16 ISSUE – August 2021
Bringing the Experts to You

The HIM Times Newsletter

MARSI MEDICAL AUDIT RESOURCE SERVICES INC.

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
- HCC Coder/Auditor Online Course

Send an Inquiry through HIMExperts.com

SOFA SCORES AND SEPSIS

Authors: *Cindy Falen, RHIT, CCS, Kimberly Lane, CCS, Aaron Drummond, CCS*

Coding has been and always will be based on physician documentation in the record. These indicators can help in determining if a query is needed to obtain physician's clinical evaluation of the diagnosis of sepsis that does not meet "clinical criteria" or to determine if the patient may have sepsis.

Per Coding Clinic 16:4Q

"The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis."[1]

Coding Clinic further indicates, "whether a physician uses the new clinical criteria for sepsis, the old criteria, his personal clinical judgment, or something else to decide a patient has sepsis (and document it as such), the code for sepsis is the same—as long as sepsis is documented, regardless of how the diagnosis was arrived at, the code for sepsis can be assigned. Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded."[2]

For example, if a physician documents sepsis and the coder assigned a code for sepsis, and a clinical validation reviewer later disagrees with the physician's

Furthermore, coders should not code sepsis in the absence of provider documentation simply because they believe the patient meets sepsis clinical criteria either. A facility or a payer may require that a provider use a particular clinical definition or criteria set when establishing a diagnosis, but that is a clinical issue outside the coding system. Clinical validation is beyond the scope of DRG (coding) validation and the applicability of the coding guidelines. This type of review can only be performed by a clinician.[3]

"Sepsis" is defined as "a systemic response typically to a serious usually localized infection (as of the abdomen or lungs) especially of bacterial origin that is usually marked by abnormal body temperature and white blood cell count, tachycardia, and tachypnea specifically: systemic inflammatory response syndrome induced by a documented infection." [4]

From 1991 to 2016, four terms were used to describe/indicate "sepsis." These terms included:

- SIRS (systemic inflammatory response syndrome)
- Sepsis, severe sepsis
- Septic shock

In 2016, a new definition was created called "sepsis -3" and eliminated the terms SIRs and severe sepsis. Sepsis-3 was then defined as "the life-threatening organ dysfunction caused by dysregulated host response to infection." [5]

16 ISSUE – August 2021
Bringing the Experts to You

The HIM Times Newsletter

MARSI MEDICAL AUDIT RESOURCE SERVICES INC.

SOFA SCORES AND SEPSIS

Authors: *Cindy Falen, RHIT, CCS, Kimberly Lane, CCS, Aaron Drummond, CCS*

"Shock" can be defined as inadequate tissue perfusion, which can lead to ischemia. Ischemia can lead to necrotic tissue which can lead to organ failure.[6] Septic shock is defined as a "subset of sepsis in which the underlying circulatory and cellular metabolism abnormalities are profound enough to substantially increase mortality." It is determined by persistent hypotension requiring vasopressors (MAP >65 mmHg) and a lactate level of >2 despite adequate fluid resuscitation.

The sequential organ failure assessment score (SOFA scores) is used to track a patient's status during a hospital admission. The total score is based on six different scores for the patient's respiratory, cardiovascular, hepatic, coagulation, renal and neurological status. The score is calculated at admission and every 24 hours until discharge. The score tables below describe points-giving conditions with the scores ranging from 0 to 4 with 4 being the most intensive indicator for total scores ranging from 0 to a high of 24. The SOFA scoring system was used in predicting the clinical outcome of critically ill patients and the higher the score, the higher the risk of mortality. [7]

Scoring SOFA [8]

Respiratory system

PaO_2/FiO_2 [mmHg (kPa)]	SOFA score
≥ 400 (53.3)	0
< 400 (53.3)	+1
< 300 (40)	+2
< 200 (26.7) **and** mechanically ventilated	+3
< 100 (13.3) **and** mechanically ventilated	+4

Nervous system

Glasgow coma scale	(GCS) SOFA score
15	0
13–14	+1
10–12	+2
6–9	+3
< 6	+4

Cardiovascular system

Mean arterial pressure OR administration of vasopressors required	SOFA score
MAP ≥ 70 mmHg	0
MAP < 70 mmHg	+1
dopamine ≤ 5 µg/kg/min or dobutamine (any dose)	+2
dopamine > 5 µg/kg/min OR epinephrine ≤ 0.1 µg/kg/min OR norepinephrine ≤ 0.1 µg/kg/min	+3
dopamine > 15 µg/kg/min OR epinephrine > 0.1 µg/kg/min OR norepinephrine > 0.1 µg/kg/min	+4

Liver system

Bilirubin (mg/dl) [µmol/L]	SOFA score
< 1.2 [< 20]	0
1.2–1.9 [20-32]	+1
2.0–5.9 [33-101]	+2
6.0–11.9 [102-204]	+3
> 12.0 [> 204]	+4

Coagulation system

Platelets×10^3/µl	SOFA score
≥ 150	0
< 150	+1
< 100	+2
< 50	+3
< 20	+4

Kidneys system

Creatinine (mg/dl) [µmol/L] (or urine output)	SOFA score
< 1.2 [< 110]	0
1.2–1.9 [110-170]	+1
2.0–3.4 [171-299]	+2
3.5–4.9 [300-440] (or < 500 ml/d)	+3
> 5.0 [> 440] (or < 200 ml/d)	+4 (5)

Correlation of Total Score and Hospital Mortality indicator with

Maximum SOFA Score	Mortality
0 to 6	< 10%
7 to 9	15 - 20%
10 to 12	40 - 50%
13 to 14	50 - 60%

(6)

Organ dysfunction was indicated with acute change in SOFA score of >= 2, which indicates approximated 10% in general hospital population with suspected infection. [9]

16 ISSUE – August 2021
Bringing the Experts to You

The HIM Times Newsletter

MARSI MEDICAL AUDIT RESOURCE SERVICES INC.

SOFA SCORES AND SEPSIS

Authors: *Cindy Falen, RHIT, CCS, Kimberly Lane, CCS, Aaron Drummond, CCS*

Quick SOFA score

The Quick SOFA score was introduced in February 2016 as a more simplified and quicker way to score high-risk patients. The qSOFA simplifies the SOFA score by only having three clinical criteria and by changing the neurological scoring of requiring a GCS <15 to be any altered mentation. Utilizing the qSOFA score is a much easier methodology for determining sepsis.

Assessment	qSOFA score
Low blood pressure (hypotension) (SBP ≤ 100 mmHg)	1
High respiratory rate (tachypnea) (≥ 22 breaths/min)	1
Altered mentation (GCS ≤ 14)	1

The qSOFA score ranges from 0-3 points with the presence of 2 or more points indicating a greater risk of death or prolonged ICU stay. As this scoring system was easier and quicker, the Third International Consensus Definitions for Sepsis recommend using qSOFA as a way to identify patients who are likely septic (2016). [10]

What does this all mean?

The coding of sepsis has been, and most likely, always will be problematic. The use of SOFA or qSOFA scores should help in supporting the clinical indicators for the diagnosis and thus reducing denials from payers.

SOURCES

1. AHA Coding Clinic Fourth Quarter 2016
2. AHA Coding Clinic Fourth Quarter 2016
3. The Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) Scope of work 2013
4. Merriam-Webster dictionary
5. Intellect Medicos Sepsis (New definition) I Sepsis-3 (with Animations)! – Dr. Shruti, Dr. Shirag Madaan
6. Merriam-Webster dictionary
7. https://en.wikipedia.org/wiki/SOFA_score#:~:text=The%20sequential%20organ%20failure%20assessment,function%20or%20rate%20of%20failure.
8. https://en.wikipedia.org/wiki/SOFA_score#:~:text=The%20sequential%20organ%20failure%20assessment,function%20or%20rate%20of%20failure.
9. Intellect Medicos
10. Wikipedia

16 ISSUE – August 2021
Bringing the Experts to You

The HIM Times Newsletter

MARSI MEDICAL AUDIT RESOURCE SERVICES INC.

MODIFIER 22: FACTS & BEST PRACTICES

Authors: Kimberly Bowes, CPC, CRC, CEMC

Every surgeon's goal is getting paid for the work they perform, and helping the physician get paid should be the goal of every coder. Most surgical specialties understand the intent of Modifier 22, but it is also important to understand the proper documentation required to support this modifier.

Modifier 22 Definition:

Increased Procedural Service; requiring substantially greater work than typically required for the procedure.

Appropriate Use[1]

- Surgical procedures when the work involved is significantly greater than usual.
- Anatomical variants could be an appropriate use.
- Assistant at surgery when a procedure is significantly greater than usual.
- Surgical Procedures with 0, 10, or 90 global day(s) as set by the Medicare Physician Fee Schedule.
- Procedures having a global period but not classified as a surgical service (i.e., 77761, 77777, 77782).

Inappropriate Use[2]

- Additional time alone is not justification for modifier usage.
- When there is an existing code to describe the service.
- When the documentation supports another existing code.
- When the service was provided by a specialist.
- Do not use on Evaluation and Management (E/M) service codes.

Documentation[3]

- Many payers will require 2 separate documents to support the use of Modifier 22:
  - ⇒ The operative report
  - ⇒ A separate statement describing how the service differs from the usual
- Check your payer website for available forms.
  - ⇒ Payers that require 2 separate documents will likely process the service based on the normal fee schedule when the proper information is not received.
  - ⇒ The reimbursement will be typically based on the information in the documentation.
  - ⇒ The operative report must include a clear and concise statement describing the substantial additional work that was involved.

Modifier 22: Correct Use[4]

- To use Modifier 22 effectively, three areas must be addressed in documentation. It is not sufficient to only state the amount of time addressing the unusual extra work. The surgical documentation must include the following elements:
  - ⇒ A description of the extenuating circumstances encountered during the procedure that differentiated the surgery from others of a similar type, including severity.
  - ⇒ The technical aspects of and effort required for the increased procedural services (e.g., extensive lysis of adhesions, control of unexpected bleeding).
  - ⇒ The amount of time, beyond what is normally expected for the procedure performed, that the surgeon spent addressing the extenuating circumstances intra-operatively.

Documentation Examples

"As noted, Mrs. Jones is morbidly obese with a BMI of 52 which added an extra 60 minutes to the typical surgical time. An extra 20 minutes were spent in positioning, prepping the patient, and establishing a clear airway. An additional 40 minutes spent during the procedure to access and gain clear visual surgical field due to excessive fatty liver."

"Extensive adhesions were found throughout the entire surgical field. Total time spent performing lysis of adhesion added 80 additional minutes to this typical 60-minute surgery. Details for the lysis of adhesions are included in the body of the operative report."

"As noted in the body of the operative report; the removal of the tumor was much more involved than normal requiring substantial additional work that encompassed both large and small intestines which added an additional 90 minutes to the surgical time."

16 ISSUE – August 2021
Bringing the Experts to You

The HIM Times Newsletter

MARSI MEDICAL AUDIT RESOURCE SERVICES INC.

MODIFIER 22: FACTS & BEST PRACTICES

Authors: Kimberly Bowes, CPC, CRC, CEMC

Example: Modifier 22 Documentation Form [5]

A Modifier 22 may be used when a case is clearly out of the range of ordinary difficulty for that type of procedure.

Two separate documents are required to support the claim.

- An operative report must be submitted.
- A separate statement indicating how the service differs from the usual difficulties.

Avoid using generalized or vague statements like “patient was obese” or “surgery took longer than usual” or “multiple adhesions.”

Patient Information
Name: _____ Medicare ID: _____
DOB: _____

Provider Information
Name: _____
PTAN: _____NPI: _____

Claim Information
DOS: _____

Statement describing unusual service which may warrant additional reimbursement:

_____
Signature

SOURCES

1. https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/modifier 22/!ut/p/z0/fY2xDolwFEV_BQfG5tWaEFY0GmIgGgcDXUxTCjyFFtqifr7o5GAcz8299wCHArgWd2yER6NFN3PJo8sxTaN0GdPswHJKk3x3Xm3jbB2fIrAH_r8wPzCbb_IG-CB8S1DXBopmwko5InRFrHJmsII5KHpTYY3KEsbeO7yOI0-AS6O9enooHoMLPqB9oHTToWtD6s2Aksg5UzakshPYu5D-EoT0WzDceBm7ZPECn-qmig!!/#
2. https://www.aapc.com/blog/33193-maximize-reimbursement-using-modifier-22/
3. https://www.wpsgha.com/wps/wcm/connect/mac/41c0e056-8566-4f49-9283-42614454bc1d/J8B+Modifier+22+Documentation+Form.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_J9IA1280M86460A9F22N9C30G2-41c0e056-8566-4f49-9283-42614454bc1d-ndthTpx
4 https://www.aapc.com/blog/33193-maximize-reimbursement-using-modifier-22/
5. https://www.wpsgha.com/wps/wcm/connect/mac/41c0e056-8566-4f49-9283-42614454bc1d/J8B+Modifier+22+Documentation+Form.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_J9IA1280M86460A9F22N9C30G2-41c0e056-8566-4f49-9283-42614454bc1d-ndthTpx

16 ISSUE – August 2021
Bringing the Experts to You

The HIM Times Newsletter

MARSI MEDICAL AUDIT RESOURCE SERVICES INC.

WHAT IS HIPAA AND THE IMPORTANCE OF HIPAA

Author: Heather Ernest, LPN, COC, CPC, CRC

HIPAA, the Health Information Portability & Accountability Act of 1996, is a federal rule that gives a person the rights over their health information, including the right to get a copy of all information, ensuring it is correct and knowing who has seen the information. The Department of Health and Human Services (HHS) Office for Civil Rights has a slogan for an individual's rights for HIPAA - "Get It. Check It. Know Who Has Seen It.".

GET IT

A person has the right to see or get a copy of their medical records and all other health related information. If requesting a copy, a request in writing must be submitted, with the patient/ individual paying for any related fees regarding the copying and mailing of the records.

CHECK IT

It is important that an individual review their medical records for any discrepancies or errors. If there are any errors, an individual has the right to ask that the incorrect information be corrected or add information that may be missing. In the case where a facility believes the records to be accurate, the individual has the right to have their disagreement documented in the records.

USE IT / KNOW WHO HAS SEEN IT

Did you know that by law your medical/health information can be shared and used for reasons other than your care? An individual's health and medical information can be used for making sure facilities are safe and clean, doctors are providing the best care possible, reporting communicable diseases in their area or for any reason that may be required by law to be reported to the state or federal government.

In most cases, a person's information cannot be used for reasons unrelated to their health/medical care without the individual's permission. Providers cannot release a patient's information to an employer, for marketing/advertising, etc. without an individual's written permission.

- If an individual prefers not to have their information shared with certain groups, people, companies, etc., they can request that from their providers and health insurance company. Take note, however a request may not be agreed to if the request could affect a person's care.
- If an individual prefers to be contacted in a different way or different place than it was what on file, a request can be made to do so.

The OCR has provided specific guidance related to mental health and substance abuse disorders. An individual with a mental health or substance abuse disorder should be aware in the means that family, friends and others actively participating in their care will be able to gain access to information needed to support treatment, coordination of care and recovery.

If there is ever a question about an individual's rights being denied or health information not being protected, they may file a formal complaint with their provider (s), insurance or the US Department of Health and Human Services. The individual may file the complaint with the OCR who can investigate the complaint. Complaints may be submitted online or in writing. To file a complaint online, please visit https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf .

The above information, in addition to all information regarding HIPAA, can be found at https://www.hhs.gov/hipaa/index.html .

Sources:
1. https://www.hhs.gov/hipaa/index.html
2. https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/consumers/consumer_rights.pdf
3. https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/consumers/privacy-security-electronic-records.pdf
4. https://www.healthit.gov/sites/default/files/YourHealthInformationYourRights_Infographic-Web.pdf
5. https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html
6. https://www.hhs.gov/hipaa/filing-a-complaint/index.html

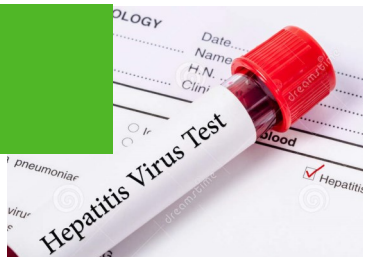
16 ISSUE – August 2021
Bringing the Experts to You

The HIM Times Newsletter

MARSI MEDICAL AUDIT RESOURCE SERVICES INC.

CHRONIC HEPATITIS B AND C

Author: Carol Vidovich, CPC



Hepatitis B and C are both viruses that cause inflammation of the liver. Both viruses can be cleared by the patient's immune system without treatment during the acute phase of the infection; however, the virus can remain causing chronic infection. Individuals may be asymptomatic while others can experience symptoms such as abdominal pain, fatigue, dark urine, loss of appetite, nausea, vomiting, etc. Inflammation of the liver can progress to irreversible scarring (cirrhosis) which can result in serious complications for the patient.

Chronic Hepatitis B and C and some of the associated complications (portal hypertension, cirrhosis, gastroesophageal varices, liver failure, hepatocellular carcinoma, hepatopulmonary syndrome, hepatorenal syndrome, and malnutrition) risk adjust; therefore, it is important to perform a thorough chart review for the presence of these conditions. As an auditor, it is important to look at the entire clinical picture including laboratory results, imaging studies, and specialists notes for the presence of complications that can occur as a result of cirrhosis and subsequent portal hypertension. This can provide various querying opportunities for possible complications as well as clarify issues regarding specificity (i.e., whether Hepatitis B or C is acute or chronic as only chronic risk adjusts).

Hepatitis B

Transmission

- Hepatitis B is transmitted through blood or body fluids through sexual contact, sharing needles or from mother to baby at birth. The chances for developing Chronic Viral Hepatitis B depend mainly on the age of the patient. Approximately 90% of infected infants with Hepatitis B will develop Chronic Hepatitis B, as opposed to only 2-6% of adults.[1]

Testing

- Hepatitis B serology tests are used to determine if a patient is susceptible to infection, immune to the infection as a result of past infection or vaccination or has acute or chronic infection. Laboratory tests include the following: Hepatitis B surface antigen (HBsAg), Hepatitis surface antibody (anti-HBs), Total hepatitis core antibody (anti-HBc) and IgM antibody to Hepatitis B core antigen (IgM anti-HBc).
- Testing for the delta agent (Hepatitis D) involves Anti-HVD followed by HDV-RNA testing.

Treatment

- The Hepatitis B vaccine was made available to the public in 1982 with the recombinant version introduced in 1986. Infants should get their 1st shot within 24 hours of birth (unless the mother is positive, then it should be within 12 hours), the 2nd dose at 1 to 2 months, and the 3rd dose between 6-15 months. For adults at risk, the schedule is 2 or 3 doses over a six-month period.[2]
- Antiviral medications include the following: Pegasys (Pegylated interferon), Intron A (Interferon Alpha), Hepsera (Adefovir Dipivoxil), Baraclude (Entecavir), Tyzeka/Sebivo (Telbivudine), Viread (Tenofovir disoproxil), Vemlidy (Tenofovir Alafenamide).[3]

16 ISSUE – August 2021
Bringing the Experts to You

The HIM Times Newsletter

MARSI MEDICAL AUDIT RESOURCE SERVICES INC.

CHRONIC HEPATITIS B AND C

Author: Carol Vidovich, CPC

Hepatitis C

Transmission

- Hepatitis C is transmitted through infected blood via IV drug use, needle stick injuries, transfusions (screening of blood has now virtually eliminated this way of transmission), and unsterilized medical equipment. The virus can also be transmitted from infected mother to baby during birth. Less likely, but still possible is infection through sexual contact and unregulated tattoos, or body piercings, and sharing razors or toothbrushes.[4]

Testing

- There are two tests for Hepatitis C. The first is the Hepatitis C antibody test. It can tell if the patient has ever been infected with Hepatitis C. The second is the Hepatitis C virus RNA test. It can tell if the patient has a current infection of the Hepatitis C virus.

Treatment

- There is no vaccine for Hepatitis C.
- Per the AASLD and IDSA HCV Guidance: Recommendations for testing, managing, and treating Hepatitis C depends on several factors including the genotype and whether cirrhosis is present. There are 7 genotypes and 67 subtypes.
- Antiviral Medications include the following: Pegasys (Pegylated interferon), Intron A (Interferon Alpha), Zepatier (Elbasvir/Grazoprevir), Mavyret (Glecaprevir/Pibrentasivir), Harvoni (Ledipasvir/Sofosbuvir), Epclusa (Sofosubivir/Velpatasvir), and Vosevi (Sofosubivir/Velpatasvir/Voxilaprevir).

ICD-10 Codes[5]

B18.0 Chronic viral hepatitis B with delta-agent

B18.1 Chronic viral hepatitis B without delta-agent

Carrier of viral hepatitis B

Chronic (viral) hepatitis B

B18.2 Chronic Viral Hepatitis C

Carrier of viral hepatitis

Other codes:

K74.60 Cirrhosis of the liver
K76.6 Portal Hypertension
I85.10 Secondary Esophageal varices without bleeding
I85.11 Secondary Esophageal varices with bleeding
E43 Unspecified severe protein-calorie malnutrition
E44- Protein calorie malnutrition of moderate and mild degree
E46 Unspecified protein-calorie malnutrition
K76.81 Hepatopulmonary syndrome
K76.7 Hepatorenal syndrome
K72-Hepatic Failure
C22.0 Liver Cell Carcinoma

Sources:
1. https://www.webmd.com/hepatitis/digestive-diseases-hepatitis-b #1
2. https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fschedules%2Fhcp%2Fchild-adolescent.html #2
3. ICD-10-CM Expert for Physicians 2021 pg 456 #3
4. https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm #4
5. https://www.cdc.gov/hepatitis/hbv/index.htm#:~:text=Hepatitis%20B%20is%20spread%20when,mother%20to%20baby%20at%20birth. #5
6. https://www.hhs.gov/hipaa/filing-a-complaint/index.html
7. https://www.idsociety.org/globalassets/idsa/topics-of-interest/2012-hcv-guidelines.pdf
8. https://www.hcvguidelines.org/treatment-naive/simplified-treatment
9. https://www.immunize.org/catg.d/p2017.pdf
10. https://www.cdc.gov/hepatitis/hcv/cfaq.htm
11. https://www.niddk.nih.gov/health-information/liver-disease/viral-hepatitis/hepatitis-c
12. https://www.hepatitisc.uw.edu/go/key-populations-situations/treatment-acute-infection/core-concept/all
13. https://www.cdc.gov/hepatitis/hbv/pdfs/SerologicChartv8.pdf
14. https://www.mountsinai.org/health-library/diseases-conditions/delta-agent-hepatitis-d

16 ISSUE - August 2021
Bringing the Experts to You

The HIM Times
Newsletter

MARSI
MEDICAL AUDIT RESOURCE SERVICES INC.

A NOTE FROM DR. HUSTY

THE FUTURE

This morning I watched another historic 1st: Richard Branson and crew flew in the first, privately funded, spacecraft which he named after his mother, Eve, and returned safely. Although this is currently just for billionaires, we can look at this and predict what is going to happen in the future.

There are uncertainties all around us when looking into the future, but I think that there are some predictabilities of what is going to take place in the United States in healthcare. Right now, and into the near future, there has been and will continue to be a transformation from fee for service medicine to the funding of the quality treatment of diseases. It only makes sense. Along with that change in focus comes many other sidebar activities such as monitoring for medical necessity and quality measures, but also for the possibility of fraud or abuse of the new system. And, because change is not easy, there is a great need for assisting physicians and healthcare systems through this transition.

But what about other changes, such as transitioning to a single payer system? Some people in healthcare feel that that will be disrupting but, if you look closely at it, it would be simply more of the same. Reimbursement to practitioners and healthcare systems will most likely to continue to be based on the quality treatment of diseases, because it will still make sense. The old pay for volume mentality is not likely to return. There will be even greater emphasis on documentation, appropriate coding, quality measures, and medical necessity.

I am not saying that I am in favor of such a system, I just don't see it being disruptive to health information management. I think we should feel confident that this is our future…we gotta wear shades!