CONVENTUS | HCPM Health Care Practice Management, Inc.

Getting Paid and Keeping it:

Documentation & Coding Requirements

Wednesday, April 3, 2019

Cindy Groux, CHBME

Practice Protectors | Forward Lookers | Solution Partners

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Technical Assistance

- Technical Assistance Telephone Number
  - **732-362-5724**
- Question Submission for Q&A Session
  - Type your question into the Questions Box on the control panel on your screen

Please jot down this information

Conventus Practice Resources

For Conventus Members Only:

- 24/7 Practice Advice Hotline
  - ***Contact the hotline for "Audit Hotspots and Triggers"***
- Consulting Services
  - Risk and Compliance Management Consultation
  - Practice Transformation and Quality Improvement Consultation
  - Patient and Staff Engagement Services (CARE Program)
- Strategic Partnerships
  - Fraud & Program Integrity Services, HIPAA, OSHA, Security Risk Analysis, CME for MOC, & more!
- Practice Management Resources
  - Out-of-Network Toolkit, Pain Management Toolkit and more

Presenter

CINDY GROUX, CHBME

Health Care Practice Management, Inc.
1602 Newport Gap Pike
Wilmington, DE 19808-6208

Office: 302-633-5840 ext. 320
Mobile: 302-593-6239
cgroux@hcpm.net
www.hcpm.net

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What You Will Learn

- Auditors tool utilized to review your documentation
- General principles of E/M Coding and Documentation
- Documentation guidelines to establish the appropriate level of service
- M.E.A.T guidelines to accurately evaluate and document for chronic diseases
- Hierarchical Condition Coding (HCC) and why it is important
- Avoid billing risk adjustments – Use of modifiers 25 and 59

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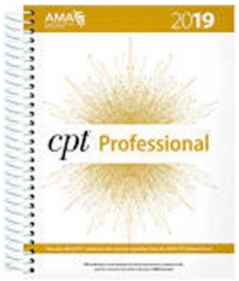
Evaluation and Management (E/M) Coding



- Introduced in 1992
- E/M codes range from 99201 – 99499
- These codes can be found in the CPT (Current Procedural Terminology) book updated ***every year***.
- The E/M codes are designed to *classify* services provided by physicians in ***evaluating*** patients and ***managing*** their medical care.
- These codes incorporate the ***key*** and ***contributing components*** of a physicians service to determine ***the level of service***.
- These codes are utilized to receive reimbursement for the services provided.

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E/M Categories Based on Site and/or Type of Service

Office or Other Outpatient Service	Hospital Observation Services	Hospital Inpatient Services	Consultations	Emergency Department	Nursing Facility Services Domiciliary
New – 99201-99205	Observation discharge – 99217	Initial Hospital Care – 99221-99223	Office/Outpatient – 99241-99245	99281-99285	Initial NF Care – 99304-99306
Established – 99211-99215	Initial Observation Care – 99218-99220	Subsequent Hospital – 99231-99236 Hospital Discharge – 99238-99239	Inpatient – 99251-99255		Subsequent NF Care – 99307-99310 – 99316 Other NF services – 99318
					Domiciliary New Pt – 99324-99328 Established – 99334-99337

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E/M Categories Based on Site and/or Type of Service (Cont'd)

Prolonged Services (Face-to-Face)	Preventive Medicine Services	Newborn	Non-Face-to-Face Physicians Services	Care Plan Oversight	Special E/M Services
With direct PT contact – 99354-99357	New Pt – 99381-99387	99431-99440	Telephone Services – 99441-99443	99374-99380	Basic life/Disability Eval – 99450 Work Related – 99455-99456
Without direct Pt Contact – 99358-99359	Established Pt – 99391-99397		On Line Medical Evaluation – 99444	Home Services	Other E/M Services
Physician Standby Services – 99360	Counseling Risk Factor Reduction and Behavior Change Intervention – 99401-99429			New Patient – 99341-99345 Established Patient – 99347-99350	9947-99499

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CPT Code Book Structure

- E/M codes all begin with 99
- Each code provides a description of the code, which includes the *site and type of service* and the level of E/M performed.
- Content of each description will provide the *key components* and *contributing components* to the service.
- Each code will provide an estimated time generally required for the physician to complete the service. (Time can be utilized as the benchmark for the level of coding which will be discussed in further detail)

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Office Visit Levels of Service

- ***New patients*** – 5 levels of service (99201-99205)
  - An individual who did not receive any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous 3 years.
- ***Established patients*** – 5 levels of service (99211 – 99215)
- The Higher the level of code – the more complex the visit.
- ***Well Visits*** (Physicals) are selected based on the age of the patient and if they are a New or Established patient. (99381-99387 and 99391-99397)

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99214 – Representing the Next to Highest (Level 4) CPT Code

- ***99214*** – Office or other outpatient visit for the evaluation and management of an established patient, which requires these three components:
  - Detailed History
  - Detailed Physical Exam
  - Medical Decision Making of **MODERATE** Complexity

  Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

  Usually, the presenting problems are 25 minutes are spent face-to-face with patient and/or family

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99215 – Representing the Highest (Level 5) CPT Code

- ***99215*** – Office or other outpatient visit for the evaluation and management of an established patient, which requires these three components:
  - *Comprehensive History*
  - *Comprehensive Physical Exam*
  - *Medical Decision Making of HIGH Complexity*

  Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

  Usually, the presenting problems are 40 minutes are spent Face-to-Face with patient and/or family

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Documentation of E/M Services – 7 Components

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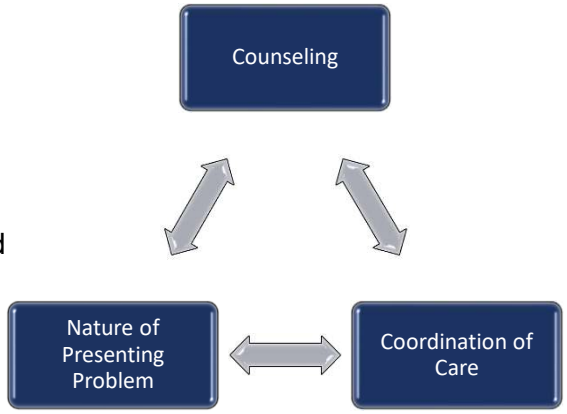
How do you choose your exam level?

3 Key Components for each level		
History	Examination	Medical Decision Making

Contributory Factors for the Majority of Encounters

- Counseling and Coordination of Care are an important part of the E/M Service. It is not required that each of these services are provided at each exam



Nature of Presenting Problem

Minimal	Self-limited or Minor	Low Severity	Moderate Severity	High Severity
• Problem may not require the presence of a Physician or other qualified health care provider	• Problem runs a definite and prescribed course • Not likely to permanently alter health status	• Risk of morbidity w/o treatment is low • No risk of mortality without treatment • Full recovery w/o functional impairment	• Risk of morbidity w/o treatment is moderate • Uncertain prognosis OR increased probability of prolonged functional impairment	• Risk of morbidity w/o treatment is high to extreme • Moderate to high risk of mortality w/o treatment OR high probability of severe, functional impairment

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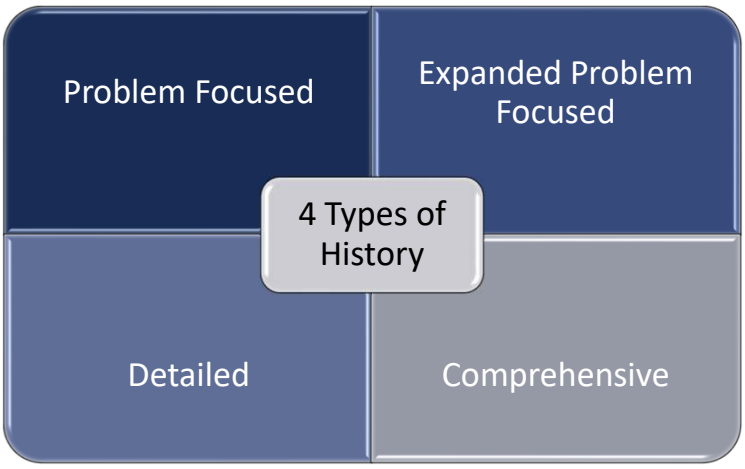
History



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Type of History

- Each type of history includes:
  - Chief complaint (CC)
  - History of present illness (HPI)
  - Review of Systems (ROS) and
  - Past, family and/or social history (PFSH)
- The nature of the presenting problem will determine the extent of the present illness, review of systems and past, family and/or social history that is obtained and documented

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Chief Compliant Must be documented for every encounter

Concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the *reason for the encounter, usually stated in the patient's words*

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History of Present Illness (HPI)

- **HPI** – chronological description of the development of the patient's present illness from the first sign and/or symptom to the present
- ***Brief HPI*** – Medical record should describe 1-3 elements of the present illness
- ***Extended HPI*** – Medical record should describe four (4) or more elements of the present illness or associated comorbidities

Elements of Present Illness

Location (right ankle)	**Quality** (aching, burning, radiating pain)	**Severity** (10 on a scale of 1 – 10)	**Duration** (started 2 days ago)
Timing (constant or comes and goes)	**Context** (lifted heavy object at work)	**Modifying factors** (better when ice is applied)	**Associated signs and symptoms** (numbness in toes)

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Review of Systems (ROS)

ROS is an inventory of the body through a series of questions seeking to identify signs/symptoms.

Constitutional Symptoms	Eyes	Ears, Nose, Mouth, Throat	Cardiovascular	Respiratory	Gastrointestinal	Genitourinary
Musculoskeletal	Integumentary (Skin or Breast)	Neurological	Psychiatric	Endocrine	Hematologic/ Lymphatic	Allergic/ Immunologic All others negative

- ***Problem Pertinent ROS*** – inquires about the system directly related to the problem(s) identified in the HPI *One system*
- ***Extended ROS*** inquires *about the system directly related* to the problem(s) identified in the HPI and a *limited number of additional systems*.
  - Patient's positive or negative response should be documented for two – nine systems.
- ***Complete ROS*** – *at least 10 organ systems must be reviewed and documented*. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least 10 systems must be individually documented.

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Past, Family and/or Social History (PFSH)

Past History	• ***Patients*** past experiences with illness, operations, injuries and treatments
Family History	• Review of medical events in patients family • Include diseases which may be hereditary or put the patient at risk
Social History	• Age appropriate review of past and current activities

- ***Pertinent PFSH*** – at least one (1) specific item from any of the three of the PFSH areas (depending on the *category* of the E/M service). For Categories of *subsequent hospital care*, *follow-up inpatient consultations* and *subsequent nursing facility care*, CPT requires only an "interval" history. It is not necessary to record information about the PFSH.
- ***Complete PFSH*** – Review of at least two of the three history areas above must be documented based on the categories of E/M Services below:

Office/Outpatient – Established Patient	Emergency Department	Subsequent Nursing Facility Care	Domiciliary Care – Established Patient	Home care – Established Patient

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Documentation of History

A Chief Complaint is indicated at all levels

All three elements required for each type of history must be met to qualify for that level

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	***Problem Focused***
Brief	Problem Pertinent	N/A	***Expanded Problem Focused***
Extended	Extended	Pertinent	***Detailed***
Extended	Complete	Complete	***Comprehensive***

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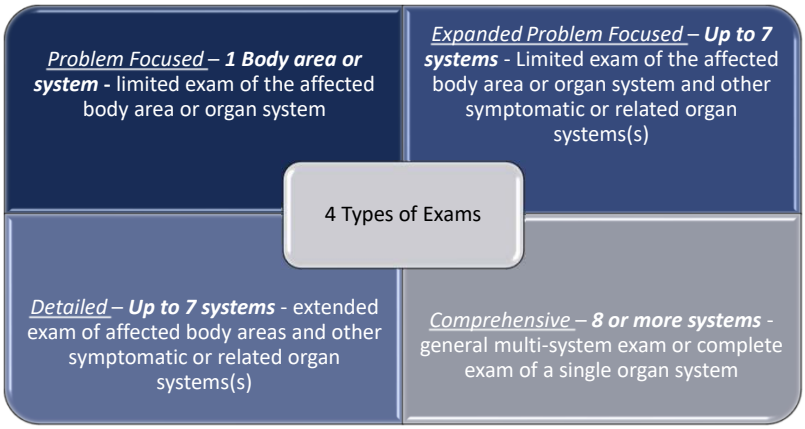
Exam Documentation Requirements



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Examination Body Areas

Head (including the face)	Neck	Chest (including breasts and axillae)	Abdomen	Genitalia, Groin, Buttocks	Back	Each Extremity

Organ Systems recognized for the purpose of the examination

Constitutional (vital signs, general appearance)	Eyes	Ears, nose, mouth and throat	Cardiovascular	Respiratory	Gastrointestinal
Genitourinary	Musculoskeletal	Skin	Neurologic	Psychiatric	Hematologic Lymphatic Immunologic

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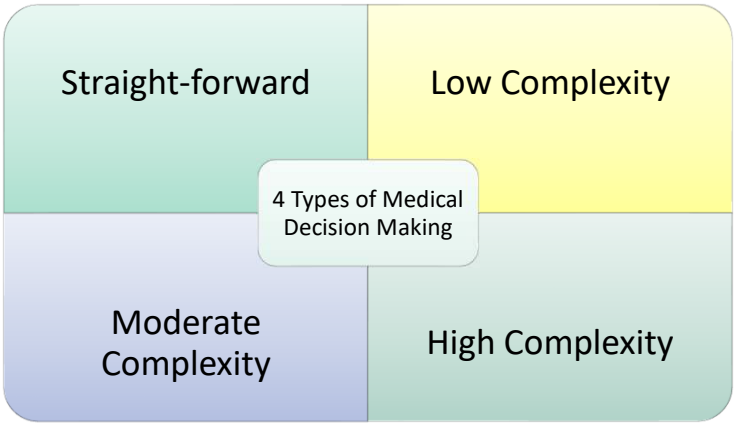
Documentation of the Medical Decision Making



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Medical Decision Making (MDM)

MDM refers to the complexity of establishing a diagnosis and/or selecting management options:

Two of the three elements in the table must be either *met or exceeded*

Number of DX or Treatment Options	Highest Risk of Complications and/or morbidity or mortality	Amount and complexity of data to be reviewed	*Type of Decision Making*
Minimal	Minimal	Minimal or low	***Straightforward***
Limited	Low	Limited	***Low Complexity***
Multiple	Moderate	Multiple	***Moderate Complexity***
Extensive	Extensive	Extensive	***High Complexity***

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MDM (Cont'd)

The number of Diagnosis codes and/or management options are based on:	• The number and types of problems addressed during the encounter • Complexity of establishing a diagnosis • The management decisions that are made by the physician
The amount and/or complexity of data to be reviewed:	• Based on types of diagnostic testing ordered or reviewed • Decision to obtain and review old medical records • Increases the amount and complexity of data to be reviewed
Risk of significant complications, Morbidity, and/or Mortality	• Based on the risks associated with the presenting problem(s), diagnostic procedure(s) and the possible management options

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Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedures(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem. e.g. Cold, insect bite	Laboratory tests requiring venipuncture, Chest x-rays, EKG/ECG, urinalysis, Ultrasound	Rest Gargles Elastic Bandages Superficial dressing
Low	Two or more self-limited or minor problems	Physiologic test (not under stress), non-cardiovascular imaging, skin biopsies,	Over the counter drugs, Minor surgery, PT, OT, IV Fluids
Moderate	One or more chronic illness with mild exacerbation, progression or side effects of treatment, Two or more stable chronic conditions Undiagnosed new problem	Physiologic tests under stress (cardiac stress test), Diagnostic endoscopies, deep needle biopsy, Cardiovascular imaging studies, Obtain fluid from body cavity	Minor surgery with identified risk factors, elective major surgery, prescription drug management, IV Fluids with additives, Closed treatment of fracture or dislocation without manipulation
High	Acute or chronic illnesses or injuries that pose a threat to life or bodily function	Cardiovascular imaging studies with contrast, Cardiac electrophysiological tests	Elective major surgery, Emergency major surgery, Drug Therapy

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Time

- When counseling and/or coordination of care dominates **(more that 50%)** the encounter with patient and/or family (face-to-face time in office or out patient setting or floor unit) the time shall be considered ***the key or controlling factor*** to qualify for a particular level of service.
- **Face-to-face time** (office and other out patient and office consultations)
  - Defined as only that time spent face-to-face with the patient and/or family
    - Includes time spent performing tasks such as obtaining history, examination, and counseling the patient
    - Time also spent doing work before or after the visit such as reviewing records, tests, arranging further services, communicating with other professionals and patient through written reports and telephone contact
- **Non face-to-face** time for hospital services
  - Unit/floor time
    - Includes time present on the patient's hospital unit and at the bedside rendering service for the patient
    - Time to establish and review patient's chart, examine of the patient, write notes, communicate with other professionals and patient's family

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Examples of Proper Documentation of Time

- I spent 30 minutes face-to-face with the patient and over half in discussion of the diagnosis and the importance of compliance with the treatment plan.
- I spent 30 minutes on the unit, over half in counseling the patent and coordinating her follow-up care after discharge.
- Avoid using for **all visits** and avoid using the **same time** for all visits. Not all visits are 15 and 25 minutes.
- **Most importantly, *Not all visits are dominated by counseling the patient!***

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M.E.A.T Really is Better When it's Well Done!

- The official ICD coding guidelines state that a condition must be present at the time of the encounter, affect the patient care or management and be clearly documented in order to be coded as a diagnosis.
- The *Diagnosis **MUST*** be based on clinical medical record documentation from a face-to-face encounter.
- A well documented progress note would include the *HPI, ROS, physical exam* and show the *MDM process.*
- ***Each diagnosis must be documented in the assessment and care plan*** and each diagnosis must show that the provider is **M**onitoring**, E**valuating, **A**ssessing/addressing or **T**reating the condition (M.E.A.T)
- *Paint the picture! If it is not documented, it didn't happen!*

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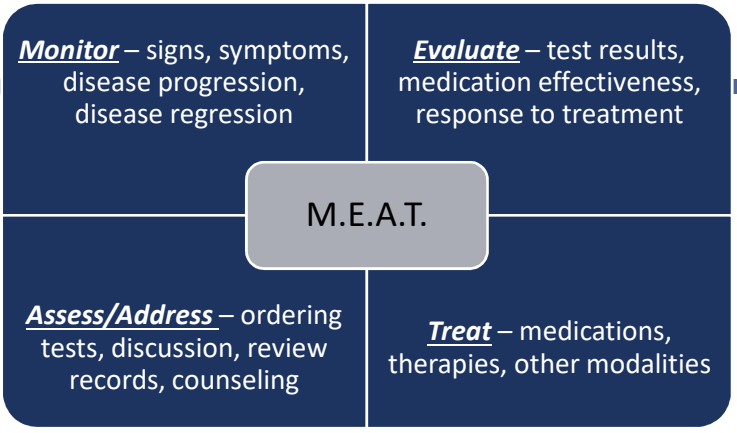

Simply listing every diagnosis in the Medical Record does not support a reported Hierarchy Coding Categories (HCC) code. An acceptable problem list must show evaluation and treatment for each condition that relates to an ICD code

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Risk Adjustments and the Impact on Your Payments

Risk Adjustment is a model CMS uses to adjust capitation payments to the private health care plans for the health expenditure risk of their members.

CMS measures the disease burden that includes 79 HCC categories (Hierarchy of Coding Categories), which are correlated to diagnosis codes. Over 9,500 ICD-10 codes are mapped to one or more of the 79 HCC categories

Patients can have more than one HCC category assigned to them

Common "chronic" conditions that Medicare Advantage plans expect to be documented in the chart

- Diabetes without complications
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Breast Cancer
- Ischemic Heart Disease
- Angina

HCC (Hierarchical Condition Category) Key Points

ICD-10 codes mapped to Hierarchical Condition Category (HCC) codes are used to determine the severity of illness of patient panels.

New payment models include risk-adjustment factors for patient health status. (Future Payment Models)

Physicians should report not only the diagnosis codes that describe why a patient was seen but also any diagnosis codes associated with chronic conditions that affect treatment choices.

Patient risk scores are reset each year, so physicians should comprehensively code chronic conditions at annual visits.

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HCC (Hierarchical Condition Category)

Each patient is assigned a risk score based on demographics and health status.

Age, Gender, Dual Medicare/Medicaid eligibility, Patients residence (Home, institution), Health Status

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Modifier 25

- ***Definition:*** Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
  - A *significant, separately identifiable E/M services* is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.
  - The E/M may be prompted by the symptom or condition for which the procedure/service was provided
  - A different diagnosis *is not* required for reporting of the E/M service on the same date

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Do Not Use Modifier 25

When billing for services performed during a postoperative period if related to the previous surgery

If there is only one E/M service performed during the office visit and no procedure

When a minimal procedure is performed on the same day unless the level of service can be supported as significant, separately identifiable

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Modifier 59

- Most commonly misused modifier
- Should not be used if a more appropriate modifier is applicable
- Should never be used to "get a claim paid"
- It is normally used to indicate that two or more procedures were performed during the same visit to different sites on the body
- Appropriate use of modifier 59 would be for a dermatologist performing a Photo Dynamic therapy session on face/scalp and then preforming the same procedure on an extremity
  - Code: 96567 and 96567-59

Modifier 59 (Cont'd)

Distinct Procedural Service

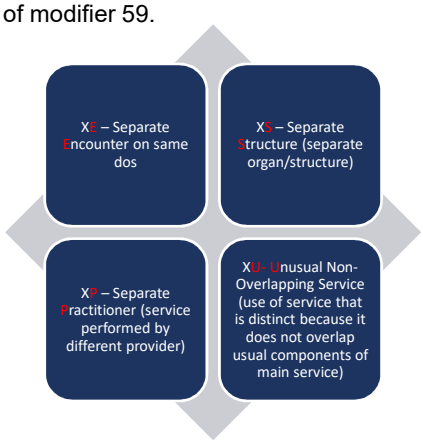
Used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.

Common use of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed at different anatomic sites, are not ordinarily performed or encountered on the same day, and that cannot be described by one of the more specific anatomic modifiers (RT, LT, E1-E4 etc.).

Documentation must support a different procedure or surgery; different site or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Modifiers XE, XS, XP and XU (effective January 1, 2015)

- These modifiers were established to provide greater reporting specificity in situations where modifier 59 was previously reported and should be used in place of modifier 59.



Effective April 12, 2019
Independence BC will deny single line claims that are billed with Modifier 59.

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About Us

HCPM offers clients a comprehensive billing and collection service, EMR, as well as a consulting program that seeks to improve practice profitability by reviewing billing procedures (including the appropriateness of current CPT and diagnostic coding). One of the most important management services we provide is helping physicians revitalize outdated billing systems.

As New Jersey's premier professional liability insurer formed by and governed through an alliance of physicians, Conventus is devoted to serving the best interests of independent physician practices. Conventus members and their staff enjoy exclusive access to insurance products and highly personalized services, gaining the practical knowledge and expert resources they need to improve practice performance, better serve their patients, and remain independent. The Conventus team prides itself on being forward lookers and solution partners whose sole purpose is to help independent physician practices thrive in today's rapidly changing healthcare environment.