19 ISSUE – February 2022
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INSIDE THIS ISSUE:

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SIGNIFICANT CHANGES TO CPT CODING FOR 2022

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

While the number of CPT code changes for 2022 was significantly lower than it was in previous years, there were several important changes from a billing/coding perspective:

Addition of Principal Care Management Codes (CPT codes 99424-99427)

The addition of these codes adds another opportunity to capture the services performed by a qualified health care professional (QHCP), or clinical staff, when evaluating and managing one complex chronic condition that places a patient at significant risk of hospitalization, acute exacerbation, functional decline, or death. A complex chronic condition is defined as a condition that requires development, monitoring, or revisions of a disease-specific care plan, including frequent adjustments to medications, and/or management of a condition that is unusually complex due to comorbidities.

A minimum of 30 minutes per calendar month are required for the initial code, as well as ongoing communication, and care coordination between relevant practitioners who are furnishing care.

Additions/Clarification of E/M Office/Outpatient Codes

Following the implementation of the 2021 Office/Outpatient codes in January 2021, CPT released additional guidelines to clarify the correct “counting of elements”, and further define services. The following clarifications were made:

Counting of Tests

A unique code is defined as those services identified with one (1) CPT code. For example, CPT code 80050 would be considered “1”, and includes a CMP, CBC, and TSH. Tests “ordered”, and the same tests “reviewed”, will be counted only once. AMA states:

“Ordering a test is included in the category of test results, and the review of the test result is part of the encounter and not a subsequent encounter.” [1]

Elective/Emergency Surgery Further Defined

Additional clarification of elective vs emergency surgery was provided. Emergency surgery has been defined as a procedure that is performed immediately, or with minimal delay, to allow for patient stabilization, while elective surgery is defined as a planned service.

Please www.ama-assn.org for additional CPT coding and guidance.

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SIGNIFICANT CHANGES TO CPT CODING FOR 2022 - *CONT.*

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

Changes to Closed Fracture Care Definition

Effective 01/01/22, CPT has redefined the closed fracture to indicate that casting, splinting, or strapping used solely to temporarily stabilize a fracture for patient comfort will no longer be considered closed treatment of a fracture.

Split Shared Services Changes

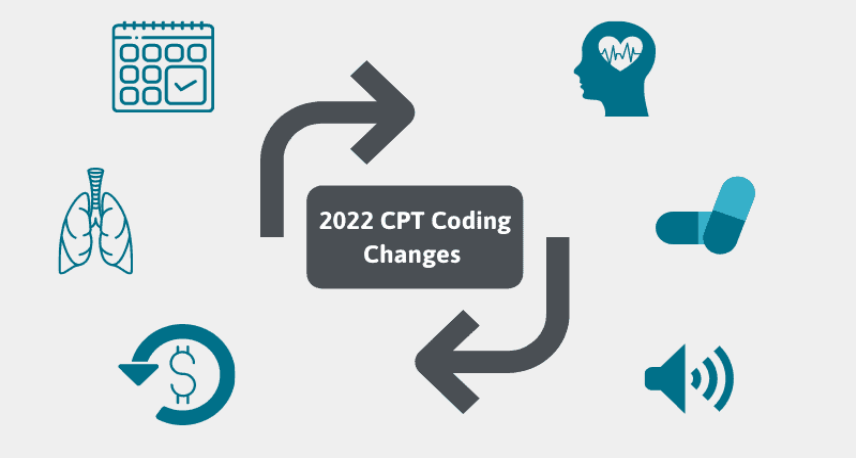
New changes to billing split/shared services require that the actual billing provider perform a "substantive" portion of the visit (i.e., Hx, Exam MDM, and/or time) as well as an updated modifier -FS to ensure that split/shared services are identified. In addition, documentation must identify both individuals who are performing the service, with the individual qualifying to bill for the service also signing/dating the record.

Critical Care Services in Addition to E/M Services

Providers can now submit claims for critical care and other E/M services may be billed on the same day if the other E/M was medically necessary and if there are no duplicate elements from the critical care visit provided later, for the same DOS.

Colorectal Screenings Converted to Diagnostic Colonoscopy

Medicare recipients that are scheduled for a screening colonoscopy, which then turns into a diagnostic colonoscopy, are currently required to pay a coinsurance/deductible for these services. This has been a difficult concept for Medicare recipients to comprehend over the years.



The coinsurance amount for these visits will be reduced to 20% starting in 2022, the then to 15% from 2023 to 2026, 10% for calendar years 2027 through 2029, and 0% by 2030.

For additional updates, please refer to your 2022 CPT or reference the Medicare Physician Fee Schedule (MPFS) Final Rule.

Sources:

1. https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

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VENOUS STASIS ULCER

Author: Heather Campbell (Ernest), LPN, COC, CPC, CRC

Coding for venous stasis can be a bit tricky, especially if the documentation states that the patient has an ulcer. Oftentimes, the documentation will state that the patient has an ulcer due to venous stasis, without providing offers clarification. When indexing a stasis ulcer, the ICD-10 directs the coder to see varix leg with ulcer or without varicose veins (I87.2). Coding Clinic (CC) states, "A basic rule of coding is that further research is done if the title of the code suggested by the Index does not identify the condition correctly" (CC 3rd Q 2017, pg. 24) . Therefore, even though the Index directs you to a code that involves varicose veins, the I83 category of codes would not be assigned when varicosities are not present. There must be documentation of varicose veins in order to use the I83 codes.

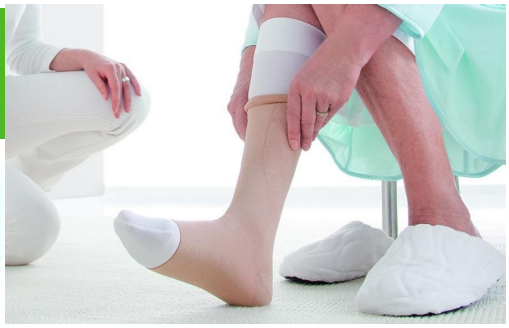
For Risk Adjustment (RA), Venous Insufficiency/Stasis Dermatitis…

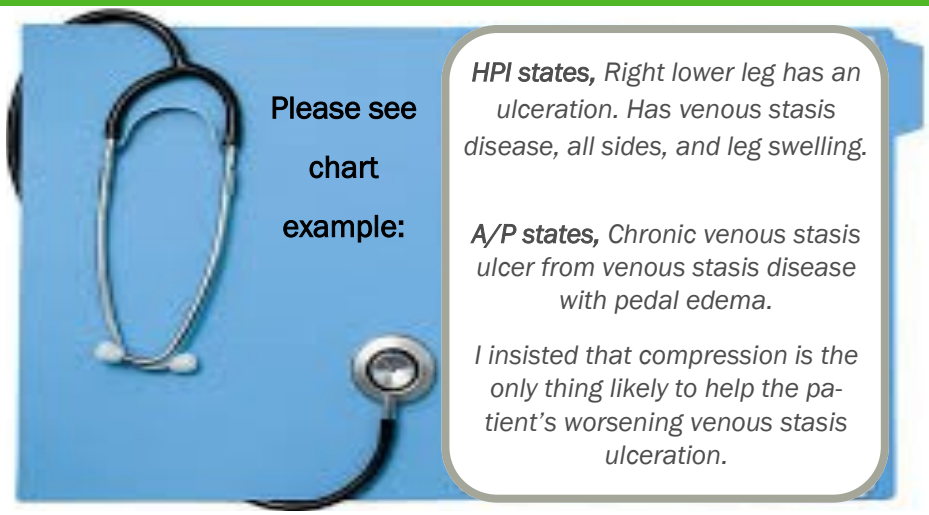
Code (I87.2) does **not** adjust for risk.

The I83 category of codes, which contain varicose veins with ulcer, as well as the I87.31 codes (Chronic Venous Hypertension with Ulcer) RA in HCC 107, **does** adjust for risk.

VENOUS STASIS ULCER - *CONT.*

Author: Heather Campbell (Ernest), LPN, COC, CPC, CRC





Please see chart example:

HPI states, *Right lower leg has an ulceration. Has venous stasis disease, all sides, and leg swelling.*

A/P states, *Chronic venous stasis ulcer from venous stasis disease with pedal edema.*

I insisted that compression is the only thing likely to help the patient's worsening venous stasis ulceration.

Correct coding assignment of the above scenario would be:

1. Stasis, ulcer without varicose veins – Venous insufficiency (chronic) (peripheral)-I87.2[2]
2. Ulcer, right lower leg-L97.919 (HCC 161)[3]

   I87.2 does not adjust for risk. Clarification from the provider would be necessary to determine if a code from I83 - varicose veins of lower extremity with ulcer, would be more appropriate.

#1	#2
Stasis	Ulcer, ulcerated, ulcerating, ulceration, ulcerative
ulcer - see Varix, leg, with, ulcer without varicose veins **I87.2**	leg - see Ulcer, lower limb
I87.2 Venous insufficiency (chronic) (peripheral) Stasis dermatitis **Excludes1:** stasis dermatitis with varicose veins of lower extremities (I83.1-, I83.2-)	lower leg NOS **L97.909** right **L97.919**

[4]

Sources:

1. ICD-10-CM Official Guidelines for Coding and Reporting (cms.gov)
2. 2022 ICD-10-CM Diagnosis Code I87.2: Venous insufficiency (chronic) (peripheral) (icd10data.com)
3. 2022 ICD-10-CM Diagnosis Code L97.919: Non-pressure chronic ulcer of unspecified part of right lower leg with unspecified severity (icd10data.com)
4. ICD-10-CM 2021 Professional for Physicians

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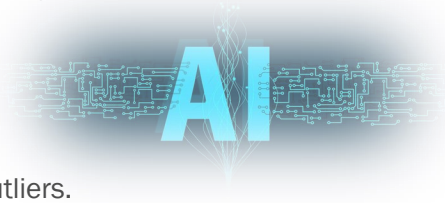
A NOTE FROM DR. HUSTY

Almost daily, I read someone's opinions about the promise of accurate coding using Artificial Intelligence (AI) and Natural Language Processing (NLP). Personally, we have been involved with that part of our industry for almost 15 years. The promise of AI and NLP will be fulfilled, but first we must consider *GIGO*...Garbage In, Garbage Out (or *PIPO* or *SISO*).



Artificial Intelligence learns from new data coming in, old data and identifies, or "learns", relationships. As more data comes in, the AI is constantly improving upon itself, in theory. If the data is reasonably accurate, the algorithms can "learn" relationships by weeding out the outliers. But what if the data is 50% flawed? Which one is the outlier? When you really dig into the essence of artificial intelligence, there is agreement that it does depend on reasonably accurate data.

Natural Language Processing is the recognition of words and phrases by a computer. NLP includes an "understanding" by the computer of those words and phrases, it can then use that information in making decisions through algorithms. The science of NLP is constantly being refined and improved. It includes not just *typed* characters, but also *verbal* language, and even *hand printed* characters, although not perfectly accurate. But consider the rock solid fact that most audit findings are due to problems with documentation, whether it's erroneous, incomplete, contradictory or simply absent. It is hard for any system to read between the lines, especially when the lines are filled with so much error if filled in at all. NLP cannot find everything.

We have told our associates with whom we work in the industry that we have faith in the development of these highly advanced computer-assisted programs, but we strongly feel that first you need to improve documentation. The data generated by documentation in the majority of practices, hospitals, facilities and healthcare systems in the US is very flawed. There are isolated and impressive exceptions, where physicians have been trained and have changed their documentation, such as hospitals that have focused on the quality of inpatient documentation, or practices that have focused on the quality of their documentation. AI and NLP probably have reasonable utility in those practices.

However, change is slow, especially with physicians and healthcare, and it will be years before most practices are up to speed. Until that time, we rely on the most advanced computer system in the world, the human brain, to identify not only obvious errors, but to read between the lines with an understanding of the entire record, the individual patient, medical care in general and physician practice patterns. It is an awesome endeavor that utilizes awesome individuals who are not likely to be replaced in the foreseeable future.