AMA issues AI adoption guidance

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News & Insights

The American Medical Association (AMA) released guidance last month for organizations developing policies around the adoption of artificial intelligence (AI) technology. AI adoption is on a rapid rise. According to an AMA survey, nearly 70% of physician respondents said they used AI tools in 2024, up 38% from the previous year.

“Technology is moving very, very quickly. It’s moving much faster than we’re able to actually implement these tools, so setting up an appropriate governance structure now is more important than it’s ever been because we’ve never seen such quick rates of adoption,” said Margaret Lozovatsky, MD, chief medical information officer and vice president of digital health innovations at the AMA, in the release.

Among their recommendations, the AMA set forth a list of items that should be included in an organization’s AI policy:

- Definitions for terms related to AI
- AI risks
- Permitted and prohibited uses of approved AI tools
- Governance, evaluation, and approval processes for AI tools
- Description of AI accountability and oversight
- Policy for how long AI generated information and a patient’s visit recordings will be retained
- Transparency guidelines on when and how providers and patients should be made aware of AI use
- Training on AI tools, including the frequency of such education

For organizations with existing AI policies in place, the AMA also includes advice on evaluating policies to ensure they are effective and comprehensive.

Editor’s note: *A version of this article originally appeared in* CDI Strategies*, ACDIS’ weekly e-newsletter.*

Related Topics:
Auditing and monitoring, Compliance, Documentation improvement, HIM/HIPAA, Medicare news

Selecting the correct pain management diagnosis code

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News & Insights

The diagnosis establishes the medical necessity for the service.

The logic of ICD-10-CM codes is very different from the organization of Current Procedural Terminology (CPT®) codes. CPT codes tell the payer what you did; ICD-10-CM codes tell why you did it. You should use particular care when selecting diagnosis codes. Always select the most specific code possible, based on the clinician's documentation. Another difference between CPT and ICD-10-CM is when the new code sets go into effect. CPT codes go into effect on January 1 of the calendar year. ICD-10-CM codes are released at the start of the fiscal year (FY). For example, FY 2023 codes went into effect on October 1, 2022.

Using vague or non-specific diagnosis codes is likely to result in denials. If the source of the pain has been diagnosed, code for the source rather than the symptom. Even when you specifically code for the source, your carrier may still deny the claim based on its particular payment policy. When you spot a pattern of denials, it's always helpful to verify directly with payers that the problem was diagnosis-related and not a result of questionable medical necessity for the entire treatment plan.

One place to check: Your carrier's website. Medicare carriers and commercial payers post their payment policies on the Internet. These policies list information about coverage of specific services, including the diagnosis codes that the payer has decided constitute medically necessary conditions for reimbursement of a procedure. It is important to be familiar with the payer or carrier's policies in order to avoid denials caused by medical necessity. The payer may not allow you to bill the patient when this happens.

Providers should never select a diagnosis code simply to receive payment.

Diagnosis coding guidelines

While it's impossible to offer a universal set of rules for diagnosis code selection, here are some general guidelines to use as a starting point:

Sometimes, pain will not be the primary diagnosis. Pain is a symptom, not the cause. Symptoms like elbow pain can be secondary diagnoses, but for the primary diagnosis, you want to code the underlying illness or injury, like arthritis, sprain, tennis elbow, etc. The most common unspecified diagnosis is low back pain without any further clarification. When you get that, ask yourself, "What is the cause of the low back pain?" After you determine what it is, use low back pain as a secondary diagnosis to further describe the primary reason for the pain.

Keep these tips in mind when selecting a diagnosis code:

- **Designate the post-operative diagnosis wherever possible.**
- **Avoid repeating the procedure in narrative form in the diagnosis section instead of giving the diagnosis.** For example, don't list a diagnosis description of lysis of adhesions instead of epidural adhesions. Include specifics, such as whether the condition included myelopathy, neuritis, or radiculopathy.
- **List a diagnosis for each procedure on the claim form.** Procedures are listed in order of value, and diagnoses are listed in a corresponding order. The exception is fluoroscopic techniques: these don't require a unique diagnosis.
- **Similarly, physician dictations should link the procedure with the diagnosis.** Documentation is very important. By linking the diagnosis to the procedure in the operative note, it will be easier for your insurance carrier to determine which procedure goes with which diagnosis. For multiple procedures, make sure the first diagnosis equals the first procedure and so forth.
- **Do NOT use the terms "rule-out," "possible," "probable," "suspected," or "working diagnosis."** Payers will deny such claims. Instead, describe the signs, symptoms, or other reasons for the procedure. If a patient has back pain and the physician performs a facet joint injection to determine whether the pain was caused by a facet joint disorder, and the block brought no relief, you'd code the claim as back pain, not rule out facet joint syndrome. If the block does bring relief, a diagnosis of lumbar stenosis might apply. Despite the common usage of the term facet joint syndrome, there is no ICD-10 code for this diagnostic descriptor. However, the notes for ICD-10 codes in the spondylosis series (M47) include degeneration of facet joints.
- **Describe the highest degree of specificity available.** If a syndrome is referenced, such as facet joint syndrome, describe the related symptoms, such as lumbar stenosis, other spondylosis with myelopathy, lumbar region code (M47.16), or the appropriate lumbar disk degeneration code (M51.36 or M51.37).
- **Avoid "not otherwise specified" (NOS) ICD-10 codes.** Payers don't like to pay for unspecified codes, and most claims are denied because the carrier's definition of what is "medically necessary" does not include NOS codes. While from a medical standpoint, they can still be considered valid, make sure to exhaust all other options before using them because, from a coding perspective, they are commonly recognized as "dump" or "catch-all" codes.

***Editor's note**: This article is an excerpt from "2025 Pain Management Coding Answers," published by DecisionHealth®, a division of HCPro LLC. Pre-order the 2026 edition here.*

Related Topics:
Coding, Denials and appeals

Help Revenue Cycle Advisor meet your education needs

September 17, 2025
News & Insights

As all revenue cycle professionals know, navigating the evolving world of Medicare regulations is extremely difficult. These individuals must routinely seek out training and education to help their organization maintain compliance with CMS requirements and receive proper reimbursement.

Revenue Cycle Advisor is designed to serve as a key Medicare education source for billing, coding, compliance, HIM, and other teams. We strive to provide our subscribers with valuable information, expert insights, and successful strategies to help them excel in their roles. To ensure our editorial content, resources, and other offerings continue to focus on relevant topics, we want to hear from revenue cycle professionals like you about your Medicare education gaps and how we can help fill them.

Which Medicare requirements do you struggle to comply with? What education methods and formats work best for your team? What resources could help you fulfill your role and responsibilities? What topics would you like to see covered on Revenue Cycle Advisor, ACDIS, NAHRI, and other HCPro sites? How can we improve our virtual and in-person events? If you have insights on these topics, click here to register for one of our upcoming focus groups and help us refine your Medicare education.

The focus groups will be held at the following times:

- 2:00-3:00 p.m. EST on Tuesday, September 30, 2025
- 10:00-11:00 a.m. EST on Thursday, October 2, 2025

Editor's note: *Focus group registrants will receive a Microsoft Teams meeting invitation via email. Contact our editorial staff at revcycleadvisor@gmail.com with any additional comments or concerns.*

Revenue Cycle Advisor launches new CEU opportunity for HIM Briefings

September 24, 2025
News & Insights

At Revenue Cycle Advisor, our primary goal is to provide our subscribers with the information, training, and education needed to succeed in their current roles and beyond.

Over the past year, we have made several significant improvements to our editorial content and other website offerings to better meet the needs of revenue cycle professionals. Among other changes, we launched a new-and-improved version of our *HIM Briefings* newsletter at the start of 2025. This publication provides extensive coverage of the latest HIM developments, trends, and expert insights. Each monthly issue contains articles on topics such as cybersecurity, interoperability, data governance, and more. In addition, *HIM Briefings* articles often highlight compliance tips, interdepartmental collaboration strategies, and other best practices that will help organizations successfully acquire, utilize, and protect health data.

Today, we are excited to announce that basic and platinum Revenue Cycle Advisor subscribers are now able to receive continuing education units (CEU) for reading *HIM Briefings.* Beginning with the September 2025 issue, these individuals can obtain one CEU from the American Health Information Management Association (AHIMA) and/or one CEU from the National Association of Healthcare Revenue Integrity (NAHRI) each month. To maintain their certifications, advance their careers, keep their skills sharp, and more, revenue cycle professionals should take advantage of this unique education opportunity.

To receive CEUs for *HIM Briefings*, subscribers must read the issue in full, evaluate the material, and get at least eight answers correct on the accompanying 10-question quiz. The link to the monthly evaluation/CEU quiz for *HIM Briefings* will be included in the final article of each issue, which will be published on the last Wednesday of the month. After completing these tasks, you will receive instructions on how to download your CEU certificate.

Subscribers must obtain their CEUs within one year of the date that the final article is posted. As the last *HIM Briefings* article of September 2025 was published today, revenue cycle professionals have until September 24, 2026, to obtain CEUs for this issue.

Click here for additional information on AHIMA's CEU and recertification process, and click here to learn more about NAHRI's Certification in Healthcare Revenue Integrity (CHRI).

For questions regarding our new *HIM Briefings* CEU offer or your Revenue Cycle Advisor membership, contact Karen Kondilis at karen.kondilis@hcpro.com.

Related Topics:
HIM/HIPAA, HIPAA

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