Centralized Billing Unit Refresher For Clinicians

October 11, 2018
10:00 AM – 12:00 PM

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This video presentation was created to assist with coding accuracy for services rendered to patients seen at the ADPH county health departments only. It is the responsibility of the clinician to use his or her professional discretion to document and bill for appropriate services rendered.

Disclaimer

Upon completion of this presentation, clinicians will have an understanding of documentation and coding guidelines used for billing at the Alabama Department of Public Health

Objective

- **At the conclusion of this presentation, participants should be able to:**
  - **Outline variables that can affect reimbursement**
    - **Global Fee**
    - **Medicaid requirements**

Conclusion

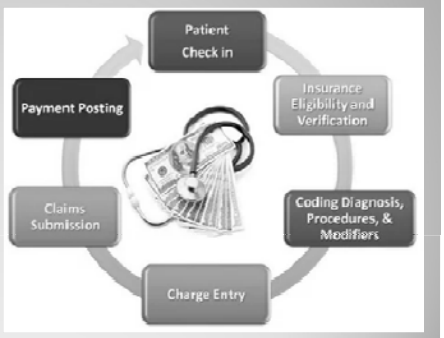
Conclusion

- Illustrate how the documentation of a patient encounter is converted into revenue
- Utilize common coding/billing terms
- List common reasons claims are denied

What is Coding?

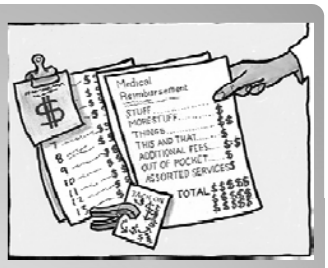
- A process of transforming descriptions of medical encounters, diagnoses, procedures, diagnostic tests and supplies provided to a patient into universal code numbers, often referred to as CPT (Current Procedural Terminology)
- For every ailment, injury, diagnosis, and medical procedure, there is a corresponding code.

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



Why is coding important to me?

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



If it <u>was not</u> documented – it <u>did not</u> happen and <u>can not</u> be coded or billed.

What can be billed?

Evaluation and Management (E/M)

- 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.”

Evaluation and Management (E/M)

- 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).

Determining the Correct E & M Code

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

Determining the Correct E & M Code

- ***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).

- **Clinicians must…**
  - **Create an accurate medical record that is compliant with coding terminology and rules.**
  - **Provide good patient care**
  - **Minimize liability issues**
  - **Develop good coding habits that will translate into efficiency and reimbursement for services.**

E&M Recap

You can not just bill for what is done…you only can bill for what is *done and documented*!

E&M Recap

Modifiers

- Modifiers must be utilized to further clarify, identify, or explain more details about what transpired during the patient's encounter.
- Modifiers are necessary to achieve the appropriate reimbursement.

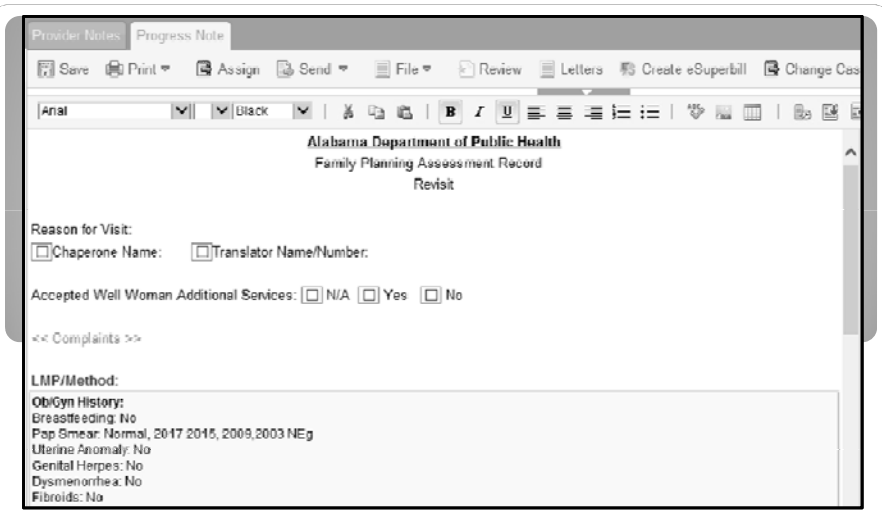
Modifiers

- Not all payers follow the same or standard rules and not all payers recognize all modifiers available.
  - FP - Service provided as part of family planning program.
  - 25 - Significant, separately identifiable evaluation and management (E/M) service by the same clinician 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.**

Modifiers

Forms Used In Billing Review



Provider Note

Documentation for all services and additional notes rendered during the encounter

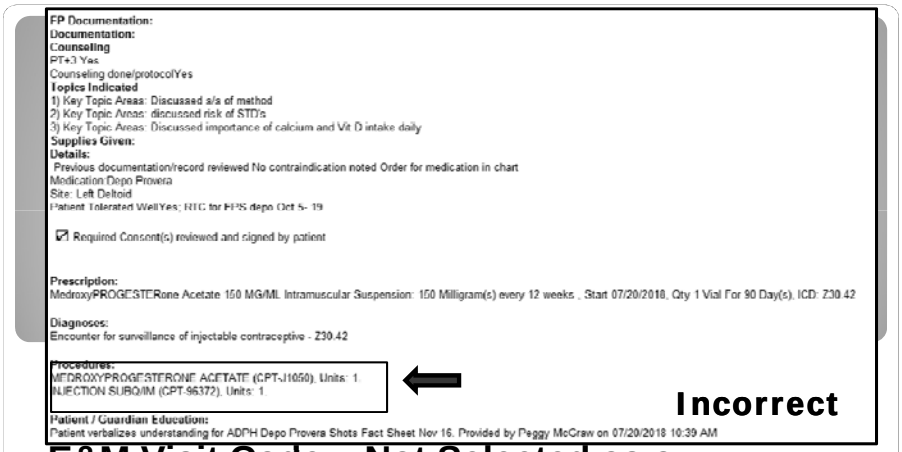
eSuperbill

Summary of all services rendered, based on documentation (CPT Codes) from the Provider Note.

Charge Screen

Billing component used in creating a bill file to submit to payer source

Common Problems on the Provider Note


FP Documentation:
Documentation:
Counseling
PT+3 Yes
Counseling done/protocolYes
Topics Indicated
1) Key Topic Areas: Discussed s/s of method
2) Key Topic Areas: discussed risk of STD's
3) Key Topic Areas: Discussed importance of calcium and Vit D intake daily
Supplies Given:
Details:
Previous documentation/record reviewed No contraindication noted Order for medication in chart
Medication Depo Provera
Site: Left Deltoid
Patient Tolerated WellYes; RTC for FPS depo Oct 5- 19

☑ Required Consent(s) reviewed and signed by patient

Prescription:
MedroxyPROGESTERone Acetate 150 MG/ML Intramuscular Suspension: 150 Milligram(s) every 12 weeks , Start 07/20/2018, Qty 1 Vial For 90 Day(s), ICD: Z30.42

Diagnoses:
Encounter for surveillance of injectable contraceptive - Z30.42

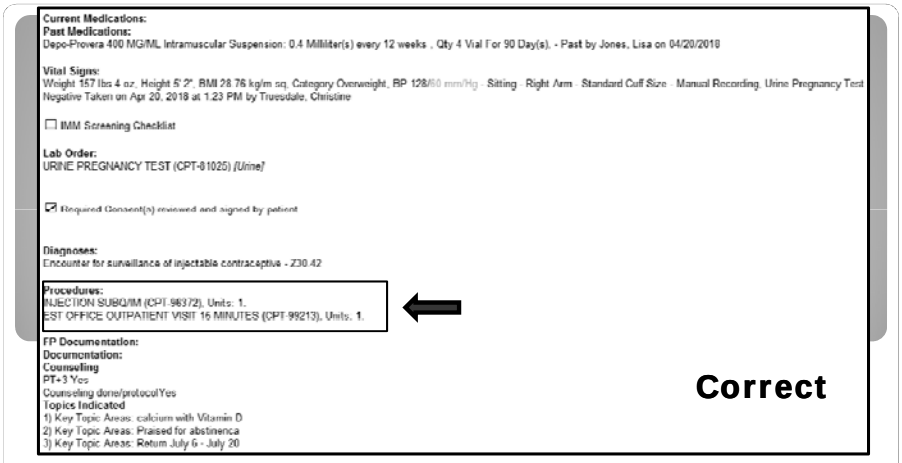
Procedures:
MEDROXYPROGESTERONE ACETATE (CPT-J1050), Units: 1
INJECTION SUBQ/IM (CPT-96372), Units: 1

Patient / Guardian Education:
Patient verbalizes understanding for ADPH Depo Provera Shots Fact Sheet Nov 16. Provided by Peggy McCraw on 07/20/2018 10:39 AM

Incorrect

E&M Visit Code – Not Selected as a Procedure Code

E/M codes MUST be selected under "Procedures" on the provider note in order to bill for the visit.


Current Medications:
Past Medications:
Depo-Provera 400 MG/ML Intramuscular Suspension: 0.4 Milliliter(s) every 12 weeks , Qty 4 Vial For 90 Day(s), - Past by Jones, Lisa on 04/20/2018

Vital Signs:
Weight 157 lbs 4 oz, Height 5' 2", BMI 28.76 kg/m sq, Category Overweight, BP 128/60 mm/Hg - Sitting - Right Arm - Standard Cuff Size - Manual Recording, Urine Pregnancy Test Negative Taken on Apr 20, 2018 at 1:23 PM by Truesdale, Christine

☐ IMM Screening Checklist

Lab Order:
URINE PREGNANCY TEST (CPT-81025) [Urine]

☑ Required Consent(s) reviewed and signed by patient

Diagnoses:
Encounter for surveillance of injectable contraceptive - Z30.42

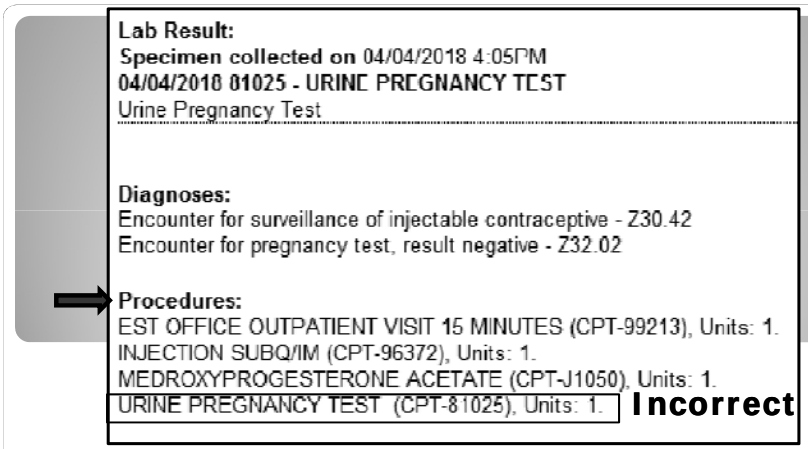
Procedures:
INJECTION SUBQ/IM (CPT-96372), Units: 1.
EST OFFICE OUTPATIENT VISIT 15 MINUTES (CPT-99213), Units: 1.

FP Documentation:
Documentation:
Counseling
PT+3 Yes
Counseling done/protocolYes
Topics Indicated
1) Key Topic Areas: calcium with Vitamin D
2) Key Topic Areas: Praised for abstinenca
3) Key Topic Areas: Return July 6 - July 20

Correct

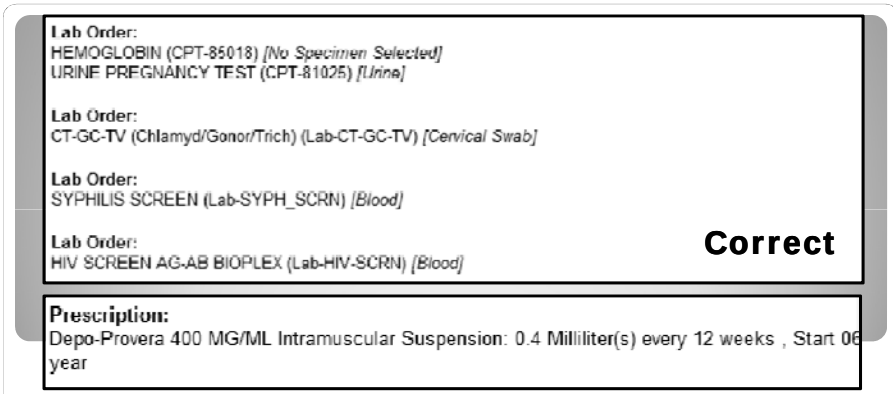
E&M Visit Code – Selected as a Procedure Code

E/M codes MUST be selected under "Procedures" on the provider note in order to bill for the visit.



Ordering Labs and/or Prescriptions

All Labs MUST be ordered under "Lab Order" and all medications MUST be ordered under "Prescription". <u>DO NOT</u> enter labs or prescriptions under "Procedures"



Ordering Labs and/or Prescriptions

All Labs MUST be ordered under "Lab Order" and all medications MUST be ordered under "Prescription". <u>DO NOT</u> enter labs or prescriptions under "Procedures"

Lab Order:
Pap Lb, HPV-hr (Lab-195050) *[Cervix]*

Lab Order:
URINE PREGNANCY TEST (CPT-81025) *[Urine]*
HEMOGLOBIN (CPT-85018) *[Blood capillary]*

Lab Order:
CT-GC-TV (Chlamyd/Gonor/Trich) (Lab-CT-GC-TV) *[Cervical Swab]*

Lab Order:
HIV SCREEN AG-AB BIOPLEX (Lab-HIV-SCRN) *[Blood]*

Lab Order:
SYPHILIS SCREEN (Lab-SYPH_SCRN) *[Blood]*

Incorrect

Documentation – Labs Not Resulted

It is required that all labs must be resulted before they can be billed.

Lab Order:
URINE PREGNANCY TEST (CPT-81025) *[Urine]*

Lab Result:
Specimen collected on 06/27/2018 2:23PM
06/27/2018 81025 - URINE PREGNANCY TEST

Urine Pregnancy Test	negative	Range Negative

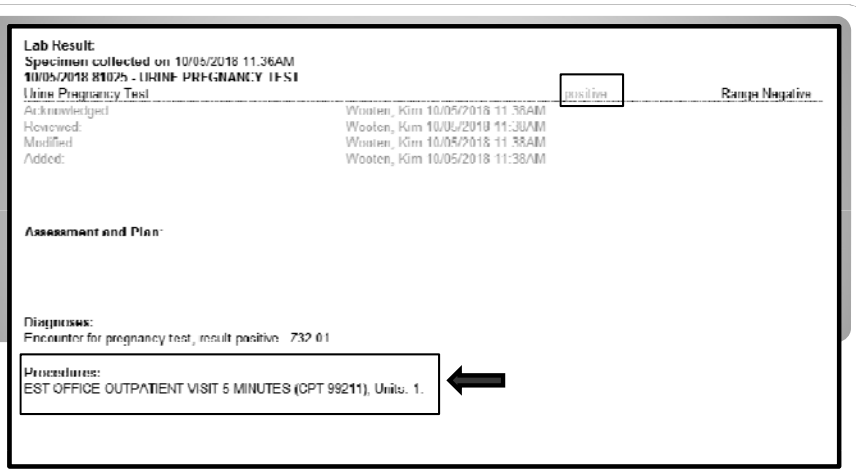
Lab Result:
Specimen collected on 08/09/2018 3:48PM
08/09/2018 87210 - VAGINAL WET MOUNT

WBC	20-30 /HPF	Range 0-3
Clue Cells	absent	Range Absent
Yeast	absent	Range Absent
Trichomonas	absent	Range Absent
RBC		
Bacteria		Range Absent
ph		
WHF	Positive	

Correct

Documentation – Labs Resulted

It is required that all labs must be resulted before they can be billed.



Lab Result:
Specimen collected on 10/05/2018 11:36AM
10/05/2018 81025 - URINE PREGNANCY TEST

Urine Pregnancy Test		positive	Range Negative
Acknowledged:	Wooten, Kim 10/05/2018 11:38AM		
Reviewed:	Wooten, Kim 10/05/2018 11:38AM		
Modified:	Wooten, Kim 10/05/2018 11:38AM		
Added:	Wooten, Kim 10/05/2018 11:38AM		

Assessment and Plan:

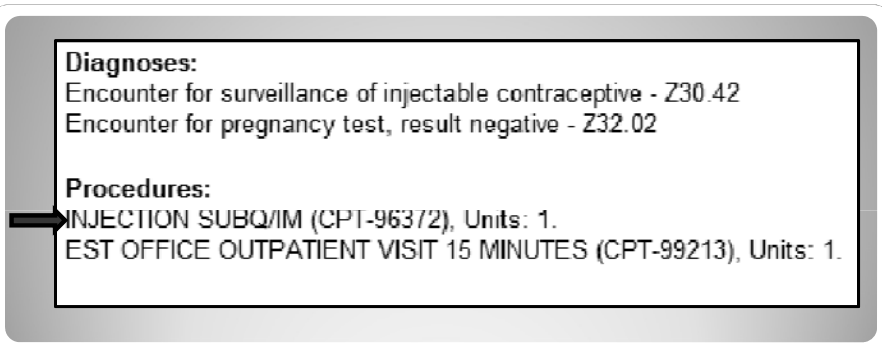
Diagnoses:
Encounter for pregnancy test, result positive - Z32.01

Procedures:
EST OFFICE OUTPATIENT VISIT 5 MINUTES (CPT 99211), Units: 1.

Positive Pregnancy Test
CPT Code 99211 is to be used to document all positive pregnancy tests

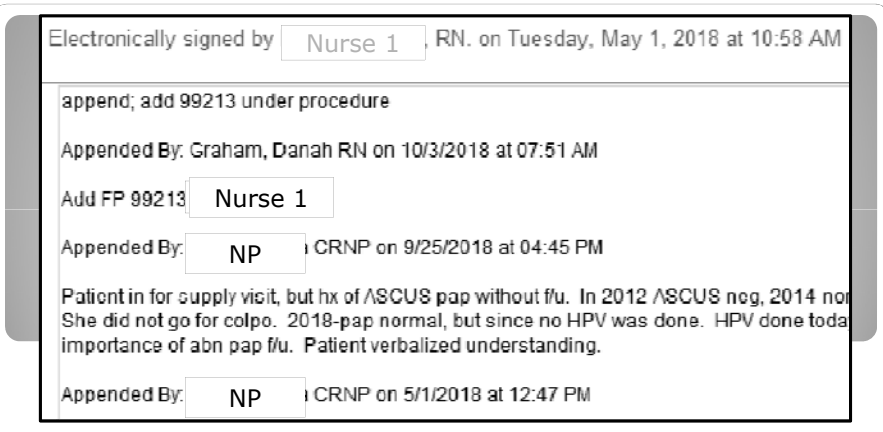
Family Planning				Additional Family Planning Diagnoses	
Contraceptive Pills	**CPT**	**MOD**	**ICD-10**	**Breast Conditions**	
Annual	99214	FP	Z30.41	Mastitis without abcess	N61.0
Def Physical / Revisit	99213	FP	Z30.41	Abcess of the breast and nipple	N61.1
Initial Visit	99205	FP	Z30.41	Unspecified lump or mass in breast	N63.0
Injectable Contraceptive	**CPT**	**MOD**	**ICD-10**	Galactorrhea (not assoc. w/childbirth)	N64.3
Annual	99214	FP	Z30.42	Nipple discharge	N64.52
Def Physical / Revisit	99213	FP	Z30.42	Retraction of nipple	N64.53
Initial Visit	99205	FP	Z30.42	Mastitis, postpartum, unspecified	O91.23
Checking of Intrauterine Contraceptive Devi	**MOD**		**ICD-10**	Mastodynia	N64.4
Annual	99214	FP	Z30.431		
Def Physical / Revisit	99213	FP	Z30.431		
Initial Visit	99205	FP	Z30.431	**Cervix**	
Insertion of Intrauterine Device	**CPT**	**MOD**	**ICD-10**	Cervical Polyp	N84.1
Annual	99214	FP	Z30.430	AGC cytology	R87.619
Initial Visit	99205	FP	Z30.430	ASC-US cytology	R87.610
Revisit	99213	FP	Z30.430	ASC-H cytology	R87.611
Removal of Intrauterine Device		**MOD**	**ICD-10**	LSIL cytology	R87.612
Annual	99214	FP	Z30.432	High Risk HPV DNA positive	R87.810
Initial Visit	99205	FP	Z30.432	Cytologic evidence of malignancy	R87.614
Revisit	99213	FP	Z30.432	Unsatisfactory cytology	R87.615
Removal & Reinsertion	**CPT**	**MOD**	**ICD-10**	Lacking transformation zone	R87.616
Annual	99214	FP	Z30.433	**Chlamydia**	
Initial Visit	99205	FP	Z30.433	Chlamydia, unspecified	A56.00

CPT Codes with Diagnosis (Dx) Codes
The Coding Guide should be used to reference Dx that correspond to the correct CPT code(s) for ADPH only



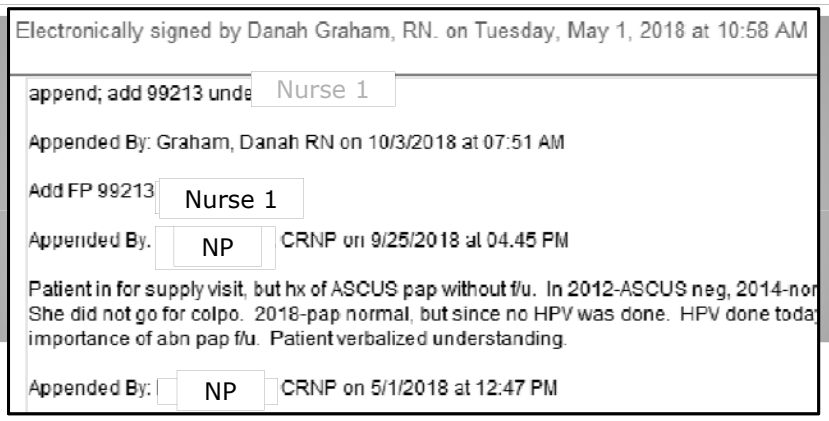
Administration Code

Whenever an injection is administered, document the appropriate administration code shown on the ADPH Coding Guide. We will not bill this to Medicaid but will bill it to other commercial insurance carriers.



Wrong Provider Signing the Note

The highest level clinician providing services should sign the provider note and create the superbill



Addendum – Wrong Person Appending the Record

Only the Clinician that created the Provider Note or eSuperbill can append it.

DO NOT:

- **Delete**
- **Remove**
- **Copy and Paste documentation into a patient's record**

Terminology NOT to Use When Appending

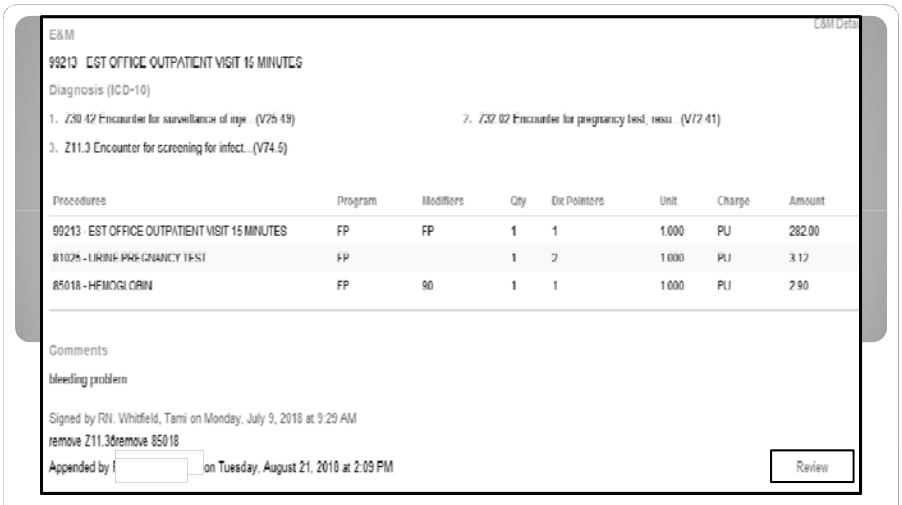
YOU CAN USE:

- **Add CPT code**
  - **Ex: Add CPT code 99211, as 99213 was used in error**
- **Add Dx code**
  - **Ex: Add Dx code Z32.02**

Terminology to Use When Appending

eSuperbill

Summary of all services rendered, based on documentation (CPT Codes) from the Provider Note.


E&M

99213 EST OFFICE OUTPATIENT VISIT 15 MINUTES

Diagnosis (ICD-10)

1. Z30.42 Encounter for surveillance of inje (V25.49)
2. Z32.02 Encounter for pregnancy test, resu (V72.41)
3. Z11.3 Encounter for screening for infect...(V74.5)

Procedure	Program	Modifiers	Qty	Dx Pointers	Unit	Charge	Amount
99213 EST OFFICE OUTPATIENT VISIT 15 MINUTES	FP	FP	1	1	1.000	PU	282.00
81025 - URINE PREGNANCY TEST	FP		1	2	1.000	PU	3.12
85018 - HEMOGLOBIN	FP	90	1	1	1.000	PU	2.90

Comments

bleeding problem

Signed by RN. Whitfield, Tami on Monday, July 9, 2018 at 9:29 AM

remove Z11.3&remove 85018

Appended by [redacted] on Tuesday, August 21, 2018 at 2:09 PM

Review

eSuperbill

Charge Screen

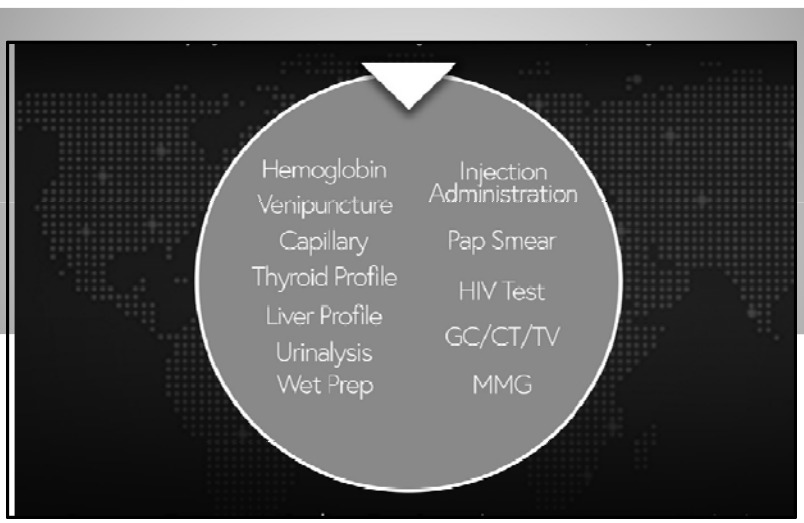
Billing component used in creating a bill file to submit to payer source

- 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.

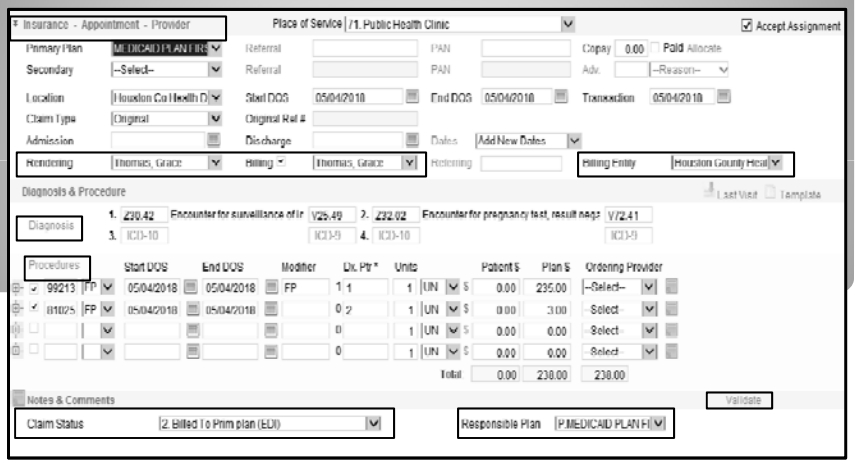
All Payers Are Not Alike

- 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.

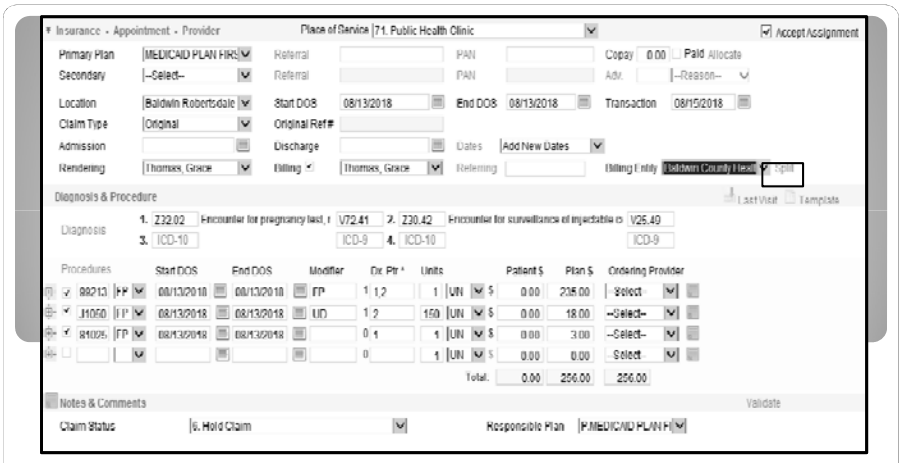
All Payers Are Not Alike



Medicaid Family Planning Global Fee

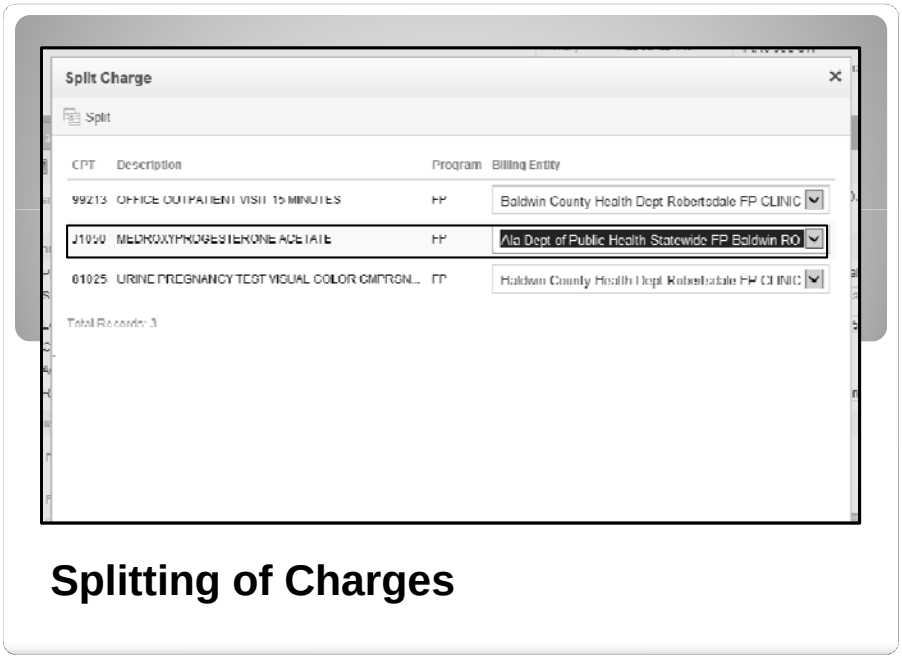


Key Elements of the Charge Screen

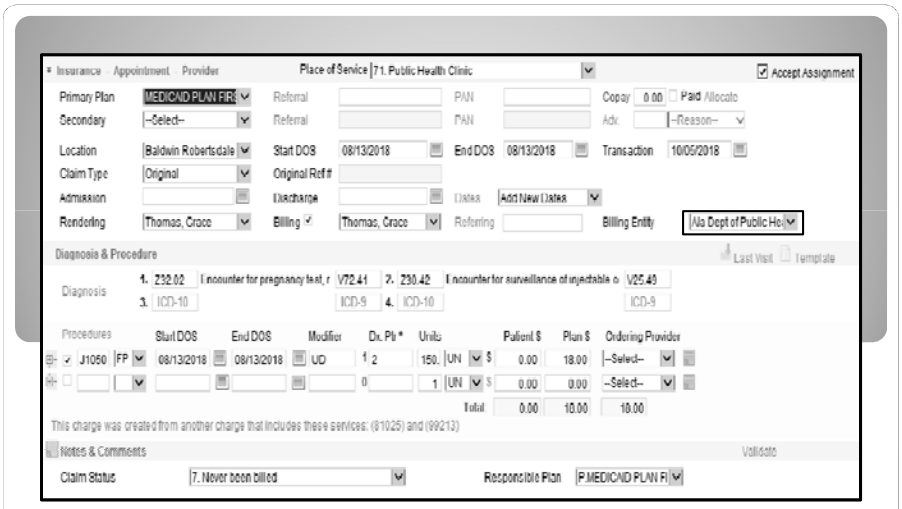


Splitting of Charges

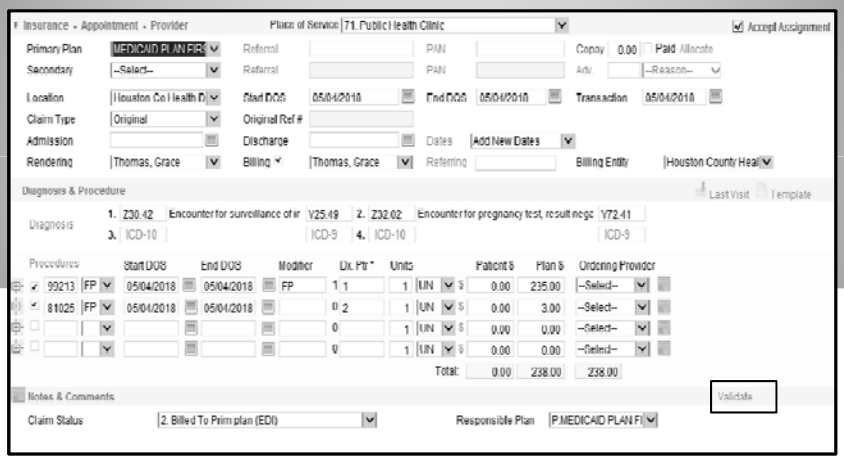
You should <u>ONLY</u> split charges if the method is billed back to the family planning state level NPI (ex. Rings, depo, IUDS)



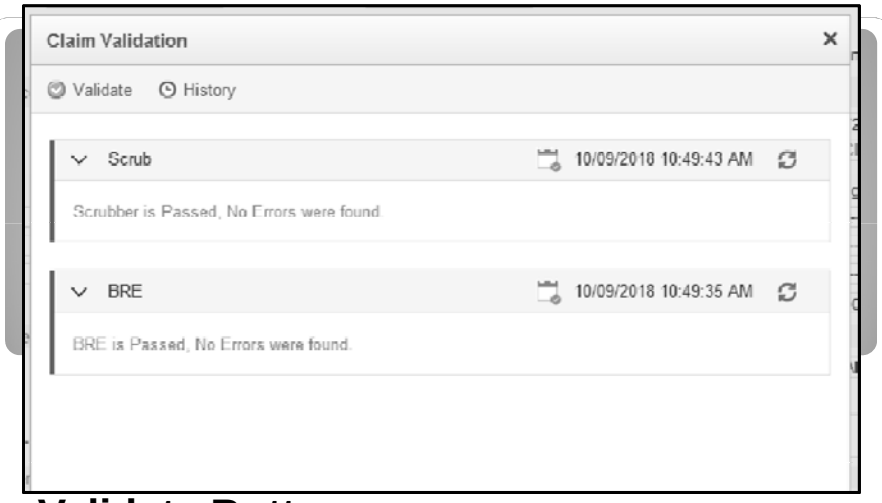
Splitting of Charges



Splitting of Charges

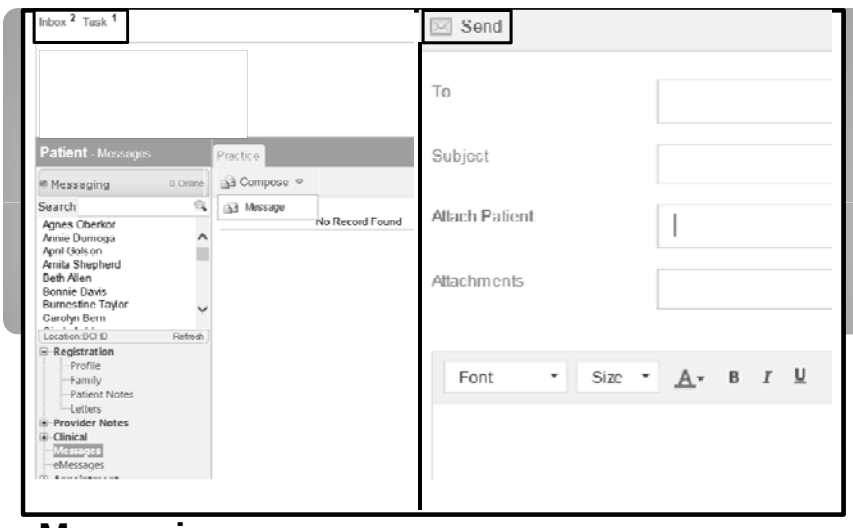


Validate Button



Validate Button

Two green bars as shown above, indicated charge is ready to be billed, based on info on charge screen



Messaging

Module used to send messages, charts, etc. to other user within the application.

CAN	CAN'T
• Document for all services rendered with the understanding of what services can be billed • Ex.: Medicaid Global Fee. Document hemoglobin and capillary but these services will not be on the charge screen but will appear on the eSuperbill • Utilize training materials for coding, provided by **CBU Only** • Proof eSuperbill for accuracy of services provided, before signing • Append eSuperbill to reflect any changes made	• Do not use **"Delete"** or **"Remove"** in any documentation, even if appending to make changes. The Provider Note must be appended to reflect the change. • Do not add services to the eSuperbill without having supporting documentation in the provider note • Clinicians were adding CPT codes to the eSuperbill that were not reflected in the Provider Note.

Recap for Clinicians

- **Patient Encounter: Doing the Work**
- **Documentation: Accurately recording the work**
- **Coding: Converting the work into numeric code(s)**
- **Billing: Charging for the work**
- **Payment: Receiving reimbursement for the Work**

Recap for Clinicians

Recap for Clinicians

- Clear and accurate documentation
  - Improve patient care, safety, and team communication
  - Support your billing and decrease risk if you are audited
  - Maximize return on your hard work

Recap for Clinicians

- Correcting Provider Documentation
  - Documentation must match the billed services – every billed service and its corresponding diagnosis code must be clearly documented in the medical record
  - Services must be medically necessary for the treatment of the patient's condition
  - If it wasn't documented – it did not happen and can not be coded or billed

- **Highest level provider MUST sign the provider note and the eSuperbill**
- **Be sure that we are using the ALFP1 for Emergency Contractive not S4993**
- **Refer to the policy for correcting documentation for retired/separated employees**
- **Incomplete exams are not to be billed to a payer.**

Quick Tips

Questions