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Welcome Back!

this issue

Summary of the 2019 Medicare Physician Fee Schedule Final Rule

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

On November 1, 2018, CMS released the CY2019 Medicare Physician Fee Schedule (PFS) Final Rule. The proposed E/M changes discussed by CMS and included in our last newsletter were scaled back and many of the requirements were delayed until 2020-2021. For CY2019, CMS finalized ONLY the following in regards to the E/M changes originally proposed:

- Need to justify providing a home visit versus an office visit
- Changed the required documentation of a patient's history to focus only on the interval history since the last documented visit
- Eliminated the need for providers to re-document information already documented in the patient record by practice staff or the patient

CMS made the decision to not move forward with the following:

- Reduction in payment for E/M with procedure on same encounter date
- Establishment of separate podiatry codes for E/M services

Modifications to the other E/M proposals to be instituted in 2020-2021 were made as follows:

- Flat rate E/M for 99202-99205 and 99212-99215 was changed to reflect only 99202-99204 and 99212-99214 levels of service. Level 1 and Level 5 visits would not be affected by the establishment of a flat rate reimbursement for E/M services.
- Changes to allow greater flexibility and reduce the burden in E/M documentation. These changes will allow providers to utilize MDM, time, or applying the 1995 or 1997 E/M documentation guidelines.
- Add on codes that allow for additional resources inherent in primary care and specific specialties
- Implementation of new prolonged services codes

CMS did make effective in CY 2019 separate payments for additional telehealth services that will not be subject to the limitations placed on other Medicare telehealth services such as:

G2012 Brief Communication Technology-Based Service (Virtual Check In)
Used to determine whether an office visit or other service is warranted
Not allowed if related E/M past 7 days or leads to an E/M service

G2010 Remote Evaluation of Pre-Recorded Patient Information
Physician use of recorded video and/or images captured by patient to evaluate patient's condition
Billable if no resulting E/M visit and no E/M within previous 7 days

99446 Interprofessional Internet Consultation
99452 Consultation between treating provider and consultant
Expansion of telehealth services for the treatment of opioid use disorder and other substance abuse

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

(P) 352.385.1881

(F) 352.385-1884

E-Mail:
marsi@himexperts.com

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Understanding Laterality

Kathy Oyler, CCS

The number of diagnosis codes drastically increased with the implementation of ICD-10 in 2015. Much of this increase involved laterality, meaning, specifying right, left, and/or bilateral diagnoses when coding. Identifying laterality is extremely important in accurate code assignment. Here are a few tips to help guide you through the process.

Per *ICD-10-CM Official Guidelines for Coding & Reporting*:

- If a condition is bilateral and a code exists for bilateral, use the bilateral code.
- If a condition is bilateral and a code does not exist for bilateral, assign both the left and right side codes.
- If a condition is bilateral and each side is treated during separate encounters, assign the bilateral code for the first encounter to treat the first side. For the second encounter, assign the appropriate unilateral code if the patient no longer has the condition on the side that was previously treated. If treatment on the first side did not resolve the condition, however, you would still assign the bilateral code.

Characters for laterality:

"1" right side
"2" left side
"3" bilateral
"0" as 5th digit to 5-character codes "unspecified"
"9" as 6th digit to 6-character codes "unspecified"

Please note, "Unspecified" codes are typically a target for audits and payer denials and, therefore, should be used as a last resort. If laterality is not clearly documented, query the provider for further specificity.

Choosing the right code(s) for laterality is not always easy. Follow the coding guidelines and latest updates for accurate code assignment when identifying laterality.

We hope the examples below help strengthen your understanding of laterality coding.

What's THE Code?!

Coding Scenario 1: A patient has bilateral traumatic arthritis of the ankles. The ICD-10-CM codebook will direct you to M12.57X. Upon reviewing that code, though, you will notice that there is not a bilateral code. Because of this, you will have to report two codes (one for each side). Correct ICD-10-CM coding for this scenario is:

M12.571 Traumatic arthropathy, right ankle and foot
M12.572 Traumatic arthropathy, left ankle and foot

Coding Scenario 2: A patient has bilateral primary osteoarthritis of both hips and is being admitted for a right hip replacement. Correct ICD-10-CM coding for this scenario is:

M16.0 Bilateral primary osteoarthritis of hip

Coding Scenario 3: The above patient in scenario 2 is subsequently admitted for a left hip replacement. Correct ICD-10-CM coding for this scenario is:

M16.12 Unilateral primary osteoarthritis, left hip
Z96.641 Presence of right artificial hip joint

Glasgow Coma Scale Score

Kathy Oyler, CCS

The Glasgow Coma Scale (GCS) score was developed by two Professors of Neurosurgery at the University of Glasgow's Institute of Neurological Sciences to assess the status of the central nervous system. The GCS score is computed from the amount of eye opening, verbal response, and motor response of the patient.

Per the *ICD-10-CM Official Guidelines for Coding and Reporting* (Effective Oct. 1 2018 – Sep. 30 2019) the GCS score codes (R40.2-):

- Can be used in conjunction with traumatic brain injury codes, acute cerebrovascular disease or sequelae of cerebrovascular disease codes.
- Are primarily used for trauma registries, but can also be used in any setting where this information is collected (e.g. ED, Acute IP, SNF, Rehab facility, etc.).
- May also be used to assess the status of the central nervous system for other non-trauma conditions.
- Should be sequenced after the diagnosis code(s) (secondary diagnoses only).
- One code from each category is needed to complete the GCS and the 7th character should match for all three codes.
- 7th character indicates the time in which the GCS was recorded (0 – unspecified time, 1 – EMT or ambulance, 2 – at arrival to ED, 3 – at hospital admission, or 4 – 24 hours or more after admission).
- At a minimum, report the initial GCS score documented on presentation; however, if desired, a facility may choose to capture multiple GCS scores.
- Assign total GCS scores only when the individual scores are not documented.
- Do not report codes for individual or total GCS scores for a patient with a medically induced coma or a sedated patient.

Additional coding guidelines that further explain the GCS state that you may code from the documentation of other qualified healthcare practitioners legally accountable for establishing the patient's diagnosis; however, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

As stated in the guidelines, all three scores are required to complete the GCS. Take a look at the note for **R40.2 Coma** in the *2018 ICD-10-CM Codebook*:

- **R40.2 Coma**
  - **Code first** any associated:
    - Fracture of skull (S02.-)
    - Intracranial injury (S06.-)
  - **Note:** One code from each subcategory, R40.21-R40.23, is required to complete the coma scale.

Coding the GCS score can also impact the DRG. In fact, some of the GCS scores are MCC's when grouped with certain diagnoses. Please see the below example on how adding the GCS score can affect the DRG and the payment that you facility receives.

We recommend training staff on properly documenting the GCS. Accurate and complete documentation is ***essential!***

What's THE Code?!

Example: Patient admitted with a CVA. The ED nurse documents the GCS as eyes open – never; best motor response – none; best verbal response – none.

If the appropriate codes for the GCS scores are included, the DRG will be 064 – intracranial hemorrhage or cerebral infarction with MCC.

I63.9 Cerebral infarction, unspecified
R40.2112 Coma scale, eyes open, never, at arrival to emergency department
R40.2312 Coma scale, best motor response, none, at arrival to emergency department
R40.2212 Coma scale, best verbal response, none, at arrival to emergency department

If the codes for the GCS are not included, the DRG would be 066 – intracranial hemorrhage or cerebral infarction without CC/MCC.

I63.9 Cerebral infarction, unspecified

Myocardial Infarction

I21.XX – I22.9

Kim Logan, MT, COC, CRC, CHCCS

HCC 86

Myocardial Infarctions:

The cause of a myocardial infarction is often because of atherosclerotic buildup of fatty plaque and other material inside the artery. The plaque is covered by a lining of fibrous material. That lining can rupture, allowing the plaque to be released and a blood clot to form. (John Hopkins website).

Symptoms of MI can vary, not only among individuals, but also between men and women. The most common symptoms found in both genders include breaking out into a cold sweat, weakness, light-headedness, syncope, dyspnea, orthopnea, nausea and vomiting, or abdominal bloating; all symptoms either occurring singly or in any combination. The heart rate may range from marked bradycardia to tachycardia, and the blood pressure may be high or low, depending on if the individual is in shock. (Current Medical Diagnosis and Treatment 2017, McGraw Hill/Lange, pg. 370).

Lab values and testing to look for MEAT when coding myocardial infarction include CK-MB, troponin I and troponin T, ECG, chest radiography and echocardiography. Of note, we cannot code from results of these tests unless the physician interprets the findings in his/her documentation.

Initial treatment of myocardial infarctions include aspirin and P2Y inhibitors (Plavix, Brilinta). Reperfusion therapy (either primary percutaneous intervention or fibrinolytic therapy (t-PA)) should be done in patients who seek medical attention within 12 hours of the onset of symptoms.

Treatments ordered status post MI: Patients often receive antiplatelet agents, a statin (atorvastatin), a beta blocker, and Ace inhibitors, as preventative measures.

I21 category codes:

Used for Myocardial infarction with a duration of 4 weeks or less, including transfers to another acute setting or post-acute setting.

Type 1 (I21.0-I21.4, I21.9):

- Caused by a coronary thrombosis at the site of existing arteriosclerotic stenosis.
- Includes NSTEMI (I21.4) and STEMI (I21.0-I21.2, I21.3) which is further classified according to the wall or artery affected.
- If a Type 1 NSTEMI evolves to an STEMI, assign the code for the STEMI.
- If a Type 1 STEMI converts to a NSTEMI due to thrombolytic therapy, assign the code for STEMI.
- I21.9 is used for unspecified Type 1 Myocardial infarction/Unspecified Acute MI/Unspecified Myocardial Infarction (this is a new code as of 10/1/17).

Type 2 MI (I21.A1):

- Caused by demand ischemia or ischemia imbalance from conditions such as anemia, heart failure, paroxysmal tachycardia, renal failure, shock, COPD, etc.
    - If a Type 2 AMI is described as a NSTEMI or STEMI, only assign code I21.A1.

Type 3, 4, (A, B, and C) and Type 5 (I21.A9):

- Type 3 MI is assigned when the patient expires from a presumed cardiac etiology without confirmatory cardiac biomarkers.
- Type 4 MI's are associated with percutaneous coronary intervention (Angioplasty), stent thrombosis, or restenosis equal to or greater than 50% after an initially successful PCI.
- Type 5 MI is assigned when it occurs in association with a Coronary Artery Bypass Graft (CABG).

I22 Category codes:

- Used for Subsequent Myocardial Infarction.
- Used when a new MI (Type 1 or unspecified) occurs within the 4 week time frame of the initial MI (Type 1 or unspecified).
- For subsequent type 2 AMI assign only code I21.A1 and for subsequent type 4 or 5, assign only code I21.A9.
- A code from category I22 must be used with a code from category I21.

Other Things to Remember Regarding Coding Myocardial Infarctions:

- If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial acute myocardial infarction.
- There are also several "code first" and "code also" notes which should be reviewed to determine the correct code assignment.
- If the documentation does not provide the information needed, query the physician in order to avoid using the code I21.9 (acute myocardial infarction, unspecified) whenever possible.

Reference:

- Current Medical Diagnosis and Treatment 2017, McGraw Hill/Lange, pg. 370
- ICD-10-CM 2019 Expert for Physicians
- Coding Clinic 4th Q 2017, pg. 12
- 2019 AHA Coding Handbook
- https://www.hopkinsmedicine.org/heart_vascular_institute/conditions_treatments/conditions/myocardial_infarction.html
- https://www.mdedge.com/jfponline/article/64033/cardiology/which-drugs-should-post-mi-patients-routinely-receive

Risk Adjustment Models: HHS-HCC vs. CMS-HCC

Jana Marschke, CPC, CCS, QMHCC, QMC
Nancy Keenan, CPC, CCS, CHCCS, RN

The **Health and Human Services** Hierarchical Condition Categories (**HHS-HCC**) model and the **Centers for Medicare & Medicaid Services** Hierarchical Condition Categories (**CMS-HCC**) model both use diagnoses and demographic data to predict medical expenditures; however, there are some important differences that contribute to the payment calculation, such as age group populations (younger vs. older age group), prediction year (concurrent vs. prospective), and other variables.

The Affordable Care Act HHS-HCC is a commercial risk adjustment model that is concurrent, meaning current year data predicts current year expenditures. Generally speaking, this model uses demographic data (age and sex) and diagnoses (HCC's) to determine an enrollee's risk score. There are infant (0-1), child (2-20), and adult (21 and older) models and within each age group model there are different metal levels (platinum, gold, silver, bronze, and catastrophic). The calculation of the risk score for each age group includes different variables (ex. the risk score for adults is based on age/sex, HCC's, RXC's, enrollment duration, and disease interactions). Diagnoses have a hierarchy, meaning that the more acute/severe condition trumps other similarly related conditions (ex. Metastatic Cancer trumps all other cancers). Another factor that plays a role in the calculation of the risk score is whether the enrollee qualifies for a cost sharing reduction or if they are enrolled in a premium assistance Medicaid alternative plan. A separate interaction payment is also given for certain combinations of conditions. Allowable diagnoses are submitted from inpatient hospital claims, outpatient facility claims (hospital outpatient, rural health clinic, federally qualified health center, critical access hospital, and community mental health center), and professional claims. Diagnoses from outpatient facility claims and professional claims must have at least one line item with an acceptable CPT/HCPCS code (listed in Table 2 of the Model DYI Table).

The CMS-HCC Model for *Medicare Advantage* is a prospective payment model, meaning that the prior year's data determines the following year's expenditures. The CMS-HCC model uses demographic data (age and sex) and diagnoses to determine a member's risk score. A member's risk score also varies depending on the status of the member-community (further broken down into 6 different models) versus institutional. There is also a normalization factor and a disease interaction payment, which is part of the risk score calculation as well. Separate models exist for ESRD/PACE and RXHCC's (prescription drugs). Diagnoses are submitted from a face-to-face encounter from an acceptable provider type and acceptable facilities/sources. This model is also hierarchical in which payment is based on the most severe condition among related groups.

For both models, medical conditions documented in the medical record must have documentation that the condition was addressed during the current face-to-face encounter. This is commonly referred to as having MEAT (Monitored, Evaluated, Assessed and/or Treated). Both HHS-HCC and CMS-HCC require medical conditions to be documented with MEAT at least once annually. Those conditions that do not have MEAT documented in the encounter, or are not documented during the current year, will not be captured or used to calculate risk scores.

Many of the same conditions that Risk Adjust (RA) for CMS-HCC do so for HHS-HCC as well, plus a few more that are more prevalent in the younger age group. You will need to pay special attention to the age groupings in the HHS model, as these factors can affect which condition category (CC) the diagnosis is assigned to. For example, cancer of the breast has a different CC based on whether the patient is under age 50 (CC 11) or age 50 and older (CC 12).

Common Conditions that Risk Adjust for HHS that do NOT Risk Adjust for CMS-HCC:

1. Asthma J45.909
2. Anorexia Nervosa F50.00
3. Bulimia F50.2
4. Autistic disorder F84.0
5. Asperger's syndrome F84.5
6. Down syndrome (trisomy 21) Q90.9
7. Kidney transplant status Z94.0
8. Pregnancy/Newborn codes

Common Conditions that Risk Adjust for CMS-HCC that do NOT Risk Adjust for HHS:

1. Alcoholism/Alcohol Dependence uncomplicated or in remission (F10.2-)
2. Major Depressive Disorder, single episode-mild, moderate, severe or partial or full remission (F32.0-F32.5); or, Major Depression, recurrent unspecified or mild, moderate, severe or in partial, full, or unspecified remission (F33.0-F33.42, F33.9) – only Severe RA in the HHS model
3. Angina-unspecified, with documented spasm, or other (I20.1-I20.9) and Unstable Angina (I20.0) - only unstable angina RA in the HHS model
4. PVD I73.9
5. Morbid Obesity E66.01
6. Atherosclerosis of the Aorta I70.0

Reference:

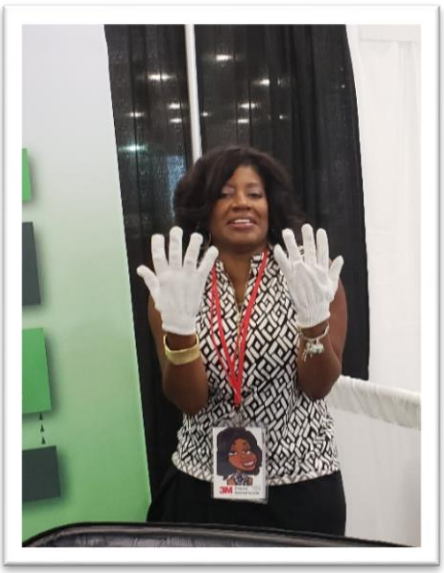
- http://www.pages02.net/hcscnosuppression/November_MedicareVSCommercialRiskAdjustment/?webSyncID=7fcd15fc-8f1d-4e8d-bbcc-4d4c8fed0ff9&vs=NzZiZDZiYzYtZDZlZS00ZDE2LTg2ZjItNTMwNWZjMjc4MWIxOzsS1
- https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/
- https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/RiskModel2019.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending
- https://www.cms.gov/cciio/Resources/Regulations-and-Guidance/index.html#Premium
- https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf
- https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2018-RA-Model-DIY-Instructions.pdf
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4214270/

In other news

We enjoyed chatting with everyone that stopped by our booth at the AHIMA Convention in Miami, FL. We appreciate your visit and hope to see you again at other upcoming events!

2018 AHIMA Annual Convention, Miami, FL
Sep. 22, 2018 – Sep. 27, 2018

Meet Our Team



Tonya Shelton, RHIT, CCS
Inpatient Compliance Specialist

Bob Palumbo
MARSI's Chief Operating Officer

Grant VanDyke, RN, CCS, CPUR
Director of Operations

Marshall Vincent, CCS
Inpatient Compliance Manager

Tonya Shelton, RHIT, CCS
Inpatient Compliance Specialist

Theresa Rosa, CCS, CPC
Outpatient Coder/Auditor

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E-Mail:
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