ADPH Coding Basics

Centralized Billing Unit
May 18, 2018

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Objectives

- Participants will understand basic coding terminology.
- Participants will understand the basics of procedural and diagnosis coding.
- Participants will learn how to properly use procedure, diagnosis codes and modifiers to correctly code a patient visit.

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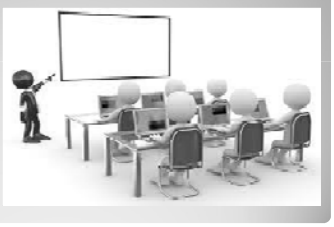
TRAINING:

- Coding, Coding, Coding
- No functionality
- Document what you do
- Tools needed to code



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All Payers Are Not Alike

- Alabama Medicaid Agency (AMA)
- Blue Cross Blue Shield (BCBS)
- Different payers have different rules.
- Different health departments programs have different rules.
- Coding only applies to services provided in the Health Department.
- Certain services are included in the global fee for Medicaid.
- Health Department is not considered a pharmacy provider therefore we can not bill certain birth control methods to BCBS.
- Patients are unique and coding should reflect this.

Medicaid

BlueCross BlueShield

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What is Coding?

- A process of transforming descriptions of medical encounters, diagnoses, procedures, diagnostic tests and supplies provided to a patient into **universal code numbers.**
- For every ailment, injury, diagnosis, and medical procedure, there is a corresponding code.

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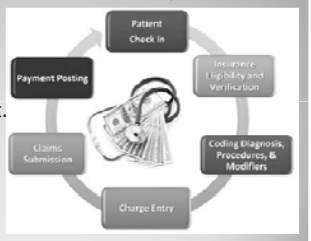
Why is coding important to me?

- Coding tells the insurers and auditors what the patient's problems were and what you did for them so that you can receive reimbursement;
- And to prepare a standardized "bill" for services provided to a patient.



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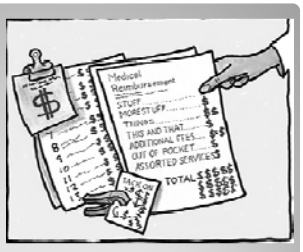
- Services provided to the patient and documented in the medical record.
- Services must be **medically necessary** for the treatment of the patient's condition.



If it wasn't documented – it didn't happen and can't be coded or billed.

What can be billed?

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- CPT stands for Current Procedural Terminology.
- A listing of descriptive terms and identifying 5 digit codes to report medical services and procedures in the care and treatment of patients.

Ex: 11976 – Implant Removal

Current Procedural Terminology (CPT)

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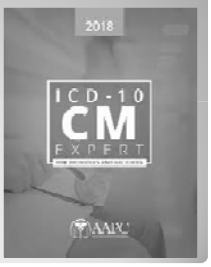
- **International Classification of Diseases, 10th Edition.**
- ICD-10 is a list of diagnosis codes that may be identified during your examinations.
- The diagnosis (ICD-10) must relate to the procedure (CPT) code.
- Ex: A60.9 – Genital Herpes



ICD – 10 Diagnosis Codes

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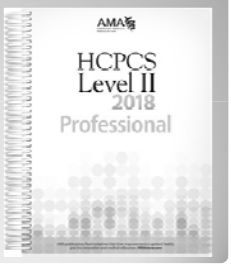
- **The Healthcare Common Procedure Coding System.**
- Used primarily to identify products, supplies, and services not included in the CPT codes.
  - S4993 – Contraceptive Pills
  - J1050 – Injection IM
  - J7307 – Implant



HCPCS Codes

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- Are used to describe *special circumstances* pertaining to the procedure code(s) billed.
- Are always two characters, and may be numeric (CPT) or alpha/alphanumeric (HCPCS).
- Are used for documentation purposes and can affect the processing or payment of the code billed. Examples:
  - FP - Service provided as part of family planning program.
  - EP – Routine healthy kids/EPSDT screening.
  - 25 - Significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure or other service).
  - 90 - Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician
  - U6 – Medicaid level of care 6, as defined by each state.

Modifiers

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- **Overcoding** can be interpreted as fraudulent and trigger audits.
- **Undercoding** can result in lower reimbursement and misrepresentation of services provided.
- **Cloning** occurs when medical documentation is exactly the same for every patient.

Correct Coding Matters…

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- "Bundling" occurs when a procedure or service with a unique CPT® or HCPCS code is included as part of a "more extensive" procedure or service provided at the same time.
- "Unbundling" errors—coding separately for procedures that should have been bundled—are a frequent cause of claims denials and negative audit findings.

Bundling & Unbundling Services

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- A new patient is one who has not received any professional service from the clinician or another clinician of the same specialty who belongs to the same group practice within the past three years.
- For ADPH this means one initial visit, per patient, per county health department, per lifetime.

What is a New Patient?

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- An established patient is one who has received professional services from the clinician or another clinician of the same specialty who belongs to the same group practice within the past 3 years.

What is an Established Patient?

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- E/M coding is the process by which clinician patient encounters are translated into five digit CPT codes to facilitate billing.
- The provider selects the appropriate billing code for the visit based on services provided.
- Codes start with "**99.**"
- Documentation within the health record must clearly support the procedures, services, and supplies coded.
- Describes:
  - Complexity of care provided to a patient for non-procedural visits.
  - The type of service (new vs. established, preventative).

Evaluation and Management (E/M)

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- **There are three key components to consider when selecting the appropriate E&M code:**
  - **History**
  - **Physical Exam**
  - **Medical Decision Making (MDM)**
- ***All three components* must be documented for a new or initial visit .**
- ***Only two of the three components* must be documented for *established* patients (seen within the past three years).**

Determining the Correct E & M Code

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Chief Complaint	History of Present Illness	Review of Systems	Past Family or/or Social History
Specify the reason for the visit	Location, quality, severity, duration, context, timing, modifying factors, associated S/S	Constitutional, Eyes, ENT, cardiovascular, respiratory, GI, GU, musculoskeletal, integumentary, neurologic, psychiatric, endocrine, hematological /lymphatic , allergic/immunologic	Past history, family, social, illnesses, operations, injuries

History – 4 Elements

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- **Problem Focused**- a limited exam of the affected body area/organ system (1 body area or system);
- **Expanded Problem Focused** - a limited exam of the affected body area/organ system and any other symptomatic or related body area(s)/organ system(s) (2-4 systems including the affected area);
- **Detailed** - an extended exam of the affected body area(s)/organ system(s) and any other symptomatic or related body area(s)/organ system(s) (5-7 systems including the affected area); and
- **Comprehensive** - a general multi-system exam or complete exam of a single organ system and other symptomatic or related body area(s)/organ system(s) (8 or more systems).

Physical Exam

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- Refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:
  - the **number of diagnoses or management options** to be considered;
  - the **amount and/or complexity of data (**medical records, diagnostic test, and/or other information that must be obtained, reviewed and analyzed);
  - the **risk** of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s).

Medical Decision Making

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New Patient Office Visit

Three of the three key components* must meet or exceed the stated requirements to qualify for a particular level of services.				
Code	99201 Problem Focused	99202 Expanded Problem Focused	99203 Detailed	99204 Comprehensive
Chief Complaint	Required	Required	Required	Required
History	1-3 HPI	1-3 HPI 1 problem pertinent (pp) ROS	4 HPI 1 pp ROS & 2-9 ROS 1 pp PFSH	4 HPI 1 pp ROS & 10+ ROS 2-3 PFSH
Exam	1-5 bulleted elements	6 bulleted elements	12 bulleted elements	All bulleted elements
Medical Decision Making	Straightforward	Straightforward	Low	Moderate

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Established Patient Office Visit

Three of the three key components* must meet or exceed the stated requirements to qualify for a particular level of services				
Code	99211**	99212 Problem Focused	99213 Expanded Problem Focused	99214 Detailed
Chief Complaint	Required	Required	Required	Required
History	Minor problem, patient may not see a Qualified Provider (QP) (can bill 3rd party if seen by RN)	1-3 HPI	1-3 HPI 1 problem pertinent (pp) ROS	4 HPI 1 pp ROS & 2-9 ROS 1 pp PFSH
Exam		1-5 bulleted elements	6 bulleted elements	12 bulleted elements
Medical Decision Making		Straightforward	Low	Moderate

** 99211 - May not require the presence of MD or NP/PA and may not include an exam. Patient must have been seen previously and this is a minimal (5 min) problem, or a follow up – not a new problem.

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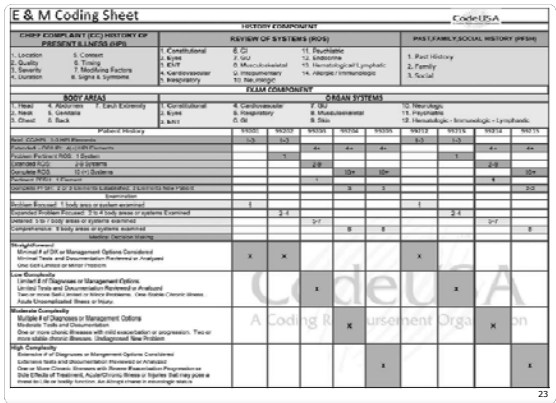

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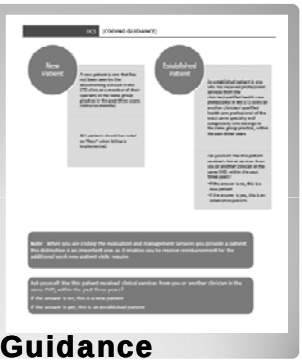
Additional E/M Coding Guidance



E/M Training Guidance

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Family Planning

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- 17 year-old established patient seen for an annual "check-up" and initiation of contraception; menses are regular; no complaints. Sexual debut 6 months ago; 2 lifetime partners; she admits to smoking about ½ pack of cigarettes daily.
- Pregnancy test and vaginal swab for STDs, Given Ortho-Tri Cyclen.

Family Planning (FP) Scenario #1

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Visit Type	CPT / HCPCS	Modifier	Diagnoses	Devices / Lab
Annual	99214	FP	Z30.41	
	S4993	FP	Z30.41	Oral Contraceptives
	81025		Z32.02	*Pregnancy test - negative
	87801		Z11.3	CT/GC
	87661		Z11.3	TV

*Z32.01 – Positive pregnancy test.
*Labs can be selected from a drop down menu in the EHR.

FP Scenario #1 Codes

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- 34 year-old female presents for an initial visit with c/o a vaginal discharge. She has a Hx of HTN (B/P elevated at 160/90), and diabetes, (currently taking Metformin 500mg bid.) HT, 5'5", weight 200 pounds.
- LMP- 45 days ago.
- Pregnancy test and vaginal swab for STDs.

FP Scenario #2

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Visit Type	CPT / HCPCS	Modifier	Diagnoses	Devices / Lab
Initial	99205	FP	Z11.3	
	81025		Z32.02	*Pregnancy test - negative
	87801		Z11.3	CT/GC
	87661		Z11.3	TV

*Z32.01 – Positive pregnancy test.
*Labs can be selected from a drop down menu in the EHR.

FP Scenario #2 Codes

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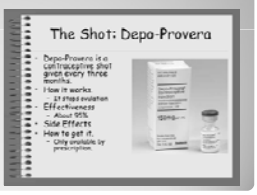
- 35 year-old female presents for Depo-Provera regimen
  - Revisit
  - Brief GYN and general exam with a Nurse Practitioner for medical clearance to start Depo-Provera
  - Labs: Urine pregnancy test
  - Injection IM Depo-Provera



FP Scenario #3

30

Visit Type	CPT / HCPCS	Modifier	ICD-10 Diagnosis Code	Devices / Lab
Revisit	99213	FP	Z30.42	
	J1050	FP	Z30.42	Depo Provera
	81025		Z32.02	*Pregnancy test - negative

*Z32.01 – Positive pregnancy test.

FP Scenario #3 Codes

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- 20 year-old female presents for Implanon insertion
  - Decision was made at her previous exam 2 weeks ago
  - Implanon inserted without difficulty

FP Scenario #4

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Visit Type	CPT / HCPCS	Modifier	ICD-10 Diagnosis Code	Devices / Lab
Revisit	99213	FP	Z30.430	
	81025		Z32.02	*Pregnancy test - negative
	J7307		Z30.8	Implanon
	11981	FP	Z30.8	Implant insertion

*Z32.01 – Pregnancy test positive.

FP Scenario #4 Codes

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- Beatriz has been a client at your clinic for several years. She has been an inconsistent condom and oral contraceptive user and at high risk for unintended pregnancy. She decides to try the Nuvaring and has been using it safely and successfully for six months. She comes into the clinic with complaints of spotting and bleeding especially after intercourse, which she believes is caused by the hormones in the ring. She wants to quit the ring and go back to condoms. She mentions something about her new boyfriend and how he won't be too happy about having to use condoms.

Scenario #5 (FP + STD on same day)

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- You are concerned that the bleeding may be caused by CT/GC and not her hormonal contraceptive and that she will again be at risk for pregnancy with a method that she didn't use well previously.
- You test her for CT/GC/TV, treat her presumptively, explain the importance of her partner getting treated and tested as well, HIV prevention, discuss the importance of condoms for STI prevention, and continue her with the Nuvaring.

Scenario #5 (FP + STD on same day)

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Visit Type	CPT / HCPCS	Modifier	ICD-10 Diagnosis Code	Devices / Lab
Revisit	99213	FP-25	Z30.8	
	81025		Z32.02	*Pregnancy test - negative
	87801		Z11.3	CT/GC
	87661		Z11.3	TV
HIV Counseling	99401		Z30.48	

*Z32.01 – Positive pregnancy test

Scenario #5 Codes

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- At the current time, STD will bill full Medicaid eligible recipients for services rendered. Other non-Medicaid recipients will be income assessed and slid to zero.
- All STD patients should be considered a new patient with the implementation of the EHR.
- Family Planning and other program clients who test positive for an STD may be seen as a new/established DCS patient on a return date of service for treatment and counseling services.

STD Notes

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- Code appropriate CPT codes for each date of service using coding guidance provided.
  - Reviewing with Alabama Medicaid correct CPT codes and modifier(s) for coding billable FP visits on same day of service as an STD Visit. For example, performing an FP Annual Visit with a wart treatment.
  - Reviewing 340B requirements to ensure we remain in compliance. For example, for FP patients treated presumptively for an STD, in the STD note – Review the medical record, Mark Medical Records reviewed, Update the medical record to reflect any additional services, document patient treated per STD Treatment Guidelines.

STD Notes

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Disease Control Table

DCS Visits Only	CPT Code	Modifer	ICD-10 Dx Code
New Problem Focused	99201		Z11.3
New Exp. Problem Focused	99202		Z11.3
New Detailed Low Complexity	99203		Z11.3
New Comprehensive Moderate	99204		Z11.3
Established Minimal	99211		Z11.3
Established Problem Focused	99212		Z11.3
Est. Exp. Problem Focused	99213		Z11.3
Established detailed Moderate	99214		Z11.3
In HOUSE LABORATORY SERVICES			
Wet Prep	87210	U6	Z11.8
Amine Odor	82120	U6	Z11.8
Vaginal PH	83986	U6	Z11.8
Venipuncture	36415	90	Z11.3
STAT RPR	86592	U6	Z11.3
Finger Stick	36416	90	Z20.2
PROCEDURES			
Warts TX Female	56501	25	B07.9
Warts TX Male	54050	25	B07.9
Out of HOUSE STD LABS			
Syphilis Screen	86592		Z11.3
OraSure Western Blot	86689		Z11.4
[illegible]	[illegible]		Z11.4
Chlamydia - (All sites)	87801		Z11.3
Gonorrhea	87801		Z11.3
Trichomoniasis	87661		Z11.3

DCS: Evaluation and Management Codes

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- 23 year old female presents with concerns about STI and wants to be tested.
  - New patient
  - General exam with focus on clinical manifestations of STI.
  - HIV counseling and testing.
  - Laboratory tests for CT/GC/TV, syphilis and HIV test.

DCS Scenario #1

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Visit Type	CPT / HCPCS	Mod	ICD-10 Diagnosis Code	Devices/Lab
New -Initial	99203	25	Z11.3	
HIV Counseling	99401		Z30.9	
	87801		Z11.3	CT/GC
	86592		Z11.3	Syphilis
	87661		Z11.3	TV
	87389		Z20.6	HIV test

DCS Scenario #1Codes

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- A 22 year old established male patient with complaints of a “bump” on his penis presenting today for wart treatment. A detailed history and exam are completed.

DCS Scenario #2

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Visit Type	CPT/ HCPCS	Mod	ICD-10 Diagnosis Code	Devices/Lab
Established	99214	25	B07.9	
	54050*		B07.9	

Note: Subsequent visits allowed every 10 days. Code procedure only UNLESS a "significantly, separately, identifiable" problem raised at time of wart destruction which would not result in also coding E/M.
*56501 – Female wart treatment.

DCS Scenario #2 Codes

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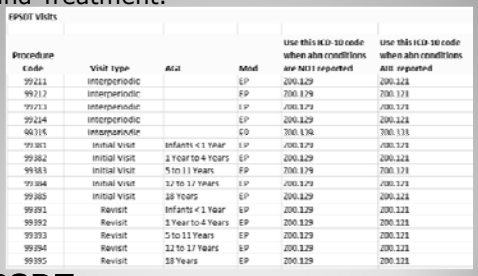
- Early and Periodic Screening, Diagnostic, and Treatment.



Procedure Code	Visit Type	Mod	Use this ICD-10 code when abn conditions are NOT reported	Use this ICD-10 code when abn conditions are reported
99211	Interperiodic	EP	Z00.129	Z00.121
99212	Interperiodic	EP	Z00.129	Z00.121
99213	Interperiodic	EP	Z00.129	Z00.121
99214	Interperiodic	EP	Z00.129	Z00.121
99215	Interperiodic	EP	Z00.129	Z00.121
99381	Initial Visit	Infants < 1 Year	EP	Z00.129	Z00.121
99382	Initial Visit	1 Year to 4 Years	EP	Z00.129	Z00.121
99383	Initial Visit	5 to 11 Years	EP	Z00.129	Z00.121
99384	Initial Visit	12 to 17 Years	EP	Z00.129	Z00.121
99385	Initial Visit	18 Years	EP	Z00.129	Z00.121
99391	Revisit	Infants < 1 Year	EP	Z00.129	Z00.121
99392	Revisit	1 Year to 4 Years	EP	Z00.129	Z00.121
99393	Revisit	5 to 11 Years	EP	Z00.129	Z00.121
99394	Revisit	12 to 17 Years	EP	Z00.129	Z00.121
99395	Revisit	18 Years	EP	Z00.129	Z00.121

EPSDT

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Immunization	CPT Code	ICD-10 Diagnosis Code
DT	90702	Z23
DTaP	90700	Z23
HPV	90651	Z23
Influenza	90658	Z23
MMR	90707	Z23
Varicella	90716	Z23
All immunizations are billed using Z23 as ICD-10 diagnosis code.		

Immunizations

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- A 5-year-old established patient is at a physician's office for her annual well-child examination. The patient is scheduled to receive her first hepatitis A vaccine; her fifth diphtheria, tetanus, and acellular pertussis (DTaP) vaccine; and the influenza vaccine. After distributing the Vaccine Information Statements and discussing the risks and benefits of immunizations with her parents, the nurse administers the vaccines.

EPSDT Scenario #1

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Visit Type	CPT/ HCPCS	Mod	ICD – 10 Diagnosis Code	Devices/Lab
Revisit	99393	EP	*Z00.129	
	90700		Z23	DTaP
	90633		Z23	HEP A
	90657		Z23	Influenza

*Use Dx code Z00.121 if ABNORMAL conditions are reported.

EPSDT Codes #1

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- Follow established ADPH clinic protocols.
- Follow coding guidelines.
- Different payers have different rules.
- The diagnoses code must support the reason for the procedure.
- There are specific requirements for 99211 for STD billing. Refer to STD Coding Guidance.

REMEMBER…

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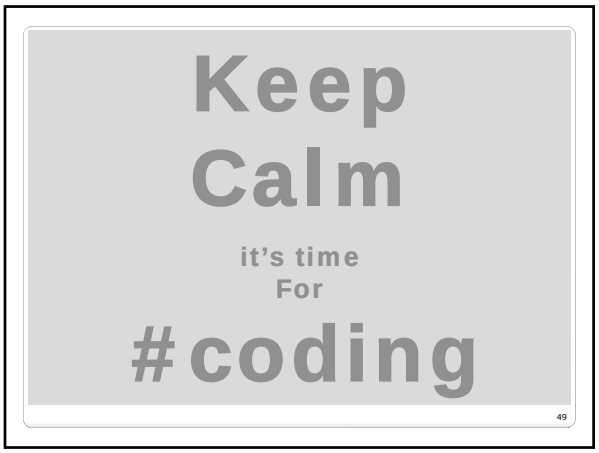
Keep
Calm
it's time
For
#coding
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