Coding and Documentation
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My Background
• My connection to coding and documentation
• My connection to clinical processes
• My connection to ICD-10
• My connection to YOU

Disclaimer
The information provided within this presentation is for educational purposes only and is not intended to be considered legal advice. Opinions and commentary are solely the opinion of the speaker. Many variables affect coding decisions and any response to the limited information provided in a question is intended to provide general information only. All coding must be considered on a case-by-case basis and must be supported by appropriate documentation, medical necessity, hospital bylaws, state regulations, etc. The CPT codes that are utilized in coding are produced and copyrighted by the American Medical Association (AMA).
Agenda
- Discuss what medical documentation facilitates
- Medical Necessity and General Principles of Documentation
- We will discuss pros and risks of EHR/EMR documentation
- Three key components of Evaluation and Management services
- The importance of E/M coding in an FQHC
- Counseling and Coordination of Care
- Chronic Care Management
- ICD-10 specificity

What Documentation Facilitates
- Proper and complete documentation plays a crucial function in patient overall care.
- Good documentation can help avoid many future potential problems with:
  - continuity of care,
  - referrals/consults,
  - unnecessary rework
  - legal considerations
  - medical necessity
- Electronic documentation has great legibility!
- Documentation tells a story

What Documentation Facilitates
- Medical record documentation is used for a multitude of purposes, including:
  - Serving as a means of communication between the provider and the other members of the healthcare team
  - A basis for evaluating the adequacy and appropriateness of patient care
  - Providing data to support billing
  - Assisting in protecting the legal interests of patients, healthcare professionals, and healthcare facilities
  - Providing clinical data for research and education
  - Make appropriate decisions regarding healthcare policies, delivery systems, funding, expansion, and education
What Documentation Facilitates
• Five factors that improve the quality and usefulness of charted information.
  • Accuracy
  • Relevance
  • Completeness
  • Timeliness
  • Confidentiality

What Documentation Facilitates
• Accuracy
  • Each individual progress note MUST be correct.
  • Information in the medical record is relied upon for accuracy throughout the patient’s lifetime.
  • Inaccuracies (either commission or omission) lead to improper medical advice being provided in error and may result in adverse healthcare outcomes or in legal proceedings.
• Relevance
  • It is important that medical records contain only information relevant to the patient’s healthcare.

What Documentation Facilitates
• Completeness
  • The documentation should be complete and credible.
  • The documentation should be authenticated by the author.
• Timeliness
  • Medicare indicates the documentation must be completed in a timely fashion.
What Documentation Facilitates

- Confidentiality
  - Medical records are confidential and protected by authority of the Privacy Act of 1974, its amendment and HIPAA.
  - Don’t leave patient-identifiable information on your computer screen or exposed in your work area.
  - Don’t talk about patients or families in hallways, elevators, or in other public places.
  - Don’t release medical record information without the patient’s consent.

What Documentation Facilitates

- In a continuous care operation, it is critical to document each patient’s condition and history of care.
  - To ensure the patient receives the best available care, the information must be passed among all members of the interdisciplinary team of caregivers.
  - Incorrect information, or no information at all, may result in serious injury or death of a patient.
  - Negative legal repercussions are often avoided because of proper documentation and appropriate communication of patient information.

Medical Necessity - CMS

- Per the Social Security Act 42 U.S.C. § 1395y(a)(1)(A), “SSA” Medicare only pays for medical items and services that are “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member”, unless there is another statutory authorization for payment.

- National coverage determinations (NCDs) and Local Coverage Determinations (LCDs). Section 522 of the Benefits Improvement and Protection Act (BIPA) defines an LCD as a decision by a Medicare carrier whether to cover a particular service in accordance with the SSA.
Medical Necessity - AMA
• “Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:
  • (a) in accordance with generally accepted standards of medical practice;
  • (b) clinically appropriate in terms of type, frequency, extent, site and duration; and
  • (c) not primarily for the convenience of the patient, physician, or other health care provider”

Medical Necessity
• National Coverage Determination
• Local Coverage Determination
• Other Payors
• CPT “stays out of it” — does give scenarios in CPT Assistant and other publications but not related to medical necessity

Medical Necessity
• Just because it is medically necessary in your provider’s eyes does not mean it is a covered service!
Medical Necessity and ICD-10

• How does ICD-10 affect Medical Necessity or does it?

Documentation to support Medical Necessity
• Describe the patient and their condition
• Tell the story
• Don’t assume level of knowledge
• Don’t rely on diagnosis documentation in the assessment/impression alone
• Review any payor medical policies – document in terms they use

EMR Benefits and Risks
Potential Benefits of EMR

- Improved documentation of the patient encounter to assist in reduction of medication errors through computerized physician order entry (CPOE)
  - Legible
  - Many systems have safe guards to cross-reference for drug interactions and potential drug allergies.
  - Improves compliance with clinical best practices
  - Allow patient’s to receive tests in a more timely manner — patient’s don’t have to wait for the handwritten order to be delivered

Potential Benefits of EMR

- Improved tracking of ancillary and diagnostic tests combined
  - Reduce duplicative services
  - Allow multiple providers access to the patient’s information when they are part of the same organization

Potential Benefits of EMR

- Improved documentation of the service actually provided when the EMR is used correctly
  - Time and date stamping
  - Legible notes
  - Improved storage capabilities
    - Paper charts were limited – sometimes patient’s had 2 and 3 volume charts
    - Customizable and scalable electronic medical records that can grow with your practice
Potential Benefits of EMR

- Quick access to patient records from remote locations for more coordinated, efficient care
- Enhanced decision support, clinical alerts, reminders, and medical information
- Interfaces (i.e. with labs, registries, etc.)
- Reduced need to fill out the same forms at each office visit
- Reliable point-of-care information and reminders notifying providers of important health interventions
- Convenience of e-prescriptions electronically sent to pharmacy

Potential Benefits of EMR

- Better communication between the patient and physician and other providers
  - Patient’s receive a clinical summary of their visit
- Improved efficiency in regards to staff looking for lost medical records
- Allows you to track outcomes for quality care initiatives
  - Improved outcomes
  - Financial incentives
- More accurate billing and more efficient charge entry

Potential Benefits of EMR

- Efficiencies and Cost Savings
  - Reduced transcription costs and overtime
  - Reduced chart pull, storage, and re-filing costs
  - Reduced medical errors through better access to patient data and error prevention alerts when used correctly
  - Improved patient health/quality of care through better disease management and patient education
Risks Associated with EMR

- There can be cloning notes from previous appointments
  - The word 'cloning' refers to documentation that is worded exactly like previous entries. This may also be referred to as 'cut and paste' or 'carried forward.' Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.
  
  Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Source: Palmetto GBA – Jurisdiction 11 – Part B

Risks Associated with EMR

- Financial issues, including adoption and implementation costs, ongoing maintenance costs, loss of revenue associated with temporary loss of productivity, and possible declines in revenue.
  
  - Changes in workflow
  
  - Privacy and security concerns
  
  - Several unintended consequences

Risks Associated with EMR

- Learning curve for the providers = decreased productivity
  - Frustration
  - Working late hours
  - Not completing documentation
  
  - Inadequate training can lead to increased coding
    - "Buttons"
    - Pulling forward the previous information
    - Selecting an all negative button
  
  - Identical documentation
    - Copy and paste
    - Bringing forward the previous note
    - Standard "buttons"
Risks Associated with EMR

- Loss of human touch and individuality
  - Providers are so busy typing their note in the patient room they don’t actively listen to the patient
  - Disengaged
- Difficult to determine what the provider is recommending for the patient
- The documentation does not really tell a story

Risks Associated with EMR

- Documentation is not always patient and chief complaint specific
  - Providers are clicking buttons to meet other requirements (i.e. quality initiatives, etc.)
  - Inconsistencies in the documentation (i.e. patient presents with depression and ROS indicates “denies depression”)

Risks Associated with EMR

- Difficult to determine who performed specific elements
  - Who performed the History of Present Illness
- Power outages and computer crashes
Risks Associated with EMR

- **Time and date stamping**
  - Documentation not completed in a timely fashion

- **CPOE**
  - Drop down menus can cause the provider to select the incorrect drug or dosage
  - Provider ignore warnings from routine pop-ups related to drug dosages, interactions, and allergies

- **Templates – limitations**

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Risks Associated with EMR

- The EMR can drive a provider to include documentation that is **not** applicable for the severity of the presenting problem.
  - A 25 year old patient who comes in for a cough has documentation to support a complete review of systems (i.e. 10 or 12 point) and a family history because the EMR can automatically imports such text from the previous visit.

- Medicare and other payors will look to see whether the severity of the patient’s problem matches the documentation, and if it doesn’t it’s a red flag.

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Risks Associated with EMR

- Documentation templates default to multisystem reviews, exams, past problems that are no longer active, but still indicate “Active Problems,” etc. whether you do them or not.
  - Usually it takes too much time and trouble to edit them out so the providers leave the information in the note for that date of service.

- Although excellent features of EMR systems, default settings and documentation templates can be dangerous
Real Case

• Patient presented with knee pain. A complete review of systems was documented including breasts and ob/gyn – this was a male patient and breast and ob/gyn issues would be unrelated and not relevant for knee pain.

Real Case

• A specialty provider (cardiologist) saw a patient for heart issues. The provider saw the patient multiple times and on the initial visit the history and review of systems indicated the patient was coughing up blood and also their weight was down 10 pounds. Every note after the initial had the exact same review of systems, however, the history outlined the weight was up by xx pounds, etc.

Real Case

• During the documentation review for well child visits. The ROS indicated the patient denied libido, memory loss and other strange ones for children that probably were not appropriate.
Real Case

• A child came in for sore throat
  • The ROS indicated the patient did not have any breast issues
  • The exam supported a breast exam
  • The exam supported a rectal exam

Real Case

• A gastrointestinal provider had a complete physical including "genitourinary" when evaluating the patient for a colonoscopy.
  • When I asked the provider about it, the provider said "oh my gosh, I had no idea that was in there. I was told if the patient’s exam is completely normal, I can click the button and then if I need to make any changes about abnormalities or more detail I can just add it in."

Real Case

• I was reviewing documentation in a surgeons office and noticed several instances where the ROS was positive for several items that were not addressed (i.e. short of breath, heart palpitations, chest pain, depression, etc.)
  • The surgeon told me that he never reviews that information it is a bubble sheet that is completed and scanned into the system. He also said he does not base his coding on these ROS.
Real Case

• The documentation has discrepancies:
  • He versus she or he/she
  • Positives in one section of the note, negative in other sections
  • Smoker or tobacco user in one section and either not a smoker/tobacco user or quit

Reduce Risk

• Obtain an independent assessment of your EMR documentation
  • Evaluate the documentation in comparison to the presenting problem
    • Review several dates of services, types of services, etc.
    • Review 2-3 dates of service in for the same patient by the same provider
  • Ask the auditor to look at the templates you have
    • Is the template prompting for more information than required for the presenting problem

Reduce Risk

• Ask for a list of everything that automatically pulls forward and a list of everything that can pull forward
  • Query the provider on how they are using the EMR.

• Print out the note
  • Can you tell who did what work?
Reduce Risk

• Secret Patient
  • A secret patient is similar to a secret shopper. Ask the patient to see a few of the providers with different issues and then determine if the documentation adequately reflects the work performed.
  • Example: if a complete Review of Systems is documented – was a complete Review of Systems performed?

Reduce Risk

• Clearly understand who is doing what in the EMR.
  • Audit trails offer a back-end view of system use.

• Technology is only as good as the user

• The leading cause of failure for Electronic Medical Record usage is inadequate training.

• Investing time and effort on the front end will ensure you get the best out of your system.

OIG Work Plan

• Review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments.

• Medicare contractors have noted an increased frequency of medical records with identical documentation across services.
Coding Module

- Is your coding module turned on?
- Should we turn it on or leave it off?

Section II

Medical Necessity and E/M

- Medical necessity is the y “overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”
E/M Codes

• 3 Key Components:
  • History
  • Examination
  • Medical Decision Making

• Contributory Components:
  • Counseling
  • Coordination of Care
  • Nature of the Presenting Problem
  • Time

History

• Chief complaint - CC/Reason for visit

• History of present illness – HPI

• Review of systems – ROS

• Past, Family, Social history - PFSH

Chief Complaint/Reason for Visit

• A concise statement describing the reason for the encounter

• A statement describing the symptom, problem, or provided recommended return that is the reason for the encounter
History of Present Illness (HPI)

- Location — specific location
- Quality — balanced or no thoughts of harm
- Severity — moderate; 1-10 on the pain scale
- Duration — time frame (2 days, 6 hours) since yesterday
- Timing — frequency, how long it lasts, when first notices

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History of Present Illness (HPI)

- Context — related to a certain activity, occurs at a certain time of the day (i.e. notices anxiety when out in public)
- Modifying factors — aggravating: what makes it worse; alleviating: what makes it better (meditating makes it better)
- Associated signs & symptoms — if the patient volunteers the info it is an HPI (if the patient responds to a question it is a ROS)

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HPI

- Sally presents with blurry vision and left sided headache for 2 days
HPI

- Mr. Smith presents today in follow-up and indicates he is doing very well and doesn’t have any complaints.

Review of Systems

- Constitutional symptoms - fever, weight loss
- Eyes – blurry vision, pain
- Ears, Nose, Mouth, Throat – congested, sore throat
- Cardiovascular – chest pain, edema, palpitations
- Respiratory – coughing, dyspnea, wheezing
- GI – heartburn, nausea, diarrhea, appetite
- GU – nocturia, frequency, lumps, pain

Review of Systems

- Musculoskeletal – aching muscles, pain, swelling joints
- Integumentary – itching, rash, changes in mole
- Neurological – numbness, convulsions, dizzy, headache
- Psychiatric – loss of memory, crying, sleep pattern changes
- Endocrine – sweating, thyroid replacement medication
- Hematological / Lymphatic – swollen nodes, bleeding
- Allergic / Immunologic – NKDA, allergic to; immunizations
Past Medical, Family &/or Social History

- Past History
  - Allergies, current meds, immunization, surgeries, previous illness, age appropriate feedings

- Family History
  - Health of parents, siblings or children, hereditary diseases that put the patient at risk (blood relatives)

- Social History
  - Age appropriate review of past and current activities
    - Marital status
    - Employment
    - Drug, alcohol, and tobacco use
    - Education
    - Sexual history

Documentation Guidelines

- HPI is qualitative
  - Trying to describe the reason for the encounter

- ROS is quantitative
  - An inventory and investigating an organ

- Double Dipping
  - You may use same piece of information in HPI and ROS
    - Only with...
  - Further development in the ROS
  - You may not use the same piece of information twice in HPI

Types of History

<table>
<thead>
<tr>
<th>Type of History</th>
<th>Chief Complaint</th>
<th>History of Present Illness</th>
<th>Review of Systems</th>
<th>Past Medical, Family and/or Social History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>X</td>
<td>1</td>
<td>NONE</td>
<td>NONE</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>X</td>
<td>1</td>
<td>1</td>
<td>NONE</td>
</tr>
<tr>
<td>Detailed</td>
<td>X</td>
<td>4</td>
<td>2-9</td>
<td>At least one</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>X</td>
<td>4</td>
<td>10 or more</td>
<td>2/3 or 3/3</td>
</tr>
</tbody>
</table>
Patient is seen for low back pain with right thoracic discomfort for about a week. The back pain is sharp and is pretty constant and severe at times. Patient states she is having difficulty in taking in a full inspiration. She states she has not recently had any upper respiratory problems, including sinus drip, ear congestion or pain, any eye discharge/other symptoms, sore throat, or cough. From the time of developing her complaints, she has had progressive severe shortness of breath. She has felt pain in her right shoulder blade and it radiated to her front chest wall last night. It was sharp and catching which made it difficult to breathe completely.

She has a history of headaches that occur on an average of twice a month. She states she is not sure if she has a history of sinus problems. She has not reported any skin rash. She does not have a stiff neck today but she has been having some neck discomfort with her headaches posteriorly. She has not had issues with ataxia or balance. She had a motor vehicle accident 10 years ago, where she struck her right side and she had subsequent contusions related to that, particularly in the upper shoulder, thorax and lower extremity. She has had a history of Hepatitis A but no blood transfusions and no chronic liver problems. She has had no bleeding episodes or bilirubin problems. She denies any trauma to her abdomen. She is not having any bowel movement issues, urinary complaints or vaginal discharge. She is afebrile today.

### Determining the Level of History

<table>
<thead>
<tr>
<th>Subjective (History)</th>
<th>Past, Family, and Social History</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Present Illness (HPI) Location</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Quality</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Duration</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Timing</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Context</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Associated Signs &amp; Symptoms</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Monitoring Factors</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Review of Systems (ROS)</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Constitutional</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Eye</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Ear/Abnormality</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Nasal Sinus</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Oral Cavity</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Thoracic</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Neurologic</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Skin</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Lymphatic</td>
<td>Past Medical Family Social History</td>
</tr>
<tr>
<td>Allergic/Immunologic</td>
<td>Past Medical Family Social History</td>
</tr>
</tbody>
</table>

Remember to always start in the highest level of history and work toward the lowest level—the element located in the lowest level will determine the overall level of history.

### Examination
Physical Examination

- Two sets of guidelines
  - 1995 vs. 1997
- Is a specialist bound to 1997 guidelines?
- What are the differences?

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Physical Examination

- 1995 Exam Guidelines
  - More subjective than 1997
  - Did not define documentation needed for a single system exam
  - Not all specialties are represented by a single system exam
  - Easier in most cases for providers to meet these requirements
  - The difference between Expanded Problem Focused and Detailed Exam never clarified

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Determining Level of Physical Examination

<table>
<thead>
<tr>
<th>1995 - Body Areas/Organ Systems</th>
<th>1997 - Bullets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem</strong></td>
<td><strong>Multi - Sys</strong></td>
</tr>
<tr>
<td>1</td>
<td>1 - 5</td>
</tr>
<tr>
<td>Expanded</td>
<td>6 - 11</td>
</tr>
<tr>
<td>Detailed</td>
<td>12 - 17</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>18 / 9</td>
</tr>
</tbody>
</table>

This is vague so refer to 1997 “bullets”
Example - 1995

VITALS: Stable, afebrile.
GENERAL: NAD
CARDIOVASCULAR: RRR
LUNGS: CTA
ABDOMEN: Soft, tenderness in right lower quadrant, no guarding

VITALS: Stable, afebrile.
GENERAL: NAD
CARDIOVASCULAR: RRR
LUNGS: CTA
ABDOMEN: Soft, tenderness in right lower quadrant, no guarding, no rebound, bowel sounds in all 4 quadrants, no acute abdomen, no hepatosplenomegaly.

Medical Decision-Making
(MDM)

Medical Decision Making (MDM)

• The medical decision-making should drive the visit

• The history and exam should match the severity of the problem(s) and complexity of decision-making
Medical Decision Making (MDM)

- The plan helps create the severity of the patient’s condition and work performed by the provider.
- Tell the story

Medical Decision-Making

<table>
<thead>
<tr>
<th>Problems</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or</td>
<td>Max = 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>worsening)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Established problem (stable or improved)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Established problem (worsening)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem; no additional workup or</td>
<td>Max = 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>diagnostic procedures ordered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem; additional workup planned</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical Decision-Making

<table>
<thead>
<tr>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than the patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than the patient</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing, or specimen itself (not simply a review of the report)</td>
<td>2</td>
</tr>
<tr>
<td>Enter Total</td>
<td></td>
</tr>
<tr>
<td>Problem/Question</td>
<td>Diagnostic Procedures ordered</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1. multi-limb or multi-system injury: Cold, need heat, fine osseous changes</td>
<td>Ultrasound, x-rays, MR, CT, Mi-electrodiagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. or more self-limited or minor problems:</td>
<td>Physiologic test for underlying disease</td>
</tr>
<tr>
<td>1 stable chronic disease</td>
<td>Nerve/conduction studies</td>
</tr>
<tr>
<td>Acute uncomplicated/acute injury</td>
<td>Superficial nerve blocks</td>
</tr>
<tr>
<td></td>
<td>Critical lab test requiring arteriography</td>
</tr>
<tr>
<td></td>
<td>Skin biopsy</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>1 of 10 multi chronic diseases with exacerbation, progression, or side effects of treatment:</td>
<td>Physiologic test and/or blood test</td>
</tr>
<tr>
<td>Acute exacerbation</td>
<td>Diagnose endoscopically re-identified risk factors</td>
</tr>
<tr>
<td>Acute or chronic diseases or injuries that pose a threat to life or healthy function:</td>
<td>Deep rectal or bladder biopsy</td>
</tr>
<tr>
<td>Abrupt change in neurologic status</td>
<td>Carboxyhemoglobin testing</td>
</tr>
<tr>
<td></td>
<td>Diagnostic endoscopically re-identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Cardiorespiratory testing</td>
</tr>
</tbody>
</table>

### Levels of MDM

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Number of Dx or Treatment Options</th>
<th>Amount and/or Complexity of Data to Review</th>
<th>Risk of Complications and/or Morbidity or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight forward</td>
<td>≤ 1</td>
<td>0-1 Minimal</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>2</td>
<td>2 Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>3 Multiple</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>4+ Extensive</td>
<td>4+ Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

### Acute or Chronic Patient

**Acute**

- Level 2: No interventions. Go home
- Level 3: Acute uncomplicated problem
- Level 4: Acute problems with complicating factors
- Level 5: Acute problem with threat to life or healthy function

**Chronic**

- Level 2: No interventions. Go home
- Level 3: Chronic stable problem
- Level 4: Chronic stable problem or 1/2 chronic stable
- Level 5: Severely exacerbation or threat to life or healthy function
Example

- **History:** Patient presents with abdominal pain. She states the pain has been there for 2 days and worse when she is up moving around. Low grade fever, no diarrhea, some nausea

- **Exam:** Vital Signs: Wt. 136, BP 122/84, HR 82, RR 16; General Appearance: pleasant but appears in pain; Abdomen: soft, tender on RLA percussion; HE: WNL, Resp: clear to auscultation

- **Assessment:** RLQ pain; Fever
- **Plan:** CMP, CBC with diff; CT abdomen

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Bullet Proof your EM

- Make the chief complaint a real complaint
- Answer the who, what, when, where, why, how
- Don’t ignore the ROS
- Use the exam guidelines that work best for you
- Incorporate the language of the MDM into your documentation

---

New versus Established Patient for FQHC

- A new patient is one who has not received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within the past three years prior to the date of service.
Preventive vs. E/M

- Why are you seeing the patient?
  - Preventive:
    - Well Adult
    - Well Woman
    - Well Child
    - Medicare AVW, IPPE/Welcome to Medicare, etc.

Section III

Selecting E/M Based on Time

- For visits that involve more than 50 percent counseling and/or coordination of care, time can determine the level of coding.

- For example, if a 40-minute office visit with an established patient involved more than 20 minutes of counseling and coordination of care, the visit would be reported with 99214 if everything was documented and medically necessary.
Chronic Care Management (CCM)

• Effective January 1, 2016, FQHCs are paid for CCM services when a minimum of 20 minutes of qualifying CCM services during a calendar month is furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Chronic Care Management:

CPT Code

• CPT code 99490 (Chronic Care Management Services) at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
  • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  • Comprehensive care plan established, implemented, revised, or monitored

Other Information on CCM

• There is no prerequisite service(s) to bill CCM
  • Medicare does recommend providing the AWV or IPPE first
• You cannot bill the following during the same calendar month:
  • TCM
  • Home healthcare supervision
  • Hospice care supervision
  • ESRD
Chronic Care Management (CCM)

• You can bill for CCM services when an FQHC practitioner furnishes a comprehensive E/M visit, AWV, or IPPE to the patient prior to billing the CCM service, and initiates the CCM service as part of this visit.

Chronic Care Management (CCM)

• Coinsurance is applied as applicable to FQHC claims.
• The FQHC face-to-face requirement is waived for CCM services.
• You must inform eligible patients of the availability of CCM services and obtain consent for the CCM service before furnishing or billing the service.

Chronic Care Management (CCM)

• Informing the patient of the availability of the CCM service and obtaining written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers.
• Explaining and offering the CCM service to the patient and documenting this discussion in the patient’s medical record, noting the patient’s decision to accept or decline the service.
• Explaining how to revoke the service.
• Informing the patient that only one practitioner can furnish and be paid for the service during a calendar month.
Chronic Care Management: Requirements

- Inform the beneficiary of the right to stop the CCM services at any time
  - Effective at the end of a calendar month

- Inform the beneficiary that only one practitioner can furnish and be paid for these services during the calendar month service period.

Chronic Care Management: Written Consent

- You can’t bill until you have the written consent from the beneficiary
  - Must be in writing that the provider has explained:
    - Nature of chronic care management
    - How chronic care management may be accessed
    - Only one provider at a time can furnish chronic care management
    - Health information will be shared with other providers for coordination of care (this must be done through electronic exchange)
    - The beneficiary may stop chronic care management at any time by revoking consent (this would be effective at the end of the current calendar month)
    - The beneficiary will be responsible for any co-payment and deductible

Chronic Care Management: Capabilities Required by CMS

- Five Specified Capabilities:
  1. Use a certified EHR
  2. Maintain an electronic care plan
  3. Ensure beneficiary access to care
  4. Facilitate transitions of care
  5. Coordination of care
Chronic Care Management (CCM)

- The CCM service includes:
  - the structured recording of patient health information,
  - an electronic care plan addressing all health issues,
  - access to care management services,
  - managing care transitions,
  - coordinating and sharing patient information with practitioners and providers outside the practice.

- Some of the CCM Scope of Service elements require the use of a certified EHR or other electronic technology.

Chronic Care Management: Use a Certified EHR

- Must be available to all practitioners at all time (within the practice)
  - Any individuals whose minutes would count toward billing CCM need access even outside of normal business hours
  - All members within the practice MUST have electronic access to the electronic care plan at all times

Chronic Care Management: Use a Certified EHR

- Sharing information with other practitioners must be accomplished electronically (excluding facsimile)
  - Remote access to EHR
  - Web-based access to a care management application
  - Web-based access to a health information exchange service that captures and maintains care plan information, secure messaging or participation in a health information exchange
  - There is no specific electronic technology requirement for sharing information
Chronic Care Management:

Care Plan

- Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues).
- Provide the patient with a written or electronic copy of the care plan and document its provision in the medical record.
- Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service.
- Share the care plan electronically outside the practice as appropriate.

Chronic Care Management:

Maintain a Care Plan

- Provider must develop and regularly update (at least annually) an electronic care plan – assessment or re-assessment with the following elements:
  - Physical
  - Mental
  - Cognitive
  - Psychosocial
  - Functional
  - Environmental

Chronic Care Management:

Maintain a Care Plan

- Should also include:
  - List of current practitioners and suppliers – regularly involved in the patient’s care
  - The assessment of the beneficiary’s functional status related to chronic health conditions
  - The assessment of whether the beneficiary suffers from any cognitive limitations or mental health conditions that could impair self-management
  - Assessment of the beneficiary’s preventive healthcare needs
  - Address all health issues (not just chronic conditions) and be congruent with the beneficiary’s choices and values
Chronic Care Management:
Comprehensive Care Plan
- For all health issues typically includes, but is not limited to, the following elements:
  - Problem list;
  - Expected outcome and prognosis;
  - Measurable treatment goals;
  - Symptom management;
  - Planned interventions and identification of the individuals responsible for each intervention;
  - Medication management;
  - Community/social services ordered;
  - A description of how services of agencies and specialists outside the practice will be directed/coordinated; and
  - Schedule for periodic review and, when applicable, revision of the care plan.

Chronic Care Management:
Access to Care
- Ensure 24/7 access to care management services, providing the patient with a means to make timely contact with health care practitioners in the practice who have access to the patient’s electronic care plan to address his or her urgent chronic care needs.
- Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient’s care. Do this through telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods, in compliance with HIPAA.

Care Management Services
- Systematic assessment of the patient’s medical, functional, and psychosocial needs;
- System-based approaches to ensure timely receipt of all recommended preventive care services;
- Medication reconciliation with review of adherence and potential interactions; and
- Oversight of patient self-management of medications. Manage care transitions between and among health care providers and settings, including referrals to other providers, including:
  - Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.
  - Coordinate care with home and community based clinical service providers.
Chronic Care Management

• CMS requires the use of certified EHR technology to satisfy some of the CCM scope of service elements. In furnishing these aspects of the CCM service, CMS requires the use of a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year (referred to as “CCM certified technology”). For more information, visit [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms) on the CMS website.

Chronic Care Management: Documentation of Time

• Set up a system that can keep track of time spent on non-face-to-face services provided, including:
  • phone calls and email with patient;
  • time spent coordinating care (by phone or other electronic communication) with other clinicians, facilities, community resources, and caregivers; and
  • time spent on prescription management/medication reconciliation.

Chronic Care Management: Documentation of Termination

• Document death, transfer of patient to another clinician, or termination from the CCM plan for any reason
Chronic Care Management - Resource


ICD-10

- Is there ever a time when we should be using unspecified codes?
ICD-10 Specificity (or lack thereof)

• Diabetes
• CKD
• Nicotine
• Laterality
• Asthma
• Depression
• Fractures
• Pregnancy

Diabetes

• Documentation must include:
  • Type of diabetes
  • Body system affected
  • Complication or manifestation
  • If a patient with type 2 diabetes is using insulin, a secondary code for long term insulin use is required

Asthma

• Documentation must include:
  • Severity of disease:
    • Mild intermittent
    • Mild persistent
    • Moderate persistent
    • Severe persistent
  • Acute exacerbation
  • Status asthmaticus
  • Other types (exercise induced, cough variant, other)
Neoplasms

• Documentation must include:
  • Type:
    • Malignant (Primary, Secondary, Ca in situ)
    • Benign
    • Uncertain
  • Unspecified behavior
  • Location(s) (site specific)
  • If malignant, any secondary sites should also be determined
  • Laterality, in some cases

ICD-10

• Unspecified codes are available in ICD-10

  • Payors can request return of their payment when performing audits of their medical records

ICD-10 Coding and Documenting

• Document and report diagnosis codes to their highest level of specificity to reflect medical necessity as documented by the physician

  • Sequence and link ICD-10 codes to CPT codes on claims

  • When multiple ICD codes are used to accurately represent an encounter or service
ICD-10

• Why the patient received healthcare services

• The severity of the patient's conditions they are being seen for on the specific date of service

ICD-10

• Report the ICD-10 codes that describe signs and symptoms when a diagnosis has not been established.

• Should we code signs/symptoms and a definitive diagnosis when documented?
  • Assessment: Bronchitis
  • Cough

ICD-10 Denials/Rejections

• Instructional guidelines
  • Code first
  • Use an additional code
• Excludes 1 - Indicates that code excluded should never be used at the same time as the code in the section of codes you are using
• Includes – gives examples of content of a code
### J00 Acute nasopharyngitis [common cold]

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J00.0</td>
<td>Acute rhinitis</td>
</tr>
<tr>
<td>J00.1</td>
<td>Acute suppurative pharyngitis NOS</td>
</tr>
<tr>
<td>J00.2</td>
<td>Acute suppurative pharyngitis, acute tonsillitis</td>
</tr>
<tr>
<td>J00.9</td>
<td>Acute suppurative pharyngitis, NOS</td>
</tr>
</tbody>
</table>

### F51.95 Insomnia due to other mental disorder

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F51.95</td>
<td>Gender identity disorder in adulthood</td>
</tr>
</tbody>
</table>

### D63.1 Anemia in chronic kidney disease

- Erythropoietin resistant anemia (EPO resistant anemia)
- Code first underlying chronic kidney disease (CKD) (N18-9) (N19)

### D63.4 Anemia in other chronic diseases classified elsewhere

- Code first underlying disease, such as:
  - diaphyseolathesis (E70.0) (E70.9)
  - hookworm disease (B76.0-B76.9) (B76.0-B76.9)
  - hypothyroidism (E00.0-E03.9) (E29.0-E29.9)
  - malaria (E55.0-E55.9) (E55.0-E55.9)
  - symptomatic late syphilis (A52.70) (A52.70)
  - tuberculosis (A18.9) (A18.9)
Maternity

• Codes from chapter 15 and sequencing priority
• Obstetric cases require codes from chapter 15, codes in the range 000-09A, Pregnancy, Childbirth, and the Puerperium.
• Chapter 15 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 15 codes to further specify conditions.

Maternity

• For routine outpatient prenatal visits when no complications are present, a code from category Z34, Encounter for supervision of normal pregnancy, should be used as the first-listed diagnosis.
  • These codes should not be used in conjunction with chapter 15 codes.
• For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category 009, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis.
  • Secondary chapter 15 codes may be used in conjunction with these codes if appropriate.
Example #1
• CC: ER F/U
• HPI – went to ED
• ROS: nasal congestion
• Exam: no sinus pain, normal sinus transcluency, erythematous nasal passages with mild discharge, neck supple, CVS s1s2 rrt, resp cta
• Rx: Claritin, nasal spray and cough syrup
• A/P: ? rhinitis medimucosa; drug induced
• Pt requesting promethazine with codeine I have educated pt several times not a chronic medication for sinus issues. Concerned about addictive behavior will check UDS, advice check wright stain nasal smear and sinus x-ray and non narcotic medication. Conversion disorder Pt has seen ENT Pt states they don’t take the nasal spray provided to them.

Example #2
• CC: Test results
• HPI: got MRI
• Exam: MRI chronic compression fx T12. Multiple level disc degeneration w/o maj disc space narrowing
• Lumbar spondylosis
• Back pain – MRI
• Hip Pain – MRI
Example #3

- CC: HTN
- Patient has been consuming a lot of seafood and sodium lately. She said her BP was almost 200. She also has been dizzy. She states that she stopped her Lasix and potassium. She started taking Lisinopril/HCTZ. She thinks her edema is reduced. She said she still has U/S Doppler bilateral lower extremity.
- All other systems negative.
- Vitals were documented (not typed for this example except BP 105/76)
- Oriented to person, place and time. Appears well developed and well nourished.
- Neck with normal ROM and supple
- CV: RRR: Lungs: effort normal and breath sounds normal
- Musculoskeletal: Normal ROM, no edema, Mild edema noted ankle
- Neu: alert and oriented to person, place and time
- Psych: normal mood and affect. Behavior is normal. Judgement and thought content normal

Example #3

- A/P:
  - Essential HTN
  - Metatarsus Varus
  - Hyperthyroidism
  - Pre-diabetes
  - Bilateral leg edema
  - Cigarette nicotine dependence
- Lab draw today
- f/u 2 wks
- reduce sodium
- f/u with cardiology
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• www.ccipro.net

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