INTRODUCTION TO BILLING AND CODING

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Coding 101

- CPT and HCPCS codes describe “what” was done
- Some services may require more than one CPT and/or HCPCS code, such as injections and immunizations
  - HCPCS J codes: descriptions vary for multiple units

E/M Section

- New vs. established and initial vs. subsequent
- Determined by site of service
- Critical care, preventive medicine, prolonged services
- Consultations
- Documentation guidelines

Medicine Section

- Immunizations
- Injections
- Psychiatry
- Ophthalmology
- Cardiovascular
- Many noninvasive medical services

Surgery Section

- Global surgery package
- Starred surgical procedure
- Separate procedures
- Lesion removal, lacerations
- CCI edits, bundling

Coding 101

- ICD-9-CM codes describe “why” the service was performed
- Be specific !!!
- Code what you know at the time the service is performed…signs and symptoms are okay
- V codes are our friends

Coding Signs & Symptoms

- Definitive diagnosis not available
- Possible, probable, rule out
- Used widely in primary care

V Codes

- Describe a reason for the encounter without active illness
- Personal history and family history
- V codes are our friends

Diagnosis Code Linking

- Helps identify medical necessity
- Helps justify the reason for the CPT code
- Multiple codes present challenges…who links?
- Medicare has local and national coverage policies

Education

- Everyone needs to know the rules
- Communication within the office
- Don’t forget the patient
- Education for patients
- Education for staff

Keep yourself informed

- New coding books
- Additional resources
- Seminars
- Newsletters and journal articles
- Seek outside assistance

Areas to Monitor/Look for Improvement

- Compare the medical record, encounter form, and CMS-1500
- Do all three tell the same story?
- Forms in the medical record
- Updated encounter forms
- Updated computer information

Compliance Plan

- Work your compliance plan
- Education
- Monitoring
- Correction
- Internal reviews
- External reviews

Coding Compliance

- Watch for consistent dating
- Compare record, encounter form and CMS-1500
- Also provider of service, location of service, code series
- Out-of-office services are sometimes a problem

E/M with procedure

- E/M with procedure on same day
- Must be significant and separately identifiable history/examination/medical decision making
- Use modifier -25 if 0-10 global days

Coding Compliance

- Medical necessity above all else
- Regardless of documented history or examination
- Diagnosis codes help support medical necessity…who links?

Billing Incident to

- Incident-to rules
- NP's and PA's…incident to or under own provider numbers?
- RN's, etc…office only
- Physician on premises

CMS's Teaching Rules

- Teaching rules may apply in your practice
- Area with much attention
- "agree" isn't enough
- Learn the rules and follow them

How does Medicare monitor?

- Pre-pay audits
- Post-pay audits
- Comparisons to CMS “norms”
- LCD’s and NCD’s
- Targets for review: E/M codes, teaching rules, critical care, etc …..

E/M Coding

- Documentation must support the level of service billed
- Service performed vs. level billed vs. level documented
- 95 vs. 97 Documentation Guidelines

E/M Coding

- Record must be complete and legible
- Even the signature or identification
- Record stands on its own…but can incorporate by reference
- Signature log
- The "Seven Commandments" of medical record documentation of E/M services

3/3 or 2/3 ??

- Key components = history, examination, and medical decision making
- New patient visits, consultations, hospital admits require 3/3
- Established patient visits, daily hospital care require 2/3

History

- ROS and PFSH can be incorporated by reference by reviewing and updating prior information, noting the date and location of earlier information…but not HPI
- Can also incorporate by reference information recorded by ancillary staff or patient
- If unable to get history, say why
- "all others negative"

Past, Family, Social History

- Only one item from an area is “required”
- For higher levels of care, some codes require something from all three history areas: past, family, and social
- Allergies and medications are past history

Examination

- 1995 guidelines are more generic by body system
- 1997 guidelines are very specific..the "bullets"
  - numeric requirements must be met
  - parenthetical examples are for clarification and guidance only
  - "and" really means "or"

Medical Decision Making

- Based on the average of :
  - number of diagnoses/management options
  - data to be ordered/reviewed
  - risk (nature of presenting problem, diagnostic procedures, management options)

E/M Auditing

- Proper use of audit tool
- Different criteria for different levels and various categories of codes