Medicare and most Commercial payers stopped giving a grace period for non-specific diagnosis codes on October 1, 2016. There has been an increase in denials and pended claims with denial reason “lacks specificity.”

- Be SPECIFIC in your assessment and plan and rank the most significant/concerning diagnosis in the #1 slot in your record as well as your operative report.
- Your reimbursement is supported by diagnosis coding. The correct, valid, and specific codes can trigger a level of reimbursement that unspecified codes can’t.
- Submitting non-specific diagnosis codes leads to pended claims and denials for medical necessity which costs your practice around $40 per claim.
- Providers have a medical obligation to submit the most specific diagnosis code(s) which has to be supported in the medical record.

- Bottom line: You are leaving money on the table if you choose to submit non-specific diagnosis codes.

Patient with history of Crohn’s large intestine presents with rectal bleeding, LLQ abdominal pain, and diarrhea.

- **K50.111**: Crohn’s Disease large intestine with bleeding
- **K50.118**: Crohn’s Disease large intestine with other complications
**CLINICAL EXAMPLES: SPECIFICITY IS KEY**

Patient presents to the office in follow-up to discuss his Barrett’s Esophagus that was found on recent EGD. Pathology was reviewed which showed low grade dysplasia.

- K22.710: Barrett’s Esophagus with low grade dysplasia

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**CLINICAL EXAMPLES: SPECIFICITY IS KEY**

Patient presents with morbid obesity with a current BMI of 42 counseled on diet and exercise.

- Z71.3: Dietary counseling/surveillance
- E66.01: Morbid obesity due to excess calories
- Z68.41: BMI 40.0-44.9, adult

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**CLINICAL EXAMPLES: SPECIFICITY IS KEY**

- Patient admitted with alcohol induced acute pancreatitis who has a history of alcohol induced chronic pancreatitis. He has a strong history of alcoholism and continues to drink on a daily basis.

- K85.20 alcohol induced acute pancreatitis without necrosis or infection
- K86.0 alcohol induced chronic pancreatitis
- F10.220 alcohol dependence with intoxication, uncomplicated
AVOIDING PITFALLS OF THE ELECTRONIC HEALTH RECORD: CREATING LIST OF FAVORITES IN THE ELECTRONIC RECORD

1. Angiodysplasia of stomach and duodenum without bleeding
   - Electronic Record: The provider’s ability to search is limited to “angiodysplasia” when the disorder can have multiple terms.
   Provider list of favorites:
   - K31.819 Gastric AVM without bleeding
   - K31.819 Watermelon stomach
   - K31.819 Angiodysplasia without bleeding
   - K31.819 GAVE
   - K31.819 Angioectasia without bleeding

2. Abnormal LFT’s – providers must be specific as to which LFT’s are elevated/abnormal.
   - Electronic Record: If the provider searches “elevated LFT’s” in the system, it will most likely choose R94.5 which is incorrect. What the provider is looking at is abnormal blood/ enzyme values and not an abnormal liver function study such as a HIDA scan.
   Provider list of favorites:
   - R74.0: Elevated transaminase (includes AST, ALT)
   - R74.8: Other abnormal liver enzymes (includes acid phosphatase, alkaline phosphatase, amylase, and lipase)
   - R79.89: Elevated bilirubin

3. Abnormal CT scan of GI tract
   - Electronic Record: when provider searches “abnormal CT” in the system, it will most likely choose R93.5 for abnormal imaging of other parts abdominal regions when the abnormality is really in either the GI tract OR biliary tract
   Provider list of favorites:
   - R93.2 abnormal imaging of liver and biliary tract
   - R93.3 abnormal imaging of other parts of digestive tract
AVOIDING PITFALLS OF THE ELECTRONIC HEALTH RECORD: CREATING LIST OF FAVORITES IN THE ELECTRONIC RECORD

4. Hemorrhoids
   • Electronic Record: when the provider searches “hemorrhoid” in the system, it will most likely choose K64.8 for “other hemorrhoid” (without mention of degree). If the provider is treating the hemorrhoid with a banding procedure for example, they should document the grade/stage of hemorrhoid. If this is done, they need to search by degree in order to assign the correct code.
   Provider list of favorites:
   – K64.0 First degree hemorrhoid
   – K64.1 Second degree hemorrhoid
   – K64.2 Third degree hemorrhoid

AVOIDING PITFALLS OF THE ELECTRONIC HEALTH RECORD: CREATING LIST OF FAVORITES IN THE ELECTRONIC RECORD

4. Abdominal Pain
   • Electronic Record: the provider most likely searches for “abdominal pain” and the first code to come up is R10.9 for non-specific abdominal pain. Then they may have a drop-down list with all the specific quadrants, etc.
   Provider list of favorites:
   R10.10 Upper abdominal pain R10.30 Lower abdominal pain
   R10.11 RUQ pain R10.31 RLQ pain
   R10.12 LUQ pain R10.32 LLQ pain
   R10.13 Epigastric pain R10.33 Periumbilical pain
   R10.84 Generalized pain

ICD-10 GI CODING ISSUES

Benign Neoplasm of colon
D12.0 cecum
D12.1 appendix
D12.2 ascending colon
D12.3 transverse colon (includes hepatic and splenic flexure)
D12.4 descending colon
D12.5 sigmoid colon
D12.6 colon, unspecified

Inflammatory polyp of colon (K51.4-), polyp of colon NOS (K63.5)

Chapter 2 (Neoplasm) guidelines state in order to assign a code from this chapter histologic confirmation of the neoplasm must be made.

Unite K63.5 when histologic confirmation has not been confirmed or the polyp is not neoplastic in nature.
ICD-10 CODING ISSUES

ICD-10 Helicobacter Issue
With ICD-10 came new LCDs (Local Coverage Determinations) for EGDs. (not all Medicare providers have LCDs for EGDs.) On the new LCD, there was no ICD-10 code for helicobacter gastritis.
B96.81: Helicobacter pylori [H. pylori]] as the cause of diseases classified elsewhere
This means that the disease would be the primary diagnosis and B96.81 would be secondary to explain the cause.
For example, pathology comes back as chronic gastritis with positive helicobacter immunostain. You would choose both codes:
• K29.60 Other specified chronic gastritis without bleeding
• B96.81 Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere

ICD-10 Coding for Esophageal Varices

ICD-10 Coding for Esophageal Varices

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ICD-10 Coding for Esophageal Varices

ICD-10 Coding for Esophageal Varices

This has been a major issue since some LCDs and commercial payers don’t allow cirrhosis or liver condition as an indication for EGD and if you submit the secondary varices as the primary diagnosis, it comes back as not a primary diagnosis.
ICD-10 CODING ISSUES

Rectal Bleeding versus Melena
K62.5: Rectal bleeding
gastrointestinal bleeding NOS (K92.2)
melena (K92.1)
neonatal rectal hemorrhage (P54.2)

• The problem with the ICD-10 codes is the diagnosis for hematochezia is linked to K92.1 (melena) and there is a separate code for rectal bleeding (K62.5).
• Be sure your documentation is specific as to if the bleed is from a rectal source or specifically hematochezia.

ECONOMY PROOF YOUR PRACTICE FOR ICD-10

• Make sure that demographic information is updated on every patient visit.
• Make sure that your documentation is specific.
• Make sure to assign the most specific diagnosis codes according to rank.
• Make sure that every document has a date of service and provider signature.
• Make sure that ALL providers are educated on proper leveling of E&M visits both in the office and the hospital.
• Make sure that your staff and providers are educated on the proper usage of modifiers.
• Make sure that your patients are informed of their benefits and co-pay amounts.

ICD-10 CONCLUSION AND TIPS

• Improving documentation will support medical necessity.
• Documentation is often requested by payers to ensure medical necessity is met.
• Improving the quality of your documentation will lead to a more accurate medical record.
• Decrease in claim denials.
• Improved documentation and accurate medical records translate into good patient care.
• Documentation is not just a billing tool but a medical legal document. Accuracy is a must.
• Research denials.
• Create a process for working denials.
• Often times payers want further information to process the claim (signatures, place of service correction, medical records).
WHAT IS MACRA?
- Medicare Access and CHIP Reauthorization Act
- Created by Congress (April 2015)
- Repealed the Sustainable Growth Rate and replaced it with the Quality Payment Program (QPP)
- Shifts payment equation from number of services provided to a system that rewards clinicians for their work on improving overall quality of care.

QUALITY PAYMENT PROGRAM
- The new Merit-based Incentive Payment System helps to link fee-for-service to quality and value
- Participation in Alternative Payment Models provides incentives and bonus payments to those in the most highly advanced APMs

MEDICARE REPORTING PRIOR TO MACRA
- Physician Quality Reporting Program (PQRS)=Quality
- Value-Based Payment Modifier (VBPM)=Cost
- Medicare Electronic Health Records (EHR) Incentive Program (Meaningful Use)=Advancing Care Information
**MIPS PERFORMANCE CATEGORIES**
- Quality
- Cost
- Improvement Activities
- Advancing Care Information

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**QUALITY**
- 60% of total MIPS Composite Score in the first year
- Replaces PQRS and the quality component of the VBPM
- Report on 6 quality measures
  - At least 1 outcome measure if available
  - Specialty measure set instead if available

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**COST**
- 0% of total MIPS Composite score in first year
- Replaces cost component of VBPM
- NO reporting required for clinicians
- Episode-based measures in development to be tested in the first year
IMPROVEMENT ACTIVITIES

- 15% of total MIPS Composite Score in the first year
- Clinicians rewarded for clinical practice improvement activities
- Clinicians select activities from a list of 93 options

ADVANCING CARE INFORMATION

- 25% of total MIPS Composite Score in the first year
- Formerly Meaningful Use
- 3 Scoring Components:
  - Base score = 50 points
  - Performance score = 90 points
  - Bonus score = 15 points
- 100 points to full 25% credit

MIPS REPORTING

- Third parties can act as intermediaries on behalf of clinicians, to submit data for MIPS categories
- Third parties include:
  - Registries
  - Qualified Clinical Data Registries (i.e., GIQuIC)
  - Health Information technology developers
  - Certified survey vendors
MIPS ELIGIBLE CLINICIANS

- Physicians
- Nurse Practitioners
- Physician Assistants
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

MIPS EXEMPTIONS

- Clinicians newly enrolled in Medicare
- Low-volume clinicians or groups
  - ($30,000 in Medicare charges and ≤100 Medicare patients)
- Clinicians participating in an Advanced APM

2017 PARTICIPATION OPTIONS

- MIPS: Don’t Participate = -4% payment adjustment
- MIPS: Submit Something = 0% payment adjustment
- MIPS: Submit Partial Year = -4% payment adjustment
- MIPS: Submit Full Year = ++ payment adjustment
- Join an advanced APM = +5% payment adjustment

Begin January 1, 2017 and start collecting your performance data. If you were not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you’ll need to send in your performance data by March 31, 2018. You can also begin participating in an Advanced APM.

The first payment adjustments based on performance go into effect on January 1, 2019.
MIPS FUTURE ADJUSTMENTS

- Maximum negative adjustment (penalty)

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- Maximum positive adjustment (bonus)

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PERFORMANCE PERIOD

- Reporting Year: 2017 (January 1, 2017)
- Payment Year: 2019

MIPS SUMMARY

- Quality Payment Program defines how Medicare will pay clinicians
- Most Gastroenterologists will be reimbursed by MIPS
- MIPS Composite Performance Score defines positive, negative, or neutral finance adjustments and is based on 4 performance categories:
  - Quality
  - Cost
  - Improvement Activities
  - Advancing Care Information
RESOURCES

ASGE MACRA Implementation Resource Center
www.asge.org/MACRA

Centers for Medicare and Medicaid Services
www.qpp.cms.gov