22 ISSUE – August 2022
Bringing the Experts to You

The HIM Times Newsletter

MARSI
MEDICAL AUDIT RESOURCE SERVICES
An HMA Company

INSIDE THIS ISSUE:

Did You Know?

MARSI OFFERS TRAINING COURSES :

- MARSI Training Courses can be customized to your needs.
- Outpatient, Inpatient and Risk Adjustment Presentations for Office Staff and Clinical Providers.
- Risk Adjustment School

Send an Inquiry through HIMExperts.com

SIGNIFICANT E/M CHANGES ON THE WAY FOR 2023

Author: Kayla Walker, CCS, CPC-A

The end of the year is fast approaching and with that usually comes coding changes. Effective **January 2023** many changes are being made, once again, to the **CPT E/M** coding section. In an attempt to streamline the split between office visits and facilities the following changes will be made.

All **introductory guidelines** for the following will be revised:

- ⇒ Hospital inpatient and observation care services
- ⇒ Consultation codes
- ⇒ Emergency department services
- ⇒ Nursing facility services
- ⇒ Home/resident services
- ⇒ Prolonged services

These codes/code ranges will be **deleted entirely:**[1]

- ⇒ Hospital Observation services *99217-99220*
- ⇒ Subsequent Observation services *99224-99226*
- ⇒ Consultation codes *99241* and *99251*
- ⇒ Nursing facility service code *99318*
- ⇒ Domiciliary, rest home, (i.e. Boarding home) or custodial care services *99324-99328* and *99334-99337*
- ⇒ Home service code *99343*
- ⇒ Prolonged services *99354-99357*

Additional Changes:

- New prolonged services code- 993X0 with guidelines
- Emergency department services will not have any code changes but will see some changes in the guidelines.
- The MDM -medical decision-making table will also receive changes.

Be sure to check out the AMA website for a closer look at all these changes ahead. Please see future issues of our newsletter for further information and suggestions for implementation. These are some of the most significant volume of E/Ms changes in decades, so there will be a lot of preparation required to implement these codes correctly.

Sources:

1. American Medical Association (ama-assn.org)

ENCEPHALOPATHY

Author: Jaime Walter , RHIA

Encephalopathy is defined as any disseminated brain disease that changes or impairs brain function or structure. Encephalopathy is caused by a variety of conditions.

Infectious agents (such as bacteria, virus, or prion)	Chronic progressive trauma
Brain tumors or increased pressure in the skull	Poor nutrition
Prolonged exposure to toxic elements (including solvents, drugs, radiation, paints, industrial chemicals, and certain metals)	Lack of oxygen or blood flow to the brain

[1]

The neurological signs and *symptoms* depend upon the type and the severity of the encephalopathy and may range from progressive memory and cognitive ability loss to dementia. Encephalopathy may be temporary or permanent. There is no one specific test to diagnose encephalopathy. A diagnosis of encephalopathy is based on symptoms. Providers may *diagnose* encephalopathy from blood and spinal fluid tests such as CBC, drug screen, urine cultures, imaging (such as CT or MRI scans), and/or electroencephalograms (EEGs) to determine the root cause of the disease. *Treatment* may vary depending upon the underlying cause. There will be a focus on removing the precipitating factors and normalizing systemic function.

For example:

A patient with septic encephalopathy will require treatment of the underlying infection. Drugs that may relieve symptoms of encephalopathy may include *Haldol* (neuroleptic) which has an antipsychotic effect and dopamine-receptor blockage in the central nervous system, Vitamin B1/thiamine, and other electrolytes.

Codes for encephalopathy may be found in various chapters depending upon the pathophysiology of the disease.

Common types include:

- Hepatic, a result of liver disease
- Alcoholic, a result of alcohol abuse or dependence
- Metabolic: due to infections, toxins, organ failure
- Toxic-Metabolic, a result of infections, toxins, drugs, or organ failure
- Septic, associated with a septic inflammatory response
- Hypertensive, a consequence of severely high blood pressure
- Hypoxic, an effect of a lack of oxygen to the brain
- Post traumatic, due to blows to the head

ENCEPHALOPATHY

Author: Jaime Walter , RHIA

Reference AHA Coding Clinic 4Q 2003 pgs. 58-59 which states that *"Encephalopathy is always due to an underlying condition."* [2] It is necessary that providers document the following information in the medical record to ensure encephalopathy is correctly coded.

- ☑ **Type** of encephalopathy (metabolic, toxic, hepatic, alcoholic, anoxic/hypoxic, hypertensive)
- ☑ **Description** of symptoms and manifestations of the encephalopathy to support the diagnosis and demonstrate severity and complexity of the patient's condition
- ☑ Underlying **cause** of encephalopathy. The provider should link the related conditions
- ☑ **Additional information** as required by instructions in the code book, such as: Vaccination information; Alcohol or substance use, abuse, or dependence; Medications; Organ failure Causative organisms; Type and location of cancer.

Refer to the following list of AHA Coding Clinics that discuss encephalopathy.[3]

This may not be an all-encompassing list.

- 1Q 2017 pgs. 39-40
- 1Q 2022 pg. 52
- 2Q 2016 pg. 35
- 2Q 2021 pg. 3
- 1Q 2021 pg. 13
- 2Q 2017 pgs. 8-9

Encephalopathy is often frequently under coded/under documented as confusion or delirium, which does not truly reflect the severity of the patient's illness. The term encephalopathy is needed to capture a true picture of the patient's condition and prevent understating the severity of illness of patients. When documentation in the medical record indicates delirium and/or altered status and systemic toxic or metabolic factors are present, and the patient improves after the abnormalities are corrected, it would be appropriate to query the provider for a more specific diagnosis of encephalopathy.

Sources:

1. https://www.ninds.nih.gov/health-information/disorders/encephalopathy#:~:text=Encephalopathy%20may%20be%20caused%20by,metals)%2C%20chronic%20progressive%20trauma%2C
2. AHA Coding Clinic 4Q 2003 pgs. 58-59
3. https://www.codingclinicadvisor.com/

22 ISSUE – August 2022
Bringing the Experts to You

The HIM Times Newsletter

MARSI
MEDICAL AUDIT RESOURCE SERVICES
An HMA Company

MAJOR DEPRESSIVE DISORDER

Author: Kim Logan, BS, COC, CRC, CPMA

Major Depressive Disorders F32-F33.9

HCC Category 58:

These codes are found within the block of codes termed **Mood (Affective) Disorders** F30-F39. *"A major depressive disorder consists of a syndrome of mood, physical and cognitive symptoms that occurs at any time of life".*[1]

The AHA Coding Handbook defines affective disorders as *"Common mental diseases with multiple aspects, including biologic, behavioral, social, and psychological factors. Major depressive disorder, bipolar disorder, and anxiety disorders are the most common affective disorders. Major depressive disorder is also known as monopolar depression or unipolar affective disorder. MDD causes prolonged periods of emotional, mental, and physical exhaustion."* [2]

Fourth Quarter Coding Clinic, 2021 includes ICD-10-CM New/Revised Codes: Depression Not otherwise specified. "A code has been created to identify depression (unspecified), and the narrative at category F32 was revised from "Major depressive disorder, single episode" to "Depressive episode." This retitling brings back the WHO ICD-10 category title and brings the title into better alignment with all of what has been included in the category". [5]

A new code, **F32.A** Depression, unspecified, has been added. This code includes *Depression NOS* and *Depressive disorder NOS*.

"Previously in ICD-10-CM, the default for Depression not otherwise specified (NOS) was code F32.9, Major depressive disorder, single episode, unspecified. However, this code did not separately capture the actual occurrence of depression not further specified, and statistically inflated the incidence of major depressive disorder".[5]

Therefore, after 10/01/2021, if "Depression" is documented, the correct code is **F32.A,** and if "mild depression" is documented, the same still holds true, this would be coded as **F32.A**.

After 10/01/2021, in order to code **F32.0**, "Major depressive disorder, single episode, mild" must be documented.

It is important for the provider to document to the highest specificity known at the time of the encounter. This would include a single episode or recurrent episode, the level of depression (mild, moderate, or severe), with or without psychotic features, or whether the patient is in partial, full, or unspecified remission.

F32.XX is for single episode of MDD, and **F33.XX** is for recurrent episodes of MDD. Categories F32 and F33 are further subdivided with fourth characters, and sometimes fifth characters, to provide information about the current severity of the disorder. Fourth characters 1 through 8 are assigned only when provider documentation of severity is included in the medical record.

22 ISSUE – August 2022
Bringing the Experts to You

The HIM Times Newsletter

MARSI
MEDICAL AUDIT RESOURCE SERVICES
An HMA Company

MAJOR DEPRESSIVE DISORDER

Author: Kim Logan, BS, COC, CRC, CPMA

Signs/Symptoms of Depression:

- Depressed mood most of the day, nearly every day, as indicated in the subjective report or in observation made by others.
- Markedly diminished interest in pleasure in all, or almost all, activities most of the day and nearly every day.
- Significant weight loss when not dieting or weight gain, for example, of more than 5 percent of body weight in a month or changes in appetite nearly every day.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day.
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt.
- Diminished ability to think or concentrate, or indecisiveness nearly every day.
- Recurrent thoughts of death.

[3]

Treatment for Major Depressive Disorder can include anti-depressant medications, cognitive behavioral therapy, psychotherapy, and ECT (electroconvulsive therapy), or a combination of these. Look for medications such as SSRIs including sertraline, escitalopram, citalopram, fluoxetine, paroxetine; antidepressants including bupropion, venlafaxine, and mirtazapine; anxiolytics such as buspirone; and antipsychotics such as aripiprazole.

When looking for documentation in the patient's chart, look for any of the above-mentioned signs/symptoms, whether the physician refers to depression screening such as PHQ-9, PHQ-2, or Beck Depression Inventory for Primary Care, or stating the score of these tests. Look for any of the medications mentioned above that are directly linked to MDD, referrals to psychiatrist or psychologist, and look for documentation of any psychiatric findings on physical exam.

Sources:

1. Current Medical Diagnosis and Treatment, 2017, McGraw-Hill Lange, pgs 1075-1079
2. AHA Coding Handbook: Chapter 16 Mental Disorders
3. https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007?utm_source=Google&utm_medium=abstract&utm_content=Major-depression&utm_campaign=Knowledge-panel
4. https://www.webmd.com/depression/guide/major-depression#2
5. Coding Clinic Fourth Quarter 2021

22 ISSUE – August 2022
Bringing the Experts to You

The HIM Times Newsletter

MARSI
MEDICAL AUDIT RESOURCE SERVICES
An HMA Company

A NOTE FROM DR. HUSTY

Artificial Intelligence Versus Real Intelligence

A Meeting of the Minds?

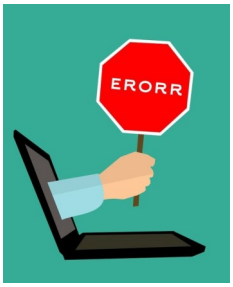
I have to be careful here. We have worked with and continue to work with many of the algorithm driven *AI* supported vendors that are out there. We've seen the good and the bad. We've seen improvement and continued hurdles. We are also seeing a realization in the industry that there are, so far, imperfections.

Why is that?

What are the imperfections?

First, we know that *artificial intelligence* works by way of gathering countless millions of data points from medical records in a relatively short period of time. Some of these are simple and incontrovertible. But others are related to documentation and coding. The machine learns from this data. But what do we know about the data, especially the documentation and coding?

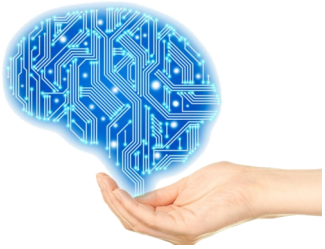
It is full of error! It is using error as part of its foundation.



Coders/auditors see the same error but, they apply knowledge about what should be or is likely to be if there was no error. They apply a knowledge of medicine, both pathological and normal, and make complex decisions based on facts, inference, logic and knowledge. I always say that if documentation were excellent, coding would be easy… I might even be able to do it.

The problem is coders/auditors are, by comparison with super chugging computer systems, very slow.

The solution is more like a marriage where the individuals bring different things to the relationship. The strength is in the relationship not the individual parts. Coder/auditors need to keep sticking their nose into charts in conjunction with the computer systems that flag possibilities. But, this is still highly dependent on the humans involved. Get the best of both worlds!



The HIM Times Newsletter

MARSI
MEDICAL AUDIT RESOURCE SERVICES
An HMA Company

A NOTE FROM DR. HUSTY

This union of machines that look through tons of data and humans who read between the lines can find missing diagnoses, but can also find diagnoses that were not supported with adequate documentation. Compliance matters. The best of both worlds!

FHIMA Annual Convention 2022

We Look Forward to Starting a Conversation

Do you have **Denials?**
We can **Manage** *that!*
Sound **Appealing?**

For more information reach out to your
MARSI point of contact or **MARSI Denial Management**