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INSIDE THIS ISSUE:

Did You Know?

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ON PHYSICIAN DOCUMENTATION

The Unfortunate Center of Hospitals' Healthcare Universe

Author: Dr. Todd Husty

For hospitals, documentation issues begin with observation versus Inpatient but continues with primary diagnoses, secondary diagnoses, quality measures, coding and billing which are all dependent upon emergency physician documentation, history and physical, admit note, progress notes, operative reports, consultants notes and a comprehensive discharge summary.

These physician documentation pieces seem to be separate and distinct, but they are basically similar.

Let's start at the beginning. The moment a patient enters a hospital, the documentation continuum begins. There is so much being documented by many different people. However, it is the physician documentation that is in the center. Therefore, it is extremely important that providers' documentation includes all the elements that are necessary to accurately depict the patient's condition and status because there are so many issues dependent up that documentation. Physicians frequently see this as just a chore and an unwanted one. Many of us feel that we don't have to document everything because we are doing it. We use our training and logic to assess and treat patients and all of the good care we provide makes perfect sense in our head. That should be enough. But it's not.

We need to paint a picture of our patients. Why are they here? What have we found out about them from history, physical and testing? How have they responded to treatment? And, at the time of admission or discharge, how are they now? Stability, instability or relative instability are important concepts. And, if they need to stay in the hospital, why are they staying and what are our major concerns? How sick are they (severity of illness)? What interventions are they going to need (intensity of service)? And what is the likelihood that they are going to stay more than two days or two midnights? Yes, we can make an educated guess.

Who should make that guess? Both the emergency physician and the admitting physician should be involved and the reasoning should be clearly documented. The emergency physician has had eyes and ears on the patient and knows more about their current condition than an admitting physician that is not in attendance. We know that we don't want to send the patient home. We know the reasons why. And we know, based on the stability or instability of the patient and their medical problems, whether or not it will take a while for the patient to get better. We should have an opinion on observation versus inpatient status that reflects our opinion of the patient, medically, at the time of admission. There is no penalty for making an honest determination based on the facts surrounding the patient. There is no reason not to do this. The emergency physician should have a detailed discussion with the admitting physician and thoroughly document what they have discussed.

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The admitting physician should have a detailed discussion with the emergency physician and thoroughly document what they have heard. It's called a handoff. Patients can be fumbled during handoffs. Fumbling patients is never good. After evaluation of the patient, the admitting physician may disagree with the status of the patient suggested by the emergency physician. That should be documented and then discussed with utilization managers to decide upon the course of action. That rarely happens. Unfortunately, it is also rare for the admitting physician to document what they were told by the emergency physician.

There is a concept in physician documentation of being "*necessarily thorough*". Quality care of patients means that we are thorough in their evaluation, management, and continued care. That is based on the patient's conditions, stability and needs. We need to be thorough while recognizing that not every patient needs everything. We need to think about how we can document with accuracy and completeness and remind ourselves to be thorough. That's the use of a differential diagnosis. We need to include "*pertinent positives*" from our evaluations and also include "*pertinent negatives*" which can be equally important. This includes noting information from the history and physical but also the treating physician's interpretation of diagnostics such as lab and x-ray. The radiologist's interpretation does not change the clinical course or treatment. It is the decisions by the clinician taking care of the patient that is important. And, as we in health information management know, only the clinician's interpreted results are codable. Many physicians don't understand that.

So, what are the documentation requirements for attending physicians? The concepts just discussed are the guide. The admission note should include pertinent positives and pertinent negatives along with a differential diagnosis and interpretation of diagnostics. There should be a statement of stability or instability and there should be an opinion about observation versus inpatient status that is supported by the documentation.

Progress notes are similar, but it is not necessary to repeat everything in a progress note. Rather, updates to each day's progress note should include changes in the differential diagnosis, stability, and treatment plan.

Perhaps the most important documentation by physicians during an acute care stay is the **discharge summary**. It should clearly summarize the details of the patient's stay, as understood at the time of discharge…hence the name.

Surprisingly, many if not most attending physicians don't actually understand the importance of the document. Besides the importance for medical/legal and quality, they don't understand that the physician that writes the discharge summary receives the most queries because they are responsible for what can be coded and what cannot. Many attending physicians merely copy and paste excerpts from the admit note and progress notes without consideration of the purpose of the discharge summary which is to accurately reflect the patient's course throughout the stay.

ON PHYSICIAN DOCUMENTATION

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Author: Dr. Todd Husty

The discharge summary should tie up all the initial findings with the ongoing findings and with the plan of care at the time of discharge. The discharge summary should include ALL of the possible and probable diagnoses at the time of admission and at the time of discharge. It should highlight the pertinent negatives, that is those diagnoses that have been ruled out. Any discrepant documentation during the stay needs to be clarified. As I teach physicians, paying attention to the necessities of the discharge summary will decrease the volume of queries that they receive.

Unfortunately, many of our clients look at documentation through the monocular view of their particular silo. Utilization managers are concerned with admission status and discharge planning. CDI specialists are trying to clarify medical necessity and documentation discrepancies. HIM specialists are concerned with principal and secondary diagnoses that are supported by documentation in the chart. Revenue cycle managers are concerned with the optimal coding. Compliance managers are concerned about over coding. We, at MARSI, feel that every hospital should try to combine these efforts to influence documentation practices throughout the continuum of care; from the time the patient arrives at the emergency department to the time of discharge, and everything in between.

It's not a fast or easy process and, just as important as the process itself, it requires motivated providers and support from the management and administrative teams. We have had excellent results with documentation and coding improvement initiatives when the silos work as a team. Again, it is not easy, but our clients find the rewards in having thorough and accurate documentation that impacts everything from compliance and the revenue cycle to quality of care.

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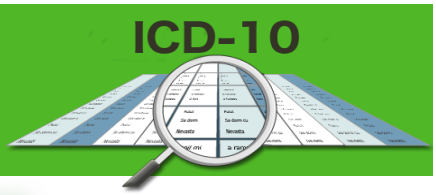
ICD-10-CM/PCS UPDATES *Effective April 1*

Author: Davin Vandale, CCS, CPC-A



New ICD-10-CM Codes

Three new diagnosis codes will be implemented into ICD-10-CM for reporting COVID-19 vaccine status, effective with discharges on and after April 1, 2022.

Under immunization for COVID-19 status:

- Z28.310 Unvaccinated for COVID-19

  May be assigned when the patient has not received at least one dose of any COVID-19 vaccine.
- Z28.311 Partially vaccinated for COVID-19

  May be assigned when the patient has received at least one dose of a multi-dose COVID-19 vaccine regimen, but has not received the full set of doses necessary to meet the CDC's definition of "fully vaccinated" at the time of encounter.

Other under immunization status:

- Z28.39 Other under immunization status

  May be assigned for delinquent immunization status and lapsed immunization schedule status.

New ICD-10-PCS Codes

Nine new procedure codes will be implemented into ICD-10-PCS to report on the introduction or infusion of therapeutics, including vaccines for COVID-19 treatment, effective April 1, 2022.

Administration of fostamatinib (Tavalisse®):

Fostamatinib is a spleen tyrosine kinase (SYK) inhibitor that is approved as a treatment for adult chronic immune thrombocytopenia.

A request for emergency use authorization (EUA) for fostamatinib is under review by the US Food and Drug Administration (FDA) for the treatment of hospitalized adult COVID-19 patients.

- XW0DXR7 Introduction of **fostamatinib** into mouth and pharynx, external approach, new technology group 7
- XW0G7R7 Introduction of fostamatinib into upper GI, via natural or artificial opening, new technology group 7
- XW0H7R7 Introduction of fostamatinib into lower GI, via natural or artificial opening, new technology group 7

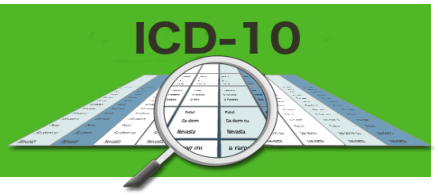
Administration of tixagevimab and cilgavimab monoclonal antibody (Evusheld™):

The FDA granted Evusheld EUA for the pre-exposure prophylaxis of COVID-19 in adults and pediatric individuals who are not currently infected with SARS-CoV-2 and who have not experienced a known recent exposure to an individual infected with SARS-CoV-2 and...

* have moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications, or
* for whom vaccination with any available COVID-19 vaccine, according to the approved or authorized schedule, is not recommended due to a history of severe adverse reaction

- XW023X7 Introduction of tixagevimab and cilgavimab monoclonal antibody into muscle, percutaneous approach, new technology group 7

ICD-10-CM/PCS UPDATES *Effective April 1*



Author: Davin Vandale, CCS, CPC-A

Other new monoclonal antibody COVID-19 treatments that are administered intramuscularly that may become available and do not yet have a unique code:

- XW023Y7 Introduction of other new technology monoclonal antibody into muscle, percutaneous approach, new technology group 7

Four new COVID-19 vaccine codes:

- XW013V7 Introduction of COVID-19 vaccine dose 3 into subcutaneous tissue, percutaneous approach, new technology group 7
- XW013W7 Introduction of COVID-19 vaccine booster into subcutaneous tissue, percutaneous approach, new technology group 7
- XW023V7 Introduction of COVID-19 vaccine dose 3 into muscle, percutaneous approach, new technology group 7
- XW023W7 Introduction of COVID-19 vaccine booster into muscle, percutaneous approach, new technology group 7

Two codes were created for vaccines described as a third dose and two codes were created for vaccines described as boosters.

- Third dose refers to an additional vaccine dose administered to people with moderately or severely compromised immune systems. The CDC currently recommends that individuals ages 12 years and older who are moderately or severely immunocompromised receive a primary series of three doses of an mRNA COVID-19 vaccine, plus one booster of an mRNA COVID-19 vaccine.
- A booster is an additional dose of vaccine given after the protection provided by the original shot(s) has begun to decrease over time. Currently, the CDC recommends booster doses for individuals aged 12 and older after getting two doses of an mRNA COVID-19 vaccine (Pfizer-BioNTech or Moderna vaccine) or one dose of Johnson & Johnson's COVID-19 vaccine.

Sources:

1. https://www.cms.gov/medicare/icd-10/2022-icd-10-pcs
2. ICD - ICD-10-CM - International Classification of Diseases, Tenth Revision, Clinical Modification (cdc.gov)
3. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/immuno.html?s_cid=11707:covid%20booster%20immunocompromised:sem.ga:p:RG:GM:gen:PTN:FY22

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HHS-HCC OR CMS-HCC?

Author: Jana Marschke, CPC, CCS, CHCCS, CRC

There are several important differences between the Health and Human Services Hierarchical Condition Categories (HHS-HCC) Commercial Risk Adjustment model and the Centers for Medicare & Medicaid Services Hierarchical Condition Categories (CMS-HCC) model used in Medicare Advantage plans.

The Affordable Care Act HHS-HCC is a risk adjustment model that is concurrent, meaning current year data predicts current year expenditures. 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. 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.

For example:
The risk score for an adult is based on age/sex, HCC's, RXC's, enrollment duration, and disease interactions.

Diagnoses have a hierarchy, meaning that more acute/severe conditions trump 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 also part of the risk score calculation. 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 for the most severe condition among related groups.

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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 (Managed), Evaluated, Assessed and/or Treated. Both HHS-HCC and CMS-HCC require medical conditions to be documented with MEAT at least once annually. 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 MA HCC also RA for HHS HCC, plus a few more that are more prevalent in a younger age group. You will need to pay special attention to the age groupings and gender. The age of the patient may risk adjust differently, as in Cancer of the breast=under age 50 CC #11, over age 50 CC #12. Some conditions have 2 Conditional Categories such as Candidal Sepsis which includes CC #2 and #6.

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, partial or full remission (F32.0-F32.5) or Major Depression, recurrent unspecified or mild, moderate, or in partial, full, or unspecified remission (F33.0-F33.42, F33.9*
3. *Angina-unspecified, with documented spasm, or other (I20.1-I20.9)*
4. *PVD I73.9*
5. *Morbid Obesity E66.01*
6. *Atherosclerosis of the Aorta I70.0*
7. *Dependence on Renal Dialysis Z99.2*
8. *Chronic Kidney Disease N18.30, N18.31, N18.32*

CMS-HCC	HHS-HCC
◊ Used by CMS to pay Medicare Advantage plans for enrollees	◊ Used by CMS to pay health insurers in Affordable Care Act
◊ Base year (current year) diagnoses determine next year's rates	◊ Uses current year diagnosis coding to set risk payments in
◊ Developed for >65-year-olds and disabled patients of all ages	◊ Developed for all age patients
◊ Pediatrics and obstetrics diagnosis codes are not assigned risk values	◊ Includes categories for infants, children and adults, and includes obstetrical diagnoses
◊ Does not include drug costs	◊ Includes drug costs
◊ Model used by many software programs, integrated into EMR	◊ Model less well known by medical practices
◊ Rule making: proposal at the end of December, final rates in April	◊ Payment to health insurers for caring for sicker patients in ACA

Sources:

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COLONOSCOPY CODING: Screening vs Diagnostic

Author: Kimberly Bowes, CPC, CRC, CEMC

To assign the appropriate colonoscopy code, one must understand whether it is being performed as a *screening* or *diagnostic* procedure. Additionally, understanding the criteria for a high-risk screening is of importance.

The documentation is always key in identifying whether the patient is having a screening or diagnostic colonoscopy. A *screening* colonoscopy is defined as a procedure performed without symptoms to test for the presence of colorectal cancer or polyps. The surgeon will usually identify the procedure as a screening colonoscopy in the operative report as the "procedure performed" or in the indications for the procedure. In the absence of this information the H&P may also be helpful.

The same holds true for whether the patient is average risk or high risk. In a perfect world, the physician will clearly note this information as part of the indications for the procedure. But understanding the criteria is beneficial for those times when the provider does not state the patient is "high risk." [5]

Average Risk:
No personal history of colon cancer, polyps, or inflammatory bowel disease or a family history of colorectal cancer.

High Risk:
Has a personal history of colon cancer, polyps, or inflammatory bowel disease and/or family history of colorectal cancer.

Screening Diagnosis and Procedure Codes:

- Screening Diagnoses Codes: [2]
  - Z12.11 – Encounter for screening for malignant neoplasm of colon
  - Z85.038 – Personal history of other malignant neoplasm of large intestine
  - Z86.010 – Personal history of colonic polyps
  - Z80.0 – Family history of malignant neoplasm of digestive organs

- Medicare Screening Procedure Codes (HCPCS Codes): [3]
  - G0121 – Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
  - G0105 – Colorectal cancer screening; colonoscopy on individual at high risk
  - G0104 – Colorectal cancer screening; flexible sigmoidoscopy (risk is not a factor)

Commercial Payer Procedure Codes (CPT Codes): [1]

- 45378 – Colonoscopy, flexible; diagnostic, including collection of specimens(s) by brushing or washing, when performed (separate procedure)
- 45330 – Sigmoidoscopy, flexible; diagnostic, including collection of specimens(s) by brushing or washing, when performed (separate procedure)

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Screening to Diagnostic Colonoscopy

Often there is confusion concerning whether the procedure is still a screening when a **polyp** is encountered and removed during the procedure. The removal of a polyp does not change the original intent of the procedure; in this situation a screening diagnosis code is still appropriate.

When a polyp is encountered and removed during the screening procedure; report the appropriate CPT code based on the technique of removal and append modifier 33 for commercial payers or modifier PT for Medicare patients.

For example:
A Medicare patient presents for a screening colonoscopy and a polyp is encountered and removed with cold forceps.
Report the service as follows:

- CPT Code: 45380-PT
- ICD-10 Codes: Z12.11, K63.5

- Screening Colonoscopy Modifiers:
  - 33 (preventative services)
  - PT (colorectal cancer screening test; converted to diagnostic test or other procedure)

Diagnostic/Therapeutic Procedure CPT Codes (Medicare or Commercial)[1]

- 45380 – Colonoscopy, flexible; with biopsy, single or multiple (cold forceps)
- 45381 – Colonoscopy, flexible; with directed submucosal injection(s), any substance
- 45382 – Colonoscopy, flexible; with control of bleeding, any method
- 45384 – Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
- 45385 – Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- 45388 – Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
- 45390 – Colonoscopy, flexible; with endoscopic mucosal resection

Diagnostic Colonoscopy

Anytime a patient presents with gastrointestinal signs and/or symptoms the colonoscopy automatically becomes a diagnostic procedure, regardless of whether the patient is within the timeframe to qualify for a screening colonoscopy. In these situations, the appropriate CPT code should be used.

Note: CPT code 45378 Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) is appropriate if no other procedure is performed. If a polyp is encountered and removed, use the CPT code based on the technique of removal. No screening diagnosis or preventive modifier is necessary in this situation.

2022 Medicare Payment Changes

Medicare is making changes to the amount patients will be responsible to pay beginning in 2022 which will result in reducing amount of coinsurance for screening colonoscopies converted to diagnostic from 20% in CY 2022, to 15% in CY 2023-2026, 10% in CY 2027-2029 and 0% beginning in 2030.

Sources:

1. 1. CPT 2022 Copyright American Medical Association. All rights reserved
2. 2. 2022 ICD-10-CM
3. 3. 2022 HCPCS Level 2
4. 4. CPT Assist, April 2011, Volume 21, Issue 4, page 12
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SPOTLIGHT ON DEPARTMENTS

Author: Tonya Shelton, , RHIT, CCS, CCDS, Manager, Inpatient Denials

The Denials Process

Hospital treats patient

Hospital files claim expecting payment

Hospital is denied full payment

Hospital must now appeal this

This is a common scenario for many hospital facilities. They are often bombarded with these denials on a regular basis. Requests are made to MARSI for assistance in appealing these decisions. These requests are handled by the MARSI Denials Team. There are several types of denials, including *DRG* (incorrect code assignment, improper sequencing of PDX, wrong procedure code, etc.), *Clinical* (reported lack of clinical criteria/documentation in the medical record) and *Admission* Denials (Observation vs. Inpatient, Readmissions, etc.). MARSI also receives requests involving Outpatient visits, which are handled by the Outpatient Department. Assistance in appealing *Clinical* denials are the most received. *Clinical* denials typically involve the payor stating a certain set of criteria must be met in order for code assignment to be justified.

For example:

Sepsis-3 consensus definition defines Sepsis as a life-threatening organ dysfunction caused by a dysregulated host response to infection. Organ dysfunction can be represented by an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of 2 points or more, which is associated with an in-hospital mortality greater than 10%.

Although many private payors use this definition for sepsis, it has not been accepted by **CMS** (Center for Medicare & Medicaid Services), and Sepsis-2 is still endorsed by many medical associations. MARSI assists our clients in appealing these decisions by reviewing the record for physician documentation of the criteria used by that physician to establish the condition, in addition to reviewing well-established criteria in the medical field for the diagnosis in question. We also review for clinical significance of the condition (i.e., was admission impacted by care provided? was there consistent documentation of the condition?, etc.) as well as coding guidelines and Coding Clinics for additional guidance. Although defending some of the denials is at times very challenging, MARSI has been successful in getting some cases overturned/withdrawn.

A NOTE FROM DR. HUSTY

All systems are go!... Or almost go.

MARSI has undertaken an effort to make sure that our training programs in inpatient and outpatient hospital and physician practice, as well as risk adjustment/HCC are up-to-date. The programs include redacted practice charts and their corresponding spreadsheets accurately coded and available for trainees. Our clients and placement companies tell us that there is a need for coders and auditors with specialty training and experience.

How can you get experience without a job and how can you get a job without experience? We are committed to taking coders with some experience and training them to become MARSI experts. We are also finishing a trial of taking new graduates, the best of the best, and putting them through a training program with redacted charts and expert instruction. Some have not made it, but others are excelling. We found in the process that the use of the redacted charts was cumbersome and could be improved. We will spend the next few months on that process and then will be ready to start a new group.

We are not ready to do that today. Please follow this newsletter for future announcements.

I personally am convinced, as are my managers, that MARSI has the expertise, online courses and charts for actual experience to expand this to many others, those who can't get a job without experience and can't get experience without a job.