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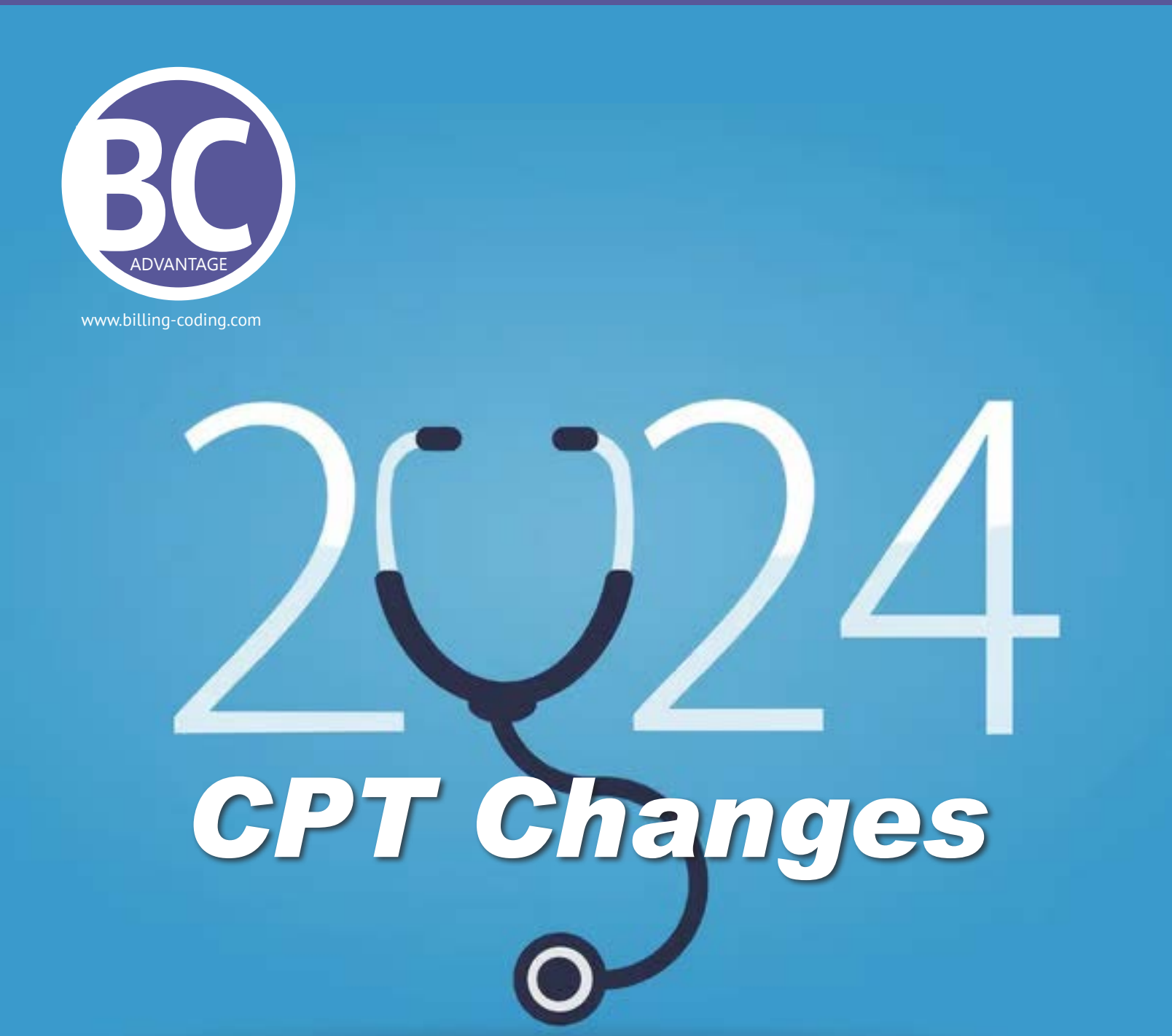

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March / April 2024 | Issue 19.2

SP COLLABORATIVE

"The Art of Business Medicine"

www.spcollaborative.net

OUR HISTORY

SP Collaborative, LLC was founded by Sonal Patel, BA, CPMA, CPC, CMC, ICDCM. She serves as the CEO & Principal Strategist.

OUR STORY

Sonal utilizes her unique background and education in the humanities, fine art, and art history to complement her partnerships with her clients in healthcare.

OUR VISION

We serve as the bridge between the art of clinical documentation and the science of medical coding. SP Collaborative, LLC recognizes the beauty beneath art and science of medicine.

OUR MISSION

SP Collaborative, LLC believes in the voices of all its partners and strives to maintain mutually beneficial relationships.

GALLERY OF SERVICES

Sonal Says

Our service if you are in need of email support for your medical coding, billing, auditing, appeals, and compliance questions.

QA Audits

Our service if you are a provider needing to achieve coding compliance through quality reviews.

Content Creation

Our service if you are a healthcare professional needing copywriting and content creation.

Collaborative Solutions

Our service if you are a coding compliance champion needing collaborative solutions and support.

SONAL PATEL, BA, CPMA, CPC, CMC, ICDCM

Sonal Patel is a nationally recognized business of medicine professional, speaker, author, podcast creator and host. She has over 14 years of experience in medical coding, auditing, and healthcare compliance. Sonal has utilized her creative strengths in writing hundreds of winning appeals letters for various specialty physicians to overturn denial letters they received. Sonal has had the honor to work with healthcare attorneys as well.

www.spcollaborative.net contact@spcollaborative.net

SP COLLABORATIVE

CEO Letter

I'm cold. It's cold. At time of print, it's winter and I'm counting down the days until spring and summer. Enough said.

This issue brings together an interesting group of writers who have put together some great (somewhat longer) articles for you. Our cover is from Betty Hovey, CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I, from Compliant Health Care Solutions. Betty has written an expansive article attending the 2024 CPT updates—of which there are many. She has also completed multiple webinars for us that will be released shortly. Betty will be working with another editorial board member, Sonal Patel, BA, CPMA, CPC, CMC, ICDCM (who has also contributed to this issue), on other projects and webinars throughout this year, so please watch out for those collaborations between these two fantastic ladies.

We have another piece from L.E. Shepherd, Jr., discussing changes in healthcare over the years. L.E. has always written passionately about this subject over our many years of publishing his work and I've always found his articles to be interesting, full of information, and sometimes, quite opinionated. Our editor, Amber, has been challenged at times to help his points come across in a more diplomatic way for our readers, but you cannot fault him with his passion for healthcare business owners, staff, and patients alike. He always sets my brain alight with his perspective and I hope he does yours too.

Natalie Tornese from Managed Outsource Solutions has written an excellent piece about the thyroid and we're so glad to publish her work as we always learn a lot from her. Rachel Rose, JD, MBA, has put together an article on the recent developments in protecting patient and consumer data. The challenges surrounding this issue can be overwhelming at times as there are so many horrible stories about breaches and information being taken, causing issues for business and individuals alike, so take advantage of the insight shared here.

We also have great articles written by Adam Phillips, Erin Stephens, Taylor (Ross) Webster, Anitha Ligala, and the RRCS team consisting of Kelly M. Ellis, RHIA, CDIP, CCS, CCS-P; Ashley Carson, CPC, CCS-P; and K-cee Cagle, CPC.

So grab your beverage of choice and enjoy the read!
Until next time,

Storm

Storm Kulhan

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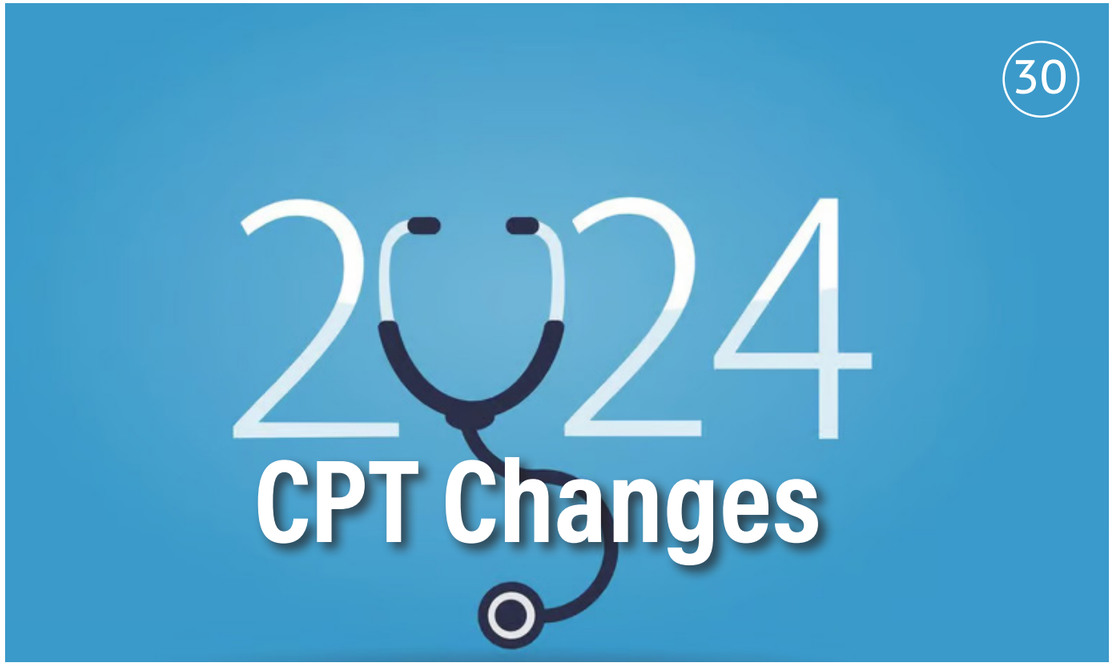

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Adam Phillips is the author of 9 Ways Doctors Let Money Slip Through Their Fingers - And How A Few Simple Ideas Can Guarantee a Private Practice Will Thrive in Today's Post-Pandemic World. He is the CEO of American Business Systems, a training and support company for individuals wishing to start their own medical billing business. He hosts bi-weekly educational webinars at www.ABSystems.com.

Rachel V. Rose, JD, MBA, is an Attorney at Law in Houston, TX. Rachel advises clients on healthcare, cybersecurity, securities law, and qui tam matters. She also teaches bioethics at Baylor College of Medicine. She has been consecutively named by Houstonia Magazine as a Top Lawyer (Healthcare) and to the National Women Trial Lawyer's Top 25. She can be reached at rvrose@rvrose.com. www.rvrose.com

L.E. Shepherd, Jr., is the CEO of MedBizonics. Mr. Shepherd has successfully provided comprehensive business advisory and management services to the healthcare industry and others for over 30 years. Over the course of his business career, Mr. Shepherd has developed a broad knowledge base of business acumen and expertise, with an extensive focus on the business of medicine, the consumer-patient, the healthcare industry, and employer benefits. www.medbizonics.com

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Taylor (Ross) Webster is the Head of Coding Quality at Fathom, a health technology company that uses deep learning artificial intelligence to automate medical coding for a wide range of specialties and practices. Webster manages strategic analysis, client analytics, and reporting. www.fathomhealth.com

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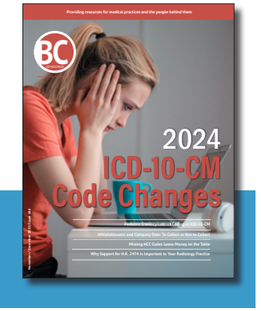

The Ultimate: G2211 Reference Guide

The latest CMS code G2211 is here, which means we need to implement internal policies, train our coders/auditors, educate our physicians, and closely focus on documentation. While it may still be rescinded, let's prepare for success!

NAMAS has been working hard to create a free downloadable reference card that is comprehensive and informative.

The front of the card helps physicians identify patients who qualify for the G2211 complexity service and provides appropriate documentation to support the service's work.

The back of the card includes reference information on terms used to describe the services provided by G2211.

Visit: https://namas.co/

What Is HIPAA Right of Access Compliance?

The Right of Access provision is found at 45 C.F.R. 164.524 and falls under the HIPAA Privacy Rule. The HIPAA Privacy Rule generally provides individuals with a legal, enforceable right to see and receive copies, upon request, of the information in their medical and other health records maintained by their healthcare providers and health plans. HIPAA Right of Access is enforced by the Office for Civil Rights (OCR).

OCR Enforcement Initiative

In 2019, the OCR launched the HIPAA Right of Access Initiative to advocate for individuals trying to obtain their health records in a timely manner at a reasonable cost as required by covered entities in the HIPAA Privacy Rule.

If your organization is not responding timely to requests for medical records, a complaint to the Office for Civil Rights can trigger an investigation resulting in fines and other consequences, such as being posted on the OCR HIPAA website and a forced Corrective Action Plan.

A dedicated government webpage lists HIPAA News Releases & Bulletins listing OCR cases after investigating organizations which includes Right of Access settlements.

Training Solution Now Offered by AIHC

As a Licensing/Certification Partner with CMS, the American Institute of Healthcare Compliance now offers a Right of Access online training program with option to certify (online, with an assigned proctor).

Prerequisite To Certify: To qualify to certify, you must have at least two years of experience working for a HIPAA covered entity or an organization defined as a HIPAA business associate. During your two years of such employment, your job is related to viewing, accessing, storing, maintaining, and/or releasing any patient information. Certification exam fee is $75.

Visit: https://aihc-assn.org/

Practice Management Institute Names Washington County Community College 2023 Outstanding National Host Partner

Practice Management Institute (PMI) has named Washington County Community College (WCCC) its 2023 Outstanding National Host Partner. The award, chosen nationally from among hundreds of hospital, college, medical society, physician service group, and program host partners, is given to an organization who has demonstrated exceptional commitment to partnering with PMI for the purposes of advancing educational opportunities within their service area and state.

Washington County Community College, a part of the Maine Community College System, has been recognized for a number of ground-breaking initiatives. For five years, PMI and WCCC have been partnering to meet the training needs of existing medical office personnel throughout the state of Maine, while expanding ground-breaking training opportunities in support of Maine workforce and transitional residents, aimed at long lasting and sustainable employment within the healthcare industry.

The WCCC Pathways in Health Sciences program, which includes other PMI training options such as Certified Medical Coder, Certified Medical Insurance Specialist, Certified Medical Office Manager, and Certified Medical Compliance Officer, successfully

launched the ground-breaking Patient Services Representative certificate program. The two-phase program was developed by PMI for WCCC, specifically to meet a workforce training need identified by Maine regional Federally Qualified Rural Health Centers, hospitals, and medical offices. The success of the program has now expanded beyond the state of Maine and is offered nationally by PMI.

Interested in a similar academic partnership with PMI? If your college would like more information about partnering with PMI, please contact Michael Moore at 1-800-259-5562, Ext. 270, or email Michael directly at mmoore@pmimd.com.

Visit: https://www.pmimd.com/

Penn State Health to Pay $11 Million Over Medical Billing Issues

Penn State Health is agreeing to pay more than $11 million to resolve allegations of improper billings to Medicare.

The U.S. Attorney's Office said the health system voluntarily disclosed that between December 2015 and November 2022, it submitted claims to Medicare for annual wellness visit services that violated Medicare rules and regulations and were not supported by medical records.

After discovering the problems, Penn State Health disclosed the issues to the U.S. Attorney's Office.

Visit: https://www.wgal.com/

CMS News: Evaluation and Management (E/M) Visits

Beginning January 1, 2024, CMS is finalizing implementation of a separate add-on payment for healthcare common procedure coding system (HCPCS) code G2211. This add-on code will better recognize the resource costs associated with evaluation and management visits for primary care and longitudinal care. Generally, it will be applicable for outpatient and office visits as an additional payment, recognizing the inherent costs involved when clinicians are the continuing focal point for all needed services, or are part of ongoing care related to a patient's single, serious condition or a complex condition.

For example, a primary care clinician, as the continuing focal point for all needed healthcare services for a patient, often bears the cognitive load, responsibility, and accountability for building the most effective, trusting relationship possible amidst evaluating and managing other healthcare problems during a visit. Building an effective longitudinal relationship, in and of itself, is a key aspect of providing reasonable and necessary medical care and will make the patient more likely to comply with treatment recommendations after the visit and during future visits. It's the work building this important relationship between the practitioner and patient for primary and longitudinal care that has been previously unrecognized and unaccounted for during evaluation and management visits. In the rule, CMS provided greater detail on how clinicians can utilize the code, as requested by commenters, and may produce educational materials as is necessary.

Implementing payment for this add-on code has redistributive impacts for all other CY 2024 payments under the Medicare Physician Fee Schedule, due to statutory budget neutrality requirements.

However, these redistributive impacts are comparatively less than what was initially estimated for this policy in CY 2021 when CMS originally finalized this policy in the CY 2021 Medicare Physician Fee Schedule final rule. At that time, Congress suspended the use of the add-on code by prohibiting CMS from making additional payment under the PFS for these inherently complex E/M visits before January 1, 2024. Since this policy will improve the accuracy of payment for primary and longitudinal care, CMS is finalizing implementation of the policy with certain modifications for 2024.

CMS is finalizing refinements to the 2021 policy after considering information from interested parties who shared feedback in earlier rulemaking about CMS's utilization assumptions and the estimated redistributive impact of the code on PFS payments. These changes have reduced the estimated redistributive impacts of this policy. Specifically, CMS is finalizing that the add-on code cannot be billed with an office or outpatient evaluation and management visit that is itself focused on a procedure or other service instead of being focused on longitudinal care for all needed healthcare services, or a single, serious or complex condition. Further, in response to public feedback, CMS will also consider refinements to this prohibition and monitor how the service is furnished. Second, CMS has refined their utilization estimates for HCPCS code G2211 in response to public feedback. Together, these modifications reduce the redistributive impact to the CY 2024 conversion factor by nearly one third from the estimated impact described in the CY 2021 Medicare Physician Fee Schedule final rule.

Visit: https://www.cms.gov/

Breaking Down Misconceptions:

Understanding Thyroid Diseases

Imagine a tiny butterfly-shaped gland quietly regulating your body's energy levels and overall health. Your thyroid, which uses iodine to make thyroid hormones, helps control blood pressure, body temperature, heart rate, metabolism, and the reaction of your body to other hormones. Thyroid disorders occur when the gland becomes overactive (hyperthyroidism) or underactive (hypothyroidism). When the thyroid is not working as it should, it can result in serious health problems.

The American Thyroid Association (ATA) estimates that more than 12% of the U.S. population will experience a thyroid condition at some point in their lives. One in eight women will also develop a thyroid disorder during their lifetime. Hypothyroidism is more common than hyperthyroidism. However, despite the prevalence and impact of thyroid diseases on health, there are many misconceptions surrounding it, often leading to confusion, misinformation, and sometimes unnecessary fear.

This article shares some expert insights to bust the common misconceptions about thyroid function to foster clarity and awareness about thyroid disease. This is important to understand and navigate this aspect of health more effectively.

10 Common Misconceptions Linked with Thyroid Conditions

Here are 10 common misconceptions linked to thyroid disease and the truth behind them:

1. **Misconception: Treating thyroid disease requires the expertise of an endocrinologist in every case.**
   Fact: Various healthcare providers play a role in managing thyroid issues. Your primary care provider can manage simpler cases, but complex conditions may require an endocrinologist or a specialist. Situations where you might need specialized care include pregnancy, thyroid problems in children, nodules, goiter, or any form of hyperthyroidism, including Graves' disease.

2. **Misconception: Thyroid disease is easy to diagnose and treat.**
   Fact: One prevalent misconception is that diagnosing thyroid disease is straightforward. However, the varied and uncertain symptoms associated with these illnesses make their diagnosis challenging. Also, treating thyroid problems is a personalized journey that evolves over a lifetime, with treatment plans differing among individuals. The process demands careful monitoring and collaboration with a specialist to determine the most effective treatment approach and medication dosage for you.

3. **Misconception: You should take iodine supplements if you have hypothyroidism.**
   Fact: The Institute of Medicine has set the Recommended Dietary Allowance (RDA) for iodine intake in adult men and women at 150 micrograms per day. While iodine deficiency is one cause of hypothyroidism, taking iodine supplements isn't recommended for all cases of hypothyroidism. You usually don't need iodine supplements if you live in the United States and other developed countries where iodine is added to salt and other foods.

   "If the underactive thyroid isn't caused by iodine deficiency, then iodine supplements give no benefit and shouldn't be taken. In fact, for some people with an underactive thyroid, too much iodine can cause or worsen their condition," opines Todd B. Nippoldt, M.D. (www.mayoclinic.org).

4. **Misconception: Once you start taking thyroid medication, your symptoms will disappear.**
   Fact: Treatment for hypothyroidism involves a daily replacement thyroid hormone taken on an empty stomach. Thyroxine is slow acting; it can take weeks or even months for levels of this hormone to rise to the target level. Factors affecting improvement include dosage, timing, health conditions, and absorption concerns. Duration for hyperthyroidism treatment varies based on its cause, and discovering the right dose is a personalized journey.

5. **Misconception: You can stop taking medication once the thyroid stimulating hormone (TSH) value is normal.**
   Fact: Typically, if thyroid medication effectively maintains the TSH at the normal level, there's no need to discontinue it. In fact, stopping the medication or not maintaining the correct dosage might lead to the reappearance of hypothyroidism symptoms.

6. **Misconception: If you have a thyroid condition, you need to take medication for life.**
   Fact: Thyroid conditions often require lifelong medication, but there are exceptions. Temporary factors like pregnancy or specific medications might necessitate only temporary medication. After pregnancy, hormone levels stabilize, restoring normal thyroid function. Also, prescriptions can change as those with an underactive thyroid may require increased hormone supplementation during pregnancy.

7. **Misconception: You shouldn't eat cruciferous vegetables if you have a thyroid disorder.**
   Fact: Cruciferous vegetables include broccoli, cauliflower, cabbage, kale, bok choy, arugula, Brussels sprouts, collards, watercress, and radish. While eating cruciferous vegetables is good for your health, they are thought to interfere with the way your thyroid uses iodine.

   The truth is that they may induce or exacerbate hypothyroidism only if you eat very large quantities.

   "Cruciferous vegetables are part of a healthy and balanced diet, and I encourage patients with thyroid disorders to continue eating them in moderation," says Northwestern Medicine Endocrinologist Ayla Bakar, M.D. (www.nm.org). You would have to consume an excessive and unrealistic amount of these vegetables for them to interfere with iodine and thus hormone production in the thyroid, she notes.

8. **Misconception: Thyroid disorders only affect women.**
   Fact: Hypothyroidism can affect a person of any age and

gender. While women are much more likely to be affected by thyroid disease than men, about two out of every ten cases are men. Their common symptoms include feeling cold, fatigue, constipation, depression, erectile dysfunction, weight changes, hair loss, dry skin and brittle nails, and sore muscles.

9. **Misconception: Thyroid cancer is not curable.**
   Fact: The majority of thyroid cancers are curable, especially if they haven't spread extensively. Treatment options include surgery, chemotherapy, radiation, hormone therapy, and radioiodine therapy. If a cure isn't possible, treatment aims to minimize cancer growth, spread, or recurrence by removing or controlling it as effectively as possible for as long as possible (American Cancer Society).

10. **Misconception: If you have a thyroid condition, you'd recognize the symptoms.**
    Fact: Symptoms of both an underactive thyroid and a hyperactive thyroid are vague and easy to ignore. According to the American Thyroid Association, an estimated 20 million Americans have some form of thyroid disease, and of this number, up to 60 percent are unaware of their condition.

    Why is that? Thyroid issues share symptoms with various health conditions like anemia, fatigue, and mental health disorders. Talking to your doctor about these symptoms, including whether you need a thyroid disorder blood test, is crucial. The most reliable way to diagnose thyroid disorders is through timely testing.

Coding for Thyroid Diseases

While navigating the complexities of thyroid disorders, understanding the relevant medical codes can demystify the diagnostic process. Reporting the correct codes ensures appropriate reimbursement for medical services rendered while maintaining precise and consistent clinical documentation.

The ICD-10 codes for disorders of thyroid gland fall in the range E00-E07:

- E00 - Congenital iodine-deficiency syndrome
- E01 - Iodine-deficiency related thyroid disorders and allied conditions
- E02 - Subclinical iodine-deficiency hypothyroidism
- E03 - Other hypothyroidism
- E04 - Other nontoxic goiter
- E05 - Thyrotoxicosis [hyperthyroidism]
- E06 - Thyroiditis
- E07 - Other disorders of thyroid

Some of the most frequently used ICD-10 codes for hypothyroidism and hyperthyroidism include the following:

- Hypothyroidism
  - E03.9 - Hypothyroidism, unspecified
  - E03.3 - Postinfectious hypothyroidism
  - E03.4 - Atrophy of thyroid (acquired)
  - E03.5 - Myxedema coma
  - E03.8 - Other specified hypothyroidism
  - E07.9 - Disorder of thyroid, unspecified

- Hyperthyroidism
  - E05.00 - Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
  - E05.01 - Thyrotoxicosis with diffuse goiter with thyrotoxic crisis or storm
  - E05.20 - Thyrotoxicosis with toxic multinodular goiter without thyrotoxic crisis or storm
  - E05.21 - Thyrotoxicosis with toxic multinodular goiter with thyrotoxic crisis or storm
  - E05.30 - Thyrotoxicosis from ectopic thyroid tissue without thyrotoxic crisis or storm
  - E05.31 - Thyrotoxicosis from ectopic thyroid tissue with thyrotoxic crisis or storm

Conclusion

It is important to debunk misconceptions clouding public understanding of thyroid disease. Busting myths and promoting awareness paves the way for informed discussions and proactive healthcare decisions. Accurate medical coding is pivotal for accurately representing thyroid diseases. Providers of medical coding services can ensure precise coding and sequencing based on physician documentation within medical records and adherence to the Official Coding Guidelines for inpatient care. Moreover, they leverage references such as the AHA Coding Clinic for ICD-10-CM and the American Medical Association CPT Assistant to ensure comprehensive and precise coding for thyroid disorders.

Natalie Tornese, CPC, is Director of Revenue Cycle Management: Healthcare Division. She joined Managed Outsource Solution's (MOS) Revenue Cycle Management Division and brings over twenty-five years of hands-on management experience to the company. Starting as an EMT in New York City, she has held positions of progressive responsibility throughout her career – serving a diverse range of practices and specialties.
www.managedoutsource.com

Coding Changes That Will Impact

Radiology Practices in 2024

The annual update to the Current Procedural Terminology (CPT)® for 2024 has 230 new codes, 70 revised codes, and 49 deleted codes. In addition, there are 395 new diagnosis codes contained in the ICD-10-CM update, about one-third of them describing new ways to capture accidents and injuries. Although relatively few of these changes will impact radiology practices, it's essential to know what they are and adjust your practice systems accordingly.

Diagnostic Radiology

Coronary Fractional Flow Reserve (FFR) with CT

New Category I code 75580 will replace Category III codes 0501T, 0502T, 0503T, and 0504T to describe noninvasive estimated coronary FFR derived from augmentative artificial intelligence (AI) software analysis of coronary CT angiography (CCTA) data. "Augmentative" means that a physician or other qualified healthcare professional is required to interpret and report on the analysis. When the interpretation occurs on the same day as the CCTA, then 75580 is used in conjunction with coding for the CCTA (75574).

Cardiac Intraoperative Ultrasound (IOUS) Services

New codes are available to report cardiac IOUS, as follows:

CPT Code	Description
76984	Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic.
Intraoperative epicardial cardiac ultrasound (i.e., echocardiography) for congenital heart disease, diagnostic;	
76987	Including placement and manipulation of transducer, image acquisition, interpretation, and report.
76988	Placement, manipulation of transducer, and image acquisition only.
76989	Interpretation and report only.

Cardiac IOUS is used primarily during cardiothoracic surgery procedures to evaluate structures, provide intraoperative guidance, and real-time perioperative surgical decision-making information that may affect the operative strategy.

Vascular Ultrasound Guidance

Beginning January 1, 2024, Medicare will no longer pay separately for CPT code 76937, defined as "ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites …" and associated with any procedure that "includes radiological supervision and interpretation." Ultrasound guidance is now bundled with the primary procedure. The removal of separate billing for the ultrasound guidance code means a loss of $37.66 per procedure when billing globally, or $13.43 for the professional component, using the national Medicare reimbursement rates.

Several specialty societies have filed their objection to this rule change with CMS, and there is hope that it could possibly be reversed.

Interventional Radiology

Dorsal Sacroiliac Joint Arthrodesis

New Category I code 27278 will replace Category III code 0775T, and existing code 27279 has been modified. According to the American College of Radiology (ACR)'s description of the new code changes, the new code 27278 "will allow the reporting of percutaneous intra-articular placement of one or more fusion implant(s) directly into the SI joint under imaging guidance. This is typically performed from a posterior/dorsal approach." Regarding code 27279, ACR says that it is "used to report percutaneous placement of a transfixation device, such as a screw, across the SI joint to perform fusion. This is typically performed from a lateral approach."

CPT Code	Description
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s), without placement of transfixation device.
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, with placement of transfixation device.

Transcervical Radiofrequency Ablation (RFA) of Uterine Fibroids

New Category I code 58580 will replace Category III code 0404T.

CPT Code	Description
58580	Transcervical radiofrequency ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring.

Coronary Intravascular Lithotripsy (IVL) Interventions

New Category I code 92972 will replace Category III code 0715T to describe coronary IVL, a revascularization technique used to treat heavily calcified coronary arteries. This is an add-on code, to be used in conjunction with the primary procedure codes such as those describing coronary transluminal angioplasty, atherectomy, or stent placement.

CPT Code	Description
92972 Add-on	Percutaneous transluminal coronary lithotripsy.

Cystourethroscopy

A new code has been added, as follows:

CPT Code	Description
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy when performed.

Category III Codes

Category III codes are temporary codes that allow for data collection for emerging technologies, services, procedures, and service paradigms. They are *not routinely reimbursed* by most payors, including Medicare, when they are initially issued, but that can change as they become more accepted and eventually transitioned into a Category I classification with regular reimbursement.

For 2024, several new Category III codes will be available, as follows:

CPT Code	Description
Quantitative MRI analysis of the brain with comparison to prior MRI studies, including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation, and report;	
0865T	Obtained without diagnostic MRI examination of the brain during the same session.
0866T Add-on	Obtained with diagnostic MRI examination of the brain. List separately in addition to the code for the primary procedure.

CPT Code	Description
0814T	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral.
0815T	Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, one or more sites, hips, pelvis, or spine.
0857T Add-on	Opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis, and report. Use in conjunction with breast ultrasound codes 76641 or 76642.

Diagnosis Coding

The most relevant ICD-10-CM code changes for radiology involve the expansion of coding for breast density, including laterality. Breast density is categorized by the breast imaging-reporting and data system (BI-RADS). Here are the codes to be used for 2024:

ICD Code	Description
R92.30	Dense breasts, unspecified
Mammographic fatty tissue density	
R92.311	Right breast
R92.312	Left breast
R92.313	Bilateral breasts
Mammographic fibroglandular density	
R92.321	Right breast
R92.322	Left breast
R92.323	Bilateral breasts
Mammographic heterogeneous density	
R92.331	Right breast
R92.332	Left breast
R92.333	Bilateral breasts
Mammographic extreme density	
R92.341	Right breast
R92.342	Left breast
R92.343	Bilateral breasts

Recommendation

> ***Subscribe to the Healthcare Administrative Partners radiology billing and coding blog to stay in touch with the latest news that will help your practice optimize its reimbursement.***

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Everything You Need to Know About the CMS-HCC-V28 Changes and How AI Helps

A new year brings excitement, fresh starts, and the latest changes to the CMS-HCC (Centers for Medicare and Medicaid Services hierarchical condition category) risk adjustment model, version 28 (V28). And even if you're excited about 2024, the guideline updates are probably stressful and a bit deflating. It can take months for coding and revenue cycle teams to get up to speed with the latest updates, training, and accompanying expenses—inevitable mistakes come with any coding update, which cause billing delays, underpayments, and claim denials. Most healthcare organizations likely still have last year's evaluation and management changes for emergency departments fresh on their minds. Will you experience the same struggles again with CMS-HCC-V28?

2023 brought about the mass adoption of AI. But even though AI has only recently moved into the mainstream, the technology has been used in healthcare for decades. According to Cedars-Sinai Medical Center in California, AI medical applications were first explored as far back as the 1970s. Today, the technology is used in everything from diagnosing patients to transcribing medical documents and even dealing with guideline updates. There are five ways AI can make transitioning to CMS-HCC-V28 more efficient. Before we get to those, let's look at some of the changes ahead.

What Are the Changes in CMS-HCC-V28?

The overall goal of the CMS-HCC changes is simple: Capture more accurate and complete data on chronically ill patients. Unfortunately, these changes are quite complex in practice. They impact how HCCs map, coefficient HCC values, and HCC code names and numbers. Diagnosis codes are also affected: The changes removed 2,294 codes that map to an HCC payment and added 268 previously unmapped ones.

Factor in specific updates to various condition categories, including heart disease, blood disease, and diabetes, among others, and you have an overwhelming number of changes that could slow down your revenue cycle team for months. Thankfully, AI can help.

Handle Guideline Changes With AI and Save Time, Mistakes, and Money

It might sound too good to be true, but AI can dramatically improve your transition to version 28 by increasing efficiency and guaranteeing that you receive proper reimbursement under the new model. Here are five ways it does just that.

1. **Updates with the press of a button:** What if implementing coding guideline changes was like updating your computer? All you had to do was click a few buttons, drink a hot cup of coffee, and wait for a few short hours for the changes to apply. The speed at which AI can implement guideline updates varies depending on the complexity of the changes and the technology itself. Still, the process is similar to updating a system's configuration, which means it's substantially easier, faster, and cheaper.
2. **Trains and collaborates with coders:** Just because AI can accelerate the transition to new guidelines doesn't mean you can eliminate human coders or forgo training. In fact, AI can play a critical role in training your staff and speeding up the process, thus reducing costs. How does it work? While your team codes, AI provides real-time guidance and feedback based on the new update rules. And the system works both ways: coders can give feedback to the AI, so it learns and increases accuracy.
3. **Flags insufficient documentation:** AI plays a crucial role in improving documentation accuracy, which is of vital importance when adjusting to the latest guidelines. If a diagnosis lacks enough supporting documentation, AI points out this error and acts as an early warning system to clinical teams. This forewarning allows staff to rectify and augment the documentation promptly. When healthcare organizations can catch a problem so early on, it prevents a whole flood of negative consequences further downstream in the revenue cycle, such as denied claims, delayed reimbursement, and underbilling. Avoiding this pitfall saves time, headaches, money, and ensures proper reimbursement from the start.
4. **Comprehensively captures diagnoses:** AI's ability to thoroughly review a patient's medical records means it excels at identifying nuanced diagnoses. Consider an encounter where a patient is primarily diagnosed with hypertension. A comprehensive AI analysis may uncover additional conditions assessed, such as peripheral artery disease or hypertensive heart disease, contributing to a more detailed patient profile. This detailed assessment permits the AI system to capture HCCs for accurate billing. Overall, the comprehensiveness and specificity of AI coding help to ensure that risk adjustment factors (RAFs) are determined accurately, enabling proper reimbursement.
5. **Implements proper combination coding with ease:** Comorbidities can be easily overlooked in a patient encounter. For example, if a patient who has chronic kidney disease comes in for an insulin refill, a physician may review his or her bloodwork and eGFR but not specifically account for the CKD with a code. Because the kidney disease is being monitored during the encounter, a combination code such as E11.22 can be used that captures both diabetes and CKD, leading to a higher-valued HCC. This is where AI can help. It will rigorously review the patient's medical records and spot this oversight, securing proper reimbursement.

Don't Let Guideline Changes Slow Down Your 2024

Coding guideline changes take a lot of work and can drag any healthcare practice down and hurt staff morale.

Working with AI can remove that burden and give healthcare organizations a head start. The reduced workload empowers staff to devote themselves to high-value tasks and progress on vital initiatives, instead of being bogged down with complex coding updates.

While this vision may sound hard to believe, it's already happening. AI is changing the medical coding game, not just for CMS-HCC-V28, but for all guideline updates in the years ahead. After reading about the five concrete ways AI can help healthcare organizations transition to new guidelines, are you ready to see what it can do for you?

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Thoughts Had ... Lessons Learned

U.S. Healthcare Challenges

Congratulations to the BC Advantage team for 19 years of successfully making a positive difference in the health-care industry and for supporting those of us who earn our living in this industry.

In BC Advantage Magazine's issue 18.6 (November/December 2023), Dave Jakielo authored an insightful article titled "The American Healthcare System: A Problem in Need of Solutions." Jakielo does an excellent job discussing numerous current issues that need to be addressed within the U.S. healthcare system. As Jakielo states at the end of his article, "The future of the American healthcare system is uncertain. However, if we are able to address the problems that the system faces, *we can create a system that is affordable, accessible, and equitable for all Americans"* (emphasis added). I consider these the writer's "objectives" in creating policies for the U.S. healthcare system.

A key roadblock to solving any problem that affects the entire U.S. population or any large group of people living together in any society and sharing resources is getting everyone to agree on the same goals and objectives—and agree on who will pay to accomplish those goals and objectives. As I have repeatedly stated in my previous articles, it is not just semantics; we must first get everyone to agree on the terms, definitions, and meanings of the words we use in our efforts to solve problems.

Take the terms healthcare (one word) and health care (two words) as an example. The Oxford English Dictionary gives definition to the one word. You can search "health care" (two words) on Oxford and it directs to "healthcare" (one word). On Merriam-Webster, "health care" is defined as two words, and lists "healthcare" as a variant—to be used interchangeably. Some sources, such as DocNotes, now prefer to view the terms healthcare and health care separately, noting that one form has "taken on more meaning" regarding the healthcare industry vs. the care of health. Most sources do not view the different spellings with different meanings but rather prefer one spelling over the other. Some sources simply state to use health care as two words, while others advise that healthcare as one word is more common in modern English. Who knew there was such controversy attending healthcare vs. health care?

Note: Until there is a clear distinction regarding the definition(s) or a preferred usage across both medical and reference sources, healthcare as one word will continue to be used for consistency in BC Advantage Magazine.

This word problem is quite evident in our society today with the current growing "woke" debate as to the use and meaning of pronouns, which is changing and expanding daily. These changing gender words, identities, and definitions will obviously create challenges for healthcare providers when providing medical care to patients. Even the AMA is getting involved in this gender identification debate. In June 2021, the AMA added the following AMA policy position: "Aimed at protecting individual privacy and preventing discrimination, the AMA will advocate for the removal of sex as a legal designation on the public portion of the birth certificate." The AMA did not offer an alternative pronoun or designation to be used but simply recommended leaving it blank. This will create many legal, regulatory, and medical challenges for everyone due to our current laws, regulations, and healthcare delivery system.

To move toward reaching Jakielo's stated goals of affordable, accessible, and equitable healthcare, which the entire U.S. population likely desires, it is necessary that the entire U.S. population agree on the definition of those words—as well as many, many other words.

Background

I have been working in healthcare for many, many decades, and am blessed to be able to continue. I have been lecturing and writing about the business of medical practices and the healthcare industry in general since the beginning of my career. I have also worked directly with and advised, and still do, physicians and hospitals on the applications for and operations of the business of medicine. I save all my materials for future resources, which also lets me see where I have been on my journey in the business and how many of my past thoughts about the future of healthcare were correct.

I have had the opportunity to live and participate in the major changes in healthcare over these past decades. While most of us do not provide direct medical care to patients, our participation in the business of medicine has a direct impact on the affordable, accessible, and equitable objectives that Jakielo addressed in his article. This means our participation in the healthcare industry will ultimately impact actual patient care. Besides, we are patients, too. Like any business, healthcare needs to be run cost-efficiently with high standards and quality control to produce

the optimum product, which is good medical care. It is not only our job but our obligation to the healthcare industry and the patients to try to improve the healthcare delivery system to benefit all stakeholders. At least that is my mission statement.

My Look Back

In March 1995, I gave a lecture about "The Social and Economic Trends in Health Care" to a group of physicians at the University of Virginia Medical School. It will soon have been 30 years ago that I did my prophesying and proselytizing on that topic. While I have not yet found my slides or handouts that I used back then, I did find my personal notes that I used to give the lecture—yes, back in my younger healthcare days, I was using slides and not PowerPoint. I wanted to share with you what I told the physicians in 1995, as it helps to see how much of what I predicted then about the future of healthcare was accurate and determine what is still applicable today.

In preparing to write this article, I read my March 1995 lecture notes, as well as my added thoughts during the lecture. Of course, in a room full of physicians, there was significant feedback, both positive and negative. Below is a summary of my lecture as I remember it. In that lecture, I laid the foundation for all my future lectures and writings, including those I have done for BC Advantage Magazine. Over the years, I have continued to include those initial 1995 writings and thoughts in my following writings and lectures because they continue to be as relevant today in 2024, if not more so, as they were in 1995. It is likely that many of you have done the same and have similar valuable reflections you can share.

As I stated to the attendees in my 1995 lecture, the only way to insightfully understand where you are at any point in time is to have a past starting point and the accurate historical facts that occurred on your journey to where you are now. You need to know where you have been and how you got to where you are now to understand and solve current problems. This is my personal approach, similar to the standard gap analysis process, which refers to the current state, the desired state, and the gap between. In plain terms: Where am I now? How did I get here? Where do I want to go? And how do I get there? To use an old Yogi-ism (Yogi Berra, not Yogi Bear): "If you do not know where you are going, you will end up someplace else."

So how did the American healthcare system get to this current state of being a problem needing solved?

Historical Healthcare Facts

In my 1995 lecture, I stated, "It has been estimated that 90% of the medicine being practiced today (1995) did not exist in 1950." That factor alone accounts for a tremendous positive and negative impact on the entire healthcare system and the costs of healthcare today (2024), affecting both the individual and society. Dr. Alexander Fleming developed penicillin in London in 1928-1929. That is less than a century ago. Undisputedly, this is one of the greatest contributions to healthcare and the saving of lives. Healthcare researchers and providers are getting exponentially better at understanding, diagnosing, treating, and curing diseases, which is also extending life expectancy.

The life expectancy in the United States in 1928 was 55.6 years for men and 58.3 years for women. According to the United Nations Population Division, the life expectancy in the U.S. in 2023 was 70.8 years for men and 76.0 years for women. The continued growth, power, and sophistication of computers and medical technology is driving both the success of healthcare and the costs of healthcare. The success and costs are inseparably connected by a Gordian knot.

The extension of life expectancy also increases the costs of providing healthcare because people must be provided healthcare for more years. Also, as the population ages, diseases increase, become more severe, and cost more to treat. It is estimated that 65% of a person's lifetime healthcare costs occur in the last six months of their life.

These facts lead to many questions, including:

- What is the dollar value of a human life?
- What are the dollar costs to preserve a human life?
- Who pays for saving that human life?
- Can we afford it?

Most countries with a socialized medicine system have already assigned a dollar value to a human life that is

based on the individual's remaining years' economic value to society relative to the costs to treat the individual's illness. For more information, read about the UK Healthcare system, called NICE (National Institute for Health and Care Excellence). I have been researching and writing about this topic for a long time, attending the U.S. and world healthcare rationing that exists now and is growing. Remember, my 1995 lecture was titled "The Social and Economic Trends in Health Care."

Follow The Dollar

Prior to the late 1920s, the concept of health insurance really did not exist. The financial relationship was between the patient and the healthcare provider. Hospitals first got into the act when the first hospital insurance plan was introduced in Dallas, Texas in 1929. This became the model for the first Blue Cross plan, which was introduced in Sacramento, California in 1932. Prior to that time, health insurance policies that did exist were to cover catastrophic healthcare losses. These "new health insurances" were designed to cover all healthcare costs up to certain policy limits. The reason for this model was because these new healthcare policies were designed by hospitals, not by insurance companies. This concept flowed from the hospital side to the physician side, as well—later to be called Blue Shield. When that direct and personal financial relationship between the patient and the healthcare provider was severed by an intermediary, the "cardinal sin" in the delivery of healthcare was committed. The patient was no longer the "customer" of the physician but the "customer" of the insurance company, and the insurance company became the physician's customer.

There is little incentive for the patient to shop for the most cost-effective medical care or limit the use of medi-

cal care if someone else other than the patient is paying the bill. You can just ask any healthcare provider who accepts and treats Medicaid patients. There is little incentive for hospitals or physicians to limit the amount or type of care provided to the patient if payment is guaranteed to be paid to them by an insurance company. This means that the hospital or physician does not have to bill the patient. As the U.S. society became more socially conscious at our federal level, we got the "Great Society" in 1965. Following the Civil Rights Act of 1964, the government established Medicare, for the elderly, and Medicaid, for those with limited income, in 1965.

According to the U.S. government, U.S. healthcare as a percentage of the U.S. GDP was 5.6% in 1965. When I gave this lecture in 1995, the healthcare/GDP percentage had increased to 13.5%. That is a 241% increase. In 2021, the reported healthcare/GDP percentage was 18.3% and projected to increase to 20.0% by 2031. Other sources say it is currently higher and will be even higher sooner than 2031. I agree. In U.S. dollars, the 2021 GDP was $23.3 trillion, which makes the healthcare/GDP spending at $4.3 trillion. The "experts" say this is not sustainable, even with a stable population. In the U.S. in 2021, there were a reported 3.66 million births and 3.46 million deaths. That's a net increase in the U.S. population of .2 million (200,000) people. Add to that a reported 1.5 million authorized immigrants and 1.0 million unauthorized immigrants in 2021, and you get approximately an additional 3.0 million "patients" added to the U.S. healthcare system in one year. That 3.0 million increase a year in the U.S. population, which seems to be about the average increase over the last decade, creates an unsustainable pressure on the U.S. economy and the U.S. healthcare system. My 1995 notes show that I had a handout then on the national heath expenditure, which means we knew that we had this problem almost 30 years ago, did nothing, and it has gotten exponentially worse.

Monetizing Healthcare

There were two other major factors, besides the cardinal sin already mentioned, that allowed the now fatally flawed U.S. healthcare system to be guaranteed to financially fail in the future. If the U.S. healthcare system fails financially, then that means that eventually medical care provided to patients will suffer and fail. The first of these other major factors was that the National Labor Relations Board ruled in 1948 that health benefits were subject to collective bargaining. This allowed the employer to substitute "paid health insurance" in lieu of higher wage increases. This shifted the responsibility for the health insurance premium payments from the patient to the employer. The employer could now negotiate with the insurance companies as part of the employer's costs for employees instead of having to negotiate with the labor unions on higher employee wages. The second was that the IRS ruled that the cost of employee healthcare insurance is tax deductible. This meant that the employer could pay for employee healthcare insurance premiums with "pre-tax" dollars just as the employer did with employee wages. The employer was betting that the costs of healthcare insurance premiums for employees would be cheaper than the costs of higher employee wages negotiated by the employer with the labor unions.

Now the stage is set. The patient (not all patients) has a "Health Insurance Credit Card," with no limit, and someone else is going to pay the bill. The healthcare providers providing the patient care are going to deliver to those with the Health Insurance Credit Card an unlimited amount of services because the healthcare providers know they will get paid by the insurance companies and do not have to hassle the patient. The same is true for the hospitals. Therefore, the healthcare providers know that the more services provided means more revenue and hopefully more profit. The hospitals know the same thing. Yes, I know there are differences between physician Fee-for-Service (FFS) payments and hospital DRG payments. That is a discussion for a separate article. The concept of someone else other than the patient paying the patient's bill is the same.

Now enters the U.S. government as a major payor, providing Medicare, Medicaid, Tricare, and other government-affiliated healthcare plans. This means that the U.S. federal government will now be directly involved and legally allowed to control all the U.S. healthcare policies through U.S. government healthcare laws and regulations, i.e., HHS and CMS. This will also directly impact the commercial healthcare insurance industry, as well as U.S. companies, individuals, and the entire U.S. economy. Remember, "I'm from the government, and I'm here to help" (President Ronald Reagan's opinion on the nine most frightening words spoken).

The largest monetization of U.S. healthcare was done when President George H. W. Bush signed into law the Omnibus Budget Reconciliation Act of 1989, which switched Medicare to an RBRVS payment schedule. This took effect on January 1, 1992. The commercial insurance companies soon followed. The RBRVS "price-fixing system" has now become the U.S. standard used by everyone to determine what to pay for medical services listed in the CPT code books, plus the government's HCPC codes.

As we know, there is a Relative Value Unit (RVU) for each CPT/HCPC code (some zero values) that has the following components:

- Work = Physician Work
- PE = Practice Expense
- MP = Malpractice Expense

Each of these components is multiplied by an average statewide Geographic Adjustment Factor (GAF). I do not see any RVU component or value for profit in the RBRVS system. Pointing out the RBRVS system emphasizes that U.S. healthcare has been fully monetized, which is the first step by the U.S. to determine the value of a human life.

Fast Forward to 2024

I made a general statement in my 1995 lecture: "There has been much written concerning other things affecting healthcare trends. Things such as reform, access, physician extenders, population mix, drugs, violence, attitude toward health, etc. All of these have some impact on the demand and provision of healthcare. But the current and foreseeable focus is on the costs of delivering healthcare and who pays for it." I think I got it correct in 1995 and it still equally applies in 2024. In 1995, I explained the U.S. healthcare system via two social and economic periods regarding healthcare delivery. They were the "practice of medicine" periods, pre-1990 and post-1990. I wrote an article for BC Advantage Magazine, titled "Follow the Dollar" (2018), which discusses the post-1990 period. In that article, I stated: "It has always been about managed dollars, not managed care." I also said that in 1995 and I am still saying it today.

Different Perspectives

As I stated, Jakielo did an excellent job explaining the problems in the U.S. healthcare system. I would like to comment on his statement, "The United States spends more on healthcare than any other country in the world, yet it has some of the worst health outcomes." There is no disputing the high costs of healthcare in the U.S., nor the fact that the U.S. has some of the worst health outcomes compared to other high-income nations. According to "U.S. Health Care From a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes," from the Commonwealth Fund, "The U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates" (Gunja, Gumas, and Williams, 2023). These outcomes could be explored in another article, but let's discuss another reason the U.S. is considered from a global perspective to have some of the worst health outcomes.

If your statistics only include outcomes from the low-risk patients you treated and not on the sickest of the sick you refused to treat, then your outcomes will be much better, and your healthcare costs will certainly be lower. It does not cost a lot to treat healthy people or people with low-risk health problems. The U.S. treats the sickest of the sick, where other countries will not because of the person's age, multiple morbidities, or other societal economic factors under their socialized medicine systems. Refer to the UK NICE system mentioned above.

I have traveled to other countries, studied the healthcare systems of other countries, have friends who live in other countries, and work with physicians who are from and have practiced medicine in other countries. Most people you ask across the globe will tell you that the U.S. has the most sophisticated and greatest number of high-tech medical equipment and treatments in the world, as well as the best physicians. This is why many wealthy people in other countries come to the U.S. when they have serious health problems. Ask the substantial number of Canadians who come to the U.S. every year for medical care since the medical care they need is not available in Canada or, if available, they cannot get the medical care they need in Canada in a timely manner when they need it.

I, along with many of my family and friends, have been treated over many years by the U.S. healthcare system for extremely serious injuries and diseases, and received care that we would not have found anywhere else. While nobody I know wants to go to another country for healthcare, I agree with Jakielo that the U.S. healthcare system needs many improvements to try to provide more affordable, accessible, and equitable healthcare to everyone.

Conclusion

Because I am a realist, I am not optimistic that the U.S. will be able to reach Jakielo's admirably stated objectives. The reasons include the cardinal sin stated above, the stakeholder conflicts, and the future predictions, as well as the fact that the providing of healthcare has become the business of medicine. For more on this topic, I encourage you to read my two-part article in BC Advantage Magazine, titled "Thoughts Had…Lessons Learned ® The Selling of Marcus Welby, M.D." (2022). Investment firms, both foreign and domestic, are buying up the U.S. healthcare system and have an investment strategy of "churn and burn" instead of "buy and hold." If you don't buy and hold, you cannot maintain a stable, cost-effective healthcare delivery system with good outcomes. I have been and continue to be directly involved in some of these billion-dollar transactions. It is these investment firms that have taken control of the U.S. healthcare industry. In addition, many of our medical products and, more importantly, many of our critical medical treatment drugs are manufactured

in other countries, whom are not all friendly to the U.S.

I want to conclude by sharing a story I created while thinking about equitable, a word which seems to be overused on everyone's tongue these days. We used to use the word fair before the word wars started.

Stranded In the Desert Dilemma:

There were ten people stranded in the desert for a considerable length of time. They had made progress toward safety but only had enough water remaining to provide for one person to survive the trip to safety. How do the ten people decide who gets the water? You can choose yourself to be the survivor. A compassionate pragmatist is going to select the person whose survival will benefit the world the most in the future. The ideologue equitist is going to decide that no one person gets the remaining water and that the remaining water be equally divided among the ten people. This means that none of the ten will survive and that all ten will die. To the equitist, all ten people dying is not relevant. What is equitable to the equitist at this moment is that the equitist's decision was equitable. How negatively the equitist's decision affects the rest of the world and what collateral damage it does to others is not relevant to the equitist ideology. It is the ideology of equity that overrides everything else.

This is the type of decision that all of us in America and the rest of the world are faced with now given the state of the American and world healthcare systems and the finite resources for everything. There is now a great deal of focus on the healthcare systems, and yet truly little focus or commitment on how to keep people healthy. Though, as my physician friends tell me, "We make our money treating sick people, not treating healthy people." How can we do better? We want to make the U.S. healthcare system affordable, accessible, and equitable. But a lot of this depends upon the health of the people. Are we all doing our part, caring for our own health to the best of our ability (healthy diet, regular exercise, etc.), thereby lessening the burden and thus improving the healthcare system?

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Points From the 1995 UVA Presentation

Conflicting Stakeholder Viewpoints:

Patient – I am entitled to the best healthcare in the world, and someone other than me should pay for it.

Physician – I should be able to decide what care the patients receive and how much I get paid for the care I provide, but I should not have to collect money from the patients.

Government – The government has the right to control all healthcare, to decide who receives it, what care is provided, when it's provided, and at what price.

Employer – My employees demand that I pay for their healthcare, but the rising costs reduce my profits, so I need to shift these costs to someone else to increase my profits.

Insurance Company – I am in the business to make a profit, so I need to reduce my claim payouts because paying claims increases my overhead and reduces my profits.

Future Predictions (as stated in 1995):

- There is, and will always be, a finite amount of dollars in the healthcare system.
- There are not enough resources to provide equal healthcare to all people.
- Physicians are not going to get what they want.
- Some physicians are going to do better than others; some are going to fail.
- Patients and "patient care" will suffer.
- Different specialties will be competing across medical service lines.
- Old strategies won't work.
- It's never going to be the way it used to be.
- Government is going to be the major player and payor.
- Most physicians do not have the skills, discipline, or fortitude for private practice.
- In 10 years, 75% of all physicians will work for someone other than themselves.

2024

CPT Changes

The new year has come,

and with it new CPT codes. There were 349 total changes to CPT for 2024, which brings the total number of CPT codes to 11,163. Here is the 2024 breakdown: 225 codes were added, 75 codes were deleted, and 93 codes were revised. This article will go through the new codes for the new year, except for Category III codes.

Evaluation and Management (E/M)

A few of the times have changed for the Nursing Facility Services codes. CPT code 93306 now has a threshold time of 50 minutes, up from 45 minutes, and CPT code 93308 now has a threshold time of 20 minutes, up from 15 minutes.

The Office/Other Outpatient E/M codes have also had their ranges removed and now have threshold times to align them with the other E/M codes. For example, 99214 now states: "30 minutes must be met or exceeded."

There has been a new section added to address multiple E/M services reported on the same date. The new guidelines address the following:

- Multiple encounters in different settings or facilities
- Emergency department and services in other settings (same or different facilities)
- Discharge services and services in other facilities
- Discharge services and services in the same facility
- Discharge services and services in a different facility
- Critical care services (including neonatal intensive care services and pediatric and neonatal critical care)
- Transitions between office or other outpatient, home, or residence, or emergency department and hospital inpatient or observation or nursing facility

Note: CMS still has a policy to not allow the reporting of two E/M services on the same date.

A new section has been added to address split/shared visits, too. It clarifies who should report the split/shared visit. According to the guidelines (CPT and CMS), whoever performs the substantive portion of the visit should report it. If coding by time, whoever spends the majority of the total time on the date of the encounter on the patient's care should report the service. If coding by MDM, the three elements (Problem Addressed, Data Reviewed and Analyzed, and Management Risk) come into play. Whoever approves the care plan for the problem addressed and takes responsibility related to management risk performs the substantive portion of the visit and should report it. If data is used as one of the two elements to select the MDM level, only the person who performs an independent interpretation or discussion of management or test interpretation may use those categories.

The one new code in the E/M section is CPT code +99459 for pelvic examination. It is an add-on code that

is to be reported when a pelvic exam is performed during an E/M visit.

Musculoskeletal

There were four new codes added to the Musculoskeletal System section. Three of the codes are for anterior thoracic vertebral body tethering (VBT). The regions of the spine include cervical, cervicothoracic, thoracic, thoracolumbar, lumbar, lumbosacral, sacral, and coccygeal. VBT is a surgical treatment used to treat adolescent idiopathic scoliosis (AIS) by altering the growth of the spine while allowing it to continue to develop during treatment. VBT received FDA approval in 2019.

During VBT, surgeons place screws on the side of the spinal curve that curves outward and attach a strong cord (tether) along the vertebrae. This technique applies a compressive force over the convex side of the spine, slowing down its growth and allows the concave side of the spine to grow more and create a straighter spine. The goal is to provide a less invasive alternative to other scoliosis treatments, managing scoliosis during adolescents' growth spurts, and work to reverse spinal curvature. This differs from existing procedures in CPT as it does not involve arthrodesis (fusion of the spine). Code 22836 is to be reported when VBT is performed on up to seven thoracic vertebral segments. Code 22837 is to be reported when VBT is performed on eight or more thoracic vertebral segments. Code 22838 is reported for revision, replacement, or removal of thoracic vertebral body tethering.

Below are the work RVUs for the new codes:

CPT CODE	2024 wRVU
22836	32.00
22837	35.50
22838	36.00

The other new musculoskeletal system code is 27278 for percutaneous arthrodesis of the sacroiliac (SI) joint with placement of an intra-articular implant. The SI joint is located where the sacrum connects with the ilium, which is the large bone that forms the pelvis. Arthrodesis is joint fusion. SI arthrodesis may be performed for significant lower back pain and instability due to conditions like SI joint dysfunction or degenerative sacroiliitis.

SI joint arthrodesis involves fusion and stabilization of the SI joint to prevent its movement by placing an intra-articular implant (fixation device) within the joint. This promotes bone growth, stabilizes the joint, and leads to a reduction of pain caused by joint movement. Code 27278 is a unilateral procedure, so if performed bilaterally, modifier 50 should be appended. This code replaces the Category II code 0809T.

Below is the work RVU for the new code:

CPT CODE	2024 wRVU
27278	7.86

Respiratory

Two new codes have been added for the Respiratory System section of CPT for posterior nasal nerve ablation. This procedure is mainly used to treat chronic rhinitis, aiming to reduce the symptoms, including runny or stuffy nose, sneezing, and itching. The procedure targets the posterior nasal nerve that carries sensory information from the nasal cavity and helps regulate nasal secretions.

Code 31242 is reported when the ablation is achieved with radiofrequency ablation. This involves the application of radio waves to generate heat used to ablate the nerve. Code 31243 is reported when the ablation is achieved with cryotherapy. This involves the application of extreme cold to destroy the nerve.

Below are the work RVUs for the new codes:

CPT CODE	2024 wRVU
31242	2.70
31243	2.70

Cardiology

A new section has been added in the Cardiovascular System section for phrenic nerve stimulation systems (33276-33288). This device is used to electronically stimulate the phrenic nerve to improve breathing function in patients with respirator insufficiency. The phrenic nerve controls the diaphragm and, when it is stimulated, it causes the diaphragm to contract rhythmically, allowing the lungs to expand and take air in.

The codes for this system are like codes for a pacemaker system; there are codes for inserting a system, pieces of the system, removing the system, removing pieces of the system, repositioning leads, and removal and replacement of a system. The system has a pulse generator which contains the electronics and a battery. Pulse generators are placed in a pocket in the pectoral region. The stimulation lead is transvenously placed in the right brachiocephalic or left pericardiophrenic vein. If a separate sensing lead needs to be placed to augment the system, it is separately reportable with code 33277 and is placed in the azygos vein. Initiation of diagnostic mode and associated system evaluation are bundled into initial system placement. The codes include vessel catheterization and all imaging guidance required for the procedure.

Be sure to read the instructional notes with the codes for important details on unit limits. Codes 33279 and 33288 for removal of transvenous stimulation or sensing lead(s) have a note to report the code only once whether one or more than one lead is removed. Code 33281 for repositioning of transvenous lead(s) has a note stating the code is only reported once per patient per day.

Below are the work RVUs for the new codes:

CPT CODE	2024 wRVU
33276	9.50
+33277	5.43
33278	9.55
33279	5.42
33280	3.04
33281	6.00
33287	6.05
33288	8.51

Urinary System

There is one new code in the Urinary System section. Code 52284 is for cystourethroscopy with mechanical urethral dilation and urethral therapeutic drug delivery by a drug-coated balloon catheter for urethral stricture or stenosis on a male patient. Urethral stricture or stenosis is a narrowing of the urethra due to scarring or inflammation. Cystourethroscopy can help identify the location and extent of the narrowing. Mechanical dilation involves the use of specialized instrumentation to gently stretch the narrowed part of the urethra which can help relieve the symptoms associated with urethral stricture/stenosis like difficulty urinating. A drug-coated balloon catheter is coated with a drug designed to reduce the likelihood of re-narrowing after the dilation. The balloon is inserted into the urethra via the cystoscope, inflated at the narrowed site, and the drug helps to minimize inflammation, preventing scar tissue from reforming. By combining these together, a physician is able to diagnose and treat the urethral stricture or stenosis.

Below is the work RVU for the new code:

CPT CODE	2024 wRVU
52284	3.10

Female Genital System

In the Female Genital System section, one new code has been added for transcervical radiofrequency ablation of uterine fibroids, 58580. This was a Category III code (0404T), which has been deleted. Uterine fibroids are benign soft tissue tumors of the female genital tract. Radiofrequency ablation (RFA) uses heat to destroy tissue, and in this case, uterine fibroids. Transcervical RFA is performed with a miniaturized ultrasound transducer that is inserted into the vagina to the uterine fibroid. The fibroids are located perioperatively by sonography.

Below is the work RVU for the new code:

CPT CODE	2024 wRVU
58580	7.21

Nervous System

The Nervous System section has three new codes for skull-mounted cranial neurostimulator systems, which is a responsive neurostimulator (RNS). This type of device is a brain stimulator that involves either implanted depth electrodes or surface cortical electrodes and a cranial mounted implanted pulse generator that can accept up to two different electrodes. These devices chronically record EEGs from the electrodes and are programmed to stimulate the brain in response to any abnormal EEG patterns. So, unlike deep brain stimulators that continuously stimulate, this device only stimulates in response to signals it monitors from the brain. Unlike existing deep brain stimulator generators that are usually subcutaneously placed in the tissue of the chest or abdominal cavity, the RNS device is placed in a cut-out in the skull via craniectomy and the generator is placed in a metallic holder within the cut-out.

Code 61889 is reported for insertion of the pulse generator or receiver and includes craniectomy or craniotomy, direct or inductive coupling, and connection to the depth and/or cortical

strip electrode array(s). Code 61891 is reported for revision or replacement of the pulse generator and includes connection to the depth and/or cortical strip electrode array(s). Code 61892 is reported for removal of the pulse generator and includes cranioplasty to fill in the craniectomy that was created to seat the generator. Placement of the electrodes is separately reportable.

Below are the work RVUs for the new codes:

CPT CODE	2024 wRVU
61889	25.75
61891	11.25
61892	15.00

Three new codes have also been added for integrated peripheral neurostimulator electrode arrays, and the spinal neurostimulator electrode array codes have been revised. Traditional neurostimulator systems have an electrode implanted into the spinal epidural space or near peripheral nerves and are connected to an implanted generator that is placed in a subcutaneous pocket. With the newer technology of integrated neurostimulator systems, the electrodes contain a receiver and circuitry for power delivery, but there is no implanted generator. The power is delivered through a transcutaneously placed power source that is worn over the skin where the electrode is placed.

Code 64596 is reported for insertion of an electrode array in a peripheral nerve with an integrated neurostimulator. Code +64597 is reported for each additional array inserted or replaced. Code 64598 is reported for revision or removal of an electrode array in a peripheral nerve with an integrated neurostimulator.

These three new codes are contractor priced, so there are no RVUs assigned to them.

Eye/Ocular Adnexa

There is one new code for a suprachoroidal space injection of a pharmacologic agent in the Eye and Ocular Adnexa section. It is used to report the administration of a drug into the suprachoroidal space between the sclera and the choroid, formerly Category II code 0465T. The new code is 67516 and has an instructional note to report medication injected separately.

Below is the work RVU for the new code:

CPT CODE	2024 wRVU
67516	1.53

Radiology

There are five new cardiology-related radiology codes in Radiology. CPT code 75580 is used to report noninvasive coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography (CCTA). This is a computer-assisted technique that estimates blood pressure changes in the coronary arteries that have partial blockages. Instructional notes for 75580 state that it is only to be reported once per CCTA. If CCTA is performed on the same day as 75580, the CCTA (75574) may be reported separately.

Below is the work RVU for the new code:

CPT CODE	2024 wRVU
75580	0.75

Four new codes have also been added to Radiology for intraoperative diagnostic cardiac ultrasound. Prior to 2024, there was one code for intraoperative ultrasonic guidance, 76998. When the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) studied the code, they found it being reported inconsistently in regard to patient type and physician work, so the new codes were created to carve out specific intraoperative ultrasounds.

Diagnostic intraoperative ultrasound (IOUS) is used to detect aspects of a procedure that may impact the intraoperative strategy including altering the planned procedure. Code 76984 is reported for diagnostic IOUS of the thoracic aorta, also called epiaortic. Codes 76987-76989 are reported for diagnostic IOUS for congenital heart disease. These codes are broken down by which portion of the IOUS is performed by the reporting physician. Code 76987 is reported for placement and manipulation of the transducer, image acquisition, and interpretation and report; 76988 is reported for placement and manipulation of the transducer and image acquisition only; 76989 is reported for interpretation and report only.

Below are the work RVUs for the new codes:

CPT CODE	2024 wRVU
76984	0.60
76987	1.90
76988	1.20
76989	0.70

Pathology and Laboratory

There were 14 new codes in the Pathology and Laboratory section for 2024. There are six new codes added to the Genomic Sequencing Procedures (GSPs) and Other Molecular Multianalyte Assays subsection, along with guideline revisions. The new codes are panel codes for solid organ neoplasms (81457-81459, 81462-81464). Three new codes were added for acetylcholine receptors (AChR), including binding antibody (86041), blocking antibody (86042), and modulating antibody (86403).

The other codes are:

- Multianalyte Assays with Algorithmic Analyses (MAAA) for liver fibrosis and liver-related clinical events within five years (81517)
- Anti-mullerian hormone (AMH) (82166)
- Muscle-specific kinase (MuSK) antibody (86366)
- Hepatitis D (87523)
- Orthopoxvirus by amplified probe technique (87593)

Medicine

In the Medicine section, two new codes have been added for respiratory syncytial virus (RSV) in the immune globulins subsection and are broken down by dosage; code 90380 is used to report 0.5 mL dosage and code 90381 is used to report 1 mL dosage.

There are many changes that were made to the COVID-19 vaccine codes that are not shown in the 2024 printed CPT book as they were made after the book was printed.

The AMA has made a download with this information, which contains the vaccine codes, administration codes, age range for the vaccine, and manufacturer: www.ama-assn.org/system/files/cpt-assistant-guide-coronavirus-august-2023-updated.pdf

There are also other various vaccine/toxoid codes, including RSV, smallpox, and smallpox/monkeypox.

Other additions in the Medicine section include:

- **Audiologic Function Tests subsection**
  - 92622 - Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
  - +92623 - Each additional 15 minutes
- **Coronary Therapeutic Services and Procedures subsection**
  - +92972 - Percutaneous transluminal coronary lithotripsy
- **Phrenic Nerve Stimulation System subsection**
  - 93150 - Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming
  - 93151 - Interrogation and programming of implanted phrenic nerve stimulator system
  - 93152 - Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography
  - 93153 - Interrogation without programming of implanted phrenic nerve stimulator system
- **Cardiac Catheterization for Congenital Heart Defects subsection**
  - +93584 - Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; anomalous or persistent superior vena cava when it exists as a second contralateral superior vena cava, with native drainage to heart
  - +93585 - Azygos/hemiazygos venous system
  - +93586 - Coronary sinus
  - +93587 - Venovenous collateral originating at or above the heart
  - +93588 - Venovenous collateral originating below the heart
- **Intra-Arterial Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration**
  - +96547 - Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes
  - +96548 - Each additional 30 minutes

Final Thoughts

Be sure to go through your 2024 CPT code book and learn the new, deleted, and revised codes and guidelines.

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Reduce Improper Payments
by Complying with Medicare Regulations

Medicare Fee-for-Service (FFS) is a payment model in which healthcare providers and physicians receive payments based on claims submitted for the individual and/or unique services rendered to the beneficiaries. A fee schedule developed and released annually by the Center for Medicare and Medicaid Services (CMS) lists FFS for physicians, ambulance services, clinical laboratory services, durable medical equipment (DME), prosthetics, orthotics, and supplies.

Medicare Administrative Contractors (MACs) are private healthcare insurers who process claims for Medicare beneficiaries, and whose activities are overseen by the CMS Center for Program Integrity. MACs follow CMS coverage guidelines as defined by National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and CMS manuals that include Benefits (100-02), Claim Processing (100-04), and Program Integrity (100-08).

Ensuring Payment Integrity

The U.S. Department of Health and Human Services (HHS) conducts risk assessment audits every year to identify risk-susceptible programs for improper payments according to statutory thresholds. These include Medicare FFS, Medicare Part C, and Medicare Part D, which involves the revenue cycle. Payments may be considered improper whether they are monetary or non-monetary, based on outliers.

CMS uses the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the FFS program. Under CERT, a random sample of Medicare FFS claims are audited to determine if they were paid correctly under Medicare coverage, coding, and billing rules. Once the CERT program identifies a claim in the sample, it requests the associated medical records and other related documentation from the provider or supplier who submitted the claim. CERT medical review professionals examine the claim and related documentation and identify any outliers.

Two types of Medicare FFS claim review programs are intended to prevent or identify improper payments through pre-payment and post-payment audits. These audits are conducted to ensure that claims are billed according to coding and billing policies, to reduce coding errors, to prevent improper payments, and to recover the payments made in error.

Types of Audits:

- Recovery Audit Contractors (RACs) conduct post-payment audits, which are divided into five regions: four cover Part A and Part B claim audits, while the fifth focuses on DME, prosthetics, orthotics, supplies, and home health/hospice.
- Supplemental Medical Review Contractors (SMRCs) are similar to RACs, but the SMRC additionally performs medical reviews on Parts A and B, and DME providers and suppliers.
- CERT Contractors perform annual post-payment audits on stratified random samples of claims processed by the MACs, to validate payment compliance and adherence to FFS policies and procedures.

Results of the most recent annual HHS audits were released in the agency's 2023 Medicare Audit Report, which found that, while Medicare FFS paid approximately 92.62% of claims correctly (corresponding to $391.78 billion), there were an estimated 7.38% improper payments (valued at approximately $31.23 billion), of which:

- 63.6% was attributed to insufficient documentation.
- 13.8% were due to errors in medical necessity.
- 10.5% resulted from incorrect coding.
- 3.8% had zero documentation.
- 8.3% was categorized as "other."

As noted by HHS, the staggering cost of improper claims payments—exceeding $30 billion—is largely due to human error in coding and documentation. These results point to the need for industry professionals to pursue additional education and become more familiar with the following guidelines to ensure Medicare compliance.

Step 1: Educate providers on measures to prevent documentation issues.

A. Incomplete notes: Any medical record document that is not signed by the treating physician is considered an incomplete note in terms of billing and compliance. Make sure the notes are signed and all the addendum/orders with the reason/medical necessity are captured in the medical records and signed in a timely manner. Check that any changes to the therapy plans are made in writing in the patient's record and signed by designated healthcare professionals responsible for and managing the beneficiary in the encounter/episode of care.

B. Certification and recertification: Each skilled nursing admission inpatient on Medicare must have a Medicare Part A certification/recertification completed and signed by a physician who is knowledgeable of the beneficiary's care and treatment. Depending upon the individual state's practice standards for Nurse Practitioners (NPs) and Physician Assistants (PAs), the NP and/or PA may sign the certification. The certification/recertification must include the reason for Medicare coverage and the skilled services to be delivered. Certifications are required upon admission, on or prior to day 14, and then every 30 days thereafter, from the date of the previous signature, while the resident/beneficiary continues to be Medicare Part A-covered. Signature stamps are not acceptable for the Medicare

certification, and the date of the signature must be completed by the physician at the time of signing the certification form. The facility staff may document the specific reasons for the Medicare services being provided but cannot sign and/or date the certification. The certification may be recorded in various formats as long as it contains the specific certification terminology. There is no federal requirement for a specific form to document the certification.

C. Medicare's signature requirements: Medicare claim reviewers look for signed and dated medical documentation meeting its signature requirements. The attestation must be associated with a medical record and created by the author. Attestations may be considered, regardless of their creation date, unless the regulation or policy indicates the signature must be in place before a given event or date. Refer to Medicare's policies for additional medical review guidelines for using an electronic signature.

Step 2: Address incorrect coding areas.

A. Diagnosis codes: Diagnosis codes should be reviewed and reported in the medical records. When coding for complications and manifestations of the medical conditions, the coding must be in accordance with the CMS guidelines specified in the ICD-10-CM for each specific year reporting period.

B. NCCI edits: CMS developed National Correct Coding Initiative (NCCI) Edits and Medicare NCCI Procedure-to-Procedure, which are applicable to code the services using the American Medical Association and Current Procedural Terminology Manual, along with the National and Local Medicare Policies and Guidelines, that are developed to incorporate standard medical and surgical practices, and respective specialty societies from the medical associations, and updated based on evolving technologies. If a claim contains the two codes of an edit pair, the Column One code is eligible for payment, but CMS will deny the Column Two code. However, if both codes are clinically appropriate and you use an appropriate NCCI-associated modifier, the codes in both columns are eligible for payment. The medical record must include supporting documentation for the appropriate NCCI-associated modifier.

C. Advance Beneficiary Notice (ABN) Forms: You cannot bill Medicare beneficiaries for services denied based on NCCI edits. Because the denials are due to incorrect coding, rather than medical necessity, you cannot use an ABN Notice of Noncoverage (Form CMS-R-131) to seek payment from a Medicare beneficiary. Also, because the denials are based on incorrect coding rather than a legislated Medicare benefit exclusion, you cannot use a "Notice of Exclusions from Medicare Benefits" form to seek payment from a Medicare beneficiary.

D. Medically Unlikely Edits (MUEs): An MUE for a Healthcare Common Procedure Coding System (HSPCS)/Current Procedural Terminology (CPT) code is the maximum units of service that a provider would report, under most circumstances, for a single beneficiary on a single date of service. MUEs are categorized into claim line edits and date-of-service edits based on policy or clinical benchmarks. MUEs do not exist for all HCPCS/CPT codes. Proposed edits are reviewed by national healthcare organizations, and their recommendations are considered before implementation. While the majority of MUEs are publicly available on the CMS website, CMS will not publish all MUE values because of fraud and abuse concerns. CMS updates MUEs quarterly. Providers should not interpret MUE values as utilization guidelines. MUE values do not represent units of service that providers may report and avoid further medical review. Providers should continue to report only services that are medically reasonable and necessary.

Step 3: Recognize remedies for the top five service types in Part B with the highest percentage of improper payments.

To better understand common problems associated with Part B, the following focuses on the service types that had the highest percentage of improper payment errors:

1) Office Visits (Established): For this service type, incorrect coding was identified as the main reason for the improper payments. The probable areas where improper coding can occur is billing for the wrong E/M level of service. Here are some tips to prevent this from occurring:

A. Identify visit status correctly. Make sure the office visit is coded as a new or established visit, per the criteria regarding whether the patient has received any professional services (a new patient is one who has not received any professional services from the same physician or other qualified healthcare professional of the same specialty and subspecialty within the same group practice in the past three years).

B. Select the appropriate E/M level of service. This is based on the E/M guidelines, the type of medical deci-

sion-making (MDM), or total time spent by the physician for the E/M level reporting.

C. Avoid double dipping. Any tests reviewed or ordered, and independently interpreted and reported as separate CPT codes for the service by the same physician, should not be calculated in the data points for the E/M selection criteria.

D. Meet E/M elements. At least two of the three elements must be met for an E/M level of service to be assigned when MDM is used for the EM selection. There are three elements in the MDM table per the AMA CPT: (1) number and complexity of problems that were presented and addressed; (2) amount or complexity of data reviewed/interpreted (not separately reported) and analyzed in the MDM; and (3) risks/complications and the morbidity/mortality of the patient's management.

E. Know what is and is not included in total time. For selecting an E/M level of service, the total time includes the time spent face-to-face with the patient, and the non-face-to-face time spent in collecting the patient data, coordinating, counseling, educating, and communicating the test results to the patient on the day of the encounter. The time does not include the physician's travel time, or the physician's time teaching residents and/or clinical staff, but it does include time spent exclusively discussing patient management with clinical staff. Time spent performing any services that are reported separately on the same day along with the E/M level of service must not be counted in the total time of the E/M visit.

F. Review procedure coding along with E/M level of service. Ensure that an E/M level of service is not billed when the office visit was scheduled relative to a procedure, and the pre- and post-procedure E/M are included in the procedure coding. E/M services on the same date of service as a minor surgical procedure are included in payment for the procedure and considered part of the work of the procedure. However, a significantly identifiable E/M service can be billed if the E/M service performed is in an encounter resulting in performing the procedure. Use correct E/M modifier(s) to report both services.

G. Link appropriate E/M and diagnosis codes. The problem-oriented E/M level of service should be linked to the appropriate diagnosis code(s). The codes that represent the status of the personal history or codes that cannot be reported as primary diagnosis codes can either cause a denial or do not justify the reason for the visit and can therefore cause medical necessity denials. Examples of these scenarios include code Z01.419 (Encounter for gynecological examination [general] [routine] without abnormal findings) or Z83.3 (Family history of diabetes), which cannot justify as a medical necessity for an E/M level of service.

2) Lab Tests: Improper payments were most often found to be a result of insufficient documentation. Medicare pays the labs based on the weighted median of the private payors' fee schedule, based on the data collected and analyzed. Here's how to fix the typical problems:

A. Document medical necessity. Documentation must include the diagnosis or sign/symptom for the test ordered. Do not use the Internal Classification of Diseases (ICD) code simply to tag with the order for a test, when it is not a reason for a test ordered.

B. Provide the clear reason for the test ordered. The reasons, studies, and what prompted the order for further testing should be included.

C. Include signature/attestation. The treating physician must sign the orders for all the diagnostic tests. Documentation must show the intent and medical necessity for the orders placed with the approval/signature. Medicare does not accept standing orders; always send the written/electronic documentation with necessary signature/attestation.

D. Do not exceed medical necessity levels. Frequency of the tests ordered should not exceed medical necessity levels. This is defined by the practice rules and clinical guidelines.

E. Ensure correct coding. Coders should make sure the correct ICD code is paired/linked to the lab CPT code.

F. Verify NCDs and LCDs. Verify the National Coverage and Local Coverage Determination policies to ensure the codes are assigned based on the guidelines.

G. Review insufficient documentation. If the signature is missing, the reviewers in audits consider it as insufficient documentation. There are certain times when the tests/orders are not signed; however, the medical documentation should support the intent to perform the tests to avoid insufficient documentation issues.

3) Minor Procedures: Insufficient documentation was the primary cause of improper payments. To help ensure sufficient documentation, be sure to:

A. Keep in mind that Medicare Part B categorizes CPT as a minor procedure based on the global period of 0-10 days. The global period is the time when related post-procedure services are performed during the normal recovery process; therefore, these follow-up visits are included in the procedure CPT code during that 0-10-day global period.

B. Remember that documentation of the minor procedure must include the decision for the procedure. This is if it has been planned or resulted from an E/M encounter for the patient on the same day.

C. Indicate the purpose of the procedure. This includes why it is needed during the E/M visit.

D. Attain appropriate informed consent with patient signature. ABN forms are included as needed.

E. Explain how the procedure is performed. Attend use of the surgical prep to completion of procedure for detailed notes.

F. Ensure the procedure report is complete. This includes beneficiary identification, date of service, practitioner details, relevant history/physical, vital signs as needed, pre-op evaluation, and anesthesia details, whether local, regional, etc. Documentation must include the devices, implant, products, or medications used during the procedure, suture material, type of closure of the wound, any complications, and include a final procedure completion note that includes patient's status in recovery as needed, with discharge instructions.

4) Other Drugs: Insufficient documentation is cited as the cause of improper payments. For complete documentation, remember the following:

A. Document the reason for the medications ordered and authenticated. Include appropriate diagnosis reporting and the outcome planned, based on the assessment and plan. Include valid electronic physician and/or clinician signatures; if an Electronic Health Record (EHR) is used, the electronic order signature process should be submitted to verify provider's electronic ordering system is secure.

B. List all the current medications of the beneficiary. Include identification and signature of the beneficiary with the date.

C. Make sure the physician orders for the medications ordered have a valid signature and date. Ensure the drug ordered has the dosage details in terms of quantity and frequency. Include the physician or Non-Physician Practitioner (NPP) order for date(s) of service and date medication was administered, including name(s) of medication, dose, route of administration, and frequency.

D. Include diagnostic test results/reports and imaging and/or laboratory reports. This involves those prior to the claim date(s) of service if related, to support medical necessity and the reason for medication administration, if applicable.

E. Ensure the Medication Administration Record (MAR) flow sheet is complete. This includes the start time, stop time, quantity administered, and the quantity discarded, to report the HCPCS codes for the

supplies with correct modifiers.

F. Document any pre- and post- medication administration protocols followed. Attend any adverse reactions that are noticed and all the follow-up guidelines.

G. Confirm when the drug has been received by the beneficiary. This supports complete documentation.

H. Report the correct CPT/HCPCS code for the administration and medication with accurate quantity in terms of units. Code the drugs per the bundling and unbundling guidelines of chemotherapy services. For example, infusion of saline during the administration of Infliximab (chemotherapy) is included, and the reporting of saline with HCPCS code other than the HCPCS code for Infliximab in this case is incorrect.

I. Keep in mind that the ordering physician must be a qualified Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DM), Doctor of Optometry, chiropractor, podiatrist, or a non-physician practitioner (NP or PA). The Doctor of Pharmacy (PharmD) is not qualified to order or sign for the Medicare purpose.

J. Bill unclassified drugs appropriately. Documentation must clearly include the drug name and dosage administered.

K. Include the route of administration, units, drug name, and dosage. If it is a compounded drug, then specify names clearly.

5) Specialist (Other): Improper payments here are also due to insufficient documentation. To decrease improper payments, be sure in your documentation to:

A. Send the correct notes and information in support of the billed claim for the representation of the documentation.

B. Make sure the documentation has a legible signature and date. Include a signature log for the reference with record submission.

C. Ensure the reason for the patient's visit and that the E/M details are fully enclosed. Include the referrals received and referrals sent as appropriate for the specialist services when ordered/received by the beneficiary.

D. Ensure all the orders, tests, and results are reviewed, validated, and assessed when the encounter is billed with those findings.

E. Report accurate CPT and ICD codes on the claim.

F. Document consultations and referrals. When the orders are placed for referrals, the treating physician must be able to support the reason for the consultation with the request note and provide the patient's pertinent medical history. When consultations are rendered, the providers must ensure they have completed the evaluation and managed the patient for the problems/conditions and documented for further course of action and treatment plan.

Conclusion

Along with these "top five" service types, insufficient documentation was also the culprit for improper payments in the next five service types, which include Hospital Visits (Subsequent), Major Procedure (Other), Nursing Home Visits, and Ambulance—for which medical necessity was also a contributing factor to improper payments. For Hospital Visits (Initial), improper visits were largely attributed to incorrect coding. Many of the remedies outlined above for the "top five" will be applicable—in the same or a similar form, per appropriate guidelines—to preventing improper payments in other service types. Billing and coding professionals who understand the guidelines and potential pitfalls, and who are conscientious about providing full and accurate documentation, will achieve higher rates of compliance.

Although CMS has publicly acknowledged that the vast majority of improper payments are due to unintentional errors, the aggregate value of $31 billion in 2023 makes for a very costly mistake. With more attention to the details of our profession, we can all be part of the solution.

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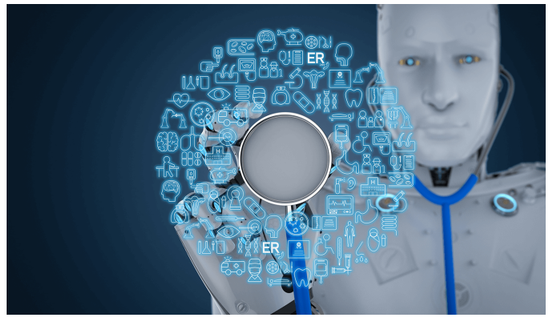
Will Advancements in AI

Take Over My Job as a Medical Biller or Coder?

By now, you may be sick of hearing about "AI." It's everywhere. According to a recent report, "Artificial Intelligence Market Size and Share Report, 2030," published by Grand View Research, "The global artificial intelligence market size was valued at USD 196.63 billion in 2023" and shows no signs of slowing down. The technology has made its way into nearly every industry imaginable. That's exactly what AI is: "technology," which is simply defined as tangible or intangible tools that assist humankind. Tools alone, without humans to wield them, don't produce great results. It is up to humans to use tools to get something done, perhaps faster, or in the case of medical billing and coding, more accurately.

What AI excels at is data analyzation and pattern detection. A large segment of practice management/billing/EHR systems are now integrating these AI features into their software. Another significant use for AI is the ability to "listen" to a doctor talking to a patient and then "write down" the encounter SOAP notes as with the new AI ally, NextGen Ambient Assistant. This feature produces 90% accuracy, saving doctors roughly two hours per day. Is it completely replacing a transcriptionist? Not necessarily. The charts still need to be reviewed and finalized by a human. Same with billing and coding functions.



As with the case of medical billing and coding, this critical function of most medical practices requires impeccable accuracy. What AI can now do is quickly look at chart notes and determine what codes should be used for each patient encounter, with limitations based on complexity of each case, and the fact that there are still numerous note-taking formats. AI is able to make your job as a biller/coder, in effect, easier.

The human element remains crucial for complex decision-making, understanding nuanced medical cases, and ensuring accuracy in coding. Instead of replacing jobs, AI may transform them, creating opportunities for collaboration between humans and machines.

For now, charting and coding that has been analyzed or adjusted by AI still requires a human to do final review and authorization before processing.

Learn as much about AI as you can. Staying updated on industry trends and technological advancements can help professionals in the medical billing and coding field stay relevant in the face of evolving technologies.

While AI may bring changes to the tasks involved in medical billing and coding, it is unlikely to completely replace human professionals. The collaboration between AI and human expertise has the potential to enhance the overall efficiency and accuracy of healthcare processes, creating a symbiotic relationship between technology and skilled professionals in the field.

Adam Phillips is the author of 9 Ways Doctors Let Money Slip Through Their Fingers - And How A Few Simple Ideas Can Guarantee a Private Practice Will Thrive in Today's Post-Pandemic World. He is the CEO of American Business Systems, a training and support company for individuals wishing to start their own medical billing business.

He hosts bi-weekly educational webinars at www.ABSystems.com.

The Advantages of Remote Medical Coding

In recent years, the healthcare industry has witnessed a shift toward remote workers, with the field of medical coding leading the way. This emerging trend has brought about numerous benefits, positively impacting providers and professionals in the field.

Through remote work, professionals can work from the comfort of their home. This flexibility improves job satisfaction and enhances work-life balance. Coders can tailor their hours to suit their needs, which leads to decreased stress and increased productivity.

Remote work allows insurance carriers, providers, and facilities to tap into a larger talent pool. This helps with filling shortages of qualified coders in certain regions. It can also have significant cost savings, including decreased office space, utilities, and infrastructure, as well as hiring in areas where salaries are not as high when compared to metropolitan areas. Remote work can also decrease other costs, such as overtime, commuting allowances, and other related expenses to onsite employees.

There have been studies that have shown an increase in productivity, as well as decreased errors in quality. Remote employees no longer have workplace distractions and can therefore fully focus on work. With the use of technology and specialized coding software, this has enabled the remote staff to be more productive and accurate. It has been argued that it is harder to manage remote staff, but we have not seen that. Instead, we are able to manage more staff across multiple time zones with less leadership. With clear processes in place and flexibility, we have seen less turnover and higher employee satisfaction.

A remote environment has also proved to be an advantage over the past few years with workplaces shutting down due to the COVID-19 pandemic and following outbreaks. Remote coding staff were able to continue working, which allowed continuity of care and a steady stream of revenue coming into carriers and providers—when other areas of business lost revenue.

The integration of remote medical coding staff into the healthcare landscape brings with it a multitude of advantages. From increased productivity and cost savings to access to a wider talent pool, remote medical coding has proven to be a viable solution for healthcare organizations looking to optimize their coding operations. As the industry continues to evolve, embracing remote work in medical coding not only benefits professionals but also contributes to the overall efficiency and effectiveness of healthcare services.

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Their mission is simple – to help their clients improve efficiency, ensure compliance, and thrive in the complex and ever-changing healthcare industry. Their staff have experience in the full revenue cycle, from the front- and back-end reimbursement processes to general outpatient coding and radiation and medical oncology specialty charge capture, they're the experts other experts turn to.

When Revenue Cycle Inc. and Coding Strategies combined forces in 2017, they also combined their legacies. The companies were initially founded within a year of each other, and it's worth having an extended celebration for this monumental milestone! This year we mark an outstanding achievement for the company – 25 years in business! We'll be commemorating this accomplishment in a variety of ways, including highlighting our excellent leadership staff in our Content Library.

Recent Developments in
Protecting Patient and Consumer Data

It is no secret that cybersecurity and the increased potential for cyberattacks, which could not only shut down providers' operations but also adversely impact patient care, is at the top of many organizations' risk lists. Given that HIPAA's Security Rule compliance date has been around since April 2005 and requires that specific technical, administrative, and physical safeguards be met, HIPAA compliance and cybersecurity risk management is something that should have been ingrained in covered entities and business associates' cultures for nearly a decade.

When approaching HIPAA and cybersecurity compliance, it is important to appreciate the laws and regulations, as well as changes to recognized standards, such as the National Institute for Standards and Technology (NIST) and the International Organization for Standardization (ISO), but also recent cases and government enforcement action. Hence, this article highlights an item related to a law, another related to a NIST update, and finally one related to a recent case.

Notable News

Below is a highlight of a recent development in each "bucket" mentioned above:

- **New York Senate Bill 158D –** Following in the footsteps of the Federal Trade Commission's 2023 and 2024 enforcement actions regarding the utilization of consumer's health data and location data without their knowledge and consent, SB 158D imposes significant restrictions on tech companies selling consumers' health data, given the expanding nexus between reproductive rights law and digital privacy in the post-Roe era.
- **NIST SP 1800-28 (Draft) –** Released in December 2023, "Data Confidentiality: Identifying and Protecting Assets Against Data Breaches" keys in on evaluating an organization's security and technology posture in order to implement appropriate and effective response and recovery plans.
- **Personal Touch Holding Corp. Class Action Settlement –** An Eastern District of New York Judge announced a preliminary class action settlement (Case No. 21-cv-02061) regarding a data breach affecting approximately 750,000 people. As noted in a January 23, 2024, Law360 article, "Judge Joan Azrack of the Eastern District of New York gave her initial blessing to the $3.6 million settlement Personal Touch agreed to pay last year to a class of approximately 753,107 individuals who alleged the company failed to safeguard their personally identifiable information. That data included names, passport numbers, driver's license numbers, retirement benefits information, addresses, birthdates, Social Security numbers, credit card information, medical records, and other data might have been exposed during a January 2021 cybersecurity attack on the company's systems."

Learning from the three aforementioned items can help persons integrate what happened when evaluating its cybersecurity preparedness in relation to prevention, detection, and correction.

Conclusion

A cybersecurity attack cannot only adversely impact an organization's financial health, the potential harm to patients is an even greater consequence. The cost of responding to a cyberattack, coupled with the potential downstream legal issues, whether through a class action, a government enforcement action, or a combination thereof, can have significant and potentially devastating financial consequences. One way to emphasize the importance of continued vigilance is to periodically send out updates in the form of articles or government bulletins that raise awareness. The timing should not cause email fatigue but should be consistent enough to serve as a reminder. In sum, the requirements to protect patient and consumer data are not going away, and therefore, it is incumbent upon organizations to remain watchful and stay abreast of this dynamic landscape.

Rachel V. Rose, JD, MBA, has a unique background, having worked in many different facets of healthcare throughout her career, including: work in acute care hospitals including the operating room and dietary department; consultative work as a top performing representative for the pharmaceutical and medical device industry; work for the Chairman of the Reform and Oversight Committee on Capitol Hill; intern at the Department of Health and Human Services; and compiling policy papers at the Royal College of Nursing in London. She has worked on Wall Street and at one of the Big Four consulting firms. Prior to opening her law firm, she was Director of Business Development and Assistant General Counsel for a healthcare advisory company. She is published and presents on a variety of healthcare topics including: the False Claims Act, the Foreign Corrupt Practices Act, physician reimbursement, ICD-10, access to care, anti-kickback and Stark laws, U.S. Supreme Court cases impacting the medical device industry, international comparative healthcare laws, and the HIPAA/the HITECH Act. Her practice focuses on a variety of healthcare and securities law issues related to industry compliance and Dodd-Frank. Visit www.rvrose.com for more information.

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CPT® E&M Coding Tool

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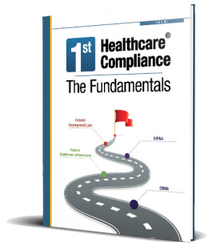
Thousands of physicians and coding professionals use the E & M Coding Tool daily to choose and validate E & M codes for documentation and billing purposes. This simple and easy-to-use two-sided tool helps you choose and validate E & M codes. The coding tool is continuously revised and updated, makes E & M coding faster and easier and is a great coding aid for both new and experienced coders.

Two-Sided Tool

The Coding Tool has two sides. Side A covers Office/Other Outpatient Services, Hospital Inpatient/Observation Care , and Consultations. Side B covers Nursing Facility Services, Home/Residence Services, and Non-Face-to-Face Services.

Healthcare Regulations and Compliance Guidebook: The Fundamentals



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This healthcare regulations and compliance guidebook from First Healthcare Compliance is a comprehensive resource designed to help physicians, compliance professionals, and other healthcare professionals in private practice, hospital networks and health systems, healthcare billing companies, and skilled nursing facilities comply with federal rules and regulations and to better understand their compliance responsibilities at a time of heightened scrutiny and increased regulations. The book addresses the four major areas of healthcare regulations and compliance: HIPAA, OSHA, federal waste and abuse laws, and federal employment laws. It can be used as a stand-alone resource or as a companion guide to The Fundamentals online course.

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