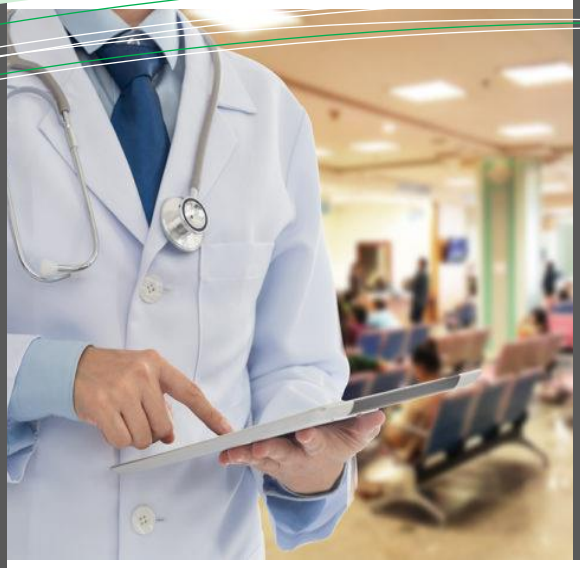
ISSUE
09
MARCH 2019

BRINGING THE HIM EXPERTS TO YOU!

The HIM Times

Welcome Back!



this issue

Embracing Change in Risk Adjustment

Nancy Keenan, RN, CPC, CCS

An important aspect of coding, regardless of what area you are employed, involves keeping up with constant changes - HCC is no different. Recent changes in Risk Adjustment Payment methodology are a result of the requirements of the 21st Century Cures Act. The proposed model changes will begin in 2019, with full implementation in 2022. These changes will be finalized in the 2020 CMS announcement on April 1st. Proposed changes include a Payment Condition Count (PCC) methodology and an alternative PCC methodology. The PCC methodology includes counting the number of payment conditions the patient has with a cap of 10 conditions. In this model, payment starts at 4-6 conditions (payment is not given for 3 or less conditions) depending on the model segment (ex. 4 conditions for community non-dual aged and 5 for community non-dual aged disabled) and a separate payment is not given if the member has more than 10 conditions (the last designated payment is for 10 or more conditions). The alternative PCC model is similar to the first proposed model; however, it also includes the addition of 3 HCC's: Dementia with and without complications and pressure ulcer of the skin with partial thickness skin loss. The proposed risk score calculation for PY 2020 is 50% of the risk score from RAPS (diagnoses from RAPS records and FFS claims) using the 2017 CMS-HCC model with the other 50% of the risk score from EDPS (diagnoses from encounter data, FFS claims, and RAPS inpatient records) using the PCC CMS-HCC Model.

Since Risk Adjustment is always changing, it is important to continuously check the following websites for changes in Risk Adjustment:

- CMS website for Announcements and Documents-early preview, advance notice, and announcements are found on the following link: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/announcements-and-documents.html
- CMS website for the most current ICD-10 mappings are found on the following link: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html
- CMS website for weekly HPMS memos on various topics are found on the following link: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly.html

References:

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part1.pdf
https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2020Part1.pdf

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.

Neoplasm Coding

Kathy Oyler, CCS

Determining how to code and sequence anemia associated with malignancies can be a challenge. Remember, good documentation is key and, unfortunately, queries are often needed to get all the information needed. Luckily, there are guidelines available to help you along the way. Let's take a look at some coding scenarios that benefit from using the appropriate *ICD-10-CM Official Guidelines for Coding and Reporting*.

Anemia due to the malignancy:

Coding Scenario 1: The patient presents with fatigue and weakness. The physician determines that she has severe anemia due to bladder cancer and admits her to the hospital.

The index provides us with the following information:

Anemia (essential) (general) (hemoglobin deficiency) (infantile) (primary) (profound) **D64.9**
in (due to) (with)
- chronic kidney disease **D63.1**
- end stage renal disease **D63.1**
- failure, kidney (renal) **D63.1**
- neoplastic disease (see also Neoplasm) **D63.0**

The tabular provides us with the following information:

D63.0 Anemia in neoplastic disease;
Code first neoplasm (C00-D49)
- Excludes1: aplastic anemia due to antineoplastic chemotherapy (D61.1)
- Excludes2: anemia due to antineoplastic chemotherapy (D64.81)

The *ICD-10-CM Official Guidelines for Coding and Reporting* states:

1) Anemia associated with malignancy: *When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, Anemia in neoplastic disease).* **(Section I.C.2.c.1)**

Following the coding rules and guidelines, the correct coding and sequencing for this scenario is:

C67.9 Malignant neoplasm of bladder, unspecified
D63.0 Anemia in neoplastic disease

In this scenario, even though the admission was to treat the anemia, the guidelines tell us that the malignancy is coded first.

Anemia due to chemotherapy, immunotherapy or radiation therapy:

Coding Scenario 2: The patient presents with extreme fatigue and the physician determines that the patient has anemia due to recent chemotherapy for bladder cancer and admits her to the hospital.

The index provides us with the following information:

Anemia (essential) (general) (hemoglobin deficiency) (infantile) (primary) (profound) **D64.9**
due to (in) (with)
- antineoplastic chemotherapy **D64.81**

The tabular provides us with the following information:

D64.81 Anemia due to antineoplastic chemotherapy
Antineoplastic chemotherapy induced anemia

The *ICD-10-CM Official Guidelines for Coding and Reporting* states:

2) Anemia associated with chemotherapy, immunotherapy and radiation therapy: *When the admission/encounter is for management of an anemia associated with an adverse effect of the administration of chemotherapy or immunotherapy and the only treatment is for the anemia, the anemia code is sequenced first followed by the appropriate codes for the neoplasm and the adverse effect (T45.1X5-, Adverse effect of antineoplastic and immunosuppressive drugs).*

When the admission/encounter is for management of an anemia associated with an adverse effect of radiotherapy, the anemia code should be sequenced first, followed by the appropriate neoplasm code and code Y84.2, Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure. **(Section I.C.2.c.2)**

Following the coding rules and guidelines, the correct coding and sequencing for this scenario is:

D64.81 Anemia due to antineoplastic chemotherapy
C67.9 Malignant neoplasm of bladder, unspecified
T45.1X5A Adv. effect of antineoplastic & immunosuppressive drugs

Coding Scenario 3: The patient presents with extreme fatigue and the physician determines that the patient has anemia due to recent radiation treatments and admits her to the hospital.

The index provides us with the following information:

Anemia (essential) (general) (hemoglobin deficiency) (infantile) (primary) (profound) **D64.9**
aplastic **D61.9**
- congenital **D61.09**
- drug-induced **D61.1**
due to
- drugs **D61.1**
- external agents NEC **D61.2**
- infection **D61.2**
- radiation **D61.2**

The tabular provides us with the following information:

D61.2 Aplastic anemia due to other external agents;
Code first, if applicable, toxic effects of substances chiefly nonmedicinal as to source (T51-T65)

Following the coding rules and guidelines, the correct coding and sequencing for this scenario is:

D61.2 Aplastic anemia due to other external agents
C67.9 Malignant neoplasm of bladder, unspecified
Y84.2 Radiolog proc/radiothrpy cause abn react/compl, w/o misadvnt

The documentation must link the anemia to the malignancy, chemotherapy, or radiation therapy to code the above scenarios. If the documentation is not clear then you will need to query the physician.

Follow the appropriate general and chapter guidelines when the physician documents that the cause is due to a diagnoses unrelated to the malignancy or treatment of a malignancy.

Reference:
ICD-10-CM Official Guidelines for Coding and Reporting FY2019 Page 31

Do Your Facility Acuity Levels Meet CMS Guidelines?

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

Despite the fact that CMS has granted each facility the ability to develop their own acuity model (Federal Register, Volume 72, No. 227, page 66805), there are still requirements that must be met in order to be in compliance with CMS/Medicare guidelines.

The acuity methodology adopted by each facility may be calculated by patient severity, time, interventions or any combinations of methods as long as the facility uses their model consistently. There are also a number of organizations who have developed guidelines such as AHIMA and ACEP which may be of use in developing/reviewing the facility acuity level system.

However, CMS makes it clear, that despite these different methodologies, certain elements must still be met including:

- Based on hospital facility resources NOT physician resources
- Should only require documentation that is clinically necessary for patient care
- Not facilitating "gaming" or "up-coding"
- Being readily available to CMS/MAC to review
- Must be applied consistently across patients seen in the facility's ED
- Should follow the intent of the CPT descriptors for 99281-99285 in that the acuity system should relate to the intensity of hospital resources to the different levels of effort represented by the CPT code(s)

Therefore, CMS has told us that they expect the ED Levels 99281-99285 to equate to the facility resources utilized as they relate to the CPT descriptors. So, let's take a look at the descriptors for these services in CPT:

99281 **Emergency Department Level 1**
Presenting Problem: Self Limited/Minor
Problem Focused History/Exam
Straightforward Medical Decision-Making

99282 **Emergency Department Level 2**
Presenting Problem: Low/Moderate Severity
Expanded Problem Focused History/Exam
Low Medical Decision-Making

99283 **Emergency Department Level 3**
Presenting Problem: Moderate
Expanded Problem Focused History/Exam
Moderate Medical Decision-Making

99284 **Emergency Department Level 4**
Presenting Problem: High Severity
Detailed History/Exam
Moderate Medical Decision-Making
Requires Urgent Evaluation by Provider, Does not Pose Immediate, Significant Threat to Life/Physiological Function

99285 **Emergency Department Level 5**
Presenting Problem: High
Comprehensive History/Exam
High Medical Decision-Making
Poses an Immediate, Significant Threat to Life/Physiological Function

So, for example, despite the fact that the facility's acuity level equates to a 99285, if the problem does not pose an immediate, significant threat to life/physiological function, and, is not of high complexity, CMS does not feel the acuity level should be assigned a 99285. An example would be an ankle sprain. While this may require urgent evaluation, in most cases, the patient's condition did not pose a significant threat to life/physiological function and, therefore, despite the acuity points accumulated in the acuity level process, would not be assigned 99285.

MARSI would recommend that whatever acuity system your facility utilizes, including a computer-based system, that your facility review a representative sampling to **make certain** your acuity level assignments for your facility will meet the CMS definition for the appropriate level of service. This exercise should be performed on a regular basis, and the results recorded as part of your facility's compliance plan.

ISSUE
09
MARCH 2019

BRINGING THE HIM EXPERTS TO YOU!

The HIM Times

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

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.

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.

March 2019: Issue 9

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

MARSI
MEDICAL AUDIT RESOURCE SERVICES INC.