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Meet the Presenter…

On the topic:
Medical Coding Basics

Maxine Collins
MBA, CPA, CMC, CMIS, CMOM
Faculty
Practice Management Institute
Medical Coding Basics

Presented by:
Maxine Collins
MBA, CPA, CMC, CMIS, CMOM
Faculty, Practice Management Institute

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Introduction

Coding is not an exact science. Many times, the coder is required to research, investigate, and use very technical procedures to find the best code possible.

As medical practice changes, so does coding. Updated information is required for a coder to stay in touch with the changes in the field.

Objectives

• To familiarize you with the coding system
• To introduce you to ICD-10-CM, CPT®, HCPCS Level II, what they are, what’s in them, and how to use them
• To demonstrate how the coding books will help you code, if you let them
• To show you how to “paint a picture” of the patient’s condition(s), diagnosis(es), and service(s) rendered (CPT/HCPCS with any pertinent modifiers).
What Is Coding?

• Coding is:
  – The language used to communicate between physicians and carriers to describe conditions pertaining to the diagnosis and treatment of a patient for the purposes of reimbursement
  – A system of alpha-numeric digits representing the diagnosing and treatment of a patient
  – Used to avoid miscommunication between practices and third-party payors

Terminology: Taking Words Apart

Medical terminology is the vocabulary used in the medical profession to aid in communicating the diagnosis and treatment of patients. This is done with the use of Greek and Latin roots, prefixes, and suffixes, which together convey several pieces of information with a single word.

A medical phrase can contain several different parts.

<table>
<thead>
<tr>
<th>Root</th>
<th>The basic part of the word or meaning of the term.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefix</td>
<td>The short part of the word found at the beginning of a term used to modify the root.</td>
</tr>
<tr>
<td>Suffix</td>
<td>The short part of the word found at the end of a term used to modify the root.</td>
</tr>
<tr>
<td>Combining Vowel</td>
<td>Often added to a root or base word to facilitate pronunciation. The combining vowel is usually an &quot;o&quot; and is used between a root word and a suffix.</td>
</tr>
</tbody>
</table>
## Examples

<table>
<thead>
<tr>
<th>Term</th>
<th>Prefix</th>
<th>Root</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polyneuritis Widespread nerve inflammation</td>
<td>Poly-</td>
<td>neur</td>
<td>-itis inflammation</td>
</tr>
<tr>
<td>Pericarditis Inflammation around the heart</td>
<td>Peri-</td>
<td>card</td>
<td>-itits inflammation</td>
</tr>
<tr>
<td>Adenocarcinoma Cancerous tumor of a gland</td>
<td>Adeno-</td>
<td>carcin</td>
<td>-oma tumor</td>
</tr>
<tr>
<td>Pyronephrosis Abnormal condition of pus</td>
<td>Pyro-</td>
<td>neph</td>
<td>-osis abnormal condition</td>
</tr>
</tbody>
</table>

## Abbreviations

Every word and symbol needs to be identified before you begin the coding process. There are numerous symbols and abbreviations that can dramatically alter claims and can mean the difference between reimbursement or denial.
### Examples

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.c.</td>
<td>“ante cibos” (before meals)</td>
</tr>
<tr>
<td>ECG, EKG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td>FUO</td>
<td>fever of unknown origin</td>
</tr>
<tr>
<td>GSW</td>
<td>gunshot wound</td>
</tr>
<tr>
<td>IUD</td>
<td>intrauterine (contraceptive) device</td>
</tr>
<tr>
<td>PERLA</td>
<td>pupils equal and react to light and accommodation</td>
</tr>
<tr>
<td>q.i.d</td>
<td>“quaque in die” (four times a day)</td>
</tr>
<tr>
<td>SOB</td>
<td>shortness of breath</td>
</tr>
<tr>
<td>TX</td>
<td>treatment</td>
</tr>
</tbody>
</table>

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### The Source Document

- All coding comes from a source document. This may be in the form of a superbill, operative report, progress notes, etc. But whatever the source, this information must be complete and precise.

- **IMPORTANT: BE SURE THE DOCUMENTATION IN THE PATIENT’S RECORDS SUPPORT THE E/M CODE REPORTED.**

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• Your audit of documentation to ascertain appropriate level of service will help to point out any weaknesses or omissions in your doctor’s documentation practices.

• Finding these problem areas before they cost money by causing denial or downcoding.

Utilizing Proper Documentation Techniques

Physicians should document per AMA's/CMS' documentation guidelines. Documentation should provide information on the following:

• Reason for visit
• History elicited
• Areas examined
• Diagnosis, known and suspected
• Plan of treatment or therapy
• Lab and test results and the change in management they initiate
• Date and legible identity of observer

These notes can be in any format as long as the areas noted above are included.
Formatting

Using the same format makes it easier for the physician to assure coverage of all necessary areas. The higher the level of service, the more elaborate or detailed each area will be.

- If level of service is based on time, document appropriately. An outline or summary and notation of the time spent are necessary.
- Preprinted notes and templates
- SOAP notes
  - S Subjective information
  - O Objective information
  - A Assessment
  - P Plan

SOAP Example

7/11/XX

S. Patient complains of cough, sore throat for 3 days. No n/v or fever. Sinus clear.

  - T: 99'
  - P: 74
  - B/P: 120/80
  - R: 12

A. Imp: URI/Possible strep throat

P. Plan: C/S to R/O strep, Robitussin DM ii tsp. Q6H PRN, ASA Q4H, RTC x 3 days
International Classification of Diseases (ICD)

- Published by the World Health Organization (WHO)
- Used worldwide for morbidity and mortality statistics, reimbursement systems, and automated decision support in medicine.
- Designed to promote international comparability in the collection, processing, classification, and presentation of these statistics.
- Revised periodically and is currently in the 10th revision

ICD-10-CM

- Clinical Modification of the WHO
- Maintained by the National Center for Health Statistics (NCHS).
- Is a morbidity classification system that classifies reasons for healthcare encounters
- Code structure is Alpha-numeric, with codes comprised of 3-7 characters
- Includes the level of detail need for morbidity classification and diagnostic specificity in the United States.
- Implemented in the U.S. on 10/01/2015 and replaced the former ICD-9-CM for dates of service on and after 10/01/2015
Benefits of Adopting ICD-10

- Greater coding accuracy and specificity
- Higher quality information for measuring healthcare service quality, safety, and efficiency
- Improved efficiencies and lower costs
- Reduced coding errors
- Greater achievement of the benefits of an electronic health record
- Recognition of advances in medicine and technology
- Alignment of the US with coding systems worldwide
- Improved ability to track and respond to international public health threats
- Enhanced ability to meet HIPAA electronic transaction/code set requirements

ICD-10-CM Code Format

- Consist of up to seven digits:
  - The 1st digit is always alpha
  - The 2nd digit is always numeric
  - The remaining five digits can be any combination
Improvements Between “9” and “10”

<table>
<thead>
<tr>
<th></th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digits</td>
<td>3-5</td>
<td>3-7</td>
</tr>
<tr>
<td>Codes</td>
<td>Approximately 13,000</td>
<td>Approximately 68,000 codes</td>
</tr>
<tr>
<td>First digit</td>
<td>May be alpha (E or V) or numeric, digits 2-5 are numeric</td>
<td>Digit 1 is alpha; Digits 2 is numeric. However, Digits 3-7 can be alpha or numeric (alpha digits are not case sensitive)</td>
</tr>
<tr>
<td>Adding new codes</td>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Detail</td>
<td>Lacks detail - Ambiguous</td>
<td>Very specific</td>
</tr>
<tr>
<td>Laterality</td>
<td>Lacks laterality</td>
<td>Has laterality</td>
</tr>
<tr>
<td>Data analysis</td>
<td>Difficult to analyze data due to non-specific codes</td>
<td>Specificity improves coding accuracy &amp; richness of data for analysis</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Codes are non-specific and do not adequately define diagnosis needed for medical research</td>
<td>Detail improves the accuracy of data used for medical research</td>
</tr>
<tr>
<td>Interoperability</td>
<td>Does not support interoperability because it is not used by other countries</td>
<td>Supports interoperability &amp; the exchange of health data between other countries &amp; the United States</td>
</tr>
</tbody>
</table>

Format and Structure of ICD-10-CM

- Conventions
  - Many conventions have the same meaning.
  - Non-specific codes are available to use when detailed documentation to support more specific code is not available.

- **ICD-10-CM Official Guidelines for Coding and Reporting** accompany and complement ICD-10-CM conventions and instructions

- Adherence to the official coding guidelines in all healthcare settings is required under the Health Insurance and Portability and Accountability Act.
ICD-10-CM Examples

Nondisplaced fracture of base of neck of right femur, subsequent encounter for closed fracture with delayed healing  
\[\text{S72.044G}\]

Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side  
\[\text{I69.351}\]

Encounter for orthopedic aftercare following surgical amputation. Use additional code to identify the limb amputated (Z89.52-)  
\[\text{Z47.81}\]


- CPT – A set of codes, descriptions and guidelines used to describe procedures and services performed by physician and other health care providers.
  - Each procedure or service is identified with a five-digit code, as well as “modifiers” to give more detailed information about a specific procedure.
  - There are six major sections; each divided into subsections with anatomic, procedural, condition or descriptor subheadings.
  - Codes of procedures and services are presented in numeric order with the exception of the Evaluation and Management codes (99201-99499).
CPT Index

- Located at back of most manuals; to look up a code:
  - Procedure
  - Organ or anatomic site
  - Conditions
  - Synonyms
  - Eponyms
  - Abbreviations
- Will often be given a range of codes
- Must go to the Codes to select actual code(s)
  - Read, read, read – all guidelines and instructional notes
  - *Know the symbols used in your manual to help interpret codes*
- Never code directly from the Index – Always verify in Code section and follow instructions.

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CPT Manual

Also located on the back of the front cover of the AMA© CPT manual, the coder will find the Symbols used to indicate additional information about codes in the manual.

- Revised Code
- New Code
- New or Revised Text
- Add-on Code
- Exempt from Modifier 51
- Moderate Sedation
- Product Pend FDA
- Reinstated/ Recycled
- Out of Numeric Sequence

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CPT: Category I Codes

Six main sections:

- **Evaluation & Management**
  - 99201–99499
- **Anesthesia**
  - 00100–01999
  - 99100–99150
- **Surgery**
  - 10000–69990
- **Radiology**
  - 70000–79999
- **Pathology & Laboratory**
  - 80000–89398
- **Medicine**
  - 90281–99099
  - 99151–99199
  - 99500–99607

CPT Category II Codes

CPT Category II codes describe clinical components usually included in E/M or clinical services. These codes are not associated with any relative value and are billed with a $0 charge amount.

- **Composite Measures**
  - 0001F–0015F
- **Patient Management**
  - 0500F–0575F
- **Patient History**
  - 1000F–1220F
- **Physical Examination**
  - 2000F–2050F
- **Diagnostic/Screening Processes or Results**
  - 3006F–3573F
- **Therapeutic, Preventative, or Other Interventions**
  - 4000F–4306F
- **Follow-up or Other Outcomes**
  - 5005F–5100F
- **Patient Safety**
  - 6005F–6045F
- **Structural Measures**
  - 7010F–7025F

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CPT: Category III Codes

Category III codes are temporary codes for emerging technology, services, and procedures.

• Emerging Technology
  – 0016T–0207T

Back of Front Cover of AMA CPT Manual

• You can reference the short description of the modifiers
  – Level I (CPT) and Level II (HCPCS)
• Long description of the Modifiers can be found in Appendix A in the back of the AMA CPT Manual for Level I Modifiers and some of the Level II HCPCS Modifiers. A complete listing of Level II Modifiers can be located in the HCPCS manual.
• Place of Service Codes Guide will be found after the short description of symbols and Modifiers on back of front cover.
CPT Examples

- Fine needle aspiration, without imaging guidance: 10021
- Segmental mandibular osteotomy with genioglossus advancement: 21199
- Cryosurgical ablation of three liver tumors, open procedure, with ultrasonic guidance: 47381, 76940

Healthcare Common Procedural Coding System (HCPCS)

- **Umbrella system**
  - **Level I** – CPT, 5 digits, all numeric – codes we are most familiar with for physician coding; 2 digit Modifiers (22, 25, 50…); Responsible Party – AMA©
  - **Level II** – National HCPCS, 5 characters, Alphanumeric (A-V + 4 numbers); Alpha and Alphanumeric Modifiers (RT, TC, E1…); Responsible Party – CMS
HCPCS Manual

- Contains important information (A-V codes)
- Ambulance, Enteral and parenteral therapy, dental, durable medical equipment, “G” codes, injectables – “J” codes; orthotics, prosthetics, “Q” temporary codes…
- Symbols and conventions
- Medicare coverage indicators
- The Index – tests, drugs, medical equipment, services, supplies, orthotics, prosthetics, therapies, some medical and surgical procedures.
- Alpha-numeric listing of codes – must verify

HCPCS Examples

Screening cytopathology, cervical, or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physicians supervision

Syringe with needle, sterile 1cc or less, each

Catheter, transluminal atherectomy, rotational

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Modifiers

• “Modifies” or alters the five-digit code to give reason third party payers’ additional information to pay.

• Appendix A in CPT – Full description of modifiers used in Level I coding

• HCPCS manual – Full description of national, Level II modifiers.

<table>
<thead>
<tr>
<th>MOD</th>
<th>Description</th>
<th>MOD</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased procedural services</td>
<td>47</td>
<td>Anesthesia by Surgeon</td>
</tr>
<tr>
<td>23</td>
<td>Unusual anesthesia</td>
<td>50</td>
<td>Bilateral procedure</td>
</tr>
<tr>
<td>24</td>
<td>Unrelated E/M service by same provider during postop period</td>
<td>51</td>
<td>Multiple procedure</td>
</tr>
<tr>
<td>25</td>
<td>Significant, separately identifiable E/M service on same day by same provider of procedure or other service</td>
<td>52</td>
<td>Reduced services</td>
</tr>
<tr>
<td>26</td>
<td>Professional component</td>
<td>53</td>
<td>Discontinued procedure</td>
</tr>
<tr>
<td>32</td>
<td>Mandated service</td>
<td>54</td>
<td>Surgical care only</td>
</tr>
<tr>
<td>33</td>
<td>Preventive service</td>
<td>55</td>
<td>Postoperative management only</td>
</tr>
</tbody>
</table>

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# Modifiers

<table>
<thead>
<tr>
<th>MOD</th>
<th>Description</th>
<th>MOD</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>56</td>
<td>Preoperative management only</td>
<td>76</td>
<td>Repeat procedure or service by same physician</td>
</tr>
<tr>
<td>57</td>
<td>Decision for surgery</td>
<td>77</td>
<td>Repeat procedure by another physician</td>
</tr>
<tr>
<td>58</td>
<td>Staged or related procedure or service by same physician during the postop period</td>
<td>78</td>
<td>Unplanned return to OR/procedure room by the same physician following initial procedure for a related procedure during postop period</td>
</tr>
<tr>
<td>59</td>
<td>Distinct procedural service</td>
<td>79</td>
<td>Unrelated procedure/service by same physician during postop period</td>
</tr>
<tr>
<td>62</td>
<td>Two surgeons</td>
<td>80</td>
<td>Assistant surgeon</td>
</tr>
<tr>
<td>63</td>
<td>Procedure performed on infant less than 4 kg</td>
<td>82</td>
<td>Assistant surgeon (when qualified resident surgeon not available)</td>
</tr>
<tr>
<td>66</td>
<td>Surgical team</td>
<td>90</td>
<td>Reference (outside laboratory)</td>
</tr>
</tbody>
</table>

*Note: This is only a partial listing of HCPS modifiers*
### When to Use Modifiers XE, XP, XS, XU

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Modifier</th>
<th>Reasoning &amp; Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery operative sessions: One surgery procedure at 9AM and one at 6PM.</td>
<td>XE</td>
<td>• Separate encounters.</td>
</tr>
<tr>
<td>Physical therapy sessions: Group therapy services (97150) at 10AM and</td>
<td></td>
<td>• Same date of service.</td>
</tr>
<tr>
<td>therapeutic exercises (97110) at 4PM.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient is seen by her OB-GYN. During the exam, the doctor notes an</td>
<td>XP</td>
<td>• Separate practitioners.</td>
</tr>
<tr>
<td>issue and requests his partner, a Perinatologist, examine the patient</td>
<td></td>
<td>• Same date of service.</td>
</tr>
<tr>
<td>as well. Patient is under treatment for breast cancer. During her</td>
<td></td>
<td>• May or may not be the same encounter.</td>
</tr>
<tr>
<td>appointment, she is seen by two physicians in the practice – the</td>
<td></td>
<td>• May or may not be different specialties.</td>
</tr>
<tr>
<td>Medical Oncologist and the Radiation Oncologist.</td>
<td></td>
<td>• Both practitioners fall under same TIN.</td>
</tr>
<tr>
<td>Injection into tendon sheath, elbow (20550) and injection into tendon</td>
<td>XS</td>
<td>• Separate structure or organ.</td>
</tr>
<tr>
<td>sheath, knee (20550-XS).</td>
<td></td>
<td>• Different anatomical site.</td>
</tr>
<tr>
<td>A diagnostic procedure is performed. Based on the findings, a therapeutic</td>
<td>XU</td>
<td>• Same encounter.</td>
</tr>
<tr>
<td>and/or surgical procedure is required on the same day. For example,</td>
<td></td>
<td>• Same practitioner.</td>
</tr>
<tr>
<td>diagnostic cardiac catheterization is followed by a medically necessary</td>
<td></td>
<td>• Same anatomical site, structure, or organ.</td>
</tr>
<tr>
<td>cardiac procedure.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: http://www.capturebilling.com/medicare-modifiers-xe-xp-xs-xu-examples/)

---

### Evaluation and Management Codes

**THE ANATOMY OF AN E/M CODE**

1. 99201
2. Office or other outpatient visit for the evaluation and management of a
3. New patient (pt) which requires these
4. Three key components:

   - a problem focused history;
   - a problem focused examination; and
   - straightforward medical decision making

5. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the pt’s and/or family’s (fam) needs.

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Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the pt and/or fam.

1. Code Numbers 992 – to – 994
2. Type and place of service
3. Type of pt.
4. Number of key components which must be met
5. Key components
6. Contributory factors
7. Time typically spent face-to-face with pt./fam.

The correct level of service is chosen based on the following:

**Key Components**
- History
- Examination
- Medical Decision Making

These factors will be used most often in selecting the level of service

**Contributory Factors**
- Counseling
- Coordination of Care

It is not required that these services be provided at every patient encounter.

**Time**
Key Factor only when counseling and/or coordination of care dominates (more than 50%) the face-to-face.
### E/M Categories and Sub-Categories

#### Office or Other Outpatient Services
- **New Patient**: 99201-99205
- **Established Patient**: 99211-99215

#### Hospital Observation Services
- **Hospital Observation Discharge Services**: 99217
- **Initial Hospital Observation Services**: 99218-99220
- **Subsequent Hospital Observation Care**: 99224-99226
- **Hospital Observation or Inpatient Care Services (including Admission and Discharge)**: 99234-99236

#### Hospital Inpatient Services
- **Initial Hospital Care**: 99221-99223
- **Subsequent Hospital Care**: 99231-99233
- **Hospital Discharge Services**: 99238-99239

#### Consultations
- **Office Consultations**: 99241-99245
- **Initial Inpatient Consultations**: 99251-99255

#### Emergency Department Services
- **Emergency Department Services**: 99281-99285

#### Critical Care Services
- **Critical Care Services**: 99291-99292

#### Nursing Facility Services
- **Initial Nursing Facility Care**: 99304-99306
- **Subsequent Nursing Facility Care**: 99307-99310
- **Nursing Facility Discharge Services**: 99315-99316
- **Other Nursing Facility Services**: 99318

#### Domiciliary, Rest Home, or Custodial Care Services
- **New Patient**: 99324-99328
- **Established Patient**: 99334-99337
- **Domiciliary, Rest Home (e.g. Assisted Living Facility), or Home Care Plan Oversight Services**: 99339-99340

---

### Home Services
- **New Patient**: 99341-99345
- **Established Patient**: 99347-99350

#### Prolonged Services
- **With Direct Patient Contact**: 99354-99357
- **Without Direct Patient Contact**: 99358-99359

#### Standby Services
- **Standby Services**: 99360

#### Case Management Services
- **Anticoagulation Management**: 99363-99364
- **Medical Team Conference**: 99366-99368
- **Care Plan Oversight Services**: 99374-99380

#### Preventive Medicine Services
- **New Patient**: 99381-99387
- **Established Patient**: 99391-99397
- **Individual Counseling**: 99401-99404
- **Behavior Change Interventions, Individual**: 99406-99409
- **Group Counseling**: 99411-99412
- **Other**: 99420-99429

#### Non-Face-to-Face Physician Services
- **Telephone Services**: 99441-99443
- **On-Line Medical Evaluation**: 99444
- **Interoessional Telephone/Internet Consultation**: 99446-99449
- **Special Evaluation and Management Services**: 99450-99456
- **Newborn Care**: 99460-99463
- **Basic Life and/or Disability Evaluation Services**: 99470
- **Work Related or Medical Disability Evaluation Services**: 99455-99456
- **Newborn Care Services**: 99460
- **Delivery/Birthing Room Attendance**: 99464-99465
Evaluation & Management

Review Categories and Sub-Categories of the E/M section in the course manual for details on all services included in this section:

- Office/Outpatient
- Hospital Observation
- Hospital Inpatient
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Domiciliary, Rest Home, or Custodial Care Services
- Domiciliary, Rest Home, or Home Health Care Plan
- Oversight Services
What Is Documentation, and Why Is It Important?

• Required to record pertinent facts, findings, and observations about an individual’s health history including past and present illnesses, examinations, tests, treatments, and outcomes.

• The medical record chronologically documents the care of the patient.

An appropriately-documented medical record facilitates:

– Ability of physician and other health care professionals to evaluate and plan patient’s immediate treatment, and to monitor his/her health care over time.

– Communication and continuity of care among physicians and other health care professionals involved in patient's care

– Accurate and timely claims review and payment

– Appropriate utilization review and quality of care evaluations; and

– Collection of data that may be useful for research and educations

– Reduction in many of the “hassles” associated with claims processing and may serve as a legal document to verify the care provided, if necessary

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General Principles of Medical Record Documentation

1. Medical record must be complete and legible.

2. Documentation of each patient’s encounters should include:
   - Reason for the encounter and relevant information
   - Assessment, clinical impression, or diagnosis
   - Plan for care
   - Date and legible identify of the observer

3. If not documented, rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient’s progress, response to and changes in treatment, as well as revision of diagnosis should be documented.

7. The CPT© and ICD-10-CM codes should be supported by the documentation in the medical record.
Documentation of E/M Services

• Documentation guidelines are identified by the symbol •DG.
• Descriptors for the levels of E/M services recognize 7 components that are used in defining the levels of E/M services. The first 3 “key” components are:
  1. History
  2. Examination
  3. Medical decision making
• The remaining 4 elements are contributory factors in determining the level of services documented in the medical record.
  4. Counseling
  5. Coordination of Care
  6. Nature of the presenting problem
  7. Time
  • Note: Time can become the overriding determining factor for the level to bill out.

Documentation of History

• Official Documentation Guidelines state:
  – “The medical record should clearly reflect the chief complaint.”
  • A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words.
Four Types of History

1. Chief Complaint (CC)
2. History of Present Illness (HPI)
3. Review of Systems (ROS)
4. Past, Family, and/or Social History (PFSH)
   - The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon the clinical judgment and the nature of the presenting problem(s).
   - A chief complaint is indicated at all levels.

Chief Complaint (CC)

• A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other reason for encounter.
  - **DG**: *The medical record should clearly reflect the chief complaint.*
History of Present Illness (HPI)

- A chronological description of development of patient’s present illness
- Includes the following elements:
  - Location
  - Timing
  - Quality
  - Context
  - Severity
  - Modifying factors
  - Duration
  - Associated signs/ symptoms

- **Brief** HPI
  - **DG:** The medical record should describe one to three elements of the present illness (HPI).

- **Extended** HPI
  - **DG:** The medical record should describe at least four elements of the present illness (HPI) or status of at least three chronic or inactive conditions.

Review of Systems (ROS)

- An inventory of body systems obtained through a series of questions to identify signs and/or symptoms in patient.
- Recognized systems:
  - Constitutional symptoms
  - Genitourinary
  - Ears, nose, mouth, throat
  - Musculoskeletal
  - Endocrine
  - Cardiovascular
  - Integumentary
  - Hematologic/ Lymphatic
  - Respiratory
  - Neurological
  - Allergic/ Immunologic
  - Gastrointestinal
  - Psychiatric

- **Problem pertinent** ROS
  - **DG:** The patient’s positive responses and pertinent negatives for the system related to the problem should be documented.

- **Extended** ROS
  - **DG:** The patient’s positive responses and pertinent negatives for two to nine systems should be documented.
Review of Systems (ROS)

- **Complete** ROS
  - *DG*: At least 10 organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least 10 systems must be individually documented.

Past, Family, and/or Social History (PFSH)

PFSH consist of a review of three areas:

1. **Past History** – The patient’s past experiences with illnesses, operations, injuries and treatments.
2. **Family History** – A review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk.
3. **Social History** – An age-appropriate review of past and current activities.

For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an “interval” history. It is not necessary to record information about the PFSH.
Past, Family, and/or Social History (PFSH)

- **Pertinent PFSH**
  - **DG:** At least one specific item from any of the three history areas must be documented for a pertinent PFSH.

- **Complete PFSH**
  - **DG:** At least one specific item from two of the three history areas must be documented for a complete PFSH for the following E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.
  - **DG:** At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office/other outpatient services, new patient; hospital observations services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.

Past History

- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies
- Age appropriate immunizations
- Age appropriate feeding/dietary status
Family History

• The health status or cause of death of parents, siblings, and children.

• Specific diseases related to problems identified in the chief complaint or history of the present illness and/or review of systems.

• Diseases of family members which may be hereditary or place the patient at risk.

Social History

• Marital status and/or living arrangements
• Current employment
• Occupational history
• Use of drugs, alcohol, and tobacco
• Level of education
• Sexual history
• Other relevant social factors
Documentation of Examination

- Levels of E/M services are based on four types of examination that are defined as:
  - **Problem Focused** – a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
  - **Expanded Problem Focused** – an extended examination of the affected body area(s) or organ system(s).
  - **Detailed** – an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
  - **Comprehensive** – a general multi-system examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

Note to reviewers: Inclusion of examinations identified by an asterisk is dependent on a demonstration that the physician work is equivalent to that of a general multi-system examination.

The types of examinations have been defined for general multi-system and the following single organ systems:

- Cardiovascular
- Immunologic
- Ear, Nose, Mouth and Throat
- Musculoskeletal
- Eyes
- Neurological*
- Genitourinary (Female)
- Psychiatric
- Genitourinary (Male)
- Respiratory
- Hematologic
- Skin*
- Lymphatic

* Note to reviewers: Inclusion of examinations identified by an asterisk is dependent on a demonstration that the physician work is equivalent to that of a general multi-system examination.
General Multi-System Exam

- Constitutional
- Eyes
- Ears, Nose, Mouth and Throat
- Neck
- Respiratory
- Cardiovascular

- Gastrointestinal (Abdomen)
- Genitourinary
- Lymphatic
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric

The Progression Required Elements For Each Level Of Medical Decision Making

To qualify for a given type of decision making, 2 of the 3 elements in the table must be either met or exceeded.

<table>
<thead>
<tr>
<th># of Dx or Management Options</th>
<th>Amount and/or Complexity of data to be reviewed</th>
<th>Risk of Complications and/or Morbidity/Mortality</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
• **DG for # of Diagnoses or Management Options**

  **DG:** For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation:
  
  – Presenting problem with an established diagnosis
    a) improved, well controlled, resolving or resolved
    b) inadequately controlled, worsening, or failing to change as expected.
  – Presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnosis or as a “possible,” “probable,” or “rule out (R/O) diagnoses.”

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• **DG for # of Diagnoses or Management Options**

  **DG:** The initiation of, or changes in treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.

  **DG:** If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.

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Documentation of an Encounter Dominated by Counseling or Coordination of Care

• **DG:** If a physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or unit floor time for inpatient, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.

Selecting the Level of Decision-Making

**Step 1:** Evaluate the number of diagnoses or management options.

**Step 2:** Evaluate the amount and/or complexity of data.

**Step 3:** Figure out the degree of risk of complication and/or morbidity, mortality.

**Step 4:** Figure out the type of medical decision-making.
### Step One

**Evaluate the number of diagnoses or management options.** Use the following evaluation system to determine whether the number of diagnoses or management options is minimal (1 point), limited (2 points), multiple (3 points) or extensive (4 or more points).

<table>
<thead>
<tr>
<th>Problem Categories</th>
<th># of points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single self-limited or minor problems</td>
<td>1 point</td>
</tr>
<tr>
<td>Two or more self-limited or minor problems</td>
<td>2 points</td>
</tr>
<tr>
<td>For each established presenting problem (other than self-limited or minor) that is improved, well controlled, resolving or resolved</td>
<td>1 point</td>
</tr>
<tr>
<td>For each established presenting problem (other than self-limited or minor) that is inadequately controlled, worsening or failing to progress as expected</td>
<td>2 points</td>
</tr>
<tr>
<td>For one or more presenting problem(s) not previously identified or diagnosed (other than self-limited or minor) for which additional assessment, consultation or diagnostic studies are not required</td>
<td>3 points</td>
</tr>
<tr>
<td>For each presenting problem not previously identified or diagnosed (other than self-limited or minor) for which additional assessment, consultation or diagnostic studies are ordered, planned or performed</td>
<td>4 points</td>
</tr>
</tbody>
</table>

**Total Number of Points**

### Step Two

**Evaluate the amount and/or complexity of data.** Use the following evaluation system to determine whether the amount and/or complexity of the data is minimal or none (0-1 points), moderate (3 points) or extensive (4 or more points).

<table>
<thead>
<tr>
<th>Type of Data</th>
<th># of points</th>
</tr>
</thead>
<tbody>
<tr>
<td>For the order and/or review of the report of one or more tests or services in the pathology and laboratory section of CPT (80047-89398)</td>
<td>1 point</td>
</tr>
<tr>
<td>For the order and/or review of the report of one or more tests or services in the radiology section of CPT (70010-79999)</td>
<td>1 point</td>
</tr>
<tr>
<td>For the order and/or review of the report of one or more diagnostic studies or services in the medicine section of CPT (90281-99607)</td>
<td>1 point</td>
</tr>
<tr>
<td>For the direct visualization and independent interpretation of a specimen, image or tracing which has been previously interpreted by another physician</td>
<td>2 points</td>
</tr>
<tr>
<td>For discussion of results of laboratory, radiology or diagnostic tests with the physician who performed or interpreted that study</td>
<td>1 point</td>
</tr>
<tr>
<td>For evaluating the appropriateness of and deciding to obtain old records and/or history</td>
<td>1 point</td>
</tr>
<tr>
<td>For summarizing a review of old records and/or to obtain additional history from the family, caretaker or other source to supplement that obtained from the family, caretaker or other source to supplement that obtained from the patient</td>
<td>2 points</td>
</tr>
</tbody>
</table>

**Total Number of Points**
Step Three

Figure out the degree of risk of complications and/or morbidity, mortality. Use the tables in the “Tables of Risk” (Tables 1-3) for guidance to determine whether the risk associated with the presenting problem(s), diagnostic procedure(s) and management options selected are minimal, low, moderated or high. Select items from tables 1, 2, and 3. Then, go to table 4 to determine the correct level for these three components.

Step Three: Table 1

Presenting Problems

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>• One self limited or minor problem, e.g. cold, insect bite</td>
<td>• Two or more self-limited or minor problems</td>
<td>• One or more chronic illness with mild exacerbation</td>
<td>• One or more chronic illnesses with severe exacerbation</td>
</tr>
<tr>
<td>• One stable chronic illness, e.g., well controlled hypertension or diabetes</td>
<td>• One stable chronic illness, e.g., well controlled hypertension or diabetes</td>
<td>• Two or more stable chronic illnesses</td>
<td>• Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI</td>
</tr>
<tr>
<td>• Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain</td>
<td>• Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain</td>
<td>• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast, rectal bleeding</td>
<td>• Severe respiratory distress</td>
</tr>
<tr>
<td>• Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis</td>
<td>• Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis</td>
<td>• Acute complicated injury, e.g. head injury with brief loss of consciousness</td>
<td>• Progressive, severe rheumatoid arthritis</td>
</tr>
<tr>
<td>• Depression with suicidal ideation</td>
<td>• Depression with suicidal ideation</td>
<td></td>
<td>• Depression with suicidal ideation</td>
</tr>
</tbody>
</table>
### Step Three: Table 2
#### Diagnostic Procedures

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab tests requiring venipuncture</td>
<td>Physiologic tests not under stress, e.g. pulmonary function tests</td>
<td>Physiologic tests under stress, e.g. cardiac stress test</td>
<td>Cardiovascular imaging studies with identified risk factors</td>
</tr>
<tr>
<td>Chest X-rays</td>
<td>Non-cardiovascular imaging studies with contrast e.g. barium enema</td>
<td>Endoscopies with no identified risk factors</td>
<td>Cardiac electro physiological tests</td>
</tr>
<tr>
<td>EKG</td>
<td>Ultrasound, e.g. echo-cardiography</td>
<td>Deep needle or incisional biopsy</td>
<td>Endoscopies with identified risk factors</td>
</tr>
<tr>
<td>EEG</td>
<td>Superficial needle biopsies</td>
<td>Cardiovascular imagining studies with contrast and no identified risk factors; e.g. arteriogram, cardiac catheterization</td>
<td></td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Clinical lab tests requiring arterial puncture</td>
<td>Lumbar puncture</td>
<td></td>
</tr>
<tr>
<td>Ultrasound, e.g. echo-cardiography</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Step Three: Table 3
#### Management Options

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest</td>
<td>Over the counter drugs</td>
<td>Minor surgery with identified risk factors</td>
<td>Elective major surgery with identified risk factors</td>
</tr>
<tr>
<td>Gargles</td>
<td>Minor surgery with no identified risk factors</td>
<td>Referral for or decision to perform elective major surgery with no identified risk factors</td>
<td>Referral for or decision to perform emergency major surgery</td>
</tr>
<tr>
<td>Elastic bandages</td>
<td>Physical Therapy</td>
<td>Simple prescription drug management</td>
<td>Parenteral controlled substances</td>
</tr>
<tr>
<td>Superficial dressings</td>
<td>Occupational therapy</td>
<td>Therapeutic nuclear medicine</td>
<td>Multiple drug therapy requiring intensive monitoring for toxicity</td>
</tr>
</tbody>
</table>

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Step Three: Table 4
Level Determination

<table>
<thead>
<tr>
<th>Presenting problem(s) (table 1)</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic procedures (table 2)</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Management options (table 3)</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Overall risk</td>
<td>1 Minimal</td>
<td>2 Low</td>
<td>3 Moderate</td>
<td>4 High</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Step Four

Figure the type of medical decision-making. Here’s where you bring the results from steps 1-3 together. Select the final values from Steps 1, 2, and 3 transfer that information into the table below. Imagine a line down any column with 2 or 3 circles and select the level of decision-making in that column. Otherwise, drop the lowest level out, then pick the lowest remaining level.

<table>
<thead>
<tr>
<th>Step 1: Number of diagnoses or management options</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 1 Minimal</td>
<td>2 Limited</td>
<td>3 Multiple</td>
<td>≥ 4 Extensive</td>
<td></td>
</tr>
<tr>
<td>Step 2: Amount and complexity of data</td>
<td>1</td>
<td>2 Limited</td>
<td>3 Multiple</td>
<td>≥ 4 Extensive</td>
</tr>
<tr>
<td>Step 3: Overall risk</td>
<td>1</td>
<td>2 Limited</td>
<td>3 Multiple</td>
<td>4 High</td>
</tr>
<tr>
<td>Type of medical decision making</td>
<td>Straightforward</td>
<td>Low complexity</td>
<td>Moderate complexity</td>
<td>High complexity</td>
</tr>
</tbody>
</table>
Conclusion

As it has been demonstrated today, coding is a science that takes practice and patience.

The basics illustrated in this webinar will help you develop the skills necessary for proper coding.

Questions?

Thank you for your attendance!

Get your questions answered on PMI’s Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp