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Bringing the Experts to You

# The HIM Times Newsletter

MARSI MEDICAL AUDIT RESOURCE SERVICES INC.

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## A NOTE FROM DR. HUSTY

MARSI has been positioning itself for growth over the past number of years. We have invested heavily into training programs that could be used internally to develop the type of HIM expert that MARSI is known for. We have an excellent reputation because, when we are contracted, we perform exceptionally. I have long been focused on growing MARSI and ensuring the long-term stability and success of the company.

After a long period of discussion with advisors and family, I decided to form a permanent relationship with **Health Management Associates**, a large healthcare consulting firm that does business across the United States. Health Management Associates (HMA) acquired MARSI earlier this month.

Joining HMA significantly increases the opportunities for us to extend our reach. The solutions we provide will expand the ways in which they can serve their clients. HMA knows our work and appreciates how our relationship will strengthen both HMA and MARSI.

MARSI and HMA are different, but complementary in nature. HMA values the expertise of our MARSI colleagues and the work they do – it's one of the main reasons they are so excited to have us – everyone at MARSI – join their team. And I am incredibly excited for this new chapter as part of HMA.

## Did You Know?

### MARSI OFFERS TRAINING COURSES :

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

**Send an Inquiry through HIMExperts.com**

## The Who - About HMA

- Founded by Jay Rosen in 1985, HMA is a leading independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation.
- Clients include government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations.
- HMA has done work in all 50 states, Washington, D.C., and Puerto Rico.
- HMA is home to over 500 multidisciplinary consultants and has offices in over 20 locations across the country.

Headquarters: Lansing, MI
HMA website: https://www.healthmanagement.com/

# A NOTE FROM DR. HUSTY

## The Why

- Our businesses are different. HMA recognizes this and embraces it. It is a benefit for both companies because, while different, our businesses are complimentary – and that means many opportunities exist for both HMA and MARSI.
- HMA is significantly bigger with a large and diverse client roster, which we believe will open new doors for us. HMA does a significant amount of work in the healthcare delivery space, including with providers, and is ramping up expansion of a business line focused on the revenue cycle. Their growing actuarial presence also presents an array of mutual opportunities. And we will have access to subject matter experts to quickly find answers to actuarial and operational questions.
- By coming together, we both have the ability to gain critical expertise and resources to serve our clients in additional ways.

## What this means for you

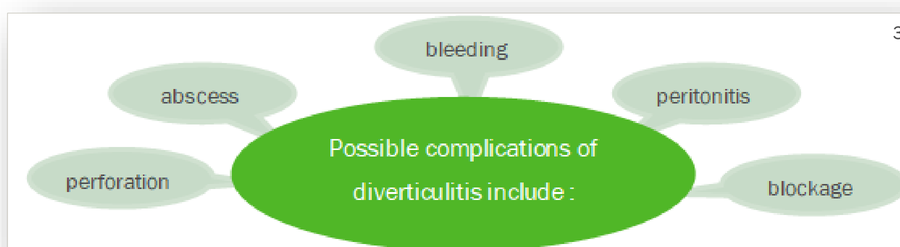
- Our clients can count on the partnerships they've formed with their MARSI contacts and the exceptional service and trusted guidance they are accustomed to. Our commitment to our clients is – as it's always been – unwavering.
- We will retain use of the MARSI name for the foreseeable future, adding "an HMA Company" to it. I will continue leading this great team as its managing director.
- The unmatched depth and breadth of healthcare expertise and experience within HMA assures new and increased ways in which we can help our clients.

*We're very excited to be joining HMA and the opportunities this presents us, and most importantly, our employees and clients. We believe this acquisition will positively impact all of us.*

# CODING CLARIFICATION : Diverticular Disease of Intestine

*Author: Davin Vandale, CCS, CPC-A*

Diverticulosis is a common gastrointestinal condition that develops when small pouches (*diverticula*) form within the wall of the intestine or colon. When stool gets trapped in the diverticula, bacteria growth can lead to diverticulitis. This is a serious condition that refers to inflammation and infection in one or more diverticula.




In ICD-10-CM, diverticular disease of the intestine, or diverticulitis is coded to category K57. These codes include location (small, large, or both small and large intestine), with or without perforation or abscess, and with or without bleeding. Category K57 has the following instructional note: *Code also if applicable peritonitis K65.-.* Some facilities did not realize that category K65, Peritonitis, includes peritoneal abscess.

**K57 Diverticular disease of intestine** [4]
*Code also* if applicable peritonitis K65.-
**Excludes1:** congenital diverticulum of intestine (Q43.8)
Meckel's diverticulum (Q43.0)
**Excludes2:** diverticulum of appendix (K38.2)

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## Example: Diverticulitis with Peritoneal Abscess

If a patient is admitted with diverticulitis of the colon and an intra-abdominal abscess, assign code **K57.20**, *Diverticulitis of large intestine with perforation and abscess without bleeding.*

Also assign code **K65.1**, *Peritoneal abscess*, to specify the location of the abscess. "Code also" notes located under both code categories support this code assignment. [1]

[4]
**K65.0 Generalized (acute) peritonitis**
Pelvic peritonitis (acute), male
Subphrenic peritonitis (acute)
Suppurative peritonitis (acute)
**K65.1 Peritoneal abscess**
Abdominopelvic abscess
Abscess (of) omentum
Abscess (of) peritoneum
Mesenteric abscess
Retrocecal abscess
Subdiaphragmatic abscess
Subhepatic abscess
Subphrenic abscess
**K65.2 Spontaneous bacterial peritonitis**
**Excludes1:** bacterial peritonitis NOS (K65.9)

## Example: Perforated Diverticulitis with Peritonitis

If a patient is admitted with peritonitis secondary to perforated diverticulitis of the colon, assign codes **K57.20**, *Diverticulitis of large intestine with perforation and abscess without bleeding*, and **K65.9**, *Peritonitis, unspecified*. It is appropriate to report both codes for discharges on and after October 1, 2020 because the former inclusion term at subcategory **K57.2-** has been deleted. [2]

Sources:

1. AHA Coding Clinic First Quarter 2022: Page 26
2. AHA Coding Clinic First Quarter 2022: Page 27
3. https://my.clevelandclinic.org/health/diseases/10352-diverticular-disease
4. ICD-10-CM 2022: The Complete Official Code Book

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# OBSTETRIC PRINCIPAL DIAGNOSIS SELECTION – A Refresher

*Author: Davin Vandale, CCS, CPC-A*

Chapter 15 codes have sequencing priority over codes from other chapters. In other words, pregnancy is queen and reigns supreme. Codes from other chapters may be used in addition to chapter 15 codes to further specify conditions affecting the pregnancy, delivery, or the puerperium. Unless the physician states the pregnancy is incidental to the encounter, the principal diagnosis is always an "O" (for obstetrics) code.

### Routine outpatient prenatal visits

For routine outpatient prenatal visits when no complications are present, a code from category Z34, Encounter for supervision of normal pregnancy, should be used as the principal diagnosis. These codes should not be used in conjunction with chapter 15 codes.

### Supervision of high-risk pregnancy

For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09, *Supervision of high-risk pregnancy,* should be used as the principal diagnosis. If there are complications during the labor or delivery episode as a result of a high-risk pregnancy, assign the applicable complication codes from Chapter 15.

### Episodes where no delivery occurs

Where no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complication codes may be sequenced first.

### Where a delivery occurs

Where an obstetric patient is admitted, the condition that prompted the admission should be sequenced as the principal diagnosis. A code for any complication of the delivery should be assigned as an additional diagnosis.

*For example, if a patient is admitted for treatment of preeclampsia, and fetal decelerations complicate spontaneous vaginal delivery, the preeclampsia should be sequenced as the principal diagnosis, rather than fetal decelerations.* [2]

If the patient is admitted for delivery without any conditions or complications, but develops a complication during delivery (such as perineal laceration during delivery), the principal diagnosis would be the perineal laceration.[2]

### Delivery with no complications

If there are no complications, assign code O80, *Encounter for full-term uncomplicated delivery.* A note in the tabular provides directions for the use of this code as follows: "Delivery requiring minimal or no assistance, with or without episiotomy, without fetal manipulation (i.e., rotation version) or instrumentation [forceps] of a spontaneous, cephalic, vaginal, full-term, single, live-born infant."
Code O80 is always principal diagnosis and is not to be used with any other code from chapter 15.

Sources:

1. 2022 ICD-10-CM Official Guidelines for Coding and Reporting
2. AHA Coding Clinic ICD-10-CM/PCS, First Quarter 2016: page 3

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# SPLIT/SHARED SERVICES CLARIFICATIONS

*Author: Marsha Diamond , CPC, COC, CCS, CPMA, AAPC Fellow*

Since the 2022 enhanced guidelines for split-shared services were introduced back in January, 2022, there has been a lot of confusion regarding *how* the guidelines should be interpreted.

From a Medicare perspective (as well as other carriers utilizing Medicare guidelines), the definition of split/shared services per the **Medicare Claims Processing Manual Publication 100-04, Chapter 12, Section 30.6.18** describes *"a split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP (Non-Physician Practitioner) each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision-making key components of the E/M services. The physician and the qualified NPP must be in the same group practice or be employed by the same employer."*[1]

The split/shared policy applies only to certain settings, such as hospital inpatient, hospital outpatient, hospital observation, emergency department and some office and non-facility clinics. When a non-hospital outpatient clinic or physician office E/M is a split/shared service, the E/M encounter may be billed under the physician's name if the patient is an established patient AND the incident-to rules are also met.

## Proper Documentation of Split/Shared Services

**The following documentation requirements must be met for split/shared services:**

- The physician's documentation must clearly demonstrate that a face-to-face visit took place, such as documenting the exam component to substantiate the physician had a face-to-face visit.
- If the physician does not personally perform and document a face-to-face portion of the E/M encounter, then the E/M encounter should not be billed under the physician's name and provider number.
- If the physician's participation is only the review of the patient's medical record, and, there is no documentation to substantiate that a face-to-face visit was performed by the physician, then the service will need to be billed under the NPPs name and provider number, resulting in payment at 85% of the Medicare Physician Fee Schedule.

Since 2022 was defined as a "transitional" year, 2023 will see additional changes to the split/shared services requirements, when CMS will require that split/shared services may only be reported by the provider who performs more than 50% of the time documented for the service. In the meantime, the billing practitioner must document the substantive portion of one of the three (3) key elements, i.e., history, exam or medical decision making or time to qualify for billing under the physician provider.

For critical care services, the billing provider must document more than ½ of the time needed to meet the critical care definition since there is no history, exam and medical decision-making components utilized to determine critical care services.

*Stay tuned for additional changes and updates to this policy in the future.*

Sources:

1. Medicare's Split/Shared Visit Policy - AAPC Knowledge Center

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# CHRONIC KIDNEY DISEASE (CKD)

*Author: Ricardo Duran, CRC, CDEO*

## Definition:

**Chronic kidney disease** (CKD) means your kidneys are damaged and can't filter blood properly. The disease is called "chronic" because the damage to your kidneys happens slowly over a long period of time [2]. The kidney's main job is to filter extra water and waste out of your blood to make urine. To keep your body working properly, the kidneys balance the salts and minerals that circulate in the blood.

Kidney disease often can get worse over time and may lead to kidney failure. If your kidneys fail, you will need dialysis or a kidney transplant to maintain your health.

## Signs and symptoms:

Early stages of CKD may not have signs and/or symptoms and may only be confirmed via Lab results. As kidney disease gets worse, a person may have *edema*.

**Edema** can occur in the legs, feet, or ankles, and less often in the hands or face. Other symptoms include dry skin, feeling tired, headaches, increased urination, and weight loss.

## Diagnosis and HCC Coding:

CKD is diagnosed primarily by lab values of the **Globular Filtration Rate** (GFR) of the kidneys. Optimally, two consecutive GFRs matching the specific CKD stage should be present to diagnose. Other tests include BUN, serum creatinine and Microalbumin.

From date of service **10/1/20** forward, the codes for CKD Stage 3 have changed.

The new codes for CKD Stage 3 are:

- CKD Stage 3, unspecified (N18.30)
- CKD Stage 3a (N18.31)
- CKD Stage 3b (N18.32)

*The other codes for CKD remain the same.*

The classification by GFR for CKD is listed below:

| Condition | ICD-10 Code | GFR Classification | HCC |
|---|---|---|---|
| CKD, unspecified | N18.9 | N/A | No HCC |
| CKD stage 1 | N18.1 | GFR = 90 or higher | No HCC |
| CKD stage 2 | N18.2 | GFR = 60 to 89 | No HCC |
| CKD stage 3, unspecified | N18.30 | GFR= <60 to 30 | 138 |
| CKD stage 3a | N18.31 | GFR = 45 to 59 | 138 |
| CKD stage 3b | N18.32 | GFR = 30 to 44 | 138 |
| CKD stage 4 | N18.4 | GFR = 15 to 29 | 137 |
| CKD stage 5 * | N18.5 | GFR = Less than 15, not req Dialysis | 136 |
| ESRD * | N18.6 | GFR dangerously low req Dialysis | 136 |
| Dependence on Renal Dialysis ** | Z99.2 | N/A | 134 |
| Patient Non-Compliant with Renal Dialysis ** | Z91.15 | N/A | 134 |

* N18.5 - Excludes 1 – Chronic Kidney Disease, stage 5 requiring chronic dialysis (N18.6)

**Code Z99.2, Dependence on renal dialysis, is to be assigned as an additional code when coding N18.6, ESRD (AHA Q1 2016, Q3 2016). If the patient is known to be noncompliant with renal dialysis, code Z91.15, Patient's noncompliance with renal dialysis, is to be applied.

## Treatment:

Treatment of CKD includes management of underlying diseases, such as high blood pressure and Diabetes, to prevent further kidney damage. Patients with CKD should monitor their diet and have their GFR and Microalbumin values checked regularly. ACE inhibitors and ARBs may slow kidney damage as well.

Sources:

1. Centers for Disease Control and Prevention. Chronic Kidney Disease in the United States, 2019. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2019
2. Race, ethnicity, and kidney disease. NIDDK website. www.niddk.nih.gov. Published June 13, 2017. Accessed June 13, 2017
3. Cleveland Clinic Kidney Function Tests, 7/14/2021
4. AHA Coding Clinic, Q1 2016 and Q3 2016