CODING AND BILLING STRATEGIES FOR SUCCESS 101

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Objectives - 101

- After attending this workshop, participants will:
  - Understand the importance of complete documentation and the impact it has on billing the visit
  - Be able to determine appropriate coding for family planning visits
  - Have increased knowledge of strategies to train clinicians on proper coding

Best Practices: Why does it matter?

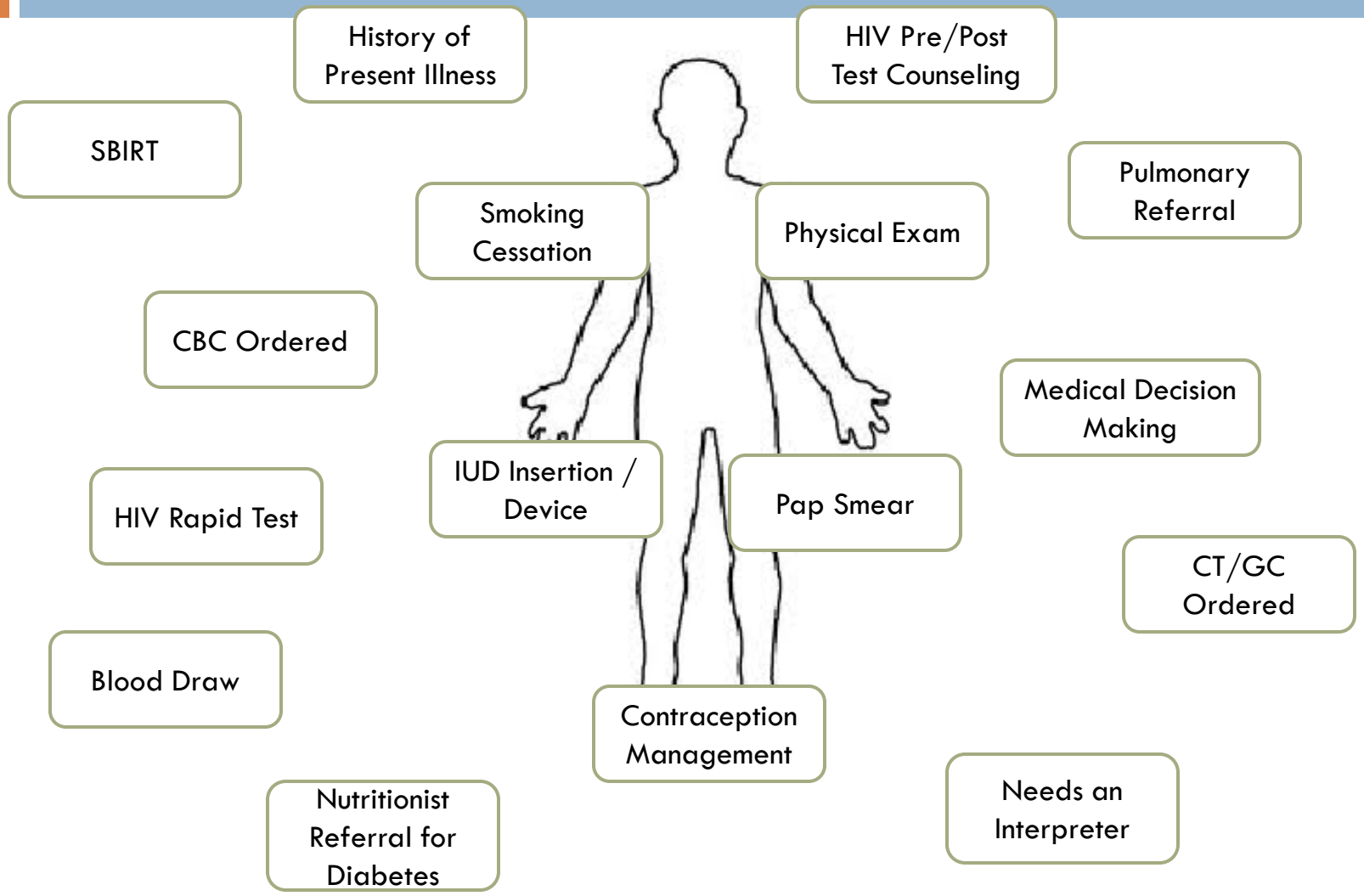
- Good coding & documentation will:
  - Lead to appropriate revenue regardless of payer and changes
  - Allow for effective advocacy and reimbursement increases which reflect services provided
    - Providers often take care of multiple health issues during visit
    - Multiple visit protocols have been streamlined to one day
  - Support billing and audit questions

Sound familiar?

- Patient comes in for annual visit
  - Complains of a discharge – ***oh by the way…***
  - Has 3 genital warts removed
  - Pap smear provided
  - Has an IUD device inserted
  - Is given STD and HIV counseling
  - Condoms provided
  - Has 5 labs tests performed
  - Appointment is at 7 pm

- Clinician documents E/M only

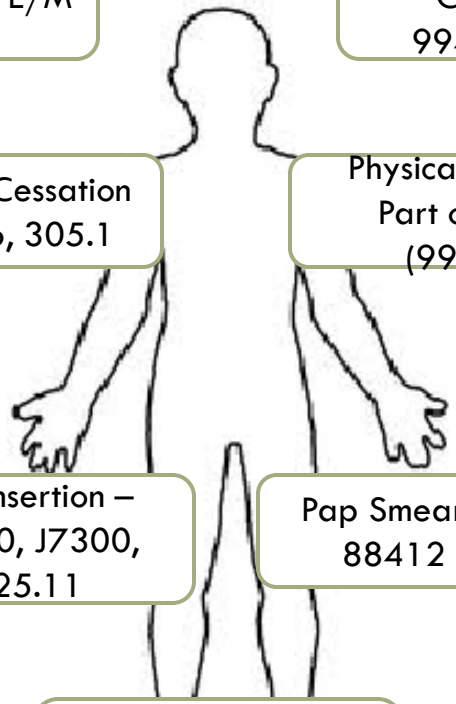
Clinical Visit - Components



What about the Add-ons?

- Maximize reimbursement by capturing additional paying services such as:
  - Weekends and Nights
  - Ancillary Tests
  - Smoking Cessation
  - HIV Testing and Counseling
  - Devices
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT)
  - Interpreter Services

Charge Capture



History of Present Illness – Part of E/M (992xx)

HIV Pre/Post Test Counseling – 99401, V65.44

SBIRT - 99408

Pulmonary Referral – Part of E/M (992xx)

Smoking Cessation – 99406, 305.1

Physical Exam – Part of E/M (992xx)

CBC Ordered - 85025

Medical Decision Making – Part of E/M (992xx)

HIV Rapid Test – 86701/3

IUD Insertion – 58300, J7300, V25.11

Pap Smear - 88412

CT/GC Ordered – 87591, 87491

Blood Draw - 36415

Contraception Management – V25.xx -

Interpreter Services T1013

Always….

- "If you didn't write it down, you didn't do it
- Follow coding guidelines and only code what is contained in the medical record – reimbursement will follow

Best Practices: Charge Capture

- Partnership between clinical and billing staff a must
- Good tools
- Time to do the job well
- Clean claim submission the first time

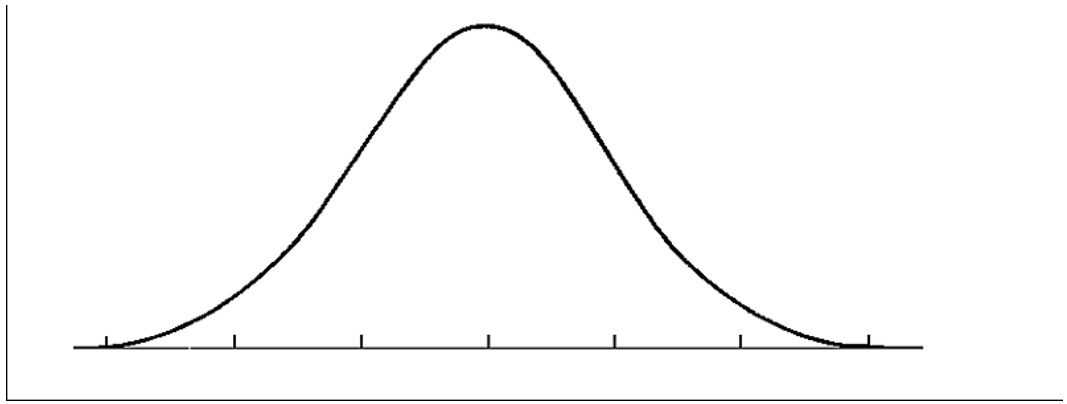
Always, Sometimes, Never…

- Aggressive vs. Timid - are you the outlier?

Provider Protocol

vs.

Medical Necessity



Key Terms – Coding the Visit

Diagnosis Codes

- ICD-9-CM (International Classification of Diseases, 9th edition, Clinical Modifications)
  - Represents illnesses and conditions
  - Supports medical necessity of services/ procedures provided
  - Supported by the documentation in the patient's medical record
  - Only the provider (physician, registered physician assistant, registered nurse practitioner, or licensed midwife) determines the diagnosis

WHO IS AUDITING TO ENSURE CORRECT CODES ARE CAPTURED?

Primary Diagnosis (PDX)

- Code assigned to the diagnosis, condition, problem, or other reason shown in the documentation to be *chiefly responsible for services provided*
  - Code to the highest level
  - Signs and symptoms may be reported if a diagnosis has not been determined
  - Do not code for ruled-out diagnoses
  - Two + Dx may be co-equal and meet the criteria for PDX
  - Don't give a patient a condition they do not have

Secondary Diagnoses (SDX)

- Co-existing conditions may occur at the same time
- "V" codes identify encounters for reasons other than illness or injury (e.g. annual exams, contraceptive management)
- Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment or management
- Review official ICD-9-CM guidelines in your current manual in Sections I and IV

For example: V72.31 & V25.02 would be reported for a client receiving both an annual exam and contraceptive management

Common Diagnosis Errors

- Diagnosis does not match documentation
- Physicians tend to code rule-out, possible, probable as definitive diagnoses
- Lack of specificity in documentation and coding
- Billing staff adds missing codes they know should be on the claim

Coding Challenges…

- Clinicians are not comfortable with E/M coding
- Diagnoses are often missed or incorrectly documented
- Co-equal diagnoses are not clearly indicated
- Procedures and lab tests are not captured or billed
- New revenue opportunities are missed because service is not documented
- Billing staff is not aware of payer changes

WHAT ARE YOUR CHALLENGES?

Procedure Codes

- HCPCS - Healthcare Common Procedure Coding System is a set of health care procedure codes
  - Level I HCPCS codes are called CPT®-4 codes (Current Procedural Terminology)
    - Every procedure and service has a distinct CPT code
  - Level II HCPCS codes identify products, supplies, materials and service which are not included in the CPT-4 codes
  - The terms CPT, HCPCS, and "Procedure Codes" often are used inter-changeably

For example: 58300 is the CPT code for Insertion of the IUD and J7300/J7302 are HCPCS used to identify the IUD device

E/M Group Codes

- Preventative Visits
  - 99381-99387 New Patient; 99391-99397 Established
  - Age Specific
  - Meant for the reporting of asymptomatic patients
  - Includes counseling, anticipatory guidance, and risk factor reduction interventions, as well as the ordering of laboratory and diagnostic procedures
  - Used for routine annual exams

For example: An annual GYN exam for a 20 year-old woman would be reported as 99395

E/M Group Codes

- Problem Focused
  - Services to evaluate patients with a medical problem or chief complaint are codes 99201 – 99215
  - New Patient: 99201 – 99205
  - Established Patient: 99211 – 99215

For example: A client visit with a NP to start Depo-Provera with an exam and counseling is reported as 99213

Chief Complaint (CC)

- Concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the patient encounter, usually stated in the patient's own words
  - Should be clearly reflected in the medical record
  - Front desk should not be filling this in prior to visit

CHALLENGE – WHO IS CAPTURING THE CC?

Components of E/M

- Three key components:
  - History
    - Includes chief complaint, history of present illness, past personal, social and family history and review of systems
  - Physical Exam
  - Medical Decision Making

  - For a new patient (not seen in 3 years) – you need all 3 components
  - For an established patient, you need 2 of the 3 components

Components of E/M

- Other contributory factors – not required
  - Counseling
  - Coordination of care
  - Nature of presenting problems
  - Time
    - May only be used when 50% or more of the time is spent face-to-face with the patient and/or family providing counseling and/or coordination of care

E/M Based on Time

- Total length of time of the encounter (physician face-to-face) should be documented and the record should describe the counseling and/or activities to coordinate care
- Level of service is determined by comparing total time spent with the patient to typical CPT times for E/M services

E/M Based on Time con't

- When coding based on time, typical E/M components (History, Exam and Medical Decision Making) **do not** have to be documented
  - However, the medical record must show the issues discussion, patient questions, physician response, and recommendations or next steps

"Oh By the Way…"

- When a client presents for a preventive visit and is found to also has a problem-focused, two E/M codes may be reported if:
  - Documentation clearly supports separate and distinct services
  - Modifier -25 is appended to the problem-oriented E/M visit
  - Provider selects the primary diagnosis for the service chiefly responsible for the services provided
    - ***Coding tip:*** Write a separate paragraph identifying your additional history and/or examination of the problem

CHALLENGE – WHY IS IT IMPORTANT TO CAPTURE THESE VISITS?

Documentation Checklist

- ✓ Is it complete and accurate?
- ✓ Are orders dated and signed?
- ✓ Are required times captured?
- ✓ Are charts reviewed on a regular basis?
- ✓ Are clinicians available to clarify / answer questions pertaining to the billing of visit?
- ✓ Ensure easy access to valid codes which reflect actual services provided
  - Encounter forms
  - EMR
  - Review explosion codes built into your billing system for accuracy

Billing Challenges

- Encounter forms / templates do not accurately reflect services
- Billing systems are limited in number of CPT and diagnoses that can be sent on claim
- Modifiers are often missed
- Explosion codes misrepresent services performed
- Can't easily adjust claims within system
- Staff does not understand why claim did not pay

WHAT ARE YOUR CHALLENGES?

Staff Training & Performance Improvement Activities

- Understanding of Specialty
  - Usual and Customary Visits
  - Procedures
- Documentation

Staff Training & Performance Improvement Activities

- Classroom
- Case Scenarios
- Chart Reviews
  - External Review
  - Self Assessment
- Job Aids

WHAT STEPS CAN YOU TAKE HOME FROM TODAY?