2020 Expert Coding Update: CPT, MIPS, and Audit Traps

DESCRIPTION
The coding rules change substantially each year and 2020 is no different. Hear the latest regarding CPT changes, the complexities of the MIPS program, and audit traps to avoid.

OBJECTIVES
- Describe the key ED specific 2020 CPT and diagnosis coding changes for emergency medicine
- Discuss how the expanded CMS audit programs will impact your practice
- Identify the 2020 CMS regulatory changes related to emergency medicine practice including the impact of the 2020 Medicare fee schedule

1/30/2020, 8:00 AM - 9:00 AM, 2020 Expert Coding Update: CPT, MIPS, and Audit Traps

FACULTY
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DISCLOSURE
(+) No significant financial relationships to disclose
2020 Coding Update

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President, LogixHealth

David McKenzie, CAE
ACEP Director of Reimbursement
The Is Who We Are!
The Safety Net

140 million visits, 39 million related to injury, >60% of hospital admissions, 4% of the work force—>50% of the care for Medicaid and CHIP
Comparative Billing Report: Phase 2 June 2019

CBR 201906:
Emergency Department Services

Compares Your Group to State and National Average
1. CPT® Code 99285
2. Modifier 25
3. Average Allowed Charges

<table>
<thead>
<tr>
<th>Topic Reviewed</th>
<th>MI</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Services Billed with CPT® Code 99285</td>
<td>49.51%</td>
<td>46.53%</td>
</tr>
<tr>
<td>Percentage of Services Appended with Modifier 25</td>
<td>12.76%</td>
<td>10.44%</td>
</tr>
<tr>
<td>Avg. Allowed Charges Medicare Part B Services, per Visit</td>
<td>$133.20</td>
<td>$126.93</td>
</tr>
</tbody>
</table>
How To Get Your CBR

- https://cbrfile.cbrpepper.org/
CMS - Target Probe and Educate

If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC).

The MAC will review 20-40 of your claims and supporting medical records.

If some claims are denied, you will be invited to a one-on-one education session.

You will be given at least a 45-day period to make changes and improve.

If compliant, you will not be reviewed again for at least 1 year on the selected topic.

1 YEAR

45 DAYS

Up To 3 Rounds

*MACs may conduct additional review if significant changes in provider billing are detected.
After three rounds of review and continued high denial rates CMS may instruct the MAC for additional action which could include:

- Extrapolation
- Referral to the Zone Program Integrity Contractor or Unified Program Integrity Contractor
- Referral to the Recovery Audit Contractor
- 100% prepay review
Dear Provider,

You are receiving this letter for educational purposes. Your claim was medically reviewed via an Additional Documentation Request (ADR) and denied because of the errors listed below for Part B services for Edit ID 2284.

The Granular Error Denial table details the reason for denial. The Granular Error Education table provides additional information.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Date of Service</th>
<th>Granular Error Denial</th>
<th>Denial Code and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Documentation received lacks high complexity decision making to support vital system function to prevent further life threatening deterioration.</td>
<td>[NOTMN] - Documentation does not support Medical Necessity (no LCD used)</td>
</tr>
</tbody>
</table>
Medical Decision Making Contributors

- Differential diagnosis
- Course of care and responses to treatment
- Conversations: EMS, Family, PCP, Hospitalist
- Severity of presentation
  - Abnormal vitals
  - Patient discomfort
- Data
  - Review of Old record
  - Independent interpretations

MEDICAL DECISION MAKING
COMPLEXITY
HIGH - 99285
MOD - 99283-84
LOW - 99282
MINIMAL - 99281
Documentation Best Practices

- 4 HPI for most presentations
- Small or large macro for ROS and PE depending on complexity
- Completed Past Medical and Social Hx
  - Family Hx as relevant
- Recognize Hx and acuity caveat opportunities
- Robust medical decision making
  - Combined with Hx/PE = LEVEL
April CMS Inquiry and Response Regarding Teaching Physicians

(1) If a teaching physician saw the patient, reviewed and verified notations by the resident, do they still have to write a personal attestation to support a Medicare part B service or is this now optional?

– In the absence of national policy, we defer to the local Medicare Administrative Contractors (MACs). Providers may wish to contact their local MAC for guidance related to their specific situations.

“We are working to update the Medicare Claims Processing Manual consistent with the regulatory changes made as part of the CY 2019 PFS Final Rule.”
SUBJECT: Documentation of Evaluation and Management Services of Teaching Physicians

EFFECTIVE DATE: January 1, 2019
*Unless otherwise specified, the effective date is the date of service.

IMPLEMENTATION DATE: July 29, 2019

For purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate:

- That the teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident; and

- The participation of the teaching physician in the management of the patient.

The presence of the teaching physician during E/M services may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.
2020 PAs Gain More Independence

- Some states up to the employer with few restrictions
- North Dakota PAs fairly independent

2020 Update: In the absence of any state rules for physician supervision of PA services, CMS states that physician supervision is “a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services.”

- Importantly no change to Transmittal 1776:
  - “We did not make any proposals specific to split/shared services.” 2020 PFS proposed rule 879/2475
In this year’s rule, CMS modifies the documentation policy to now allow physicians, **physician assistants**, or **advanced practice registered nurses** to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, **students**, or other members of the medical team.

**Definition of Student Expansing**: CMS is explicitly naming PA and NP, CNS, CNM, and CRNA students as APRN students, along with medical students, as the types of students who may document notes for review and verification.
We have heard repeatedly that a major source of burnout is the documentation burden associated with evaluation and management (E/M) coding, and that a change is long overdue.

Clinicians find themselves having to perform and document clinical activity that may be of only marginal relevance to the visit, but is required in order to receive the level of payment that their effort deserves.
“In the CY 2019 PFS final rule we finalized a number of coding, payment, and documentation changes for office/outpatient E/M visits (CPT codes 99201-99215) to reduce administrative burden. In summary, we finalized the following policy changes effective January 1, 2021.

Permitting practitioners to choose to document office/outpatient E/M 5 visits using: MDM or time, or the current framework based on the 1995 or 1997 Guidelines.”  

Physician Final Rule page 868/2475
“Throughout 2019 CMS sought comment on changing the current documentation guidelines. Specifically sought comment on whether it would be appropriate to remove documentation requirements for the history and physical exam for all E/M visits at all levels. We stated that MDM and time are the more significant factors in distinguishing visit levels, and that the need for extended histories and exams is being replaced by population-based screening and intervention.”

CMS Provider Outreach Press Release
AMA/CPT Weighs In: Need For Updated Guidelines

- "For decades, the physician community has struggled with burdensome reporting guidelines for reporting office visits and other E/M codes. Documentation requirements have encouraged “note bloat” due to the check-box nature of meeting the current documentation requirements."

- To address this, on Feb. 9, 2019, the AMA convened CPT Editorial Panel approved revisions to the CPT-E/M office visit reporting guidelines and code descriptors.
AMA/CPT Motivated Regarding Changes to The Documentation Guidelines

- Extensive Surveys, Meetings, and Analysis
- Protect the value of the CPT code set
Which Governing Body Decides Documentation Guidelines For 2021?

Everyone wants to own/monetize the documentation guidelines.
“For 2021, for office/outpatient E/M visits (CPT codes 99201-99215), we proposed generally to adopt the new coding, prefatory language, and interpretive guidance framework that has been issued by the AMA/CPT because we believed it would accomplish greater burden reduction.”  

“Therefore, we are finalizing our proposal to adopt the MDM guidelines as revised by CPT to select office/outpatient E/M visit level beginning January 1, 2021.”
The Devil We Knew: 1995 Documentation Guidelines Going Away—For The Office Codes

25 Years Ago!
Current AMA /CPT Guideline: E/M Components

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time – Used as the primary determinant only if >50% of the visit involves counselling and coordination of care
Updated AMA/CPT Guidelines: History and Physical Exam

- “The nature and extent of the history and/or physical examination is determined by the treating physician reporting the service.”

- The care team may collect information and the patient or caregiver may supply information directly (e.g., by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional.

- The extent of history and physical examination is NOT an element in selecting office other outpatient services.
MDM or Time Will Determine 2021 Office Code Choice

2021 Office Visit Code Scoring

“The CPT code changes allow clinicians to choose the E/M visit level based on either medical decision making or time.”  

2020 CMS Physician Final Rule Press Release

Requires performance of history and exam only as medically appropriate.
Updated AMA CPT Guidelines: ED and Time

- Time noted NOT to apply in The ED

“Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.”


Leaves The ED With MDM
ED Implications: 2021 Documentation Guideline Changes

2019 Rule
95 /97 DGS
MDM
Time

2020 Rule
MDM
Time

2020 AMA/CPT
MDM
ED Timeline: Transition To Updated Guidelines?

- ED Codes seen as complex – will take more time

**NO APPLICATION IN THE ED YET**

“...The proposed changes only apply to office codes: 99201 – 99215.

There are more unique issues to consider for the E/M code sets used in the emergency department care, such as unique clinical and legal issues.

We may address sections of the E/M code set beyond the office/outpatient codes in future years.”  

_CMS Physician Rule page 332/1473_
Silver Lining To New Guidelines: The Presenting Problem vs Final Diagnosis?

• “One element in the level of code selection for an office or other outpatient service is the number and complexity of the problems that are addressed at an encounter.”

• The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.

• Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.
July CPT Assistant Update: Observation and Mental Health

Resources Follow Revenue

- Historically no clear direction re coding multi day mental health “borders” or “psych holds”
- CPT Behavioral Health Vignette:
  - No Beds and has a 3 day ED stay
- Asked CPT how to report a 3 day “psych hold”

**Official Answer**
- Obs day 1 99218-99220
- Middle days 99224-99226
- Final day 99217

- 5 day stay 4.89 RVUs ➔ 13.47 RVUs
2020 Payment Factors
2020 RBRVS Equation

Work RVUs
Practice Expense RVUs
+Liability Insurance RVUs
Total RVUs for a given code

$$\text{RVU}_{\text{Total}} \times \text{Conv. Factor} = \text{Medicare Payment}$$
"We agree with the majority of commenters that ED services may be potentially misvalued given the increased acuity of the patient population and the heterogeneity of the sites where emergency department visits are furnished. As a result, we look forward to reviewing the RUC’s recommendations regarding the appropriate valuation of these services for our consideration in future notice and comment rulemaking.

- Physician Final Rule page 166/1250
ACEP RUC team made robust arguments related to the increased acuity of our patients.

The RUC accepted our survey data and recommended an RVU increase.

CMS has accepted the RUC’s recommendation.
## 2020 RVUs Increasing

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>0.45</td>
<td><strong>0.48</strong></td>
<td>0.11</td>
<td>0.11</td>
<td>0.04</td>
<td>0.05</td>
<td>0.60</td>
<td><strong>0.64</strong></td>
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<tr>
<td>99282</td>
<td>0.88</td>
<td><strong>0.93</strong></td>
<td>0.21</td>
<td>0.21</td>
<td>0.08</td>
<td>0.09</td>
<td>1.17</td>
<td><strong>1.23</strong></td>
</tr>
<tr>
<td>99283</td>
<td>1.34</td>
<td><strong>1.42</strong></td>
<td>0.29</td>
<td>0.29</td>
<td>0.12</td>
<td>0.13</td>
<td>1.75</td>
<td><strong>1.84</strong></td>
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<tr>
<td>99284</td>
<td>2.56</td>
<td><strong>2.60</strong></td>
<td>0.53</td>
<td>0.51</td>
<td>0.23</td>
<td>0.27</td>
<td>3.32</td>
<td><strong>3.38</strong></td>
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<tr>
<td>99285</td>
<td>3.80</td>
<td><strong>3.80</strong></td>
<td>0.74</td>
<td>0.71</td>
<td>0.35</td>
<td>0.40</td>
<td>4.89</td>
<td><strong>4.91</strong></td>
</tr>
</tbody>
</table>
### The 2020 Conversion Factor

- 2018: $35.9996
- 2019: $36.0391
- 2020: $36.0896

#### TABLE 117: Calculation of the CY 2020 PFS Conversion Factor

<table>
<thead>
<tr>
<th>CY 2019 Conversion Factor</th>
<th>CY 2020 RVU Budget Neutrality Adjustment</th>
<th>CY 2020 Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Update Factor</td>
<td>0.00 percent (1.0000)</td>
<td></td>
</tr>
<tr>
<td>CY 2020 RVU Budget Neutrality Adjustment</td>
<td>0.14 percent (1.0014)</td>
<td><strong>36.0896</strong></td>
</tr>
</tbody>
</table>

The conversion factor for 2020 is calculated by applying the statutory update factor and the budget neutrality adjustment to the CY 2019 conversion factor.
# 2020 Conversion Factor and RVU Increases

## 2020 ED E/M Payment Changes

<table>
<thead>
<tr>
<th>Code</th>
<th>2019 Payment</th>
<th>2020 Payment</th>
<th>$ Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>$21.62</td>
<td>$23.10</td>
<td>$+1.48</td>
</tr>
<tr>
<td>99282</td>
<td>$42.17</td>
<td>$44.39</td>
<td>$+2.22</td>
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<td>99283</td>
<td>$63.07</td>
<td>$67.85</td>
<td>$+4.78</td>
</tr>
<tr>
<td>99284</td>
<td>$119.65</td>
<td>$121.62</td>
<td>$+1.97</td>
</tr>
<tr>
<td>99285</td>
<td>$176.23</td>
<td>$178.28</td>
<td>$+2.05</td>
</tr>
</tbody>
</table>
2021 Office Visit Code Are Increasing: Ramifications?

- Office visit codes represent 20% of total Medicare physician expenditures
- “The AMA RUC-recommended values will increase payment for office/outpatient E/M visits in 2021.” Physician Final Rule page 888/2475
- Budget neutrality triggered with a decrease in the conversion factor
- Those not billing the office visits codes will be negatively impacted.
- “Many commenters expressed concerns about the redistributive impact of revaluing of the office/outpatient E/M visit code set, particularly for practitioners who do not routinely bill office/outpatient E/M visits.” Physician Final Rule page 888/2475
## TABLE 120: Estimated Specialty Level Impacts of Finalized E/M Payment and Coding Policies

<table>
<thead>
<tr>
<th>Specialty</th>
<th>(A) Allowed Charges (mil)</th>
<th>(B) Impact of Work RVU Changes</th>
<th>(C) Impact of PE RVU Changes</th>
<th>(D) Impact of MP RVU Changes</th>
<th>(E) Combined Impact*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy/Immunology</td>
<td>$236</td>
<td>-4%</td>
<td>3%</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>$1,993</td>
<td>-5%</td>
<td>-1%</td>
<td>0%</td>
<td>-7%</td>
</tr>
<tr>
<td>Audiologist</td>
<td>$70</td>
<td>-4%</td>
<td>-2%</td>
<td>0%</td>
<td>-6%</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>$279</td>
<td>-5%</td>
<td>-2%</td>
<td>-1%</td>
<td>-8%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>$6,595</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>$750</td>
<td>-5%</td>
<td>-3%</td>
<td>-1%</td>
<td>-9%</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>$787</td>
<td>-7%</td>
<td>0%</td>
<td>0%</td>
<td>-7%</td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td>$781</td>
<td>-7%</td>
<td>0%</td>
<td>0%</td>
<td>-6%</td>
</tr>
<tr>
<td>Colon And Rectal Surgery</td>
<td>$162</td>
<td>-3%</td>
<td>-1%</td>
<td>-1%</td>
<td>-6%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>$346</td>
<td>-5%</td>
<td>-1%</td>
<td>0%</td>
<td>-6%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>$3,541</td>
<td>0%</td>
<td>1%</td>
<td>-1%</td>
<td>-1%</td>
</tr>
<tr>
<td>Diagnostic Testing Facility</td>
<td>$697</td>
<td>-1%</td>
<td>-4%</td>
<td>0%</td>
<td>-4%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>$3,021</td>
<td>-6%</td>
<td>-2%</td>
<td>1%</td>
<td>-7%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>$488</td>
<td>11%</td>
<td>5%</td>
<td>1%</td>
<td>16%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>$6,019</td>
<td>8%</td>
<td>4%</td>
<td>1%</td>
<td>12%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>$1,713</td>
<td>-2%</td>
<td>-1%</td>
<td>-1%</td>
<td>-4%</td>
</tr>
<tr>
<td>General Practice</td>
<td>$405</td>
<td>5%</td>
<td>2%</td>
<td>0%</td>
<td>8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>$2,031</td>
<td>-3%</td>
<td>-1%</td>
<td>0%</td>
<td>-4%</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>$187</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Hand Surgery</td>
<td>$226</td>
<td>-1%</td>
<td>0%</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>$1,673</td>
<td>8%</td>
<td>4%</td>
<td>1%</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$13,797</strong></td>
<td><strong>-4%</strong></td>
<td><strong>-2%</strong></td>
<td><strong>0%</strong></td>
<td><strong>9%</strong></td>
</tr>
</tbody>
</table>
Future Direction and Approach

“These revised codes and values do not take effect until 2021. We believe it would be premature to finalize a strategy in this final rule as these values would not be effective until 2021. However, we intend to consider these concerns and address them in future rulemaking.”  

We are considering updating other E/M visits to maintain relativity with the revalued office/outpatient E/M code set as part of CY 2021 PFS rulemaking.”

Physician Final Rule page 888/2475

Physician Final Rule page 889/2475
Potential Solutions To Avoid Cuts In 2021

- Comments to CMS in 2021 Proposed and Final Rules
  - Reiterate historic relationship between new office and ED levels 1-3 to maintain parity
- Resurvey the ED E/M Codes Through the RUC Process
  - No guarantees of a good outcome. Feb 10, 2020 deadline to express intent
- Consider a CPT Solution
  - Perhaps a new ED add on code for high complexity
- Lobby Congress to make the Office Code Increase Exempt from Budget Neutrality Adjustments
  - Some precedent with the GPCI Work floor of 1.0
2020 CPT Update

Effective for dates of service January 1, 2020

- New code (248)
- Deleted code (71)
▲ Revised code (75)
▷ Contains new or revised text
✓ FDA approval pending
# Resequenced code
★ Appendix P Telemedicine code
2020 Intermediate vs. Complex Laceration

- Intermediate repair
  - Limited undermining
- A distance less than the maximum width of the defect
- Complex repair
  - Extensive undermining
- A distance greater than or equal to the maximum width of the defect
2020 Pericardiocentesis Code Changes

- New unifying code which adds the description of including imaging guidance and deletion of 4 codes

New Code:
- 33016 Pericardiocentesis, including imaging guidance, when performed

Deleted codes:
- 33010 Pericardiocentesis: initial
- 33011 Pericardiocentesis: subsequent
- 33015 Tube pericardiostomy
- 76930 Ultrasound guidance for pericardiocentesis
2020 Lumbar Puncture Code Changes

- **62270** Spinal puncture, lumbar, diagnostic (unchanged)
- New codes for Lumbar Puncture that include fluoroscopic or CT guidance

New codes:
- **#62328** Spinal puncture, lumbar, **diagnostic**; with fluoroscopic or CT guidance
- **#62329** Spinal puncture, lumbar, **therapeutic**, for drainage of cerebrospinal fluid (by needle or catheter; with fluoroscopic or CT guidance)
Additional New Codes of Interest

Flu vaccine formulation for 2020 season

- **90694** Influenza virus vaccine, quadrivalent (aIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use

Needle insertion not requiring an injection

- **20560** Needle insertion(s) without injection(s); 1 or 2 muscle(s)
- **20561** Needle insertion(s) without injection(s); 3 or more muscles
2020 ICD 10 Update

October 1, 2019

- 273 additions,
- 30 code revisions
- 21 deletions
2020 ICD-10 Update

- ICD-10 is updated Oct. 1- already live!

  ED relevant codes added, deleted or revised

- Atrial fibrillation
- Phlebitis/thrombophlebitis
- Cyclical vomiting
- Orbital Fracture
- Heatstroke/sunstroke
- Vaping Considerations

Hot Topics Lecture
New ICD-10-CM code for vaping-related disorder to be implemented April 1, 2020

- U07.0, Vaping-related disorder
- Currently valid!
- Considerations for reporting also include nicotine dependence, adverse events, as well as injuries

Conclusions

- Document Medical Decision Making
  - Will be increasingly important!
- ED RVUs are increasing
- The 2020 Conversion factor is increasing
- 2021 Office Visit code changes will have a big impact
- Stay Tuned!
  - Jeff Davis’ Regs and Eggs weekly blog: https://www.acep.org/regsandeggs.
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Educational Appendix
Timeline For Office Visit Code Changes

Office Visit Timeline

2020
No coding changes for any types of visits

2021
Office visits choice between: Medical Decision Making Time
Revised: 64400-64450 Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (i.e., ophthalmic, maxillary, mandibular)

All remaining nerve injections (CPT 64400-64450) have addition of “and/or steroid” to code descriptor.

Example:

- 64450- Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve branch

- 64402, 64410, and 64413 have been deleted
New classifications for persistent and chronic atrial fibrillation

- **Persistent Atrial Fibrillation**
  - I48.11 Longstanding persistent atrial fibrillation
  - I48.19 Other persistent atrial fibrillation

Former single code:
I48.1 Persistent Atrial Fibrillation

- **Chronic Atrial Fibrillation**
  - I48.20 Chronic atrial fibrillation, unspecified
  - I48.21 Permanent atrial fibrillation

Former single code:
I48.2 Chronic atrial fibrillation
Several new phlebitis/thrombophlebitis codes to allow for more specificity:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I80.241</td>
<td>Phlebitis and thrombophlebitis of right peroneal vein</td>
</tr>
<tr>
<td>I80.242</td>
<td>Phlebitis and thrombophlebitis of left peroneal vein</td>
</tr>
<tr>
<td>I80.243</td>
<td>Phlebitis and thrombophlebitis of peroneal vein, bilateral</td>
</tr>
<tr>
<td>I80.249</td>
<td>Phlebitis and thrombophlebitis of unspecified peroneal vein</td>
</tr>
<tr>
<td>I80.251</td>
<td>Phlebitis and thrombophlebitis of right calf muscular vein</td>
</tr>
<tr>
<td>I80.252</td>
<td>Phlebitis and thrombophlebitis of left calf muscular vein</td>
</tr>
<tr>
<td>I80.253</td>
<td>Phlebitis and thrombophlebitis of calf muscular vein, bilateral</td>
</tr>
<tr>
<td>I80.259</td>
<td>Phlebitis and thrombophlebitis of unspecified calf muscular vein</td>
</tr>
</tbody>
</table>
Several new codes added for orbital fractures

Anatomical specificity:
- roof
- medial wall
- lateral wall

Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S02.122A</td>
<td>Fracture of orbital roof, left side, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.831A</td>
<td>Fracture of medial orbital wall, right side, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.841A</td>
<td>Fracture of lateral orbital wall, right side, initial encounter for closed fracture</td>
</tr>
</tbody>
</table>

Revised

S02.8xxx Fracture of other specified skull and facial bones
2020 ICD-10 Update- Heatstroke/Sunstroke

- Revised previous code of T67.0XXA Heatstroke and sunstroke
  - New: T67.01XA Heatstroke and sunstroke, initial encounter
- New classifications
  - Exertional
    T67.02XA Exertional heatstroke, initial encounter
  - Other
    T67.09XA Other heatstroke and sunstroke, initial encounter

Note: additional codes for subsequent encounter and sequela
2020 ICD-10 Update- Cyclical Vomiting

- New and Revised Cyclical Vomiting codes to differentiate presence or absence of migraine

Revised
- G43.A0 Cyclical vomiting, *in migraine*, not intractable
- G43.A1 Cyclical vomiting, *in migraine*, intractable

New
- R11.15 Cyclical vomiting syndrome unrelated to migraine
Vaping - Diagnosis Considerations

Diagnosis codes to consider for presentations related to vaping:

- F17.290 Nicotine dependence, other tobacco products, uncomplicated
- T65.9x Toxic effect of unspecified substance
- T50.915x Adverse effects of multiple unspecified drugs, medicaments and biological substances
- F12.188 Cannabis abuse with other cannabis-induced disorder
- T40.7X5x Adverse effect of cannabis (derivatives)
- T20.00XA Burn of unspecified degree of head, face, and neck, unspecified site, initial encounter
- J69.1 Pneumonitis due to inhalation of oils or essences
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