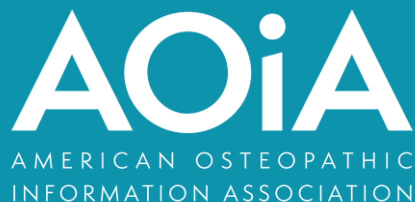
AMERICAN OSTEOPATHIC ASSOCIATION

Presents:

Billing, Coding and Documentation: A Primer

Kavin Williams, CPC
Manager of Physician Service and Coding



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Learning Objectives

- To provide information on Current Procedural Terminology (CPT), ICD-10 codes and Modifiers.
- To provide information on the relationship between documentation and coding
- To provide information on Modifiers and Place of Service
- To provide information on how physician services are valued

Current Procedural Terminology (CPT)

Current Procedural Terminology (CPT)

- The CPT is a five-digit set of codes and guidelines intended to describe procedures and services performed by physicians and other qualified healthcare professionals.
- The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians, and other healthcare providers, patients and third parties.
- The inclusion or exclusion of a procedure or service does not imply coverage or payment by any public or private insurer.
- However, payment for procedures or services begin with CPT codes.

Creation of CPT Codes

CPT Editorial Panel

- is responsible for maintaining the CPT nomenclature
- The Panel is comprised of 17 member
- 11 are physicians nominated by the AMA; one physician each nominated from the Blue Cross and Blue Shield Association, the Health Insurance Association of America, the American Hospital Association, and the Centers for Medicare and Medicaid Services (CMS), and the co-chair and a representative of the Health Care Professionals Advisory Committee Code Change Proposal

CPT Codes Components

- Preservice work
- Intraservice work
- Postservice work

How To Select A CPT Code

Locate the index in the CPT manual, select the main term:

- Procedure or service
  - For example: Endoscopy
- Organ or other anatomic site
  - For example: Colon
- Condition
  - For example: Abscess
- Synonyms, Eponyms, and Abbreviation
  - For example: EEG; Bricker Operation

ICD-10-CM Structure – Format

- 3 - 7 Characters
- P09 S32.010A
- O9A.211
- M1A.0111
- Codes longer than 3 characters always have decimal point after first 3 characters
- 1st character: alpha
- 2nd through 7th characters: alpha or numeric
- 7th character used in certain chapters (obstetrics, musculoskeletal, injuries, and external causes of injury)

ICD-10-CM and ICD-10-PCS

ICD-10-CM:

- Is a set of alphanumeric (clinical modification) codes used in the *outpatient* setting to identify and report known diseases and other health problems.

ICD-10-PCS:

- Is a set of alphanumeric (procedure coding system) codes used in the *inpatient and hospital* settings to identify and report known diseases and other health problems.

Documentation Basis

Documentation Basics

- The medical record should be first and foremost a tool of clinical care and communication.
- Must be clear and legible
- If it’s not documented, it wasn’t done

Documentation Basics
...Continued

- The documentation of each patient encounter should include or provide reference to:
  - The chief complaint and/or reason for the encounter and, as appropriate, relevant history, examination findings and prior diagnostic test results;
  - Assessment, clinical impression or diagnosis;
  - Plan for care, and;
  - Date and legible identity of the physician

Documentation Basics
...Continued

- If not specifically documented, the reason for the encounter and/or chief complaint and the rationale for ordering diagnostic and other services should be able to be easily inferred.
- Past and present diagnoses and conditions should be accessible.

Documentation Basics
…Continued

- The patient's progress, response to and changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.
- The confidentiality of the medical record should be fully maintained consistent with the requirements of medical ethics and of law.

Documentation Basics
...Continued

- The CPT and ICD-10 codes reported should:
- be supported by the documentation in the medical record
- be at a level sufficient for a clinical peer to determine whether services have been accurately coded.

Documentation Guidelines (cont.)

The documentation of each patient encounter should include:

- Reason for the encounter (chief complaint)
- History
- Physical examination findings (diagnosis)
- Plan for care (medical decision making)
- Be sure to include the date and legible identity (signature) of the provider of service

Documentation Guidelines for E/M Services

- The 1995 or 1997 documentation guidelines may be used, <u>not both</u>
- 1997 guidelines provide comprehensive single organ system examination

Documentation & Coding

- Code selection is based on what you document.
- Select the code that most accurately describes the procedure or service performed.

E/M Documentation Guidelines

- Developed jointly by the AMA (CPT Editorial Panel) and the US Government (HCFA).
- Two versions are currently in use - 1995 and 1997.

E/M Documentation Guidelines Update

- CMS has stated that Medicare carriers, when evaluating claims, will continue to use both the
  - 1995 (multisystem exam) Guidelines and
  - 1997 Single System Guidelines,
- Whichever is more advantageous to the physician

Levels of E/M services

- There are five levels of service for new (99201-99205) and established outpatient (99211-99215) E/M services.
- The level of service is determined by the extent of the three **key** components:
  - History
  - Examination
  - Medical decision making

Levels of E/M Services

- Each of the three key components has four levels of complexity
- Each level of complexity contains a variable number of elements
- Some codes require “3 of 3” key components (e.g., new patient office visit); other codes require only “2 of 3”

Components of E/M Services

There are three key components for determining the level of the E/M service.

1. History
2. Examination
3. Medical Decision Making

1. History

History

- Chief Complaint, brief statement of why the patient is at the office, preferably in their own words
- History of present illness (HPI) what's been going on
- Review of Systems: Body Systems Inventory
- Pertinent Past, Family and Social History (PFSH)

2. Physical Examination

You can have a physical examination of a;

- General multi-system **examination** involves the examination of one or more organ systems or body areas
- Single organ system examination involves a more extensive examination of a specific organ system

3. Medical Decision Making (MDM)

Consists of:

- The number of diagnoses or Treatment Options to be considered
- The amount and/or Complexity of data to be reviewed
- The risk of complication and/or Morbidity/Mortality, which addresses
  - Level of Risk
  - Presenting Problem(s)
  - Diagnosis Procedure(s) Ordered, and
  - Management Options Selected

Coding For Time

- When is it appropriate to code for time?
- What is the auditor looking for when they review a chart that was billed as time being the controlling factor?

Tips for verbage when billing for time.

- In your note it should read “ I spent 45 minutes with the patient and over 50% of that time was spent discussing ……
- Example of incorrect documentation of time:
- “I spent 45 minutes with the patient, discussed surgical options versus medical management.

3 key things to remember when coding for time

- Does the documentation reveal the total time?
- Does the documentation describe the content of the counseling and coordination of care?
- Does the documentation show that more than 50% of the visit time was spent counseling and coordination of care with/for the patient?

F/U

What does F/U means when its listed as the chief complaint?

COUNSELING/COMPLAINT REMEDY ______ TIME ______

[illegible]

PHYSICAL EXAM

Head - PERLA___ Rinse___ Conjunctiva___ Headaches___ Migraine___ Cluster___ TM___ Canals___

Nasal___ Mucous Congestion___ Deviated Septum___ Nose Bleed___ Sinuses___ Nodes___

Mouth___ Abscess___ Infection___ Mass___ [illegible]

Neck - Nodes___ Mass___ Torticollis___

Lungs - Bronchitis___ Pneumonia___ Asthma___ Excursion___ Nodes___ CHF___ COPD___ SOB___

STRIDER___ Percussion___

Heart - RRR___ MS___ MD___ Grade___ WR___ BP___ CHF___

GI - Ulcer___ Pancreatitis___ Diverticulitis___ Hernia___ Liver___ Spleen___ GB___ Diabetes___

Pancreas___ Melena___ Hemorrhoids___ Constipation___ Diarrhea___ Nausea___

Blood - Iron___ B12___ B6___ Anemia___

Endos. - Thyroid___ Pituitary___ Adrenals___ Estrogen___ Testosterone___ Parathyroid___

Gyn. - Pap___ Pelvic___ Menopause___ Oligo___ Amen___ DUB___ PID___ Endometriosis___

Infertility___ Infection___ Dyspareunia___ Yeast___ Ovarian Cyst___ Fibroid___

NEW COMPLAINT: [illegible]

[illegible]

PLAN: [illegible]

URI [illegible]

FS000753

Modifiers

Modifiers

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

A modifier may describe whether multiple procedures were performed, what that procedure was necessary, where the procedures was performed on the body, how may surgeons worked on the patient, and provide other information that may be critical to a claim's status with the insurance payer.

The Most Commonly Used Modifier

25-Significant, Separately Identifiable Evaluation and Management Service:

It may be necessary to indicate that on the day a procedure or service identified by the CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided, or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

59-Distinct Procedural Service:

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

51-Multiple Procedures

When multiple procedures, other than E/M service, Physical Medicine and Rehabilitation services or provision of supplies are performed at the same session by the same provider. Report the primary service the additional service listed should be reported and appended with Modifier-51.

Payment Process

- Schedule appointment
- Patient presents for appointment
- Clinical staff treats patient
- Document the visit
- Assign code(s) to claims (charge ticket or manually by staff)
- Submit claims for payment

Superbill or CMS 1500 Claim Form

If you don't accept Insurance:

- You may provide your patients with a Superbill;
  - A Superbill is essentially a receipt of the services you have provided your patients. Patients can submit these to their insurance companies to (potentially) get reimbursed for services.

If you accept insurance:

- Submit a CMS 1500 Claim form;
  - A CMS 1500 claim form is an insurance claim form for healthcare providers, in the outpatient setting. Inpatient claims are submitted using a form is like a UB-04.

You will complete the 1500 claim form each time you wish to submit an insurance claim.

How are Superbills and 1500 Claim Forms Different?

You use a CMS 1500 form when you are an in-network provider with an insurance company. You use a Superbill when you’re not an in-network provider.

With a Superbill, you still accept out-of-pocket payments for your services, but your client can receive reimbursement for their bill by submitting their Superbill to their insurance company.

PICA

TRICARE | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

STATE

8. RESERVED FOR NUCC USE

CITY | STATE

TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

[illegible] OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
[illegible] SIGNATURE [illegible]

DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE [illegible]

SIGNED

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

20. OUTSIDE LAB? YES NO $ CHARGES

ICD Ind.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H.	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
							NPI	
							NPI	
							NPI	
							NPI	
							NPI	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

National Provider Identifier (NPI) Number

- An NPI number is a 10 digit identification number for healthcare providers.
- There are two types of NPI numbers.
  - Type 1 is for practitioners
  - Type 2 is for the practice (solo, group)
- The NPI number is different from the Tax Identification Number (TIN)

Tax Identification Number (TIN)

A Taxpayer Identification Number (TIN) is an identifying number used for tax purposes in the United States. It is also known as a Tax Identification Number or Federal Taxpayer Identification Number. A TIN may be assigned by the Social Security Administration or by the Internal Revenue Service (IRS).

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH

X 24024
A 93779

39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE
a				
b				
c				
d				

DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-CO
CE VISIT PT, COMPLE	99213	033105	1	110 00	
567890123456789012 3					
8901234567890123456					
0123456789012345678 9					
4567890132456789012					
7890					
OF	CREATION DATE		TOTALS		
1 1.		121013		110 00	

	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	41
	33A11199	N	N		110 00	57 OTHER PRV ID	GRPNP
LD OF CA	33A11199	N	N				

	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
01234567890	18	453215616		GRP NO
JACK G	01	453215616BC		BC GROUP

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
		ABC XYZ
		GOOD JOB

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False Claims Act (FCA)

The FCA protects the Federal Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who **knowingly** submits, or **causes** the submission of, a false or fraudulent claim to the Federal Government.

- Example: A physician knowingly submits claims to Medicare for a higher level of medical services than actually provided or higher than the medical record documents. (*Upcoding*)
- The same rule apply for reporting a lover level of medical services than actually provided or higher than the medical record documents. (Down coding)
- The civil penalties for violating the FCA may include fines of up to three times the amount of damages sustained by the Government as a result of the false claims plus up to $21,563 (in 2016) per false claim filed.

Things You Should Know

- Contracts
- Salary Structure
- Payers
- Health Plans
- Audit Process

Billing for Osteopathic Manipulative Treatment (OMT) When A Resident Physician Performs The Procedure

Per guidance from the Centers for Medicare & Medicaid Services (CMS), Medicare pays for services furnished in teaching settings through the Medicare Physician Fee Schedule (PFS) if the services in question meet one of the following criteria:

1. They are personally furnished by a physician who is not a resident;

2. They are furnished by a resident when a teaching physician is physically present during the critical or key portions of the service; or

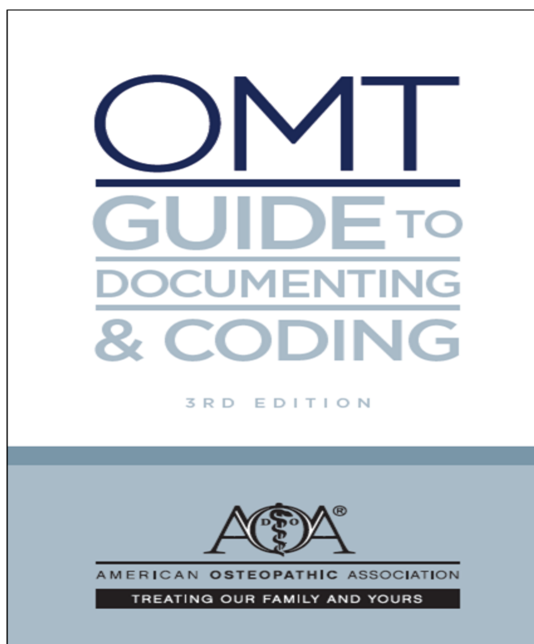
3. They are furnished by a resident under a primary care exception (PCE) within an approved Graduate Medical Education (GME) program.

Billing for Osteopathic Manipulative Treatment (OMT) When A Resident Physician Performs The procedure….cont.

- Medicare will pay for services provided by a resident only if a teaching physician is present during “critical or key portions” of the service or procedure.
- Unfortunately, there is no existing guidance on what CMS considers to be “critical or key portions” of an OMT procedure.

AOA Resources

- http://osteopathic.org/physicianservices
- http://osteopathic.org/MACRA
- www.Aoaonlinelearning.osteopathic.org
- www.osteopathic.org/AOAstore



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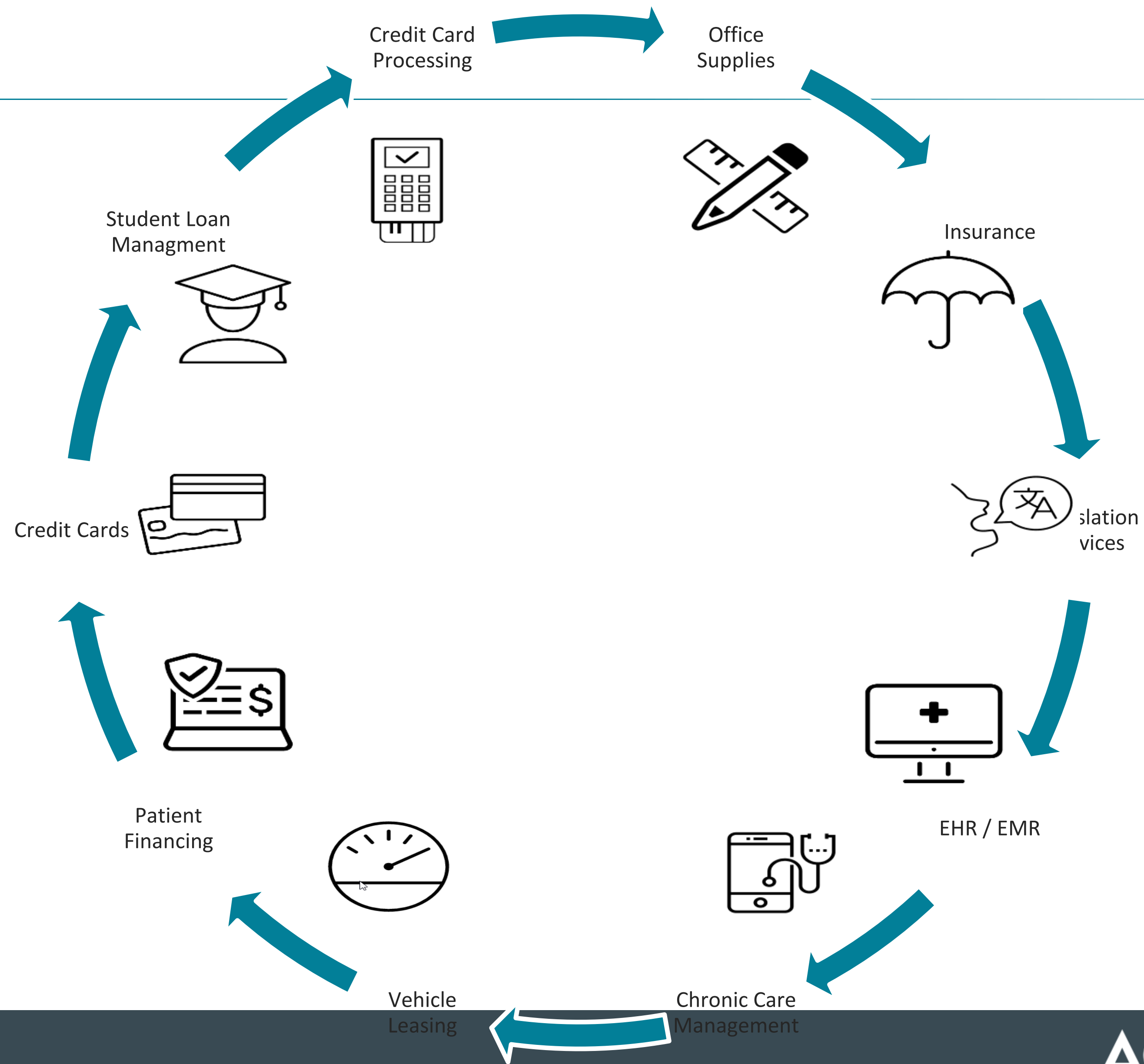

Q&A

AOA Department of Physician Services

Email physicianservices@osteopathic.org

Call (888-62-MY AOA)