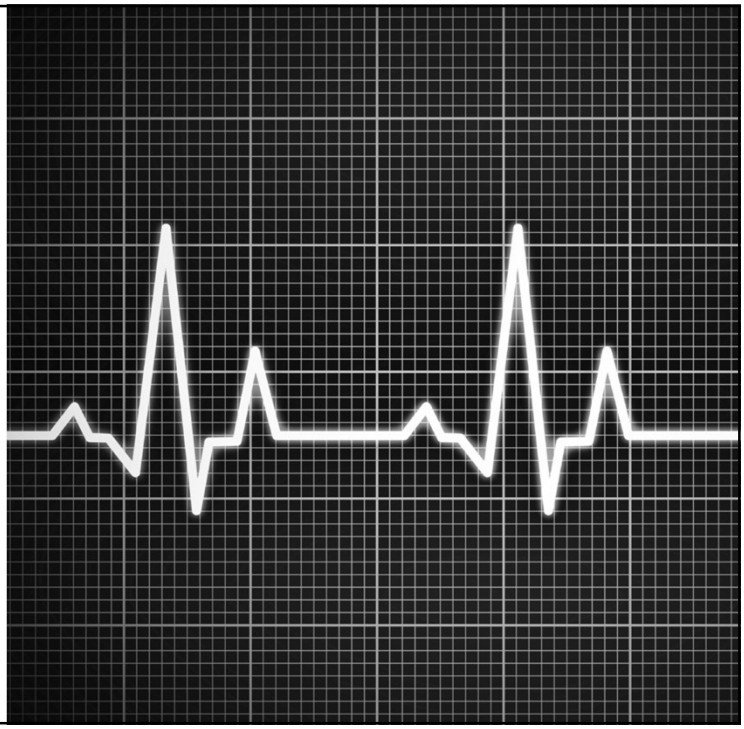
Coding & Documentation Review

AAPC-KC
February 8, 2024

PRESENTED BY:

TRACY BIRD, FACMPE, CPC, CPMA, CEMC, CPC-I



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Documentation

- There are at least four reasons for documentation.
  - Regulatory Requirements
    - K.A.R. 100-24-1
    - Missouri Title XXII Occupations and Professions: 334.097
    - Regulatory agencies
  - Billing requirements- CMS, OIG, DOJ
    - Support medical necessity
    - Correct coding
    - Support audit activity
  - Patient safety and continuity of care
    - Preserve the events of care
    - General records management
    - Electronic medical records
    - Show positive or negative progress
  - Loss Prevention/ Protection from liability
    - Legal document
    - Evidence in a legal action

2

Documentation Best Practices

- Each author in in the electronic medical record documents factually and authenticates the entry (e.g.: nursing staff, physicians, NPP etc..)
- Verify you have the right chart before entering information
- Timely documentation

3

Documentation Best Practices

- Retain copies of instructions or written information, or document what was given.
- Explain reason for conflicting information, e.g., new tests, changes in Rx given
- Initial all entries and all reports before filing. (electronic signature)

4

Documentation Best Practices

- Document call-backs to the patients
  - Test results
  - Include instructions given
  - Reminder to return to the office if…..
  - Include time and details of the call
  - Document your follow-up if you are unable to make initial contact
  - If you chart what someone else said, use quotations

5

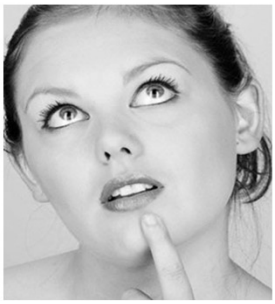
Documentation Best Practices

- **Document contact with the patient or family**

6

Documenation Best Practices

- Chart patient care at the time it is rendered
- If you chart a late entry, identify the information as a late entry with date and time.
- Document consistently enough to tell the whole story.



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Late Entries

- Identify the new entry as a "late entry"
- Enter the current date and time and your initials
- Identify or refer to the date and incident for which late entry is written
- If entry is used to document an omission, validate the source of additional information as much as possible
- Ex: Late entry 10/28/20 10:30 am please refer to 10/27/20. Patient was discharged at 9:39 pm. Spoke to Dr. Smith and he verified this information.

8

Addendums

- Document the current date and time
- Write "addendum" and state the reason for the addendum referring back to the original entry
- Identify any sources of information used to support the addendum
- Example: Addendum refer to 10/28/20 Patient's daughter, Elizabeth, has asked to be contacted if changes occur. Patient consents.

9

Clarifications

- A clarification is written to avoid incorrect interpretation of information that has been previously documented

- Ex: Clarification 10/28/20 refer to 10/27/20
  Patient was instructed to contact Dr. smith for follow up care including removal of stitches.

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EMR – A Closer Look

- Templates
  - Create new 2024 templates
  - SOAP format works well in new documentation environment
- Coding and accuracy of capturing service performed
  - Is provider selecting the level of service?
  - Is an E&M calculator being used? (most not modified since 2021 changes)
  - Do the providers know if the E&M calculator is suggesting the service?

11

EMR - A Closer Look

- Diagnosis pick lists
  - Most used should be in top 8 listed
- Link ICD-10 and CPT
  - Just like a paper record code linking important
  - Sequencing is also important

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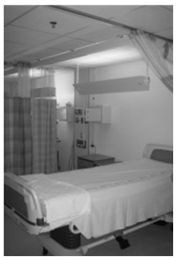
Documentation 2024

13

Evaluation and Management Services

- 80% of Medicare Claims are E&M Codes
- Codes are categorized by:
  - Type of Service
  - Place of Service
  - Patient Status



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CMS – Medical Necessity

- 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.

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Document to Support Medical Necessity

- ❑Describe the patient and their condition- Relevant History
- ❑Tell the story
- ❑Don't rely on diagnosis documentation in the assessment/impression alone
- ❑Review any payor medical policies –document in terms they use

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Hospital and Office Are Now Aligned

Code Selection
Based on:
Medical Decision Making
OR
Total Time

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CODE	TOTAL TIME	2023 Office, Hospital or Other Outpatient E/M Audit Form -MDM (2 out of 3 required) OR TOTAL TIME. Time listed without a range requires total amount of time be met.		
		Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99202 99212 99242 99252 99307 99341 99347 99282	15-29 10-19 20 35 10 15 20	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
99221
99231
99234
99243
99253
99304
99308
99342
99348
99283
	30-44
	20-29
	40
	25
	45
	30
	45
	25
	15
	30
	30
		Low
		• 2+ self-limited or minor problems; OR
		• 1 stable chronic illness; OR
		• 1 acute, uncomplicated illness or injury; OR
		• 1 stable acute illness; OR
		• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source;
			  • Review of the result(s) of each unique test
			  • Ordering of each unique test
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
99222
99232
99235
99244
99254
99305
99309
99344
99349
99284
	45-59
	30-39
	55
	35
	70
	40
	60
	35
	30
	60
	40
		Moderate
		• 1+ chronic illnesses with exacerbation, progression, or side effects of treatment; OR
		• 2+ stable chronic illnesses; OR
		• 1 undiagnosed new problem with uncertain prognosis.
		• 1 acute illness with systemic symptoms; OR
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
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			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
99223
99233
99236
99245
99255
99306
99310
99345
99350
99285
	60-74
	40-54
	75
	50
	85
	55
	80
	45
	45
	75
	60
		High
		• 1+ chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
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				Examples only:
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				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization or escalation of hospital-level of care
				• Decision not to resuscitate or to de-escalate care because of poor prognosis
				• Parenteral controlled substances

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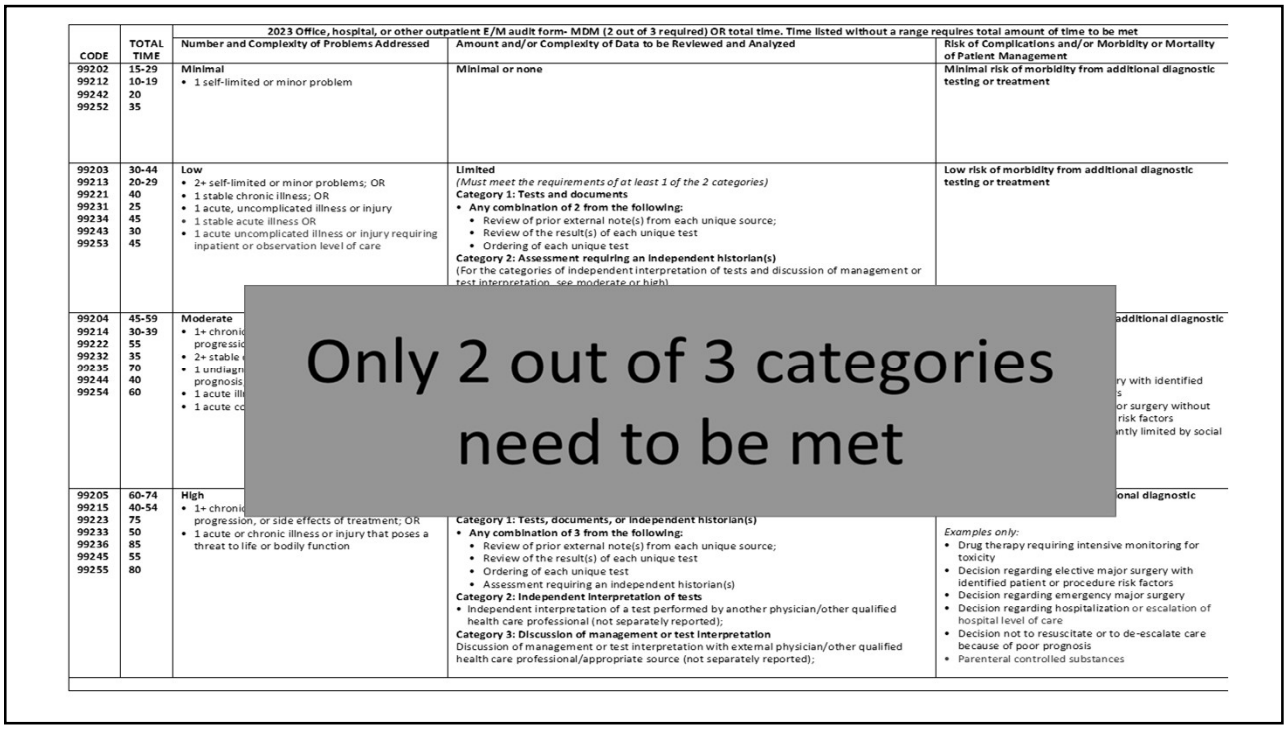

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99205 99215 99223 99233 99236 99245 99255	60-74 40-54 75 50 85 55 80	**High** • 1+ chronic progression, or side effects of treatment; OR • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);	**onal diagnostic** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Only 2 out of 3 categories need to be met

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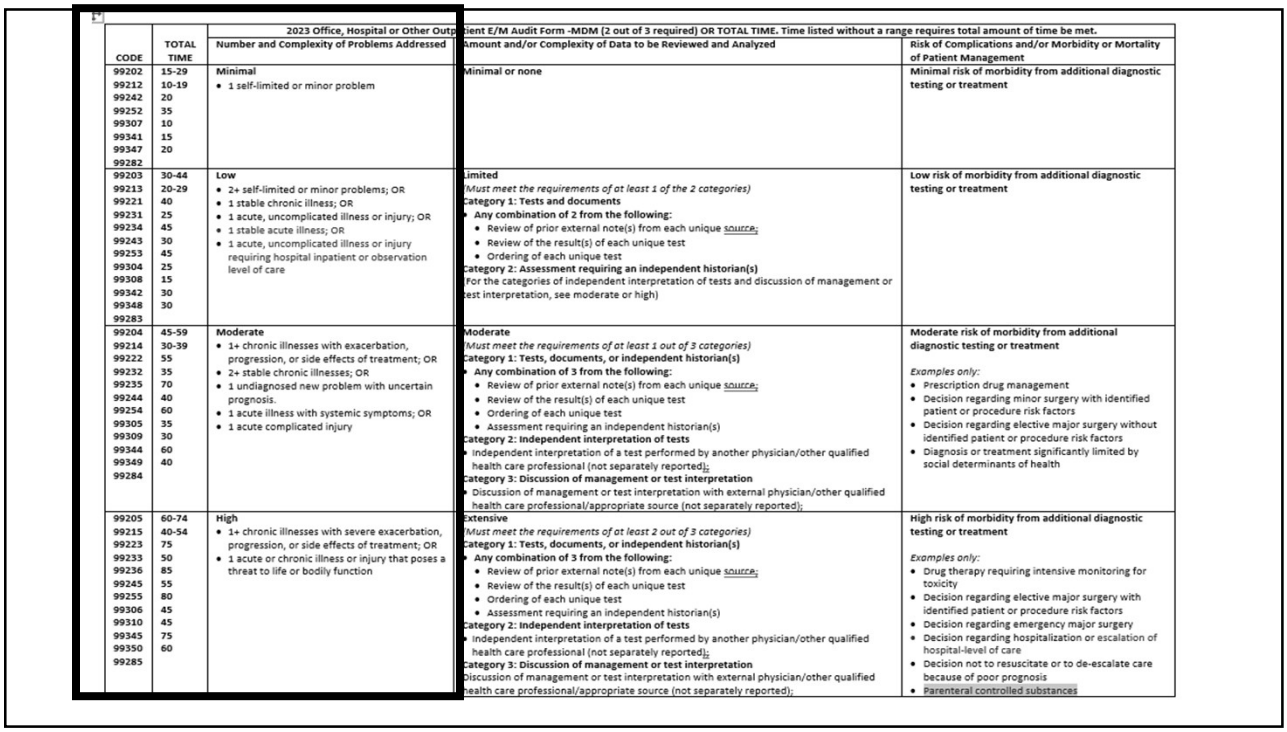

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Minimal Problems Addressed

- Minimal problem:
  - Very low complexity presenting problems
  - One that may not require the presence of the physician or other QHP.
  - "You should have called your Mom first"

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Low Complexity Problems Addressed

- **2 or more Self-limited or minor problems:**
- **One that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status.**
- **1 acute uncomplicated illness or injury**
- **Stable Chronic Problem:**
  - **<u>an individual patients specific treatment goals are met.</u>**
- **1 Stable acute illness**
- **Acute uncomplicated illness or injury requiring hospitalization either in patient or observation**

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Moderate Complexity Problems Addressed

- Chronic condition with exacerbation, progression or side effects of treatment:
  - **A patient who is not clinically at treatment goal.**
  - **Acutely worsening or poorly controlled**
- 2+ Stable chronic illnesses
  - **A patient with 2 stable problems that are clinically at treatment goal.**
- Undiagnosed new problem with uncertain prognosis-
  - A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment
- Acute complicated injury
- Acute illness with systemic symptoms:

  Has a high risk of morbidity without treatment. **Systemic symptoms such as fever, body aches, or fatigue is a minor illness that may be treated to alleviate symptoms but does NOT MEET THIS DEFINITION.**

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High Complexity Presenting Problems

- 1 or more chronic conditions with severe exacerbation, progression or side effects of treatment
- 1 acute or chronic illness or injury that poses a threat to life and bodily function

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Documenting MEAT

- A problem is considered addressed when:
  - MEAT is documented: Monitored, Evaluated, Assessed or Treated)
  - Consideration of further testing or tx that ***may be elected or not*** based on the patient and the risk/benefit.
  - Noting another professional is managing the problem without further assessment or care coordination **does not qualify as "being addressed."**
  - Referral without evaluation does **not quality as "being addressed".**

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Number & Complexity of Problems Addressed

- Symptoms may cluster around a specific diagnosis and each symptom is NOT a unique condition.
- Comorbidities and underlying disease need to be addressed. To list on the claim.
- Final diagnosis may not determine complexity or risk.
  - Extensive evaluation may be required to reach a conclusion that signs and symptoms don't represent a highly morbid condition.
  - Presenting signs and symptoms may appear as a highly morbid condition and may drive MDM even when the final diagnosis is not highly morbid.

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Number and Complexity of Problems Addressed: Common Documentation Trouble Spots

- Documentation in HPI of co-morbid conditions without status.
- No mention of chronic or co-morbid conditions until A&P
- Determining the right category of presenting problem
- Under documented HPI
- No HPI for hospital subsequent visits. E.g. “Patient better today”
- Threat to life and bodily function – documentation needs to support work up even if end result is not high complextiy

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Amount and Complexity of Data to be Reviewed and Analyzed

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Guidelines for Data

- The data includes :
  - Medical records, tests, and other information that must be obtained, ordered, reviewed, and analyzed for the encounter.
  - Includes data from multiple sources or interprofessional communication
  - Ordering a test may include those considered but not selected after shared decision making with the patient. Alternatively, a test normally performed may be too risky for the patient and is not ordered but would have been considered in another circumstance.
  - Documentation is required to support a test considered but not done.
  - Tests that have overlapping elements are not unique and only count as 1 test

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Definitions in Data Category

- Independent Historian
  - Parent, guardian, surrogate, spouse, witness who provides history in addition to history provided by patient who is unable to provide a complete or reliable history due to developmental stage, dementia, or psychosis
  - ***Does not include translation services***.
- Appropriate Source
  - Professionals who are not health care professionals but may be involved in the management of the patient lawyer, parole officer, case manager, teacher)**Does not include discussions with family or informal caregivers
- Discussion of management or test interpretation
  - .Discussion with an external provider or an appropriate source

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Limited Data

- **Must meet requirements of at least 1 of the 2 categories**
- **Category 1: requires <u>any combination</u> of 2 of the following**
  - **Review of prior external notes- unique source**
  - **Review of results of each unique test**
  - **Ordering of each unique test (defined by separate CPT code) (includes review)**
- **Category 2: Assessment requiring independent historian**

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Moderate Data

- Must meet the requirements of at least 1 out of the 3 categories
- Category 1: Any combination of 3 of the following
  - Review of external notes unique source
  - Review results of unique test
  - Ordering (includes review) of unique tests
  - Assessment requiring independent historian
- Category 2: Independent interpretation of a test ordered by another physician or QHP (not reported separately- (meaning billed)
- Category 3: Discussion of management or test interpretation (with external physician or QPP or appropriate source

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Extensive data

- Must meet requirements of 2 of the 3 categories
- Category 1: Any combination of the 3
  - Review external notes, external source
  - Review results, external source
  - Ordering unique tests (includes review)
- Category 2: Independent Interpretation of tests
- Category 3: Discussion of management or test interpretation with external physician or QPP/ appropriate source

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Amount and Complexity of Data to be Reviewed Common Documentation Trouble Spots

- Double dipping on ordering and reviewing a test
- Unclear who ordered and who is reviewing what tests
- Misinterpretation of what an independent historian is
- Not understanding unique source
- Not understanding unique test

35

Risk of Complications and/or Morbidity or Mortality of Patient Management

36

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99202 99212 99242 99252 99307 99341 99347 99282	15-29 10-19 20 35 10 15 20	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213 99221 99231 99234 99243 99253 99304 99308 99342 99348 99283	30-44 20-29 40 25 45 30 45 25 15 30 30	**Low** • 2+ self-limited or minor problems; OR • 1 stable chronic illness; OR • 1 acute, uncomplicated illness or injury; OR • 1 stable acute illness; OR • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test • Ordering of each unique test **Category 2: Assessment requiring an independent historian(s)** (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 99214 99222 99232 99235 99244 99254 99305 99309 99344 99349 99284	45-59 30-39 55 35 70 40 60 35 30 60 40	**Moderate** • 1+ chronic illnesses with exacerbation, progression, or side effects of treatment; OR • 2+ stable chronic illnesses; OR • 1 undiagnosed new problem with uncertain prognosis. • 1 acute illness with systemic symptoms; OR • 1 acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215 99223 99233 99236 99245 99255 99306 99310 99345 99350 99285	60-74 40-54 75 50 85 55 80 45 45 75 60	**High** • 1+ chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported);	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

37

Risk of Complications and/or Morbidity or Mortality of Patient Management

- Prescription Drug Management
  - Relates to any drugs or medications requiring prescription by a physician or QPP
  - Does not include over the counter medication even if a prescription is written
- Surgery
  - Minor or major based on common meanings of the terms used by clinicians not by the global surgical package.
  - Elective or emergency surgery determined by timing of the procedure related to patient' condition
  - Risk factors for surgery are those relevant to the patient and the procedure
- Social Determinants of Health
  - Economic and social conditions influencing the health of people and communities. Diagnosis codes Z55-Z65.

38

Risk of Compicatios and/or Morbidity or Mortality of Patient Management

- Drug therapy requiring intensive monitoring for toxicity
  - A therapeutic agent that has the potential to cause serious morbidity or death
  - Not primarily used for the assessment of therapeutic efficacy.
  - Not performed less than quarterly.
  - Monitoring by history or examination does not qualify- must be laboratory test, physiologic test or imaging
- Parenteral controlled substances
  - Qualifying drugs can be found at: https://www.ecfr.gov/current/title-21/chapter-II/part-1300/section-1300.01

39

Moderate Risk of Morbidity from Additional Diagnostic

- **EXAMPLES ONLY:**
  - **Prescription drug management**
  - **Decision regarding minor surgery with identified PATIENT or procedure risk factors**
  - **Decision regarding elective major surgery without identified patient or procedure risk factors**
  - **Diagnosis or treatment significantly limited by social determinants of health**

40

Example of Social Determinents of Health ICD-10 Codes Z55-Z65

Social Determinents of Health ICD-10 codes		
Z55	Problems related to Education and Literacy	
Z55.0	Illiteracy and low-level literacy	
Z55.1	Schooling unavailable or unattainable	
Z55.2	Failed school examinations	
Z55.3	Underachievement in school	
Z55.4	Educational maladjustment and discord with teachers and classmates	
Z55.5	Less than a high school diploma	
Z55.8	Other problems related to education and literacy	
Z55.9	Problems related to education and literacy, unspecified	
Z56	Problems related to employment and unemployment	
Z56.0	Unemployment, unspecified	
Z56.1	Change of job	
Z56.2	Threat of job loss	
Z56.3	Stressful work schedule	
Z56.4	Discord with boss and workmates	
Z56.5	Uncongenial work environment	
Z56.6	Other physical and mental strain related to work	
Z56.8	Other problems related to employment	
	Z56.81	Sexual harrassment on the job
	Z56.82	Military deployment status
	Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment	

Z57	Occupational exposure ot risk factors	
Z57.0	Occupational exposure to noise	
Z57.1	Occupational exposure to radiation	
Z57.2	Occupational exposure to dust	
Z57.3	Occupational exposure to other air contaminants	
	Z57.31	Occupational exposure to environmental tobacco smoke
	Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture	
Z57.5	Occupational exposure to toxic agents in other industries	
Z57.6	Occupational exposure to extreme temperature	
Z57.7	Occupational exposure to vibration	
Z57.8	Occupational exposure to other risk factors	
Z57.9	Occupational exposure to unspecified risk factor	
Z58	Problems related to physical environment	
Z58.6	Inadequate drinking-water supply	
Z59	Problems related to housing and economic circumstances	
Z59.0	Homelessness	
	Z59.00	Homelessness unspecified
	Z59.01	Sheltered homelessness
	Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing	
Z59.2	Discord with neighbors, lodgers and landlord	
Z59.3	Problems related to living in residential institution	
Z59.4	Lack of adequate food	
	Z59.41	Food insecurity
	Z59.48	Other specified lack of adequate food

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App for ICD-10 Consult

42

High Risk of Morbidity from Additional Diagnostic Testing or Treatment

- EXAMPLES ONLY:
  - Drug therapy requiring intensive monitoring for toxicity
  - Decision regarding elective major surgery with identified patient or procedure risk factors
  - Decision regarding emergency major surgery
  - Decision regarding hospitalization or escalation of hospital level of care
  - Decision not to resuscitate or to de-escalate care because of poor prognosis
  - Parenteral controlled substances

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Risk of Complications and/or Morbidity or Mortality of Patient Management
Common Documentation Trouble Spots

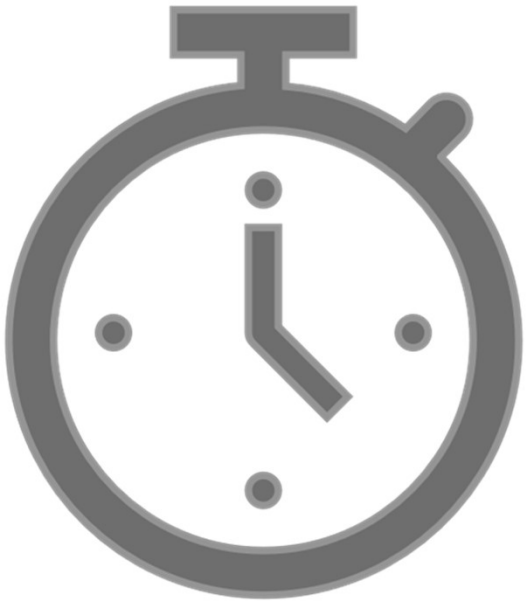
- Misunderstanding of what drugs are included in “intensive monitoring” Need to be checking toxicity not efficacy
- Understand risk factors to a patient that makes the overall risk either moderate or high. E.g. patient scheduled for colonoscopy but has a bleeding problem and stage 4 cancer.

44

Other Common Documentation Issues

- Many practices have not changed their documentation templates to reflect more succinct documentation.
  - HPI * - Good place to set up a medically necessary visit
  - ROS
  - PFSH
- Still using click box documentation creating lengthy notes that have no relevance to presenting problem
- Continue to have “note bloat” for items not relevant to presenting problem
- Medication lists for all meds, but unclear who is managing when statement says “Continue meds”

45



Billing By Time

46

Time Requirements

- Time can be used **in place of** MDM.
- Time is **NOT USED IN ER**.
- Total time on date of encounter includes face to face and non face to face time.
- Only count time related to the current patient.
- Does not include time spent performing separately reported services.
- When billing by time you must meet the entire time defined by the code to bill that level of service
  - E.g. 99222 (Moderate level hospital Admission) requires a total of 55 minutes dedicated to activities for that patient in the 24 hour period of the face to face visit.

47

Activities Included in Time

- Preparing to see the patient (review records, tests)
- Obtaining or reviewing separately obtained history
- Performing medically appropriate exam and or evaluation
- Counseling and educating patient and family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health professionals
- Documenting in the medical record
- Independently interpreting results
- Care coordination
- Documentation of activities and total time spent.

48

Common Trouble Spots Using Time

- No activity statement
- All notes document exact same amount of time on every patient
- Statements like: " I spent about …"

49

E&M with Prolonged Care Time (CPT Instructions)

- Not to be used with psychotherapy
- Used for office, office consults, home or residence services and cognitive assessment and care plan
- Can report 99417 once the time of the E&M has been surpassed by 15 full minutes with 99245, 99350, 99483
- Report 99417 with 99205 and 99215 once *minimum required time* of the E&M has been surpassed by 15 minutes.
- Report 99418 with 99223,99233,99236,99255,99306,99310 once time for E&M has surpassed 15 minutes

E/M with Designated Prolonged Care Code	1 unit Prolonged	2 units Prolonged
99205 + 99417	75 mins	90 mins
99215 + 99417	55 mins	70 mins
99223 + 99418	90 mins	105 mins
99233 + 99418	65 mins	80 mins
99236 + 99418	100 mins	115 mins
99245 + 99417	70 mins	85 mins
99255 + 99418	95 mins	110 mins
99306 + 99418	60 mins	75 mins
99310 + 99418	60 mins	75 mins
99345 + 99417	90 mins	105 mins
99350 + 99417	75 mins	90 mins

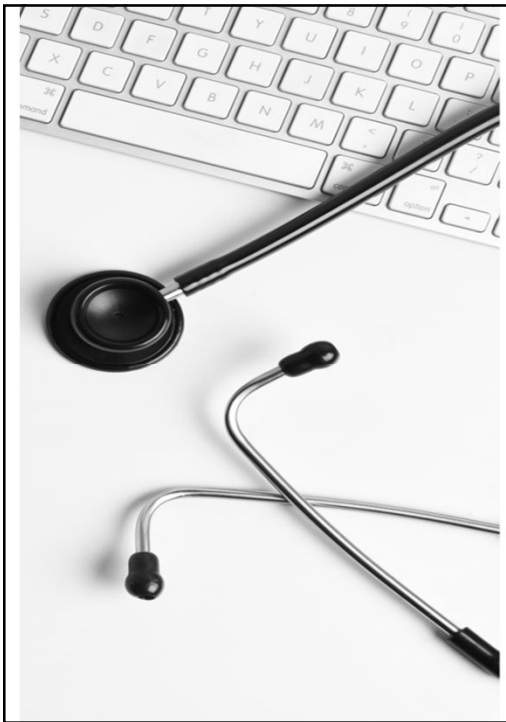
50

Prolonged Care Clinical Staff Services (Ancillary Staff)

- 2 new codes 99415 and 99416
- Cannot begin using until 30 minutes beyond typical clinical staff time for ongoing assessment of patient during a visit.
- To be used when staff are spending time with patient and/or family/caregiver. Time does not need to be continuous.

E/M Code	Typical Clinical Staff Time	99415 Time Range Minutes	99416 Time Range Minutes
99202	29	59-103	104
99203	34	64-108	109
99204	41	71-115	116
99205	46	76-120	121
99211	16	46-90	91
99212	24	54-98	99
99213	27	57-101	102
99214	40	70-114	115
99215	45	75-119	120

51



ICD-10-CM Coding

- Is there ever a time when we should be using unspecified codes?
- Unspecified codes are available in ICD-10
- Payors can request return of their payment when performing audits of their medical records

19

52

Importance of ICD-10-CM Codes

- Establish medical necessity when coupled with correct level of CPT
- Sequencing is important
- Clustered diagnoses
- Tying diagnosis codes to correct CPT codes

53

Diagnosis Coding

- Why the patient received health care services
- The severity of the patient's conditions they are being seen for on the specific date of service
- Any co-morbid or contributing diagnoses as long as they are addressed in the note.

54

Diagnosis Coding

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

55

AMA | STEPSforward

Clinical Vignette 1. Sample Progress Note, Level 4 MDM

Insert SmartText

HPI

60 y/o male here for follow up HTN and HL.

Doing well, no complaints.

Meds reviewed.

See A/P for remainder of HPI.

PEX

Vital signs: normal including blood pressure - 120/72

Heart: RRR, no murmurs

Lungs: clear to auscultation

A/P

1. HTN - well controlled on lisinopril 20 mg and thiazide diuretic 25 mg daily. Continue current medications.
2. HL - on atorva 20 mg daily. No side effects. Last lipid panel 6 mo ago at goal. Continue current treatment.

Next visit in 6 mo for follow up and wellness check.

56

Notes for the coding and documentation exercise:

Each element (number of diagnoses, complexity of data, and risk) can be classified as straightforward, low, moderate, or high.

For CPT coding, 2 of 3 MDM elements need to meet the moderate level to be considered Level 4 MDM.

Number of Diagnoses	Complexity of Data	Risk	CPT Code
This case meets criteria for **moderate** number of diagnoses (any criteria below met) ○ ≥1 chronic condition with exacerbation ● **≥2 stable chronic conditions** ○ 1 acute illness or injury with systemic symptoms ○ 1 acute illness or injury with uncertain prognosis	This case meets criteria for **straightforward** complexity of data (minimal or no data)	This case meets criteria for **moderate** risk of morbidity from additional diagnostic testing or treatment Example: ● **Prescription medication management** *(can be prescribing new medication, continuing same dose of current medication, or changing dose of current medication)*	This case meets **Level 4 criteria** for number of diagnoses and risk
Moderate/99214	Straightforward/99212	Moderate/99214	OVERALL CODE: 99214

57

Insert SmartText

HPI

40 y/o female with diet-controlled diabetes and obesity presents to establish care after moving from another state. No meds. States she had a visit with her old PCP about 6 mo ago, and blood work was done at that time.

Currently living with her cousin while looking for jobs. She is a single parent to 2 teenagers. She has not found many grocery stores in the neighborhood and is not comfortable with public transportation. She sometimes can borrow a car from her cousin, but mostly uses this for job hunting, or transporting her children to school events. Asks to defer lab testing until her next visit due to possible out-of-pocket costs.

PEX

BP 120/72 P 74 BMI 35.12

A/P

1. Diet-controlled DM. States had labs done 6 mo ago, does not recall last A1c. Will work on transfer of records and defer testing until next visit.
2. Obesity - discussed daily exercise, adding more vegetables to her diet.
3. SDOH - Patient's care may be negatively impacted by food insecurity due to her current lack of income. Based on this, patient will not be able to access healthy foods to manage her diabetes and obesity. Will consult SW for community resources and social support.

58

Notes for the coding and documentation exercise:

Each element (number of diagnoses, complexity of data, and risk) can be classified as straightforward, low, moderate, or high.

For CPT coding, 2 of 3 MDM elements need to meet the moderate level to be considered Level 4 MDM.

Number of Diagnoses	Complexity of Data	Risk	CPT Code
This case meets criteria for **moderate** number of diagnoses (any criteria below met) ○ ≥1 chronic condition with exacerbation ● **≥2 stable chronic conditions** ○ 1 acute illness or injury with systemic symptoms ○ 1 acute illness or injury with uncertain prognosis	This case meets criteria for **minimal** complexity of data (minimal or no data)	This case meets criteria for **moderate** risk of morbidity from additional diagnostic testing or treatment Example: ● **Diagnosis or treatment significantly limited by social determinants of health**	This case meets **Level 4 criteria** for number of diagnoses and risk
Moderate/99204	Straightforward/99202	Moderate/99204	OVERALL CODE: 99204

59

Insert SmartText

HPI

63 y/o male with 5 days of worsening cough productive of yellow sputum, SOB, and wheezing, as well as temp to 100.4 at home.

Hx COPD on daily LABA and inhaled steroid, former smoker, not on home oxygen. Last visit with me 2 mo ago for routine follow up - stable at that time. Most recent PFTs showed FEV1 55% of predicted. He has been hospitalized 2 times in the past 2 years for COPD exacerbation.

No known sick contacts, had a negative covid PCR test yesterday. Has been using albuterol rescue inhaler 3-4 times daily for the last 2 days.

PEX

VS - O2 sat 90% on RA, baseline is 92-94%
other VSS and unchanged from baseline

CV - RRR
Lungs - fair air movement, diffuse inspiratory and expiratory wheezes

A/P

COPD exacerbation with possible pneumonia - albuterol neb given in clinic. He felt a bit better, but O2 sat still lower than baseline. Discussed directly admitting him to observation status, but he is adamant about returning home.

Will rx Prednisone 40 mg daily for 5 days, first dose today, as well as oral antibiotics.

Follow up in clinic in 2 days, stressed need to go to ED if worsening symptoms; he understands and agrees.

60

Notes for the coding and documentation exercise:

Each element (number of diagnoses, complexity of data, and risk) can be classified as straightforward, low, moderate, or high.

For CPT coding, 2 of 3 MDM elements need to meet the high level to be considered Level 5 MDM.

Number of Diagnoses	Complexity of Data	Risk	CPT Code
This case meets criteria for **high** number of diagnoses (any criteria below met) ● **≥1 chronic condition with severe exacerbation** ○ 1 acute illness or injury with threat to life or bodily function	This case meets criteria for **minimal** complexity of data (minimal or no data)	This case meets criteria for **high** risk of morbidity from additional diagnostic testing or treatment Example: ● **Decision regarding hospitalization**	This case meets **Level 5 criteria** for number of diagnoses and risk
High/99215	Straightforward/99212	High/99215	OVERALL CODE: 99215

61

New for 2024

- G2211-
  - Visit complexity inherent to E&M associated with services that serve as the continuing focal point for all health care services
  - Or giving ongoing care of a single serious condition or complex condition
  - Is an add on code to an E&M
  - Not to be used when another service requiring 25 modifier is billed.
  - Coinsurance and deductible apply to this code
  - Medicare code

62

CODING EXAMPLES

63

Example # 1

A new patient presents with a concern about a lesion on her shoulder. It has been there for 2 years. The lesion worsens with scratching and rubbing. It will sometimes disappear and at other times be worse. No treatment to date. The provider does an appropriate history and exam and the assessment shows a seborrheic keratosis. The patient was given a Rx. For Acanya 1.2-2.5% to apply twice a day for 8 weeks. Patient is to return PRN.

What code would be assigned?

64

Answer Example # 1

Presenting problem: 1 self limited or minor problem

Data ordered/reviewed /analyzed – none

Risk – Moderate with prescription drug management

Overall Medical Decision Making: 99202

Even though the risk is moderate, the presenting problem has a prescribed course and transient in nature.

65

Example # 2

An established patient presents to the office with ankle pain and swelling. She stepped off the curb yesterday when she went to get her mail and missed the step. Her sandal caught on the edge of the curb and she rolled her right ankle. She did not fall but caught herself on the mailbox.

The provider did an appropriate history and exam..

An x-rays of the right ankle was done to rule out fracture. The diagnosis is right ankle sprain. Physical therapy is ordered.

What code would be assigned?

66

Answer Example #2

Presenting problem: 1 uncomplicated injury – (low)

Data ordered/ reviewed/ analyzed – x-ray done in the office and interpretation done by the physician

Risk- low risk of morbidity or mortality from additional treatment

Overall medical decision making – low 99213

Is the x-ray counted as part of the medical decision making?

67

Example # 3

A new patient presents with left knee pain. Patient states there has been a change over the past 2 years. She has experienced significant weight gain since giving up tennis and walking because of the knee pain. The weight gain has worsened the situation. The provider does an appropriate history and exam.

X-rays the patient brought with her were independently reviewed by physician.

The diagnosis is medial joint space narrowing but no bone on bone, no degenerative changes. Will treat conservatively for now with NSAIDs. Patient was counseled on the need to lose weight for her condition and overall health. For now weight watchers and MOBIC. Patient may benefit from total knee replacement in the future.

What code is assigned?

68

Answer Example #3

Presenting problem: 1 chronic problem with exacerbation – moderate

Data ordered/reviewed/ analyzed – x-rays brought by patient independent review – moderate (category 2)

Risk – Prescription drug management

Overall medical decision making: -99204 moderate.

** All 3 areas are met in the moderate category, but only 2 of the 3 are required.

69

Example # 4

An established patient presents with complaints of cough, stuffy nose, wheezing since leaf-blowing 3 days ago.. After being outside using the leaf blower the patient began complaining of sore throat, nasal congestion and cough. She has coughed so much she now has rib discomfort rated at 5/10 with coughing now. She also had a headache which has now resolved. She has heard herself wheeze when laying down at night. She has not taken OTC medications except Tylenol and a nasal spray she cannot remember the name of. Nasal complains are improving. After an appropriate history and exam the assessment is Upper respiratory infection. She was instructed to use Claritin and Mucinex.

What code is assigned?

70

Answer Example # 4

Presenting problem: 1 acute uncomplicated illness – low

Data ordered/reviewed/analyzed – none

Risk – low morbidity from treatment – low

Overall medical decision making – Low 99213

71

Example # 5

Established patient presents in follow up for her pancytopenia. After several bone marrow biopsies, she was diagnosed with aplastic anemia. She was started on cyclosporine and prednisone in March. She was admitted to the hospital in July with acute kidney injury. Her cyclosporine level was 555. it was thought her acute kidney injury was due to drug toxicity. She reports she is feeling well since leaving the hospital. She was transfused with 2 units packed red blood cells while in the hospital. CPC from 7/26 shows white blood cell count of 3.4, HB 10.7 and platelets at 49,000. An appropriate history and exam are done. Assessment is aplastic anemia. Plan repeat CMP today to assess kidney function. Possibly resume cyclosporine at 50% dose pending lab results. Will plan monthly CBC's. See her back in one month.

What code is assigned?

72

Answer Example # 5

- Presenting problem: 1 chronic illness with severe side effects of treatment – high
- Data ordered/reviewed/analyzed – Reviewed hospital notes, reviewed lab results external source, ordered CMP- Moderate
- Risk – Drug therapy requiring monitoring for toxicity – high
- Overall medical decision making – High 99215

73

Example # 6

Mrs. Smith is a 60 year old female seen today for labs and monitoring hypothyroidism and obesity. She is taking her Levothyroxidrine .75 nightly on an empty stomach. She feels her sleep, attention and weight have been stable but "not great" She admits she does not exercise much. The provider does a relevant history and exam. A TSH is ordered a refill for her medication is given. She is to return in 3 months.

What code is assigned?

74

Answer Example #6

- Presenting problem – 2 stable chronic illnesses – Moderate
- Data ordered/reviewed/analyzed – 1 lab test, Limited
- Risk – Prescription drug management – Moderate

- Overall medical decision making – Moderate 99214

75

Example #7

- 75 year old established patient presents with persistent and worsening cough. The cough has been present for two weeks. Over the past week she has been feeling very weak, running a fever of 101 and her daughter convinced her to be evaluated. The provider reviewed the history (4 minutes). Did a relevant exam which included A and lateral chest x-rays interpreted by the provider revealing lower lobe pneumonia. (9 minutes). The assessment and plan include the diagnosis of viral pneumonia with prescription s Levoquin and Albuterol. (2 minutes). An extensive conversation took place with the patient and her daughter about supportive care. Her daughter will be staying with her until she feels better. (17 minutes). Updated the patient medical record (1 minute).
- What code would be assigned?

76

Answer Example #7

- This visit is intended to be based on time.
- Obtain history and/or review a separately obtained history – 4 minutes
- Medically appropriate exam/ evaluation – 5 minutes
- Independently interpret results and communicate results to the patient/family- 2 minutes
- Counseling and education of the patient/caregiver – 17 minutes
- Order medications, tests or procedures – 2 minutes
- Document clinical information in the medical record – 1 minute
- Total 33 minutes
- Time range 30-44 minutes - 99214

77

Example # 8

- Established patient presents in follow up for multiple chronic conditions including DM, COPD, and HTN. This is a 54 year old female patient compliant with medication and diet for several years. She comes in for 6 month check up and medication management. She follows weight watchers, walks daily and feels great. Her recent lab work was reviewed. Her cardiac panel and HbA1c are in range. A relevant history and exam were done. The assessment includes Stable DM continue insulin, metformin and diet. COPD asymptomatic, continue current medications and HTN continue metoprolol and cardiovascular exercise.
- What code would be assigned?

78

Answer Example # 8

- Presenting problem(s)- 3 stable chronic conditions – moderate
- Data ordered/ reviewed/analyzed – 2 lab tests- limited
- Risk – Prescription drug management – moderate
- Overall medical decision making – Moderate - 99214

79

Example # 9

- An established patient presents for asthma follow up. The asthma control test and the symptom log indicate good control It is decided to continue the current plan and follow up in 3 months. Prescriptions refilled. Diagnosis is intermittent asthma.

- What code is assigned?

80

Answer Example # 9

- Presenting problem – one stable chronic illness – low
- Data ordered/reviewed/analyzed – control test reviewed –
- Risk – prescription drug management – moderate

- Overall medical decision making – Low - 99213

81

Example # 10

- Established male patient with psoriatic arthritis comes in today. He has psoriatic skin lesions, bilateral wrist pain and inflammation. He is on methotrexate. He reports he has been doing well since his last visit. His main symptom is the wrist inflammation . He has morning stiffness and also some low back pain which is worse at night. He does not have any flares. He has been having bilateral shoulder pain as well as right buttock/outer hip pain, but these issues have been chronic. He has had multiple cortisone injections in the shoulder from another physician. The patient brought records from ortho that indicated surgery recommended for removal of bone spurs in shoulder, but the patient wants conservative treatment. The assessment is psoriatic arthritis patient doing well. Will continue current regimen with 20 mg methotrexate. Also has osteopenia. Patient will continue Fosamax, calcium, and vitamin D. We will order a bone density test today and will let him know the results. Refill all medications and return in 6 months.
- What code is assigned to this visit?

82

Answer Example #10

- Presenting problem: 2 stable chronic conditions – moderate
- Data- order/review/analyze – bone density test ordered, Review of prior external notes from a unique source – Limited
- Risk – Drug therapy requiring intensive monitoring for toxicity – High

- Overall medical decision making – Moderate - 99214

83

Example # 11

A patient presents for follow up after treatment for otitis media. The patient appears well, and parents have no complaints.

Tympanic membranes are white with evidence of mild effusion. The physician explains that effusion is expected to resolve without further treatment. The patient is to return PRN or at the next scheduled preventive visit.

- What level is assigned?

84

Answer Example # 11

- Presenting problem: 1 self limited or minor problem
- Data to be reviewed & Analyzed: none
- Risk: minimal risk of morbidity from additional testing or treatment

- Code: 99212

85

Example # 12

A 6- year -old new patient presents for complaint of sore throat for 2 days. Parents report complaints of headache and abdominal pain today.. Strep test result is positive. An antibiotic is prescribed.

- What CPT code is assigned?

86

Answer Example 12

- Presenting problem:- 1 acute uncomplicated illness
- Data to reviewed and analyzed – did a strep test. Is this counted in MDM?, Independent historian
- Risk – moderate risk with prescription drug management

- Low MDM - 99203

87

Example #13

A new 8 –year- old patient presents with history of a recent ED visit for asthma. The provider reviews the hospital and prior pediatricians' records prior to the visit with the patient (Same day). The patient is new to the community and has not established care with a pediatrician. The patient has no current complaints. Parent confirm history of poor compliance with daily asthma medication due to concern about overmedication. Parents and patient are counseled about the importance of medication, and a care plan is developed with shared medical decision making. The total time of the visit is 50 minutes.

What level is assigned

88

Answer Example # 13

- Visit is billed by time.
- New patient
- Total time spent toward this patient's care on the date of the encounter is 50 minutes.
- MDM based on 50 minutes – 99204
- Is the documentation of time sufficient to support the code?

89

Example # 14

An established 10- year- old patient presents with symptoms of diabetes with ketoacidosis. Laboratory tests ordered and reviewed are a urine dip-stick and basic metabolic panel. The decision is made to hospitalize for new onset type 1 diabetes with ketoacidosis.

- What code is assigned?

90

Answer Example # 14

- Presenting problem – an acute illness with a threat to life and bodily function
- Data to be ordered and reviewed - Urine dip-stick, metabolic panel, independent historian
- Risk – Decision regarding hospitalization

- MDM - High, 99215
- Do we count the urine dip stick?
- What elements were used to arrive at 99215?

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Documentation Suggestions

- Make clear if the patient is new or established. Billing by time will be affected.
- If you are counting a review of a test today and at the next visit you review the previous test again, the review cannot be counted at the current visit. Tests ordered & reviewed are only counted once. If the test was ordered after the last encounter but before the current encounter, clarify that fact so credit can be given for order and review today.
- Time based codes include only work done on the day of the face to face visit with the patient.
- Continue to document a detailed HPI to set up medical necessity. Provide other relevant history and relevant exam. Document details of MDM showing thought process, differential diagnoses, and other considerations.

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Other Considerations

- Discuss with your EHR vendors if changes are coming to templates
- If your providers rely on code calculators in the system, have changes been implemented to accommodate the new guidelines?
- If you have built macro's in the system, will they need to be changed? (E.G. "more than 50% of the visit spent…)
- Will your EHR be able to track total time spent? Will it pull calculated time into the record?.
- Watch for other payers' guidelines and any nuanced differences in interpretation.
- Track denials

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