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Meet the Presenter...



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On the topic:

45 Coding and Billing Concepts You Should Know



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Over 45 Key Concepts every Coder, Biller, and Provider Should Know

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This Will be a Fast-Paced Presentation

- I actually have over 50 key coding, billing, documentation, and compliance topics to review today.
- For new coders you should know every concept in this presentation.
- For managers, doctors, and administrative staff, you should focus on "Why Do I Care (WDIC). What is the significance and the importance of this concept? Does it impact compliance? Does it impact reimbursement? Both?
- Let's get started!

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CPT® Codes

- Codes used to report services (procedures).
- Developed and copyrighted by the AMA. The AMA has enhanced descriptions and scenarios in the **AMA CPT™ Assistant**. However, the AMA does not reimburse or audit you, therefore, the ultimate interpretation on payment and documentation requirements is in the hands of insurance companies and auditors.
- E & M codes are CPT™ codes.
- Diagnostic (in the Medicine section) begin with 9 versus surgical codes 1xxxx or 6xxxx.
- Radiology, pathology/lab, and Medicine Sections codes are *not* surgical.
- Reporting codes is how we get reimbursed.

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What are CPT® Category II Codes?

- These codes end with the letter "F"
- Often referred to as "Cat 2" codes.
- They are used for performance measurement and clinical studies.
- No dollar amount is associated with category II Codes.
- In the US they are currently used for the Physician Quality Reporting System (PQRS) by Medicare which pays an annual bonus for clinics reporting the measures.

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Selected Examples of Cat II Codes

- 0517F Glaucoma plan of care documented.
- 1000F Tobacco use assessed.
- 1039F Intermittent asthma
- 2028F Foot exam performed
- 3011F Lipid Panel performed and reviewed
- 4003F Patient education, written/oral, appropriate for patients with heart failure, performed.

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Category III CPT® Codes

- These codes are often referred to as Cat III codes.
- Considered temporary and may become a CAT® I CPT code in the near future.
- They end with a "T"
- Used for emerging technology and experimental procedures.
- Rarely paid but has happened.

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ICD-10 Codes

- Diseases
- Conditions
- Injuries and adverse affects
- Status and history codes
- Tell a story
- List codes that are relevant and managed today.
- Be specific.
- Originally developed by the World Health Organization (WHO)
- Analysis of the codes helps us prevent and fight disease. We provide specificity and additional information because it is the right thing to do.

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Medical Necessity (for procedures)

- It the one-to-one linking of a diagnosis to a CPT code to support medical necessity.
- Some CPT codes require two diagnoses.
- Some CPT codes are paid only on a very specific diagnosis.
- The source for medical necessity is the **Local Coverage Determination**.
- Without medical necessity, the procedure is a screening.
- This is the "catch 22" of healthcare.
- If unsure if paid, have the patient fill out an ABN (Medicare) or a similar private carrier form stating they are responsible if the carrier does not pay.

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Local Coverage Determinations

- LCD's are published by your local Medicare provider.
- There are approx. 12 jurisdictions in the US.
- Medicare is not one monolithic agency regarding reimbursement. Every Medicare intermediary has slightly different rules and guidelines.
- Go to the Medicare website; find Provider information, find LCD's or publications; review the long list of LCD's and find all that pertain to your practice or specialty.
- The number of CPT codes per carrier covered will span a wide range.
- If your carrier does not have an LCD find another one from another Medicare carrier (a different state)

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HCPCS codes

- The third manual provided by Medicare. We pronounce this "Hic-Picks"
- Where we find **S codes**. Most are not paid by insurance.
- Injectables are **J codes**
- Technically, modifiers RT, LT, E1-E4, are HCPC modifiers.
- "L" codes are used in orthopedics.
- All toe and hand modifiers are HCPC modifiers.
- However they are appended to both HCPC and CPT codes.
- Technically, CPT codes are level I HCPC codes (obscure coding trivia). The HCPCS codes above are level II.
- **HCPCS codes are unchanged by ICD-10.**

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UB-04 Form

Medicare form
used to report
Hospital Services
for the room,
operating room,
ancillary
personal and
supplies.

Used by Private
Hospitals

Also known as
Medicare Part-A

The image shows a sample UB-04 Medicare form. At the top, it identifies the provider as UPTOWN MEDICAL CENTER, 140 SECOND STREET, ANYTOWN CA 958235555. The patient is JANE DOE, born 06/01/1980. The form lists several services, including 'INTENSIVE CARE PEDIATRIC' and 'MEDICAL/SURGICAL SUPPLY'. It includes a 'TOTALS' section showing a total bill amount of 2380000. The form is dated 01/23/2017 and is page 001 of 001.

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Medical terminology and anatomy

- This is very important in coding, auditing and understanding diseases and conditions.
- Know your sub-terms.
- Know your prefixes and suffixes.
- Know the different systems: cardio, neurological, musculoskeletal.
- Work with a diagram of your specialty (eye, circulatory, musculoskeletal). If new to the specialty copy it over (and over).

Example of Anatomy and Coding

- 65280 Repair of laceration; cornea ... not involving "uveal tissue" (estimated Medicare allowable amount is \$772 [fully implemented non-fac RVU=20.1])
- 65285 Repair of laceration; cornea ... with ... "uveal tissue" (estimated Medicare allowable amount is \$1,179 [fully implemented non-fac RVU=32.92]).
- If the coder never asks and the surgeon never documents that "uveal tissue" was involved, then this procedure will never be reported correctly. The difference is \$407!
- Where and what exactly is the uvea?

The uvea is the iris, ciliary body and the choroid.
These are all contiguous structures of the eye.

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Co-Management

- This is common in certain specialties, particularly Eyecare. Another provider (optometrist) provides the follow-up care (post-op care, co-management) of a 90-day global surgery patient. It can be any number of days (87, 60, 45) your reimbursement will be prorated.
- The surgeon reports with Mod-54.
- The optometrist reports with Mod-55 and RT or LT.
- Your reimbursement is 20% of the Medicare allowable.
- Some Medicare carriers have slightly different reporting rules and guidelines. A few require that units = days. Always confirm with your specific Medicare carrier.

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Co-Management – Cataract Surgery – ICD-10

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE	
MM	DD	YY	MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN	
19. RESERVED FOR LOCAL USE			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)			
1. _____		3. _____	
2. _____		4. _____	
24. A. DATE(S) OF SERVICE FROM TO		B. Place of Service	C. Type of Service
MM	DD	YY	MM DD YY
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. DIAGNOSIS CODE	
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		27. ACCEPT ASSIGNMENT? (If not govt. bills, see back) YES NO	
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			
SIGNED		DATE	

Units
1

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Screenings

- Any procedure performed in the absence of a diagnosis supporting medical necessity.
- Stress test.
- X-Ray
- Always link a well exam to the appropriate Z0*.00 or Z0*.01 code if there are no medical codes to link to it.

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Long-Term Use of a High-Risk Drug

- You are reimbursed for an office visit, and related tests linked to a screening for the long-term use of a high risk drug. The definition of "long-term use" will follow standards of care for your specialty and the specific drug. **These are reimbursed screenings.**
- Examples include:
 - Steroid use
 - Most psychiatric drugs
 - Many orthopedic drugs

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Diagnostic Tests

- In the Medicine section of CPT.
- No global period.
- No E & M component—but many insurance companies want a Mod-25 on the E & M code.
- Always include the interpretation and report.
- You cannot report an office visit based on discussing the results of a test. The Hx, Exam, and MDM must support the level. You might report a 99212 and report at least one exam element (e.g., constitutional or auscultation of the heart)

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Small surgical procedures

- 10-day global or zero day performed in the office (POS=11).
- Epilation: 67820 (forceps) modifiers E1-E4, or RT or LT.
- Punctal plug insertion: 68761, modifiers E1-E4, Add Mod-51 to second procedure on same DOS.
- Foreign body removal, cornea: (65220 or 65222 [slit lamp]) [global period is zero-day of service only]
- Need adequate documentation.
- Should always be "separately identifiable" if reported with an E & M [e.g., link E & M to glaucoma or cataract codes]

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Surgical Operative Reports

- Mostly 90-day procedures (ASC and hospital)
- For small procedures, recommend separating the surgical notes from the office visit progress notes.
- Sometimes the actual procedure does not match the Op Report description.
- Always should be spot-audited once a year.
- Watch for cloning.
- Watch for RT and LT consistency.

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NCCI Edits

- National Correct Coding Initiative
- Not in the CPT manual
- Medicare has files you can download (excel, ASCII)
- Long lists of codes that cannot be reported on the same DOS.
- Breakable edits
- Unbreakable edits
- Use Mod-59 to break an edit. This is for two procedures on the same DOS. 2nd procedure must be separately identifiable.

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Medicare PFSRVU database (46)

- Physician Fee Service and Relative Value Unit database. An ASCII/excel file on the Medicare website. It is free to download.
- Includes:
 - › RVU data
 - › Bilateral surgery modifier
 - › Global Days
 - › Breakable or not breakable NCCI edit flag.
 - › Professional and Technical Component
 - › Much more.

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Global Period

- Also called Global Fee or Global Days
- Applies to surgical procedures.
- Zero days
- 10 days
- 90 days
- Not applicable to diagnostic specialty tests (audiology, eyecare, psychological).
- Co-management
- The change to the global period codes is now on hold (Jan 2016).

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Bilateral surgery modifier

- 1 = Unilateral
- 2 = Bilateral
- 9 = Concept does not apply
- 3 = 150 % rule does not apply
- These flags are in the Medicare PFSRVU database.
- Some diagnostic codes are inherently bilateral such as fundus photography and visual field exams.
- **Not** in the CPT manual.

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Professional Component

- All radiological procedures and diagnostics with an image or tracing include a professional and technical component. If you own the equipment, use your own tech, and document the interpretation and report—simply report the procedure without any modifiers.
- MOD-26: Professional Component Only
- This is the Interpretation and Report (discussed next).

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Interpretation and Report

- Three main components.
- Do not list “normal.”
- Recommend separate from office visit documentation.
- Medicare LCD. BCBS Bulletin. AMA: owner of CPT®
- You will be sent a document more detail on the three categories below:
 1. Clinical Findings
 2. Comparative Data
 3. Clinical management

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Technical Component

- Report with MOD-TC
- This is the payment for the equipment and the tech's time for the diagnostic or x-ray equipment.
- Anything with an image or tracing.
- You do not perform the professional component (MOD-26)
- The other doctor performs the interpretation and report.
- If you have the equipment and perform the test, report the procedure with MOD-TC, the other doctor reports with MOD-26.

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Medicare Guidelines

- Well over 1400 pages.
- Very detailed payment and documentation guidelines.
- About 74% of private carriers follow Medicare guidelines.
- You will find both local and national guidelines.
- Medicare and the OIG will audit you.
- Never pays for refraction or glasses.
- Medicare Concepts:
 - "Incident To" Services
 - Local Coverage Determinations
 - 1997 Exam Guidelines

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Relative Value Units (RVU's)

- Relative Value Unit
- All reimbursable procedures/services have an RVU value; this is provided by Medicare.
- E & M codes, surgical procedures, diagnostics, labs, radiology.
- Small, minor procedures have low RVU's.
- Large, major procedures have high RVU's.
- Determines your reimbursement.
- Ritecode.com **Coding Advisor** has RVU's for all CPT codes.
- Coding specialty manuals typically include RVU's
- Report CPT codes in decreasing RVU value.
- These are **Not** in the CPT manual.

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RVU's 2017 (Atlanta GA)

E & M	Total RVU
99202	2.11
99203	3.05
99204	4.63
99205	5.83
99212	1.23
99213	2.06
99214	3.03
99215	4.08

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2017 Medicare Conversion Factor: \$35.8043

For new patients, the RVU's are higher for E & M codes.
For established patients, the RVU's are higher for 9201x codes.

Total RVU's are multiplied by the conversion factor and a geographical index to provide the Medicare allowable amount.

This includes the 0.5 percent increase required by H.R. 2, which repealed the SGR formula.

As previously announced, CMS proposes to apply the 2018 **value-based modifier** to all providers, based on their 2016 performance.

The adjustment amount will depend on the size of the physician practice. Providers could earn a bonus for high quality and low cost, based on a yet-to-be-determined formula.

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What is Medicare Advantage (MA)?

- MA (aka Medicare Part-C) is required to offer at least the same amount of coverage as Medicare Part-B, but can include other benefits, like **routine vision, dental, and hearing coverage**.
- Some **Medicare Advantage plans** include full coverage for routine vision exams, vision correction products, and other vision care. This will vary by *plan and vendor*.

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Incident-To Services (E & M Code 99211)

- A minimal **Provider E & M visit** should be a 99212, not a 99211.
- 99211 does not require the presence of a Provider. Sometimes referred to as an **"Incident-To"** Service (Medicare Concept)
- Do not report this code whenever a tech performs a test.
- If a patient has the test without seeing the provider then a 99211 could be reported.

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Advance Beneficiary Notice (ABN)

- Required by Medicare if you want to bill the patient for a non-covered service (does not meet medical necessity).
- Have the patient fill out the form. Explain that you may be paid, but if not they are responsible.
- Append **modifier GA** to the code.
- Use on screenings without medical necessity.
- Be sure you have the latest version. Download from the Medicare website.

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Carrier-Specific Rules

- Many consultants don't teach this concept.
- National conventions
- A consultant, who works in a particular clinic in the same city for 20 years.
- There are different Medicare jurisdictions and providers.
- There are over 50 different Blue Cross/Blue Shield plans.
- Every state Medicaid is different.
- You need to know the difference between a national rule and a carrier-specific one.
- MOD-50 vs RT/LT; MOD-59; requiring documentation, units for co-management are all examples.

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Medicaid

- Mostly a state program.
- Reimbursement and guidelines can vary widely by state.
- May have unique guidelines or requirements unique only to them.
- Will provide services applicable to children.

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Private Medical Insurance

- BCBS, United Healthcare, Anthem, Cigna, Aetna and many others.
- Most follow Medicare guidelines—but they don't have to.
- Always ask if their guideline is published in their manual or a bulletin when denied.
- They can have different interpretations or reimbursement guidelines than Medicare, other private payers, or CPT.

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"Casino" Health Insurance

- It's simply the best insurance plan in your area. Can you list your top three insurance carriers?
- And typically, casino's really do have good insurance.
- Use coding to find these plans. Examples are codes 99050 (non-work hours) and 99058 (disruption of schedule). Only a few carriers in any given city pay on these; those that do are considered "provider friendly" insurance companies.
- Find out where these patients work.
- Market to their employer. Visit the HR director. Conduct a health fair. Sell your medical screening services.

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Self-Pay Patients

This mainly applies to Eyecare (Optometry) but could apply to other specialties. Two main options:

1. Offer a discount if paid in full at time of service.
2. Use S codes.

Some clinics do not offer any discounts.

- You should not charge customers less than you charge Medicare if you are contracted with Medicare.
- "usual and customary fee"
- Do not have two fee schedules—two prices for the same CPT code.
- Some state societies advise to never use HCPC S codes.
- This is a legal issue. **Always check with a lawyer.**

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Place of Service Codes

POS Code	Description
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room Department
24	Ambulatory Surgery Center (ASC)

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Quick Overview of E & M

- Evaluation and Management Codes.
- These are in the front of the book because they are most often coded by the provider.
- Codes are organized by type, place of service, level and whether the patient is new or established.
- Note the CPT® manual does not list the level of detail that Medicare provides (actually counting elements or bullets). Therefore it is essential to read the Medicare E & M Guidelines (1995 or 1997 Versions).

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What is a SOAP Note?

- | | |
|-------------------------|---------------------------------|
| • Subjective | History |
| • Objective | Exam |
| • Assessment/Impression | Medical Decision Making |
| • Plan | Tests, return date, medications |
- Common format in use for many years and implemented in many EMR programs.
 - Do not mix and match history and exam.
 - The Interpretation and Report for a diagnostic test should be separate and distinct from your office notes.
 - Don't use a Problem List (history) and your Assessment (to determine MDM)

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Cloned Notes

- This is "copying and pasting" one note to another. With the increased use of Electronic Medical Records, this is the number one audit element.
- If verbiage is the exact same from visit to visit and patient to patient it can be audited as cloned. Ask if the information provides any specific information for this DOS or patient.
- If the number of ROS and exam elements do not change based on the presenting problem(s).
- If there is inconsistency in the medical record.
- Recent RAC Audits indicated that approximately 24% of EMR notes were cloned.
- Always include 3 statements that are unique to this patient on this DOS. Do not clone **counseling verbiage**.

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Selected E & M Code Types

- Office Visits
- Consultations
- Hospital Admissions/Discharge Codes
- Emergency Room Encounters
- Critical Care
- Preventive Medicine Encounters (by age)
- Work related evaluations

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Components Of E & M Services

- History
- Exam
- Medical Decision Making

These three key components are the major factors used to determine the level of E/M service performed. An exception is the case in which a visit consists predominantly of **counseling** or **coordination of care**. For these services, documented two times, the total face time and the counseling time (at least 50% of the total time) is the key or controlling factor to qualify for a particular level of E/M service.

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New versus Established Patient

- A *new patient* is one who has not received any professional service from the physician or another physician in group or the same specialty within the last 3 years.
- If the patient visits a recognized sub-specialist, then it is considered a new patient visit.
- There is a New versus Established flowchart in the front of this section in your CPT® manual. Study it carefully.

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New Versus Established patient

- 99201 – 99205 – office new patient
- 99211 – 99215 – office established patient
- 99341 – 99345 – Home Services New patient
- 99347 – 99350 – Home Services established patient
- 99221-99233 – Initial Hospital Care – *Not Relevant (if new or est).*
- 99281 – 99285 – Emergency Dept Services – *Not Relevant. (if new or est.)*

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E & M Levels

- Note that **time** is not the main determinant of the level of an E & M Service. History, Exam and Medical Decision Making are the 3 components.

For most encounters there are Five Levels:

- Level I (1) 99211/99201
- Level II (2) 99212/99212
- Level III (3) 99213/99302
- Level IV (4) 99214/99204
- Level V (5) 99215/99205

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Chief Complaint

Yes, CPT does state "it is in the patient's own words."
However, this does not mean that the following are sufficient:

- "My wife told me to come."
- "Feeling better."
- "Here for IOP."
- "Here to review labs."
- You are at risk, not the patient. Your staff needs to explain to the patient why they are returning. It is a medical diagnosis.
- There must be a medical reason, a condition or disease to link the visit to either a 920xx or 992xx codes. Otherwise, it is a routine vision exam. Do not link a refractive dx to either of these codes; only link refraction dx to 92015 (most vision plans do not care either way).

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History

- Chief Complaint (presenting Problem)
- HPI (8 components)
- ROS (14 components)
- Past, family, and social history
- Known as the "subjective" portion of the office encounter.

HPI:

Location
Quality
Severity
Duration
Timing
Context,
Modifying factors
Assoc. signs and symptoms.

ROS:

Constitutional symptoms	Musculoskeletal
Eyes	Integumentary
Ears, Nose, Mouth, Throat	Neurological
Cardiovascular	Psychiatric
Respiratory	Endocrine
Gastrointestinal	Hematologic/Lymphatic
Genitourinary	Allergic/Immunologic

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E & M Exam Codes

These are the Medicare 1997 E & M Guidelines for the General Multi-specialty Exam. Often called "bullets" or "elements" they are not listed in the CPT manual.

- 1-5: Problem Focused (PF)
- 6: Expanded Problem Focused (EPF)
- 12: Detailed (2 from 6 organ systems)
- 18 is comprehensive exam (2 from 9 organ systems)
- There are many specialty exams (the bullet counts vary by specialty): Eyecare, cardiology, orthopedic, neurology, psychiatric, dermatology, ENT, Female GUI, Male GUI, and respiratory. (some do not have specialty exams [digestive])

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Medical Decision Making (MDM)

- Single most important element in determining the level of an E & M office visit.
- The sicker the patient and the more chronic illnesses, generally, the higher the MDM. Think 3 chronic illnesses = moderate MDM.
- **Time is not a factor** (Except for counseling encounter)
- Three Tables in CPT. 1) Number of diseases 2) Data analyzed 3) Table of Risk. Medicare has more detailed guidelines.
- The MDM **scoring system** was not developed by Medicare or in the original guidelines but widely used by Medicare intermediaries and auditors.

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Medical Decision Making Tables

(A) Number of Diagnoses/Management Options.	B) Amount and/or Complexity of Data to be Reviewed.	(C) Table of Risk of Significant Complications, Morbidity and/or Mortality
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Levels are: Straightforward, Low, Moderate and High.

Only two of the three components need to be at a given level. Sometimes you will see these listed as Tables 1, 2 and 3.

The Table of Risk is further divided into three tables / columns.

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Diagnosis Problem Lists

- There is a very distinct difference between a *problem list* and the final, *differential diagnosis assessment*.
- However copying every diagnosis from previous encounters as the **current presenting problem** is very common with EMR systems. While sold by EMR vendors, this is not considered proper documentation.
- Do not list every diagnosis (i.e., a problem list) in your assessment. This is not compliant and an auditor could challenge whether you could have reviewed, and managed every condition listed during that visit.
- Only report those conditions relevant, managed, and reviewed **today**.
- If you are reporting a level IV E & M encounter always strive to list either a new dx or at least three; otherwise the encounter while most likely not support moderate MDM.

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Medical Necessity (for office visits)

- This definition is related but very different from the one-to-one linking of a diagnosis to a CPT code to support medical necessity for billing.
- Directly related to the Chief Complaint (CC), presenting problem(s) and Medical Decision Making (MDM) [commonly known as the Assessment/Impression].
- Medical Necessity is considered by Medicare as the overarching main determinant of the level of the visit.
- Medical Necessity determines the level of history and exam elements appropriate for the encounter.
- Medical Necessity is also related to the frequency of encounters, labs and diagnostic tests performed and other ancillary services.

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Upcoding/Downcoding

- **Upcoding:** reporting a higher level than documented or warranted based on documentation.
- MDM is the main culprit
- 2 of 3 rule (applies to E & M codes)
- ROS must be 10 or more. Comprehensive Exam requires 13+1
- 50% rule – auditors
- Suzie in Cleveland said she thinks the coding is just fine.
- History/Exam and MDM.
- **Downcoding** – simply losing money.
- Is it fraudulent or illegal to downcode?

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E & M: 2 of 3 Rule | 3 of 3 Rule

- For a **new patient**, to report a given level, all three key components, hx, exam, and MDM must be at the highest level. Missing 10 ROS on a comprehensive encounter (99203) is fatal.
- For an **existing patient**, either hx, or the exam, may be at a lower level, and the level is determined by MDM and the other key component.
- Remember that MDM always determines the level and can never be the lower of the three (hx, exam and MDM).
- I have seen some clinics either skip or document a minimal hx or exam for a level IV or V visit. While I must audit these as "correct" I do not recommend this unless there is a very good reason for it (patient is going to the ER or unconscious).

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Preventative Encounter plus an E & M

- Can I report an E & M encounter if I found problems during a preventive visit?
- This is a tricky one with many interpretations.
- You would need to document that the history, exam and MDM for the additional E & M are separate and discrete from the preventive exam. If you perform 18 exam elements as your standard preventive exam you could not use any of those for your E & M encounter.
- One possible encounter would be where you discover muscle weakness and/or a type of arthritis and perform a workup of their four limbs (possible 16 elements there); so you could work up a detailed exam—perhaps.

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Audits, OIG, RAC, VSP, Medicare, Board

- All providers should learn how to *think* like an auditor.
- Establish a response for common auditor questions.
- How do you justify the level of the visit?
- Cloned notes
- Mod-25
- Upcoding
- MOD-59
- Other Issues: Signatures, Interpretation and Report, binocularity and color vision, documentation on punctal plugs.

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What Exactly is a Red Flag?

- Some call them *outliers*.
- Do you *want* to be an outlier?
- If it's justified, you *want* to be an outlier (specialists, best doctors in the city, receive the most difficult cases)
- More diagnostic procedures
- More higher level codes
- A lot more revenue.
- What do you *need* to make all this happen?
- What is a concise, correct answer for skewing higher?

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Legal Issues

- Stark laws and referral.
- Undercoding
- Self-Pay patients
- **Contractual issues.** If a specific contract states that you must document a certain way or cannot use “overhead” in determining your costs, then you must abide by that contract.
- I am not a lawyer and do not give legal advice; always consult with a lawyer concerning these type of issues.

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Compliance, Compliance Plan

- You should conduct periodic audits as part of your compliance plan.
- You should have a compliance plan—even if it is only one page.
- Ritecode.com has a 37-page comprehensive compliance plan.
- There is a difference in getting paid and compliance. You could report charges for years and get paid—yet when you are audited, if your documentation does not support or match what you reported, you could owe money back.
- Few are convicted of actual fraud but cases of six-digit returns are common.

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PM software, EMR, Clearinghouse

- Practice Management (PM)
- Electronic Medical Records (EMR or EHR)
- Clearinghouse from your PM system to the individual carriers
- How good are their edits?
- How good is their progress-note logic?
- Do they calculate the history and Exam?
- How do they determine MDM? Most do not calculate it.
- How do you select ICD-10 codes? Do they flag or show ICD-10 guidelines in the manual?
- Will the software prompt you if you make a mistake?

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Top EMR mistakes

- The A+OX3 and mood and affect are in the history section. Incorrect, they are exam elements.
- Only one time documented for counseling (must have two).
- Cloning.
- Problem Lists
- Pull-down ICD-10 lists for Assessment
- No MDM calculations.
- Recommend up-coding (this could be a level 5...)
- Interpretation and Report in the office note (should be separate).

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MACRA/CHIP/MIPS/APM

- Medicare
- Access
- CHIP
- Reauthorization
- Act
- Merit-Based
- Incentive
- Payment
- System
- Children's
- Health
- Insurance
- Program
- Alternative
- Payment
- Method

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MACRA

- The Medicare Access and CHIP Reauthorization Act (MACRA) revolutionizes reimbursement to physicians. The final rule is 2300+ pages!
- The focus is now on **quality improvement activities** and **prevention of disease** rather than simply on what level of service are billed.
- As a result there will be changes in how Providers document, code, and bill under the new system.

MACRA creates the **Quality Payment Program**:

- It repeals the Sustainable Growth Rate (SGR) physician payment formula
- Provides incentive payments for participation in Advanced Alternative Payment Models (APM)
- Represents a shift from a **fee-for-service model** to a **fee-for-value model**.

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ICD-10 Coding Example

- Doctor writes on fee slip:
 - > DM
 - > Glaucoma
 - > Conjunctivitis

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Coding Example

- **Coder A converts ICD-9 codes to ICD-10 codes:**
 - > 250.00: (default) converts to E11.9, type II, no complications.
 - > H40.10X0: Unspec. Open angle glaucoma: (stage unspec)
 - > H10.30: Unspecified conjunctivitis [no eye specified] converts to: (acute and unspecified eye).
- Is this really coding?

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Coding example

- Coder B asks for additional information:

- > DM, **Type II**
- > Glaucoma, **POAG**
- > Conjunctivitis **due to Timolol™, affecting both eyes.**

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Coding Example

- Still not specific enough for accurate coding

- > DM, Type II, **controlled (A1C)**
- > Glaucoma, POAG, **moderate stage (Visual Field Exam)**
- > Conjunctivitis, chemical [code as toxic]. **This is an adverse reaction of a drug taken properly. Timolol™.**
- > **Add T code for adverse effect.**

Note: Many primary care doctors do not agree on which A1C number is controlled (5, 6, 7). It is best to agree on a *cutoff* for uncontrolled or "with hyperglycemia". A good starting number is 8. Anything lower is reported as controlled. Just be internally consistent and communicate what your coding with all referring providers.

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Add Adverse Effect Code

- Look up adverse effect Timolol™; *not found*
- What is Timolol? It's a beta-blocker. Look up beta-blocker; *not found*.
- Research some more. Beta-blockers are drugs that bind to **beta-adrenoceptors** and thereby block the binding of norepinephrine and epinephrine to these receptors.
- T44.7X5A Adverse effect of beta-adrenoreceptor antagonists, initial encounter [Bingo!]
- The ICD-10 manual instructs us to **Code First the adverse effect code**. [This is a sequencing guideline]

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Anything else in the notes?

- Patient has a family history of glaucoma. This should be reported on all claims to aid in worldwide research to prevent blindness.
- Z83.511: family history of glaucoma.
- Also the patient is **on insulin**. There is a code for a Type-2 patient on insulin (essentially anyone who is not Type 1)
- Z79.4 Long term use of insulin. This code also if very important for worldwide research.

Note: There is controversy on different methods of determining type I or type II. Again, be internally consistent and share with your referring providers. You should document the specific type.

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Accurate, specific and compliant coding

1. T44.7X5A Adverse effect of beta-adrenoreceptor antagonists, initial encounter [sequence first]
2. H10.213: Conjunctivitis, toxic. [due to Timolol™]
3. H40.1132: Glaucoma, POAG, moderate stage, both eyes*
4. E11.9: DM, Type II, controlled [A1C is less than 8]
5. Z83.511: family hx of glaucoma
6. Z79.4 Long term use of insulin.

* 3=laterality and 2=stage (moderate)

This is significantly improved from the first slide! Rarely will there be a need for more than 7 codes (except for eyelid codes).

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