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The HIM Times Newsletter

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INSIDE THIS ISSUE:

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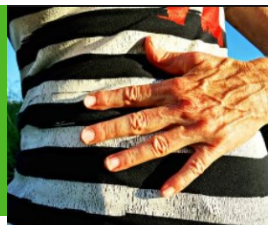
CLINICAL INDICATORS OF PERITONITIS IN DIVERTICULAR DISEASE

Author: Tammy Adkins, RHIA, CHP, Coding Consultant



Peritonitis is inflammation of the peritoneum, with exudations of serum, fibrin, cells, and pus, usually accompanied by abdominal pain and tenderness, constipation, vomiting, and moderate fever[1]. Laboratory tests are ordered resulting in such abnormal values as:

- Leukocytosis
- Hyponatremia
- Elevated hematocrit
- Elevated C - reactive protein (CRP)
- Elevated amylase levels

Radiology exams of the abdomen may show evidence of localized abscess, leakage of free fluid, purulent fluid, air or gas collection surrounding an inflamed or perforated organ in the peritoneal cavity.

Clinical evidence of peritonitis may also be found documented in the *operative* or *pathology* reports. Treatment typically involves[2] :

- Antibiotics
- Fluid resuscitation
- Bowel rest
- Antiemetic
- Gastrointestinal decompression
- Lavage
- Resection of diseased tissue

Now that you are familiar with the clinical indicators of peritonitis, let's assign the diagnoses to the case scenario below.

Case Scenario

55-year-old male patient presents with nausea/vomiting and severe abdominal pain with distention

History: Sigmoid diverticulitis

Free fluid represented by cloudy appearance surrounding area with no sign of perforation or abscess

Started on IV antibiotics, IV fluids, nothing by mouth restriction, pain, and antiemetic medications

CT abdomen reveals dilated loops of colon, inflamed diverticula

He is admitted with acute diverticulitis of the sigmoid colon

Overnight febrile, increased abdominal pain

Taken to surgery

Final operative report

Perforated colon with diverticulitis.
Procedure performed laparoscopic partial colectomy of the large intestine.
Extensive lavage due to collection of gas and purulent material encountered upon entering the abdomen.

continued on page 2

15 ISSUE – June 2021
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The HIM Times Newsletter

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Table 1[3]

K57 Diverticular disease of intestine *Code also if applicable peritonitis (K65.-)* K57.2 Diverticulitis of large intestine with perforation and abscess K57.20 Diverticulitis of large intestine with perforation and abscess without bleeding	K65 Peritonitis *Code also if applicable diverticular disease of intestine (K57.-)* Excludes1: acute appendicitis with generalized peritonitis (K35.2-) pelvic peritonitis, female (N73.3-N73.5) K65.0 (MCC) Generalized (acute) peritonitis Pelvic peritonitis (acute), male	N73 Other female pelvic inflammatory diseases N73.3 (MCC) Female acute pelvic peritonitis N73.4 (CC) Female chronic pelvic peritonitis N73.5 Female pelvic peritonitis, unspecified

Case Scenario Coding

Principal diagnosis code K57.20 (Diverticulitis of large intestine with perforation and abscess without bleeding) is the only defensible diagnosis[4]. The ICD-10-CM Official Guidelines for Coding and Reporting instructs the review of code(s) in the Tabular List[5] prior to final assignment. Let's review the Instructional Notes in the Tabular at **K57 (Diverticular disease of intestine)** *Code also if applicable peritonitis (K65.-). The "code also" note is cross-referenced at K65 (Peritonitis) Code also if applicable diverticular disease of intestine (K57.-).* This is an indication that the two conditions often present together.

The case scenario provides evidence of possible peritonitis, however, lacks a corresponding definitive diagnosis. Therefore, a physician query should be initiated in accordance with the 2019 AHIMA Practice Brief[6] and facility-specific policies for clarification. Let's profess the case scenario query resulted in documentation of acute pelvic peritonitis. Now we may assign secondary diagnosis **K65.0 (Acute (generalized) peritonitis).** K65.0 is a MCC that captures the severity of the patient's illness and supports the therapies provided.

The Tabular at K65 (Peritonitis) has an extensive list of Excludes1 instructions. Please note Excludes1: pelvic peritonitis, female (N73.3-N73.5). Next review the subentry at K65.0 Pelvic peritonitis (acute), male. This indicates female "pelvic" peritonitis is assigned to code range (N73.3-N73.5) acute, chronic, or unspecified "pelvic" peritonitis, female[7].

Coding and clinical documentation improvement (CDI) professionals review the health record to ensure code assignment is clinically supported. Review supporting documents such as pathology, laboratory, and radiology reports for clinically evident conditions that are not in the physician's diagnostic statement or that lack collation[8]. When clinically evident conditions are found and meet the definition of secondary or other diagnoses[9], clarification should be pursued prior to assignment of a code.

SOURCES

1 Dorland's Medical Dictionary
2 http://merckmanual.com/professional
2020 Merck Sharp &Dohme Corp., a subsidiary of Merck & Co., Inc., Kenilworth, NJ, USA
3 2021 ICD-10-CM Tabular List
4 Coding Clinic, First Quarter 1996 Page: 13-14, Colon diverticulitis with abscess
5 202 ICD-10-CM Official Coding Guidelines, Conventions for ICD-10-CM
6 AHIMA Practice Brief, Guidelines for Achieving a Compliant Query Practice, 2019 Update
7 Coding Clinic, Fourth Quarter 2005 Page: 74, Peritonitis
8 Coding Clinic, Third Quarter 2016 Page: 25, Coding from Pathology Report
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15 ISSUE – June 2021
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The HIM Times Newsletter

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CODING AND AUDITING CERTIFICATIONS

Author: Nancy Keenan - RN, CPC, CCS

There are many organizations that offer coding and/or auditing certifications. Most certifications recommend or require anatomy and physiology courses, as well as medical terminology. Knowledge of pharmacology and disease processes and/or clinical criteria are also important in most areas of coding. Depending on your educational background, prior experience, and career goals - there are several certifications to pursue in order to gain knowledge in other areas of coding and to expand employment opportunities.

The two main organizations that coders are most familiar with and offer certification in the coding/auditing field are the **AAPC** and **AHIMA**, which are covered below. Knowing the requirements or recommendations is an important factor when determining which certification(s) to pursue. Even if a coder is not proficient in a particular area, many organizations have articles or courses on various topics in coding that can help satisfy the recommendations.

Besides the AAPC and AHIMA, some other organizations that offer training courses or certifications are:

- Medical Audit Resource Services, Inc. (MARSI)
  Risk Adjustment/HCC Auditor Course in partnership with AHIMA (certificate course)
- National Alliance of Medical Auditing Specialists (NAMAS)
  Certified Evaluation and Management Auditor (CEMA)
- National Healthcare Association (NHA)
  Certified Billing and Coding Specialist (CBCS)

Certifications offered by the American Academy of Professional Coders (AAPC)

CPC
(Certified Professional Coder)
Is a certification that demonstrates expertise in physician and non-physician documentation review, CPT, HCPCS Level II, and ICD-10-CM coding, as well as compliance and regulatory requirements for physician services. A CPC certification provides employment opportunities in a physician's office.

COC
(Certified Outpatient Coder)
Is a certification that demonstrates expertise in outpatient coding documentation review, CPT, HCPCS Level II, and ICD-10-CM coding, as well as outpatient payment methodologies. A COC certification provides employment opportunities in a hospital/facility or ambulatory surgical center. A COC must have at least two years of medical coding experience.

CIC
(Certified Inpatient Coder)
Is a certification that demonstrates expertise in inpatient coding documentation review, ICD-10-CM and ICD-10-PCS coding, as well as inpatient payment methodologies. A CIC certification provides employment opportunities in a hospital/facility. It is recommended that the applicant for certification have at least two years of experience in inpatient coding or have taken an inpatient coding course.

CRC
(Certified Risk Adjustment Coder)
Is a certification that demonstrates expertise in the proper assignment of diagnoses for various risk adjustment models, ICD-10-CM coding, as well as risk adjustment payment methodologies. It is recommended that the applicant for certification have at least two years of experience in risk adjustment coding or have taken a risk adjustment coding course.

CPMA
(Certified Professional Medical Auditor)
Is a certification that demonstrates expertise in medical record requirements, coding and documentation guidelines, compliance and regulatory guidelines, and medical record auditing. It is recommended that the applicant for certification have at least two years of experience in medical auditing.

CDEO
(Certified Documentation Expert Outpatient)
Is a certification that demonstrates expertise in outpatient medical record review for accuracy of coding, quality measures, and clinical requirements. It is recommended that the applicant for certification have at least two years of experience in clinical documentation improvement.

CPPM
(Certified Physician Practice Manager)
Is a certification that demonstrates expertise in all business functions necessary in a physician's office including knowledge of insurance plans, compliance requirements, health information technology, physician reimbursement, medical office accounting, human resource management, and revenue cycle management.

CPCO
(Certified Professional Compliance Officer)
Is a certification that demonstrates expertise in the development, implementation, and evaluation of a practice or healthcare organization's compliance program. This certification reviews all laws and regulations that are necessary for an effective compliance program. It is recommended that the applicant for certification have at least two years of experience working in the compliance field.

continued on page 4

15 ISSUE – June 2021
Bringing the Experts to You

The HIM Times Newsletter

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Author: Nancy Keenan - RN, CPC, CCS

Certifications offered by American Health Information Management Association (AHIMA)

CCA
(Certified Coding Associate)

Is a certification that demonstrates coding knowledge in a variety of healthcare settings. It is recommended that the applicant for certification have at least one of the following: 6 months of coding experience, completion of an AHIMA approved coding program, or completion of other coding training

CCS
(Certified Coding Specialist)

Is a certification that demonstrates expertise in coding inpatient and outpatient records.

CCS-P
(Certified Coding Specialist-Physician Based)

Is a certification that demonstrates expertise in coding in physician offices, group practices, multi-specialty clinics, or specialty centers.

It is recommended that the CCS and CCS-P meet one of the following prior to taking the certification exam:

- ◊ Minimum of 2 years of related coding experience directly applying codes
- ◊ Hold the CCA credential plus one year of coding experience directly applying codes
- ◊ Hold a credential from another certifying organization plus 1 year of coding experience directly applying codes
- ◊ Hold another CCS certification, RHIT, or RHIA credential

Another recommendation prior to taking the exam for certification is completing these courses:

- A&P
- Pathophysiology
- Pharmacology
- Medical Terminology
- Reimbursement Methodology
- Intermediate/Advanced Diagnostic Coding
- Procedural Coding and Medical Services (CPT/HCPCS)

RHIT
(Registered Health Information Technician)

Is a certification that demonstrates expertise in analyzing patient data, verifying the completeness and accuracy of health records and their entry into computer systems, and coding diagnoses and procedures. The applicant for certification must have an associate degree from an accredited HIM program or a graduate from an HIM program approved by a foreign association with which AHIMA has a reciprocity agreement

RHIA
(Registered Health Information Administrator)

Is a certification that demonstrates expertise in medical, administrative, ethical, and legal requirements related to healthcare delivery and protected health information. One of the following requirements must be met by the applicant:

- ◊ Completion of a Baccalaureate-level CAHIMM Accredited program
- ◊ Completion of a Master's-level CAHIIM Accredited program
- ◊ Completion of a HIM Certificate of the Degree (Post-Baccalaureate) program approved by the CAHIIM
- ◊ Graduate from a HIM program approved by a foreign association with which AHIMA has a reciprocity agreement
- ◊ Hold the RHIT certification and meet the Proviso conditions approved by the 2017 CAHIIM

CDIP
(Certified Documentation Improvement Practitioner)

Is a certification that demonstrates expertise in clinical documentation. One of the following requirements must be met by the applicant:

- ◊ Hold an associate degree or higher or hold a CCS, CCS-P, RHIT, or RHIA credential.
- ◊ It is also recommended that the applicant have two years of clinical documentation integrity experience
- ◊ Associate degree or higher in healthcare or allied health
- ◊ Completed coursework in the following areas: medical terminology, A&P, pathology, and pharmacology.

SOURCES

https://www.ahima.org/certification-careers/certification-exams/
https://www.aapc.com/training/prepare-for-exam.aspx

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The HIM Times Newsletter

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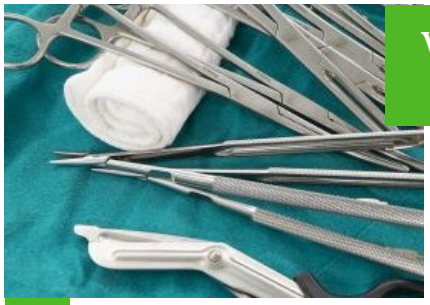

WOUND CARE: EXCISIONAL DEBRIDEMENT

Author: Kimberly Bowes, CPC, CRC, CEMC

"Close only counts in horseshoes and hand grenades." I do not know who coined this phrase, but I always felt it summed up debridement documentation for wound care. Wording is everything when it comes to the level of debridement and supporting continued wound care therapy and treatment.

First and foremost, there should always be a plan of care established. But, when a plan is not producing the intended results, the obvious solution is to re-evaluate the strategy. Meeting certain documentation criteria is important to supporting ongoing wound care.

Criteria and Documentation for Wound Care[3]

- Documented plan of treatment must be established at the initial visit.
- Documented evidence of improvements such as decrease in wound size, drainage, inflammation, swelling, pain, or necrotic tissue is vital to support the continuation of a treatment plan.
- Wounds that do not show improvement after 30 days of treatment require a new approach and changes to the treatment plan. This could include evaluation for underlying infection, metabolic, nutritional, or vascular conditions that are preventing healing. Note: verify the time frame with your local MAC.
- Documentation of wound size and appearance at each visit. Payers often require photos with dimensions to be documented in the medical record as supporting evidence of wound improvement.

Best Practice:
Always confirm with your Local MAC's LCD for documentation requirements for your area.

Elements for Complete Excisional Debridement

Wound care claims are often targeted by RAC, OIG, and CMS for further review. Excisional debridement documentation has specific requirements and wording is key to supporting the level of debridement performed. Ensuring all elements are documented to support excisional debridement is

Five Elements of Excisional Debridement[1,2]:

1. Description of the procedure as "excisional"
2. Description of the instrument used to excise the tissue (i.e., scissors, scalpel, curette)
3. Description of the tissue removed (i.e., necrotic, devitalized, or non-viable)
4. Appearance and size of the wound, which should include pre- and post-debridement sizes.
5. The depth of the debridement; subcutaneous, muscle, fascia, or bone. (i.e., "excisional debridement performed down to and including muscle")

Selecting the Appropriate Code

A person can go to the store, but if they do not go through the door, they cannot buy their groceries. This holds true with documenting and selecting the level of debridement. For example, the provider can remove tissue down to the muscle, but if they do not clearly document removing muscular tissue the code for debridement of muscle should not be assigned. Selecting the appropriate debridement code should always come down to the specific wording in the documentation.

Example1[5]:

Sharp excisional debridement of viable and nonviable tissue down to and including muscle was performed. Wound area of 12 sq cm of tissue was removed using a scalpel.

Code assignment: 11043

Example 2[5]:

Excisional debridement of necrotic non-viable tissue was performed. Skin and subcutaneous tissue was removed down to the muscle but did not involve removal of the muscular tissue. Wound area of 28 sq cm of tissue was removed using a curette.

Code Assignment: 11042, 11045[5]

continued on page 6

15 ISSUE – June 2021
Bringing the Experts to You

The HIM Times Newsletter

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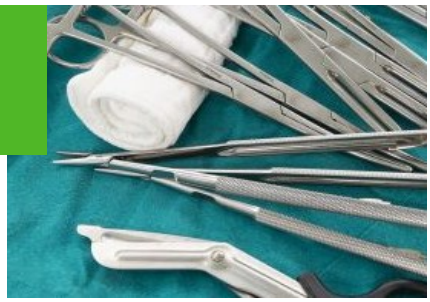

Basic Wound Care Debridement Codes:[4]

11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

⇒ 11045 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

11043 Debridement, muscle, and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less

⇒ 11046 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle, and/or fascia, if performed); first 20 sq cm or less

Note:

For debridement of skin (i.e., dermis and epidermis) see codes for "Active Wound Care Management."

These codes are used for debridement not involving subcutaneous or deeper tissue levels.

- **97597** Debridement, Open Wound, Per Session, Total Wound(s) Surface Area; First 20 sq cm Or Less
- **97598** Debridement, Open Wound, Per Session, Total Wound(s) Surface Area; Each Additional 20 sq cm

SOURCES

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2 https://www.icd10monitor.com/reporting-of-wound-debridement-procedures-properly
3 https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=37228
4 Reference: AMA CPT 2021 Professional Edition
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15 ISSUE – June 2021
Bringing the Experts to You

The HIM Times Newsletter

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A NOTE FROM DR. HUSTY

It is interesting that **risk-adjusted reimbursement methodologies** have been around for almost *40* years. However, in the last decade, there have been many more risk-adjusted reimbursement models that have been introduced into healthcare. We have noticed that many of our clients do not totally understand it and certainly, their physicians do not understand it. What struck me was that many folks who do not work directly with risk-adjusted reimbursement might not understand it either. So here is a little primer on what it is and how it works.

Diagnostic-related groups are actually the original risk-adjusted reimbursement system. What that means is that the reimbursement is tied to the risk conditions that the patients have. The more risk, the more reimbursement. How are those risks identified? Originally, they were identified by using ICD-9 codes, and now by ICD-10. I think most people that work in HIM understand that. We just never called it risk adjustment.

During the 90's some very intelligent people got together and developed a model that would work for an entire population. They tried to identify the risky health conditions that patients have and then tried to assign weight to each of those conditions. Their vision was that an entire population of patients would therefore have reimbursement that parallels the amount of risk relating to that population.

Why would anyone want to change the previous system?

The answer is that the goal was to have a reimbursement methodology that parallels the practice of Medicine. Fee-for-service reimbursement pays physicians more if they see patients more. It is based on volume and it also pays a greater amount the more ill our patients get. Actually, one of the reasons we went to medical school was to help prevent diseases. However, patients are always going to get diseases and our job is to then identify all of their diseases, treat them really well and try to keep them out of the hospital. Risk-adjusted reimbursement focuses on the treatment of diseases and actually pays for the quality treatment of diseases.

How does risk-adjusted reimbursement affect quality?

First, we need to identify all of our patients' conditions. As we do, more revenue goes into the pool that is available to take care of the entire population. In a risk-based contract, the money left over at the end of the year is shared with physician groups and practitioners. Hopefully, it is also shared with the people that work supporting the physicians.

How do you end up with money left over to share?

Again, identify all the diseases and get all of the revenue that is due. Second, try not to have unnecessary expenses such as unnecessary testing and consults. Necessary testing and consults are encouraged because they result in more diagnosis, better care, and more revenue. So how do you really drain the pool of excess revenue? By incurring unnecessary hospitalizations.

When physicians are tied to the wagon of surplus or the possibility of paying back a negative surplus, they focus on taking better care of the patients and the conditions that they have and try to keep them out of the hospital. So, in order to identify all of the patients' conditions you have to spend time with the patient. Add those things together and quality will improve.

Medicare Advantage (which is Medicare Part C, the Medicare HMO) was fully introduced well over a decade ago. It is a risk-adjusted reimbursement methodology. It uses hierarchical condition categories or HCC's that give weight to about 11,000 diagnosis that have risk, and therefore influence the revenue for the population of patients. It should be noted that until recently, most physicians rejected risk-based contracts that would tie them to the wagon of surplus or negative surplus. They feel safer with fee for service reimbursement therefore the majority of Medicare Advantage generates revenue by the conditions but pays the physician's fee for service. In other words, the physicians got paid by CPT and RVUs, and the diagnosis were not that important. The system did not change much.

continued on page 8

15 ISSUE – June 2021
Bringing the Experts to You

The HIM Times Newsletter

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A NOTE FROM DR. HUSTY

Recently, over the past few years, the health plans that are the intermediaries between the physicians and CMS have pushed to have risk-based contracts and they are succeeding because they control about 30 million Medicare aged patients. They have influence. I should point out right here that the Medicare Advantage health plans have an interest in physicians documenting and coding correctly. They want the physicians to increase revenue because they get their share too. For the first time in my life, health plans and physicians are aligned. Medicare Advantage is growing faster than predicted and is likely to become the majority of Medicare in the next few years.

Accountable care organizations or ACOs were developed to transition Medicare patients into a model that depends on risk sharing. They have a shared savings model that depends on a variety of factors, but the basis of shared saving is tied to risk and the health conditions of the population. Initially, the ACOs did not have to take any risk but that has now changed and all ACOs will be taking two sided, both up and down, risk.

Accountable care organizations

ACOs

That has driven a focus on identifying, documenting patients' health conditions just like in Medicare Advantage. Unfortunately, in ACOs, most physicians continue to be paid on a fee-for-service basis with RVUs. Again, there has been little change. But as the accountable care organizations feel the pressure of risk-based contracts, they will begin focusing on provider documentation and coding .

This article would not be complete without mentioning the Affordable Care Act Insurance exchanges. They are all risk-adjusted. They contain a slightly different group of conditions that risk adjust because Medicare Advantage does not include many risky conditions that have to do with pregnancy, labor and delivery, or pediatrics because most of the patients are 65 and older. A notable difference is that in the under 65 age range, there are much fewer risky conditions in patients overall. That makes it a little harder to be a focus of attention because the resources spent to try to achieve improvement can sometimes have less return.

Risk-adjusted reimbursement is the basis of all value-based reimbursement which is the new buzz term for the change in focus from paying for volume, fee-for-service, to paying for the quality care of disease states in patients. Done properly, there is a financial incentive to spend more time with patients, find all the diseases, take really good care of the patients, and keep them out of the hospital. Done right, physicians do not need to see as many people per day. Done right, patients get to spend more time with their physicians. I keep looking for a downside but haven't found any.