of elements. In addition, providers will not be required to re-document elements of the visit already documented by ancillary staff or the patient but only document these elements have been reviewed.

In addition, CMS has also relaxed the requirements for home visits of documenting the medical necessity for a visit performed in the home versus the office setting. Also, the home visit definition was expanded to include temporary lodging and short-term accommodations such as hotels, campgrounds and cruise ships.

Below are some additional substantial changes in CPT for 2019. Please consult your 2019 CPT manual or *CPT Changes 2019: An Insider's View* for additional clarification/information.

Other E/M Additions:

99451	Telephone/internet/electronic health record assessment and management provided by consultative physicians, 5 minutes or more
99252	30 minutes
99453	Remote monitoring physiologic parameters (BP, Pulse Ox, Respiratory), initial set up and patient education
99454	Daily recordings of programmed alert transmission, 30 days (no less than 16 days)
99457	Remote physiological monitoring treatment and management, 20 minutes or more (requires interaction between provider/patient during given month)
99491	Chronic care management by physician or QHCP, at least 30 minutes per calendar month 2> chronic conditions lasting at least 12 months or until death Place patient at significant risk of death, acute exacerbation/decompensation of decline Comprehensive care plan established, implemented, revised, monitored

*Please see next page for Section-Specific updates and/or changes.

Address:
3040 S. Tuskawilla Rd.
Oviedo, FL 32765

(P) 352.385.1881

(F) 352.385-1884

E-Mail:
marsi@himexperts.com

MARSI
MEDICAL AUDIT RESOURCE SERVICES INC.

CPT Updates 2019 Cont'd.

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

SURGERY

Integumentary Section
Addition of Final Needle Aspiration Biopsy Section (10021-10012)
Fine needle aspiration (FNA) biopsy, material aspirated with fine needle, examined by cytology
Core needle biopsy, large bore needle with tissue for histological exam

- If more than one biopsy to separate lesion – modifier 59

Other Integumentary Changes:

- Addition of specific biopsy codes (tangential, punch, incisional)
- Skin Graft Codes revised to indicate non-graft wound dressing cannot be reported separately

Musculoskeletal Section
Additions:

+20932 Allograft includes templating, cutting, placement and fixation, when performed; osteoarticular, including articular surface & contiguous bone
+20933 Hemocortical intercalary, partial
+20934 Complete

27369 Injection contrast knee arthrography or contrast enhanced CT/MRI knee arthrography

0512T Extracorporeal shock wave for integumentary wound healing; initial wound
+0513T Each additional wound

Cardiovascular System
33274 Transcatheter insertion/replacement of permanent leadless pacemaker, right ventricle
33275 Removal

Deletion of 33282/33284 and replacement with
33285 Insertion, SQ cardiac rhythm monitor, including programming
33286 Removal, SQ cardiac rhythm monitor
33289 Transcatheter implantation wireless pulmonary artery pressure sensor for long-term
Hemodynamic monitoring (includes placement, monitoring)
33440 Replacement aortic value by translocation pulmonary valve and transventricular aortic annulus, Enlargement of left ventricular outflow with valved conduit replacement of pulmonary valve
33866 Aortic hemoarch graft (anastomosis extending under 1> arch vessels, total circulatory arrest or isolated cerebral perfusion
36572 Insertion PICC w/out pump/port, includes all imaging and radiologic supervision/interpretation

Digestive System
47362 Replacement gastrostomy tube, percutaneous, includes removal w/o revision of tract
43763 Requiring revision of tract

Urinary System
50436 Dilation existing tract, percutaneous, for endourologic procedure, includes imaging,
Radiological supervision/interpretation and postprocedure tube placement when performed
50437 Includes new access into renal collecting system

Radiology
76978 Ultrasound targeting dynamic microbubble sonographic contrast characterization, initial lesion
(non-cardiac)
+76979 Each additional lesion

76981 Ultrasound, elastography, parenchyma (eg organ)
76982 First target lesion
+76983 Each additional target lesion

Deletion of 77058/77059 replaced with:
77046 MRI breast, without contrast, unilateral
77047 Bilateral
77048 MRI breast, with/without contrast, including computer-aided detection unilateral
77049 Bilateral

Pathology
Comprehensive changes to BRCA1 and BRCA2 codes and Molecular Pathology codes.
81518 Oncology (breast) mRNA, gene expression profiling by real-time RT-PCR of 11 genes,
Utilizing formalin-fixed paraffin-embedded tissue
81596 Infectious disease, chronic Hepatitis C virus infection (six biochemical assays) utilizing
Serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver

Proprietary Laboratory Analysis (New codes extensive)

Medicine Section
90689 New influenza code
Influenza virus vaccine, quadrivalent (IIV4), inactivated, adjuvanted, preservative free.
IM, 0.25 mg dosage
92773 ERG (Electroretinography), w/interpretation and report, full field
92774 Multifocal
94836 Electrocorticogram from implanted brain neurostimulatory pulse generator/transmitter,
Includes recording, interpretation and report, up to 30 days

Additional Neurostimulator codes
95976 Electronic analysis implanted neurostimulator, simple cranial nerve neurstimulator pulse generator/transmitter programming by physician, other QHCP
95977 Complex
95983 With brain neurostimulator pulse generator/transmitter programming; first 15 minutes face-to-face time physician QHCP
+95984 Each additional 15 minutes face-to-face physician QHCP

Adaptive Behavior Assessment and Treatment
97151 Assessment, physician/QHCP, 15 minutes
97152 Administered by technician under supervision of physician/QHCP, 15 minutes
97153 Treatment, one patient, by technician, under direction of physician/QHCP, each 15 minutes
97154 Group adaptive treatment, by technician, under direction of physician/QHCP, face-to-face 2> patients, each 15 minutes
97155 Adaptive behavior treatment with protocol modification, administered by physician/QHCP, face-to-face, one patient, each 15 minutes
97156 Family adaptive behavior treatment guidance, administered by physician/QHCP, face-to-face with guardian/caregiver, (with/without patient), each 15 minutes
97157 Multiple family group adaptive behavior treatment administered by physician/QHCP, face-to-face with multiple guardians/caregivers (with/without patient), each 15 minute

Improving Documentation for Coding Accuracy & Reporting

Debra Fairchild, RHIT

As we advance with ICD-10-CM and demonstrate the need for clear and concise documentation to the highest level of specificity, we are seeing great success between CDI and coding professionals collaborating in this area.

Physicians are also adapting to the CDI program as they become more informed and aware of the reimbursement loss due to claims lacking specificity and how this impacts quality of care. Adapting ways to increase physician awareness in areas such as acuity, specific disease types, stages, clinical criteria, and coding guidelines continues to be very important. Accurate reporting of this information is imperative to ascertain quality of care, physician quality scores, statistics, and appropriate reimbursement. For this article, we are going to review a scenario together to show the importance of CDI and coding professionals working together to seek clarification in documentation gaps.

Case Scenario:
Patient was admitted on 12/03 for an increase in nausea, abdominal pain, pleural effusion and leukocytosis. Chest tube was inserted for drainage of the pleural effusion. Culture showed no growth, as well as no malignant cells.

Nausea and abdominal pain noted secondary to progression of cancer. ? Pleural effusion from infection, malignancy or CHF. WBC elevated at 18.

The patient had a recent right lower lobe liver biopsy indicating a metastatic liver malignancy of unknown primary. Abdominal metastasis to adjacent structures of the liver were noted.

12/06 (Day prior to discharge), Oncology stated, "right pleural effusion, likely malignant."

12/06, Internal Medicine Resident stated, "pleural effusion likely secondary to malignancy."

***Discharge Summary**: Final diagnosis: Metastatic cancer, unknown primary. Hospital course indicates, "Patient had a moderate sized right pleural effusion seen on a previous MRI scan and patient was experiencing an increase in shortness of breath (SOB) on admission."*

Patient developed altered mental status during the stay and was diagnosed with metabolic encephalopathy. Lumbar puncture was performed to rule out meningitis. Culture came back negative. The patient ultimately expired on 12/09.

Determining the Principal Diagnosis:
After study what was the final diagnosis that occasioned the admission to the hospital and what kind of diagnostic and therapeutic treatment were performed?

Issues Identified:

- In this case, the pleural effusion (POA) did require a chest tube therefore determining the underlying cause of the pleural effusion is essential. Is documentation clear if the pleural effusion was from an infection, malignancy, other, or undetermined? No. Documentation after study is not clear whether the pleural effusion was malignant or not or even still a possible condition at discharge.

  As we know, the guideline regarding uncertain diagnoses states that if a condition is qualified as probable, suspected, likely, questionable, possible, or still to be ruled out or other similar terms indicating uncertainty ***at the time of discharge*** then the condition is coded as if it were confirmed. (OCG, sect III.C) In this case, the physician should be queried as documentation is unclear and vague. (Reference coding clinic, 2Q, 2000, pg. 17) Although we have malignant pleural effusion documented as "likely" it was NOT documented at discharge.
- Let's say the attending physician is queried and he makes a clinical judgment that the patient has "malignant pleural effusion". J91.0 is the code for malignant pleural effusion; however, there is an instructional note in the tabular list under J91.0 that states to ***code first*** the underlying neoplasm.
- To accurately code malignant pleural effusion and follow sequencing guidance, the coder would also need to know what malignant/ metastatic site caused the malignant pleural effusion; therefore, the above query should have also included verbiage such as: *Please clarify the etiology/underlying cause of the pleural effusion based on his/her medical judgement and review of the clinical indicators listed. A list of options would then be listed. One could list malignant pleural effusion as an option and include if malignant please specify the malignancy causing the effusion _____.*
- The list of options should always include option to select other pleural effusion (specify) _____ and clinically unable to determine.
- Of course, for the query to be validated, the physician must sign, date, and enter the time the query response is given.

In resolution, the physician responded to the query indicating malignant pleural effusion was from metastasis to the pleura. This changed the DRG from DRG 186 Pleural Effusion with an MCC with a weight of 1.5595 to 180 Respiratory Neoplasm with MCC with a weight of 1.696, which is a substantial increase. Documentation that was provided from the query ultimately established the correct diagnosis for quality of care.

Every medical record should provide clear and complete documentation that appropriately reflects the patient's care during his or her stay. If documentation is not clear, and/or is vague or incomplete, we must query the physician for clarification. Clear communication between healthcare providers through concise documentation improves specificity for coding accuracy and justification for resources used and/or services provided. Ultimately, good documentation should allow the coder to tell the patient's story of events that took place from admission to discharge by assigning accurate and complete code(s) that support the encounter.

Reference:
Optum 360 Learning: "2018 Coding from the Operative Report for ICD-10-CM and -PCS, "Documentation".
Official Coding Guidelines (OCG), section II Principal Diagnosis
AHA Coding Clinic, 2Q, 2000, pg. 17 effective with discharges: July 1, 2000 "Documentation Guidelines"
OCG.I.13 "Etiology/Manifestation convention – "Code first"
TruCode Encoder: Review of Code Summaries

Chronic Kidney Disease

Kim Logan, MT, COC, CRC, CHCC & Nancy Keenan, RN, CPC, CCS, CHCCS

Chronic Kidney Disease (CKD)
N18.1 = Chronic Kidney Disease, stage 1
N18.2 = Chronic Kidney Disease, stage 2 (mild)
N18.3 = Chronic Kidney Disease, stage 3 (moderate)
N18.4 = Chronic Kidney Disease, stage 4 (severe)
N18.5 = Chronic Kidney Disease, stage 5
N18.6 = End Stage Renal Disease
N18.9 = Chronic Kidney Disease, unspecified

Dialysis
Z99.2 = Dependence on Renal Dialysis (This includes Hemodialysis status, Peritoneal dialysis status, Presence of arteriovenous shunt for dialysis, and Renal Dialysis NOS)
Z91.15 = Patient's noncompliance with Dialysis

Chronic kidney disease (also called chronic kidney failure) is defined as "abnormalities in structure or function, present for > 3 months, with implications for health" according to the Kidney Disease Improving Global Health Outcomes (KDIGO). The kidneys are responsible for filtering waste and excess fluids from the blood which is then excreted in urine. Dangerous levels of electrolytes, fluid and wastes can build up in the body when chronic kidney disease reaches an advanced stage. Classification of CKD is based on cause, GFR value, and albumin-creatinine ratio and drives patient treatment and management. Severity and risk of complications increase as the stage and amount of protein (Albumin) in the urine increases.

Stages of CKD and Albuminuria
- Stage 1*: Kidney damage with normal or increased GFR (>90 mL/min/1.73 m^2)
- Stage 2*: Mild reduction in GFR (60-89 mL/min/1.73 m^2)
- Stage 3a: Moderate reduction in GFR (45-59 mL/min/1.73 m^2)
- Stage 3b: Moderate reduction in GFR (30-44 mL/min/1.73 m^2)
- Stage 4: Severe reduction in GFR (15-29 mL/min/1.73 m^2)
- Stage 5: Kidney failure (GFR < 15 mL/min/1.73 m^2 or dialysis)

*Stage 1 and Stage 2 are not diagnosed solely on the basis of GFR. There must be the presence of one or more of the following: Albuminuria, Urine sediment abnormalities, Electrolyte abnormalities due to tubular disorders, histologic abnormalities, structural abnormalities, or history of renal transplantation.

- A1: ACR <30 mg/g (normal to mildly increased)
- A2: ACR 30-300 mg/g (Moderately increased-microalbuminuria)
- A3: ACR >300 (Severely increased-macroalbuminuria)

Risk Factors for CKD
- Diabetes
- Hypertension
- Cardiovascular Disease
- Family history of kidney failure
- Hereditary kidney disease
- Other diseases (HIV, Hepatitis C, SLE, Glomerulonephritis, Goodpasture's Syndrome)
- Other factors (Elderly, Race-African American, Asians, Hispanics, Pacific Islanders, and American Indians, smoking, and obesity)
- Medications and exposure to toxins/drugs (Lithium, Lead, and certain illegal drugs)

Diagnosing CKD
- Blood tests = Kidney function tests will look at the level of waste products, such as creatinine and urea.
- Imaging tests = an ultrasound may be used to assess the structure and size of the kidneys.
- Urine tests = A sample of urine may reveal abnormalities that could indicate chronic kidney failure. This can also help identify the cause of CKD.
- Sample of the kidney for testing = A biopsy may be done to help determine the cause of the alteration in kidney function.

Treatment and Management
- Blood pressure medications (ACE, ARBs, etc.)
- Laboratory Monitoring
- Dietary Restrictions for sodium, phosphorus, protein, and potassium
- Smoking Cessation
- Blood sugar control
- Avoidance of certain medications (NSAID's, Cox2 Inhibitors, laxatives containing sodium phosphate)
- Other medications require dosage adjustments for renal impairment and some medications can be harmful if present with other disease states such as dehydration. Contrast enhanced imaging studies can cause further renal damage. CT and angiography can result in contrast induced nephrotoxicity and gadolinium contrast dye used in MRI's can result in Nephrogenic Systemic Fibrosis.
- Medications: Phosphate binders for hyperphosphatemia. There are two types that are given depending on the patient's calcium level and intake: non-calcium containing or calcium containing injections that are given for anemia. Cholecalciferol, ergocalciferol, or calcitriol is used to slow the progression of secondary hyperparathyroidism.

CKD usually gets worse over time; therefore, treatment consists of measures to control signs and symptoms, slow progression of the disease and reduce complications. Treatment and management often depends on the stage of CKD. Long term dialysis is required for End Stage Kidney Disease (ESRD) to remove toxic wastes and excess fluid from the body. This can be accomplished through hemodialysis or peritoneal dialysis. Hemodialysis involves the insertion of a fistula (direct connection between the artery and vein) or graft (use of a graft to connect the artery and vein) into the patient's arm. The patient's blood is exchanged through a dialyzer (a semipermeable membrane), which remove wastes and excess fluid and returns the cleansed blood back to the patient. Peritoneal dialysis involves the insertion of a catheter into the peritoneal cavity to administer fluid (dialysate). The dialysate dwells in the peritoneal cavity for a prescribed amount of time and then excess waste and fluid is drained from the abdomen. This process can be performed manually or through the use of a machine. A kidney transplant is also an option for the treatment of ESRD.

Complications of CKD
- Cardiovascular Disease
- Anemia
- Hypertension (HTN)
- Malnutrition
- Mineral and Bone Disease (CKD-MBD) (Hyperphosphatemia, hypocalcemia, and secondary hyperparathyroidism)
- Metabolic Acidosis

HCC Coding and Auditing
Code according to the stage of CKD documented. CKD stage 3 (N18.3), CKD stage 4 (N18.4), CKD stage 5 (N18.5) and ESRD (N18.6) risk adjust. If the stage is not documented, the code would be N18.9 (Chronic Kidney Disease, unspecified), which does not risk adjust. If both a stage of CKD and ESRD are documented, assign code N18.6 only (ICD-10 Guidelines). The I12 category is to be used when both hypertension and a condition classifiable to category N18 (CKD) are present. CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension (ICD-10 Guidelines). If the patient is on dialysis and the provider documents this, remember to code Z99.2 (Dependence on renal dialysis) or Z91.15 (Patient's noncompliance with dialysis), as these also risk adjust. Please note, if the patient has refused the recommended dialysis, the appropriate code would be Z91.15.

Reference:
https://www.mayoclinic.org/diseases-conditions/chronic-kidney-disease/symptoms-causes/syc-20354521
www.webmd.com
https://emedicine.medscape.com/article/238798-overview
https://kdigo.org/wp-content/uploads/2017/02/2017-KDIGO-CKD-MBD-GL-Update.pdf/
https://www.kidney.org/
https://www.davita.com/education
https://www.medscape.org/viewarticle/571558_2
2019 ICD-10-CM Experts for Physicians, Official Guidelines for Coding and Reporting

ISSUE
08
JANUAR 2019

BRINGING THE HIM EXPERTS TO YOU!

The HIM Times

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

We Want To Hear From *You*!

Contact us online or call us today to speak with an expert.

MEDICAL AUDIT RESOURCE SERVICES, INC.

Address:
3040 S. Tuskawilla Rd.
Oviedo, FL 32765

(P) 352.385.1881

(F) 352.385-1884

E-Mail:
marsi@himexperts.com

And don't forget about…

MARSI/AHIMA HCC Online Coder/Auditor Course

Sign up today and enjoy a 15% off discount with code: **HCCCA18**

Please visit:

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

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

Finding lost revenue, defensibly, while training your staff and physicians.

"We do it the right way."

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