Effective Billing and Coding Practices:
Family Planning-2012.

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TRAINING 3.

Objectives
- Identify commonly used procedural codes for preventive and medical services
- Correctly rank and link ICD-9 codes and CPT codes
- Define clean claim and coding nomenclature.

Statements to reflect on
- Coding payments differ from payer to payer
- You provide a wonderful service, your patients love you-you still might not get paid
- You billed for it-you might still not get paid
- We can't give our patients a condition that they don't have.
- Coding represents not what the client initially came in for—but what s/he is walking out with
Statements to Reflect on...

- Accurate coding truly represents the work that you do; evaluation, management, and level of patient acuity.
- Accurate coding reflects the nature of the service provided (RVU’s).
- Accurate coding will lead to appropriate reimbursement without having to re-submit claims.

Who is Responsible..............

- Management?
- Billing office?
- Front line staff?
- Clinicians?

Responsibilities

Management
- Insurance Verification
- Documentation Training
- Chart Audits/Feedback
- Ongoing Staff Education

- What else????????
Responsibilities

**Clinician**
- What brought the patient in....
  - Reason for service (ICD codes)
  - Service provided (CPT code)

- Insure that medical documentation reflects accurately the coded service-bill
- What else?????

Show me the $$$$$......

**In your agency,**
- Who's responsible for the money?
- Completing the visit form?
- The billing?
- Insuring a clean claim occurs?
- Following up with insurance companies/funding sources?
- Insuring forms are completed appropriately?
- Providing feedback to staff?

So, What is a 'Clean Claim'?

**Is defined as:**
- any claim that is processed without obtaining additional data from the service provider. There is no defect or no impropriety.
- There are no circumstances that delay payment-such as incomplete documentation.
Clean Claim Submission:

- Where does the bill go after submission?
- What’s your ‘clean claim rate’?
  - Percent of money paid the first time without re-submitting
  - 20-30% rejection rate
- When claims get denied, what happens?
- Back to staff for review?

9 Common Reasons why claims are denied:

- Missing or invalid patient ID number or incorrect patient information: DOB/gender.
- Missing or invalid information: i.e. social security number.
- Lack of authorization or referral.
- Failure to check assignment box.
- Invalid date of service.
- Missing or invalid modifiers.
- Missing or invalid provider information.
- Incorrect place of service: office vs. hospital
- Incorrect balance due.

What is a Lost Visit?

- There is no charge for the visit...
  - Clinician doesn’t charge or under-charges
  - Pops head in for question...
  - Partners come in together-only one is charged.
  - Hallway Medicine.
- How does your office handle check-outs?
Money out the door...

- Every time the clinician ‘pops in’ to answer a quick patient’s question..
- Needs to be coded and documented...
- If not - loss of $30.00-$40.00..
- Translates into how many visits over a year???
- How much loss revenue???

How much is at stake?

- Fact:
  - 33-52% of patient visits are under-coded
  - Difference in reimbursement
    - 99212-99213: $30.00
    - 99212-92214: $60.00
  - Assuming 30 patients/day..
    - Under-coding about 50%, loss revenue $450.00
    - 5 days week x $450.00=$2250.00
    - $2250.00 x 52 weeks=$117,000.
- What could you do with an extra $100,000??

Sign-In Sheets...

- Sign in sheets with numbers..or
- Patient fills out individual sign in slip
- Reconciliation at the end of the session...
- Sign in slip and encounter form
- Does it always match up?
**Center Costs:**

- What does an
  - annual visit,
  - initial visit,
  - medical visit
cost your agency?
- Who is seeing the patient..
  - How many staff?
  - Tests done?
  - Supplies?
  - Overhead?

**Center Costs:**

- What does your staff REALLY cost the agency?
- If you don't know-you MUST find out
- Are You looking at RVU's???

**Exp:** If your clinician costs $150.00/hr, is that amount of revenue being generated?

**Medical Personnel Costs:**

- Not just salary or hourly rate:
  - PTO
  - Malpractice coverage
  - Conference time
  - Health care costs
- What else..
Defining the terms

What is a CPT code?

What is an ICD-9 code?

What is the relationship between the two?

CPT codes:
- Current Procedural Terminology
- Provides uniform language that accurately describes medical, surgical and diagnostic services.
- 5 digit numeric code that is used to describe medical, surgical, radiology, laboratory, anesthesiology and evaluation/management services of health care providers.

http://www.med.ufl.edu/complian/Q&A/cpt-codes.html

ICD-9-CM Codes:
- International Classification of Diseases, 9th revision, Clinical Modification
- Used to code signs, symptoms, injuries, diseases, and conditions

http://www.med.ufl.edu/complian/Q&A/cpt-codes.html
ICD history

- 1600’s: Descended from the London Bills of Mortality
  - to gather statistical information - plague
- International Classification of Disease
- 1970’s: National Center of Health Statistics
  - Incorporated health statistics into the ICD for indexing purposes.
- Nothing to do with billing until 1988.
  - Medicare needed codes for billing purposes

ICD history—continued

- We are now using ICD-9.
- Tentative launch date for ICD-10:
  - October 1, 2013
- Changes between ICD 9 and 10
  - Massive amount of new diagnostic codes.
    - ICD 9: 13,500 codes
    - ICD 10-69,000 codes
    - ICD 9: 5 number code set
    - ICD 10: 7-8 number code set
- More detailed, specific codes.

ICD 10 Launch

- ICD-10 Consists of:
  - Tabular list containing cause of death titles and codes
  - Inclusion and exclusion for cause of death
  - An alphabetical index to disease and nature of injury, external causes of injury, table of drugs and chemicals
  - Description guidelines and coding

ICD 10 Launch

"The department of Health and Human Services (HHS) has mandated the replacement of the ICD-9 code sets medical coders and billers in the United States use now to report health care diagnoses and procedures with ICD-10 code sets effective October 1, 2013. Only a handful of countries, including the United States and Italy have not adopted ICD-10 as their standard for reporting"


ICD 10 Launch...Update

As part of President Obama’s commitment to reducing regulatory burden, Health and Human Services Secretary Kathleen G. Sebelius today announced that HHS will initiate a process to postpone the date by which certain health care entities have to comply with ICD-10.

ICD-10 codes are important Kathleen Sebelius. “We have heard from many in the provider community” said HHS Secretary who have concerns about the administrative burdens they face in the years ahead. We are committing to work with the provider community to reexamine the pace at which HH5 and the nation implement these important improvements to our health care system.”

https://www.cms.gov/ICD10

ICD 10 Launch

American Academy of Professional Coders

- Have six months worth of cash on hand due to back-log reimbursement concerns.
- 2-3 years for successful implementation to occur.

- What is your office doing to prepare?
- Who is training your staff?
Relative Value Unit...

- Set value for reimbursement for CPT codes:
  - Based on:
    - Clinician expertise; time and skill of a procedure
    - Practice expense
    - Professional liability expense
  - Also looks at geographic area.
  - Conversion factor...formula...reimbursement

So, What's the Relationship...

- ICD-diagnosis
- CPT-procedure
  - The critical relationship is that the diagnosis supports the medical necessity of the procedure, and:
    - Software enables payers to look at logical relationship
    - If matches: reimbursement occurs; clean claim...
    - If not: rejection.
    - Overcoding: fraud
    - Under coding: lost revenue

So...what happens now..

- Reimbursement is generated once forms are completed...
  - "Each service you provide, becomes a line item (CPT code) on an insurance claim form. Although your level of reimbursement is linked to a claims CPT codes, you need to record a symptom, diagnosis or medical complaint (ICD-9 code) to establish the medical necessity of each service."
  
E and M codes: Evaluation and Management

- Sub-set of CPT codes
- Describes:
  - Complexity of care provided
  - Place of service (outpatient or inpatient)
  - Type of service (examples)
    - New versus established
    - Consult
    - Preventive

Points to Consider

- Who is the patient
  - New or established?
- What is the place of service?
  - In patient/Out-patient
- What is the Patient Status?
  - Ill, injury, trauma, preventive visit
- What type of service is being provided?
  - Initial or subsequent visit
- What level of service is being provided?
  - Problem focused to comprehensive visit

Determining the Right Code

- 3 Key Components to Consider when Determining E and M
  - History
  - Exam
  - Medical Decision Making
History: 4 Types
- Problem Focused
- Expanded Problem Focused
- Detailed and
- Comprehensive

History Component:
Documentation needs to include:
- New or established patient
- Chief complaint
- HPI (history of the present illness)
PFSH Elements:
- Past medical history
- Social
- Family

Quick Review:
- New/Established Patient.
  - New:
    - not received any face-to-face services from a provider within the same specialty within the last 3 years.
  - Established:
    - patients who have received ongoing services within 3 years.
Chief Complaint.

Includes:
- What brought the patient to the office quoted in his/her words
- Signs/Symptoms
- Reason for the visit
- Concise statement, quoting the patient ...

HPI: History of the Present Illness

Eight Elements:
- Location: where on body
- Quality: grade...characterized by...ie: burning
- Severity: grade on scale of 1-10
- Duration: how long has this been going on

HPI: History of the Present Illness

- Timing: When does it occur...
  - After exercising, eating......
- Context: Associated with any event/situation
- Modifying factors:
  - What makes it better...what have you tried?
- Associated signs and symptoms...
  - What else is happening?
History Component:

- ROS (Review of Systems)
  - Allergic/Immunologic
  - Cardiovascular
  - Constitutional Symptoms
  - Ears, Nose, Throat, Mouth
  - Endocrine
  - Eyes
  - Gastrointestinal (GI)
  - Genitourinary (GU)
  - Hematologic/Lymphatic
  - Integumentary
  - Musculoskeletal
  - Neurological
  - Psychiatric
  - Respiratory

Past Medical, Family, Social History

- There are two levels:
  - Pertinent: One item from the past
  - Complete:
    - 2 items from 2 areas for established patients
    - 3 of 3 for new patients

Determine your Documented Level of History

Mark the entry in the farthest right column to describe your HPI, ROS and PFSH. If one column contains 3 marks, the type of history is indicated at the bottom. If no column has 3 marks, the column marked farthest to the left identifies the type of history.

HPI (history of present illness) elements:
- Location
- Severity
- Timing
- Modifying Factors
- Quality
- Duration
- Context
- Associated Signs or Symptoms

Levels of Description:
- Brief (1-3)
- Extended (4 or more)

ROS (review of symptoms):
- Constitutional
- Ears, nose
- GI
- Skin, breast
- Endo (wt loss, etc)
- Mouth, throat
- GU
- Neuro
- Eyes
- Card/vasc
- Musculo
- Psych
- Resp
- Hem/lymph
- Immuno
- All others Neg

Levels of ROS:
- None
- 1 System
- At least 2 Systems
- 10 or more Systems

PFSH (past medical, family, social history) areas:
- Past Medical History
- Family History
- Social History

Levels of PFSH:
- None
- 1 History
- Complete (3 for New, 2 for Est.)

*ROS: 10 or more systems, or some systems plus statement "all others negative"
Exam: 4 Types:
- Problem Focused
- Expanded Problem Focused
- Detailed
- Comprehensive

Medical Exam:
- Cardiovascular
- Constitutional (vitals, etc)
- Breasts (Chest)
- HEENT
- Extremities
- GI (abdomen)
- Genitourinary
- Integumentary
- Lymphatic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory

Medical Decision-Making: 4 Types:
- Refers to complexity of determining a diagnosis and/or selection of a treatment option. Measured by documenting:
  - Number of diagnosis
  - Management options
  - Complexity of data to be reviewed.
- Straightforward
- Low Complexity
- Moderate Complexity
- High Complexity
Determining A Correct Code

Ask 3 Questions:
- Is Patient New or Established?
- Where is care being provided?
  - Office, hospital, ...
- What type of service is provided?
  - Initial, follow-up, consult
- Then, look at 3 components...

Determining the Correct E&M Code

There are three key components to consider when selecting the appropriate E&M:
- History
- Exam
- Medical Decision Making (MDM)

All three components must be documented for a new patient (new to clinic or not seen within the past three years). Indicate in CC if patient is new.

Only two of the three components must be documented for established patients (seen within the past three years).

E&M selection should never be based on the allotted time on the appointment schedule!

E and M Codes: 5 Elements

- E/M codes all begin with 99
- Describe presenting problem
  - (nature of problem)
- Identifies the place where care occurred
  - In or out patient
- Identifies type of patient
  - New patient or established
- Describes level of service
- Describes time it takes to perform a service
## E and M Coding:

### New Patient
- **99201:** Problem Focused
- **99202:** Expanded Problem Focused
- **99203:** Detailed
- **99204:** Comprehensive
- **99205:** Comprehensive

### Established Patient
- **99211:** No Clinician
- **99212:** Problem Focused
- **99213:** Expanded Problem Focused
- **99214:** Detailed
- **99215:** Comprehensive

## How to Choose a Code:

### New Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>1-3</td>
<td>N/A</td>
<td>N/A</td>
<td>&lt;1</td>
<td>SF</td>
<td>10</td>
</tr>
<tr>
<td>99202</td>
<td>1-3</td>
<td>2-9</td>
<td>N/A</td>
<td>2-4</td>
<td>LF</td>
<td>20</td>
</tr>
<tr>
<td>99203</td>
<td>1-3</td>
<td>2-9</td>
<td>1 of 3</td>
<td>5-7</td>
<td>LF</td>
<td>30</td>
</tr>
<tr>
<td>99204</td>
<td>1-3</td>
<td>2-9</td>
<td>3 of 3</td>
<td>8+</td>
<td>HF</td>
<td>45</td>
</tr>
<tr>
<td>99205</td>
<td>1-3</td>
<td>2-9</td>
<td>3 of 3</td>
<td>8+</td>
<td>HF</td>
<td>60</td>
</tr>
</tbody>
</table>

### Established Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>x</td>
<td>N/A</td>
<td>N/A</td>
<td>&lt;1</td>
<td>SF</td>
<td>10</td>
</tr>
<tr>
<td>99212</td>
<td>1-3</td>
<td>2-9</td>
<td>N/A</td>
<td>2-4</td>
<td>LF</td>
<td>20</td>
</tr>
<tr>
<td>99213</td>
<td>1-3</td>
<td>2-9</td>
<td>1 of 3</td>
<td>5-7</td>
<td>LF</td>
<td>30</td>
</tr>
<tr>
<td>99214</td>
<td>1-3</td>
<td>2-9</td>
<td>2 of 3</td>
<td>8+</td>
<td>HF</td>
<td>45</td>
</tr>
<tr>
<td>99215</td>
<td>1-3</td>
<td>2-9</td>
<td>3 of 3</td>
<td>8+</td>
<td>HF</td>
<td>60</td>
</tr>
</tbody>
</table>
Final E&M Selection

Determining your Level of Service:

- **PF**: Problem Focused
- **SF**: Straightforward
- **EPF**: Expanded Prob Focused
- **D**: Detailed
- **L**: Low Complexity
- **M**: Moderate Complexity
- **C**: Comprehensive
- **H**: High Complexity

**New Office/Consults**
Requires all 3 components within a column (or choose lowest column)

**Established Office**
Requires at least 2 components within a column (or choose lowest column)

<table>
<thead>
<tr>
<th>Component</th>
<th>PF</th>
<th>EPF</th>
<th>D</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
</tr>
<tr>
<td>MDM</td>
<td>SF</td>
<td>SF</td>
<td>L</td>
<td>M</td>
</tr>
</tbody>
</table>

Levels:
- **99201 or 99202 or 99203 or 99204 or 99205**
- **99211 or 99212 or 99213 or 99214 or 99215**
- **99241 or 99242 or 99243 or 99244 or 99245**

E/M Preventive Services

<table>
<thead>
<tr>
<th>Age Group</th>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-17 year old</td>
<td>99384</td>
<td>99394</td>
</tr>
<tr>
<td>18-39 year old</td>
<td>99385</td>
<td>99395</td>
</tr>
<tr>
<td>40-64 year old</td>
<td>99386</td>
<td>99396</td>
</tr>
<tr>
<td>65 and older</td>
<td>99387</td>
<td>99397</td>
</tr>
</tbody>
</table>

Final Coding Rules

- List the principal diagnosis first
  - Code to the highest level.
- Code the most specific description available available at the completion of the visit.
  - Don't code: rule out
- Do not give the patient a condition that they do not have.
The D’s and C’s

- Documentation is what drives the level of coding...
- It will support your findings.
- So-the key to getting paid and proper coding is:
  - Document, Document, Document.....

Do's of Documentation

- Do insure that you have the correct chart
- Do write legibly
- Do chart immediately
- Do date every entry
- Do date every page
- Do sign every entry
- Do fill in the blanks: all negatives and positives
- Do chart immediately


Do's of Documentation

- Do insist that every chart contains an emergency contact
- Do insist that every page contains client name and identifying number, date of birth, etc
- Do chart errors by drawing a single line through entry; note ‘error’, initial and date.
- Do make legible corrections: date and sign.
- Do draw a line through empty space at the end of an entry
- Do use only center approved abbreviations.
Do’s of Documentation

- Do check for spelling
- Do document all client contact and services— including phone calls
- Do use objective wording rather than subjective
- Do chart client’s subjective data by directly quoting it—using quotation marks
- Do chart only what has been done; not what has not been done
- Do chart what the client response was
- When documentation continues on the next page, insure that client’s identifying name and number is noted as well as note continued—with a signature on the prior page.

Don’ts to ‘bear in mind’ when documenting

- Don’t omit any medical information about the client even if it might be regarded as potentially embarrassing to the client
- Don’t use staff names without identifying their role:
  - Don’t write—referred to Jane Smith without noting who she is

Do Not alter a client’s chart:
This is a criminal offense

- Do not add information at a later date without documenting that this was done
- Don’t add an entry so that it appears to be written at an earlier time
- Don’t add inaccurate information
- Don’t destroy records.

Using the Encounter Form/Super Bill

- Purpose:
  - Transmits information (interventions, diagnosis) from the provider to the biller
  - Advises patient of billable charges
  - Provider must document all interventions done.
  - Biller will submit claim based upon coverage

Using the Encounter Form/Super Bill

- Claim only those services that are:
  - A benefit of the insurance coverage or cash payment.
  - Medically necessary and documented
  - Performed on site.

Components of the Encounter Form/ Super Bill

- Visit: E&M Codes
- Procedure: CPT Code(s)
- Diagnosis by ICD Code(s)
- Injected drugs, devices inserted
- Drugs or supplies dispensed onsite
- Optional modifiers, explanation box, tests done off-site.
Common GYN Codes:

V Code:
used to diagnose when there is no problem or condition

V72.31: GYN exam routine-with/without pap
V25.01: Initiation of oral contraceptives
V25.02: Initiation of other Contraception
V25.03: Emergency Contraception
V25.04: Counseling and Instruction on Natural Family Planning.

V25.9: Unspecified contraceptive Management (ie: Start Ring or Patch)
V25.40: Contraceptive surveillance: Unspecified
V25.41: OC Surveillance

LARC Codes

IUCs
V25.11: Insertion
V25.12: Removal
V25.13: Removal and Re-insertion

CPT Code
58300: Insertion
58301: Removal

Subdermal Implant
V25.5: Insertion
V25.43: Removal/Check/Reinsert

CPT Code
11981: Insertion
11982: Removal
11983: Removal with reinsertion

J Codes

-Healthcare Common Procedure Coding
  System-set of healthcare procedure codes based on AMA’s CPT codes
- used to identify certain items or devices.
- May be replaced by national drug codes

J1055: Depo-Provera
J7300: Paragard
J7302: Mirena
J7307: Implanon
Common GYN codes: Problem

- **Menstrual /Bleeding Issues**
  - 625.3: Dysmenorrhea
  - 625.4: PMS
  - 626.7: Bleeding Post coital
  - 626.4:DUB/Irregular Cycle
  - 626.0: Amenorrhea

- **Breast:**
  - 611.6: Galactorrhea
  - 611.71: Mastodynia
  - 611.72: Breast Mass/Lump

- **STI/Infectious Conditions**
  - 616.10: Bacterial Vaginosis
  - 131.01: Trich Vaginitis
  - 078.11: Viral Warts/Condyloma
  - 054.10: Herpes (Genital)
  - 623.5: Vaginal Discharge
  - 788.1: Dysuria
  - 112.1: Candidiasis
  - 614.9: PID
  - 078.0: Molluscum
  - 99.41: Chlamydia

Common Male codes: Problem

- **STI/Infectious Conditions**
  - 99.41: Chlamydia-male
  - 078.11: condyloma accuminata
  - 078.19: Viral Warts
  - 054.10: Herpes (Genital)
  - 054.13: herpetic infection-penis
  - 078.0: Molluscum
  - 098.0: gonorrhea
  - 091.0: primary syphilis-primary genital chancre
  - 099.4: NGU

- **General Health**
  - 789.00: Abdominal Pain
  - 280.9: Anemia
  - 401.9: Hypertension
  - 782.1: Rash: Non-Specific Skin Eruption
  - 455.6: Hemorrhoids
  - 785.6: Lymph Node Enlargement
  - 799.81: decreased libido

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  - 625.4: PMS
  - 626.7: Bleeding Post coital
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  - 614.9: PID
  - 078.0: Molluscum
  - 99.41: Chlamydia
Maximizing Visit-Modifiers:

- Can bill for consult visit
- Can bill for time if more than 50% of visit
- Can use language barrier as time:
  - 99354-if visit took more than 30 minutes than a regular visit would
- Emergency occurrence in office that disrupts regular flow: 99058

Sample Modifiers:
- -25: separate E&M done on the same day as another E&M service or procedure.
- -22: unusual procedure service
- -53: Incomplete procedure

References/Resources:

- PPFA/Clinician Coding Sheet. 5/09. (Internal Document)
- PPFA/ Clinician ICD-9 Codes (Internal Document)
- http://www.med.ufl.edu/complian/Q&A/cpt-codes.html
- http://www.surgeryencyclopedia.com/La-Pa/Medical-Charts
- http://www.hhs.gov/ophs/
- www.famplanbilling.com (PMG Consulting)

Thank You and ANY ??