Basics in Coding

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Learning Objectives

• Understand the language used in coding
• Understand the basics of diagnosis coding
• Understand the basics of procedural coding
• Understand common allergy procedures performed
Background (opinion of Marshall Grodofsky only!)

- Common sense would suggest that billing should be linked to time spent with patients, but because we are physicians, egos got in the way of sense, and the problematic system we use was developed
  - “If I’m smarter and more efficient than my colleagues I shouldn’t be penalized!”
  Therefore we should be reimbursed for “complexity of interaction!”

Background

- The desire to develop a consistent “language” to describe standard physician/patient interactions led to the current coding system we now have

- Two types of codes: CPT Codes (procedure codes) & ICD codes (diagnostic codes)
Coding Systems

• Purpose: To provide a uniform language that will accurately describe the medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients and third parties.

Background

• AMA has standing committee that evaluates and adjusts the existence of the codes (Don Aaronson and Gary Gross are the allergy representatives).

• Just because a code exists and is used properly doesn’t mean the involved third party payer accepts the code. (We are required to diligently monitor “explanation of benefits” or “EOBs”.)
Join the Joint Council of Allergy, Asthma & Immunology (JCAAI)

- Have an on-line “coding” course
- Act as our “coding” representatives
- Provide the best advice and support when trouble arises

Coding Systems

- Health care provided to patients
- Health care services paid for by third party payers – Medicare, BC, UHC, Aetna/USHC, etc.
- Computer systems
- Communication between parties
Coding Systems

• Health Care Procedural Coding System (HCPCS):
  – First used in 1966
  – Definition: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians

• In 2000, the Department of Health and Human Services was designated as the national coding standard for physician and other health care professional services and procedures under the Health Insurance Portability and Accountability Act (HIPAA)
Payment Methodology

Usual and customary terms:

• RVU – Relative value units
• DRG – Diagnostic related group
• OPPS – Outpatient perspective payment services
• APC – Ambulatory payment classifications

CMS - RVU

• Values for RVU’s are modified on a yearly basis. Three components – work RVU, overhead RVU, malpractice RVU
• Conversion factor is determined by Congress and CMS based on economic index factor
• Budget neutrality is currently required
Medicare Part A vs. Part B

• Part A – hospitals are reimbursed with DRG’s
• Part B – physician and non-physician provider reimbursement for fee for service

Payment Methodology

• Usual and customary was used until 1992 for reimbursement of services provided by physicians and other health care entities

• RVU – Relative value units
  – Based on a scientific basis to determine values of codes: work, practice expense, malpractice
    • Non facility or facility
RVU’s CMS Fee Schedule
www.cms.gov/PhysicianFeeSched/PF SRVF/

- Headings
- Columns
- Values
- (Let’s look at some codes)

Payment Methodology

- DRG – Used by Medicare to reimburse hospitals for inpatient services
- OPPS – Outpatient perspective payment service
- ACO – Accountable Care Organizations
Main Take Home Message:

Document, Document, Document!!!!

• If it’s not recorded, it did not happen!
• If it is illegible – it did not happen!

Documentation

• HIPAA:
  – Documentation had to reflect the codes submitted for payment
  – Law created for Health Care Fraud & Abuse Control through the HHS & OIG
  – Covers Medicare, Medicaid and private health care industry
Documentation

• HIPAA;
  – Penalties
    • $2,000-$10,000 per incident & limit increased to not more than three times the amount
    • Presenting a claim for an item or service based on a code that a person knows or should know will result in greater payment than appropriate
    • Third party payers are doing a percentage error rate and then multiplying it times the universe of payments

Documentation

• Penalties
  – A person submits a claim that they know or should know is for a medical item or service not medically necessary
  – Criminal penalties for “knowingly and willingly” attempting to defraud
General Principles of Documentation

• Complete & legible

• Each encounter should include:
  – Chief complaint
  – Relevant history
  – Physical exam findings
  – Prior diagnostic tests
  – Assess/impression/diagnosis
  – Plan for care
  – Date & verifiable legible identity of the provider

Chief Complaint

• Chief Complaint can be part of the HPI or separate
  – Chief complaint is to be in the patient’s own words or summary of the reason why the patient is seeking medical care
  – If Chief complaint is for a “procedure or diagnostic test” third party payers will consider the E/M “incidental” to the procedure or diagnostic test and will not reimburse for the E/M
Relevant History

• The billing provider is responsible for obtaining and documenting the history of present illness. The review of systems, past, family and social history may be obtained by the staff, but it needs to be reviewed by the provider.

Physical Exam

• Pertinent positives and negatives need to be documented to count toward the appropriate level of E/M
• Document what you find and what you exam even if it is negative
• Remember, if it isn’t documented …..
Diagnostic Tests

- The medical decision to order tests, review tests or perform diagnostic testing needs to be indicated in the body of the E/M.
- CMS indicated several years ago the lack of medical necessity in allergy for performing allergy testing and desensitization was found in many cases reviewed.

Assessment, Impression

- If diagnosis are documented as “rule out possible, probable, I think it is consistent with, etc” the correct diagnoses to code on the billing are the signs and symptoms the patient presents.
- If a definite diagnosis is documented, then that is the appropriate diagnosis to use on the billing.
Documentation Principles

• If not specifically documented, the rationale for ordering diagnostic tests and other ancillary services should be able to be easily inferred

• Past & present diagnosis and conditions should be accessible to the treating and/or consulting provider, but not coded unless they are addressed today

Documentation Principles

• Appropriate risk factors should be identified

• Progress, response, changes in treatment, planned follow-up care and instructions, and diagnosis

• CPT & ICD9-CM codes should be the same on the billing form as in the chart
Plan/Recommendation

- This information is necessary to indicate how the patient is going to be cared for currently and for future services
- Signature of the provider indicates that the provider is attesting to the validity of the encounter and the encounter supports the charges presented to either the patient or the insurance carrier

Diagnosis Codes

- International Classification of Diseases (9th edition), Clinical Modification or “ICD-9-CM” is the code system currently used
- Multiple sources and software to find the right numerical “code” to every diagnosis
Diagnosis Codes

- All active diagnoses should be used in any patient interaction. Level of importance for that diagnosis should be documented. (Important to support complexity of visits later on and link each diagnosis to procedure!)

- Supplemental codes: “V” codes describe factors non-active diseases: Past diseases and potential exposures

- “E” codes used for external causes that affect complaint. Used in supplement to another diagnosis. (Hymenoptera Anaphylaxis is coded as 989.5 for anaphylaxis, and E905.3 for insect sting)
Diagnosis Codes

- Must link the diagnosis code with each procedure code used for billing purposes

Diagnosis Coding Guidelines

- Code for why the patient sought medical advise
- Do not code probable, possible, or rule out diagnosis
- Code to the highest level of ICD-9CM code that is available
Diagnosis Coding Guidelines

- When other conditions exist, these conditions should be coded additionally.
- Ancillary diagnostic services are coded with the appropriate V codes.
- Chronic diseases may be coded as often as necessary.

Healthcare Common Procedure Coding System (HCPCS)

- Codes that describe the patient interactions, from visits to testing procedures or treatment procedures. Fees are set for each “current procedural terminology” (CPT) code for your practice. Reimbursements are based on contract.
- Recent reviews now have established a relative value unit (RVU) for each code to try to create consistency based on work, malpractice, and overhead expense for each procedure.
New Visit Options

• Consultation (physician request) versus patient self referred. (Fact that there is no difference how we treat these interactions is meaningless) We get paid less for non-consults; therefore, we are required to document the “request”.

• Difference in “consultation codes” versus “new office visit” codes

Additional Documentation Requirements for Consultations

• Note must state that the patient was sent for consultation and state the requesting physician’s name as well as the reason for the consult
• Note must state the findings
• Note must indicate that a report was sent to the requesting physician
• Assumption is that patient’s follow up care may be provided by requesting physician
Follow Up Visits

• Follow up office visit codes require a less stringent criteria to establish “complexity” levels

• Patients seen by any provider in your office within the last 3 years is a follow up visit patient.

• More than 3 years between visits makes the interaction a “new” patient visit

Codes Based on Complexity of Visit

Three key components:

• History

• Examination

• Medical decision making
History Levels

- Patient history taking can range from brief (chief complaint only) to very detailed and extensive including complete review of systems, past history & social history
- MUST DOCUMENT IF CLAIMING TO BE DONE!!!

HPI: Chief Complaint – Reason for Encounter

- Location – specific to area of the body
- Quality – describe the pain – dull, sharp; wound jagged, dirty or clean
- Severity – measure on a scale
- Duration- how long, since when, etc.
HPI: Chief Complaint – Reason for Encounter

• Context - how complaint occurred
• Modifying factor- what has alleviated symptoms
• Signs and symptoms – additional information from patient
• HPI elements must be obtained by the physician/NPP

Review of Systems

• Ten are required for a complete ROS
• Pertinent positives and negatives must be documented
• A notation of negative for the remaining review of systems may be documented for the remaining systems
Review of Systems

- Can be documented by staff patient
- Must be reviewed by physician
- Can be separate or part of the HPI
- Cannot use one statement in both categories

Past, Family & Social History

- Past – events in the patient’s past medical/surgery history
- Family – diseases that impact patient’s health
- Social - factors which are age appropriate that impact from an environmental and social pattern
Exam

- The 1995 guidelines or the 1997 guidelines can be used for documentation
- Allergy has a specific exam for the specialty in 1997
- Abnormal findings must be described
- Normal findings can be indicated by negative
Physical Examination

- **Problem Focused** – one body area or organ system; **Level 1**
- **Expanded Problem Focused** – 2-4 body areas or organ systems – **Level 2-3** – established pt.
- **Detailed** – 5-7 body areas or organ systems - **Level 4** – established pt
- **Comprehensive** – 8 or more body areas or organ systems – **Level 5** – established pt

Physical Exam Levels

- Complexity based on number of organ systems checked; AGAIN MUST BE DOCUMENTED if performed
Medical Decision Making

- Number of diagnosis and treatment options
- Amount of data and complexity of data
- Risk

Number of Diagnosis and Treatment Options

- Established problem, stable
- Established problem, worsening
- Established problem, improved
- New problem, no workup planned
- New problem, workup planned
Amount and Complexity of Data

- Review/order lab tests
- Review/order routine x-rays
- Review/order medicine tests
- Discussion of tests results with performing physician

Amount and Complexity of Data

- Decision to obtain old records and document
- Direct visualization and independent interpretation documented
Risk

- Presenting problem
- Diagnostic procedure
- Management options

Presenting Problem

- Minimal:
  - One self limited or minor problem

- Low:
  - Two or more self-limited or minor problems
  - One stable chronic illness
  - Acute uncomplicated illness/injury
Presenting Problem

• Moderate:
  – One or more chronic illness with mild exacerbation
  – Two or more stable chronic illnesses
  – Undiagnosed new problem with uncertain prognosis
  – Acute illness with systemic symptoms
  – Acute complicated injury

Presenting Problem

• High:
  – Chronic illness with severe exacerbation
  – Acute or chronic illness/injury that may pose a threat to life or bodily function
Diagnostic Procedures Ordered

• Minimal:
  – Lab tests requiring venipuncture
  – X-rays
  – Ultrasounds

• Low:
  – Superficial need biopsies
  – Skin biopsies
  – Pulmonary function tests

Management Options

• Minimal:
  – Rest
  – Gargles
  – Elastic/superficial dressings

• Low:
  – Over the counter drugs – saline washes
  – Minor surgery – ear piercing
  – Physical therapy
Management Options

• Moderate:
  – Minor surgery with risk
  – Elective major surgery
  – PRESCRIPTION DRUG MANAGEMENT
  – Closed treatment of fracture w/o manipulation

Management Options

• High:
  – Elective major surgery with risk
  – Emergency major surgery
  – Decision not to resuscitate or de-escalate care because of poor prognosis
  – Drug therapy requiring intensive monitoring for toxicity
  – High morbidity mortality without treatment
Key Components
Medical Decision Making

- Straightforward      Level 1 & 2
- Low                Level 3
- Moderate            Level 4
- High                Level 5

Medical decision making remains the same for new patients, established patients, inpatient and outpatient consultations
Medical Decision Making

- Joint Council has training exercises available online to help you learn how to determine level of complexity

Calculation of Level of Complexity

- For new patients the level is based on the lowest level of the three key components
- For established patients based on the lowest level of 2 out of 3 components
- Medical decision making must always be one of the two components for an established patient encounter
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### MED. DEC MAKING

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**Time Based Coding**

- When counseling and coordination of care are greater than 50% of the service, code by time
- Must have total face to face time
- Total time spent in counseling or coordination
- Details of the discussion

**Time vs. Coding by Key Components**

- Code either by time or key component – you do not code by both
- Time is not a consideration when coding by key component
### Time Tables – New Patient

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### Time Tables

**Established Patient**

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<td>99215</td>
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Allergy Codes – Testing

- PFTs: 94010; …60; …70; 95070
- Skin testing codes:
  - Scratch testing: 95004
  - Intradermal: 95024
  - Precutaneous/Intradermal: 95017 and 95018
  - Patch tests: 95044
- Remember you need to document the results of the tests as part of the testing code

Allergy Codes

Immunotherapy codes

- Extract preparation codes: 95165
- 95145-8 for venoms
- Extract administration: 95115 or 95117
Beware of the Outliers!!

“What are the typical coding patterns?”

How Do You Compare to “Average”? 

• CPT curve analysis

• Calculate for group as well as individual physicians
  – Compare to Medicare data but remember that Medicare typically represents approximately 13% of productivity for allergy practices
Provider Analysis

- Compare charges and collections of multiple providers in a group
- CPT code analysis: allows for statistical analysis of coding approaches within a group, or in comparison to both regional and national data

CPT Provider Code Analysis

Medicare Allergist Coding

Year 2000

Year 1998

Medicare NOVs vs. Consults

Coding Level
Questions???

- Thank you for attending.