Billing, Coding, Auditing, Revenue Cycle Training by BCA

Tough Topics in the FQHC:

Communicating Effectively with Clinicians

Learning Objectives

At the completion of this educational activity, the learner will be able to:

01 Understand what effective communication is

02 Recognize individual roles that impact effect communication

03 Identify relevant content to communicate

04 Deliver relevant content effectively

05 Impact quality of compliance programs, quality measures and reimbursement outcomes

Agenda

01 Effective Communication Defined	02 Roles of Communicators
03 Identify relevant discussions • What is necessary • Who is involved	04 Discuss Scenarios
05 Tools & Recommendations	06 Take Homes

Effective Communication

Correct Message

Precise Message

Consideration of Recipient

Complete Message

Reliability

Sender’s Courtesy

Challenges

01

EMR Templates/Guidance

02

Identifying Gaps

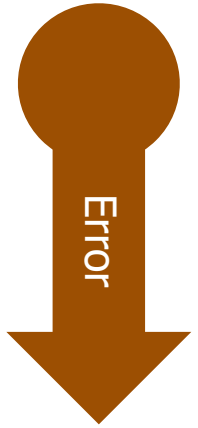
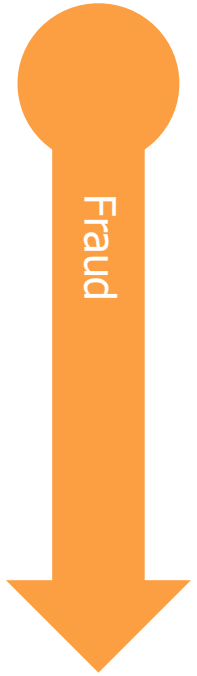
03

Communication Barriers between roles

04

Time

Spectrum of Compliance Program Integrity

Mistakes	Inefficiencies	Bending the Rules	Intentional Deception
			
Incorrect Coding	Medically unnecessary services	Improper Billing/neglecting rules	Billing for services/supplies not provided. Changing codes for reimbursement.

Communication Opportunities

01

Educational Audit Feedback

- Results
- Documentation Pitfalls
- Coding influence
- Recommendations

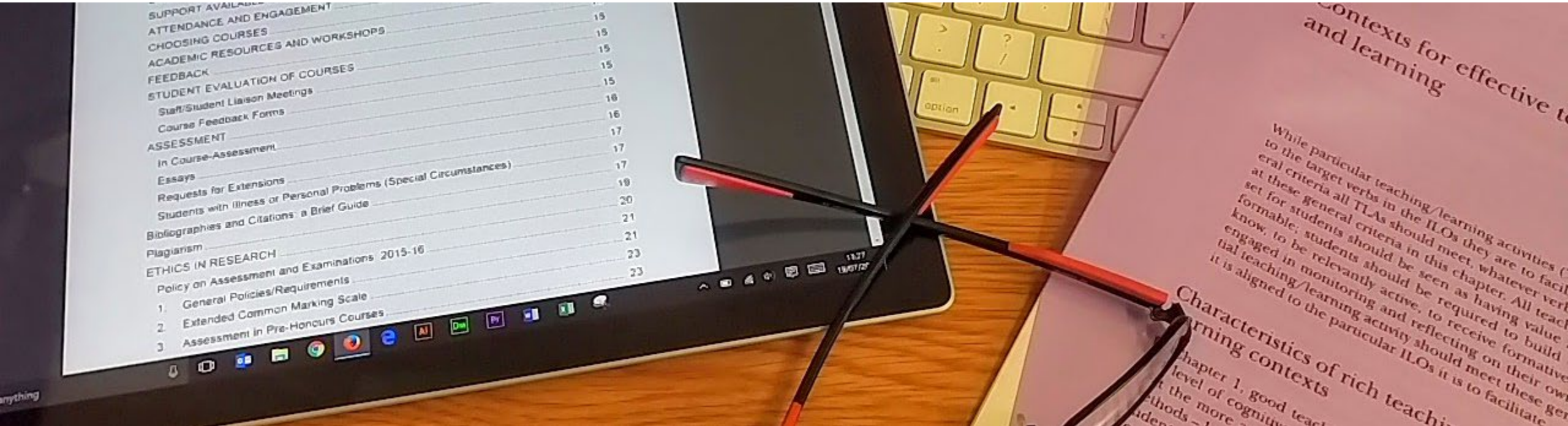
02

Queries

A Clinicians Role: Defining Documentation

"The main purpose of documentation is to support care of the patient by current and future health care team(s)."
-CPT Professional Edition 2021

- Provide quality documentation about the patient encounter
- Understand/appreciate impact of well written records



Emphasis on Documentation

ICD-10-CM Official Guidelines for Coding and Reporting
FY 2022
(October 1, 2021 - September 30, 2022)

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2021 version
***Italics* are used to indicate revisions to heading changes**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

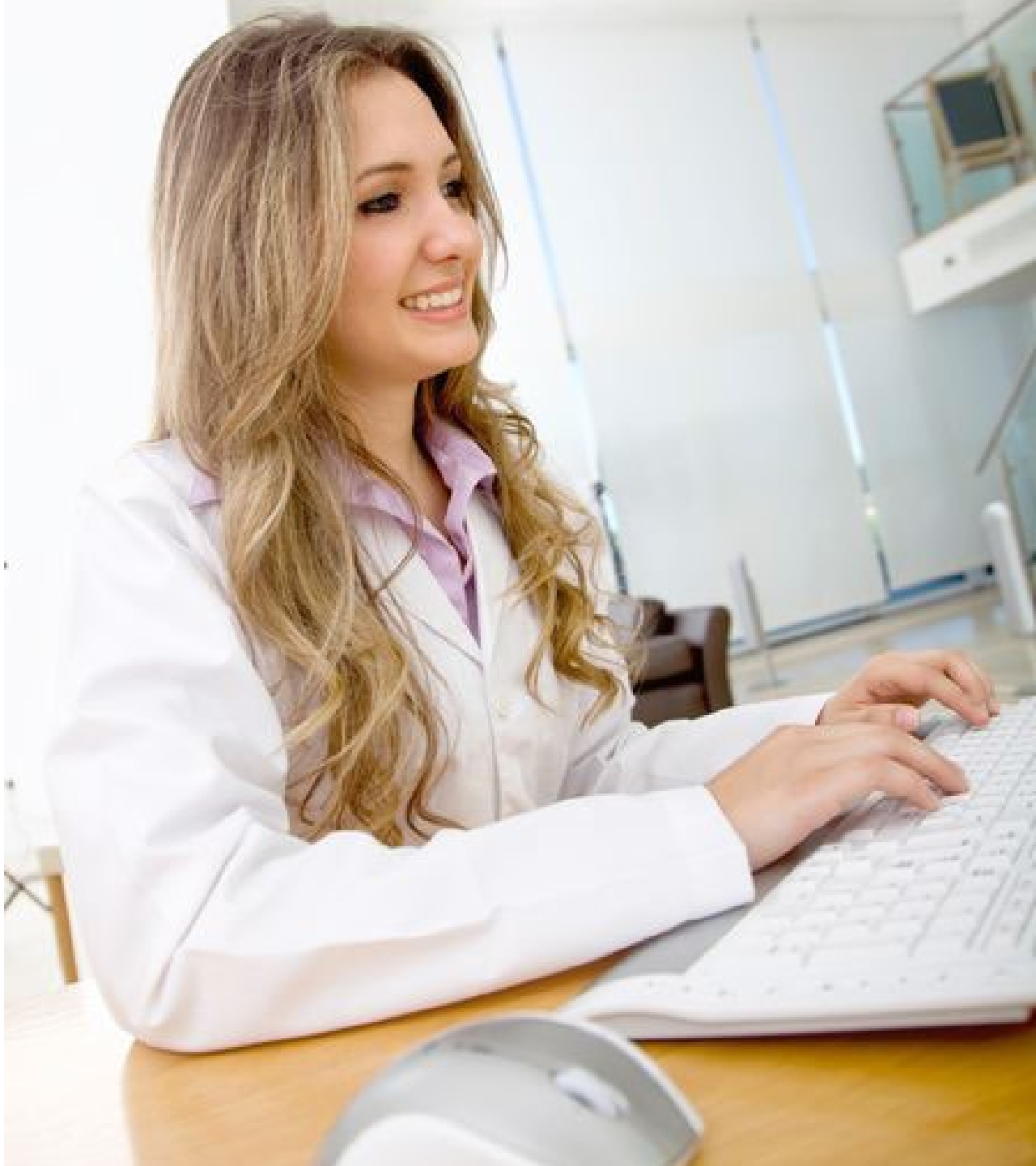
The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting. It is necessary to review all sections of the guidelines to fully understand all of the rules and instructions needed to code properly.

As stated in the introductory section of these official coding guidelines, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

A Coders Role: Defining Coding for Clinician Services

- Understand impact of appropriate coding
- Recognize and apply appropriate coding guidelines
- Educate others with effective communication



Administration Role

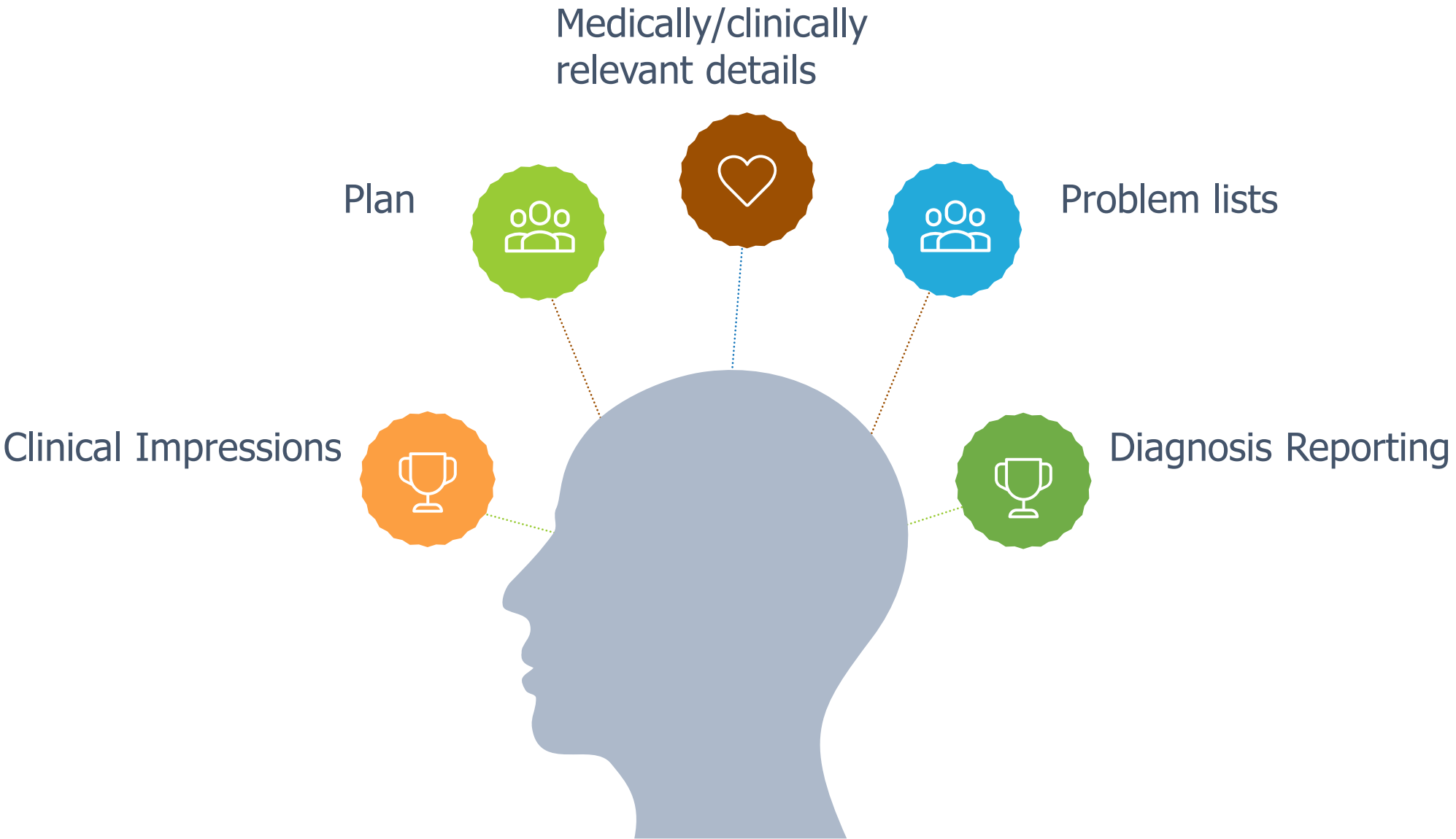
- Stay Informed
- Review Reports
- Identify Gaps
- Recognize Value
- Appreciate Resources
- Provide Support

Everyone’s Role: Tell the Story!

- Clinical Staff
- Clinicians
- Administration
- Coders & Billers
- Educators

Educational Audit Review Feedback

Documentation Issues Discussions:



Educational Audit Summary Report

BCA Provider Dashboard

Dr. Helpu Feelgood

Baseline

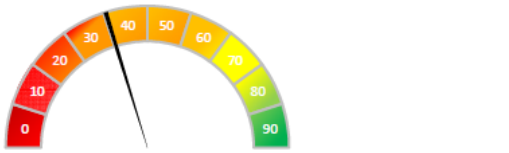
August 2021

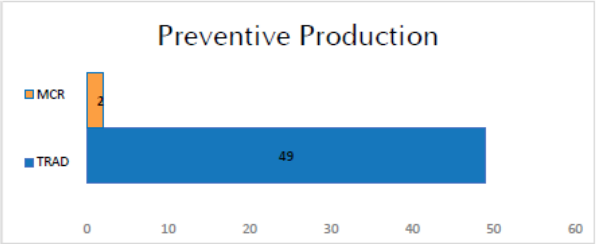
DX: Diagnosis reporting is well-done as clinician captures clinical impressions and details of problems evaluted or impacting care. As a reminder, be sure to include SDoH that increase complexity.

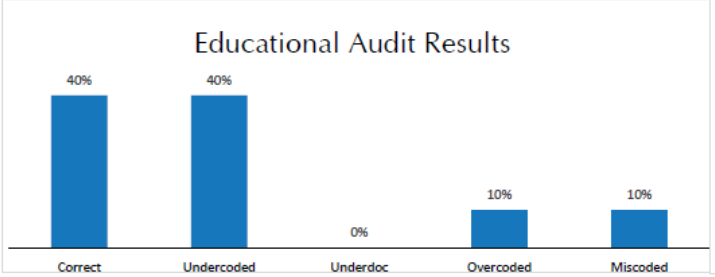
E/M: Undercoding is evident. Clinician writes clear details that describe moderately complex encounters that are being reported as low MDM of 99213. Miscoding is a result of reporting an illness service (E/M) when a preventive service was provided.

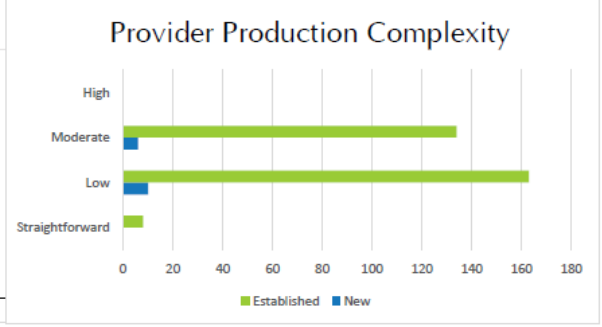
TIME: One overcoded encounter decribes visit as being lengthy do to chart review and discussion w/patient suggests reporting on total encounter time may have been more appropriate.

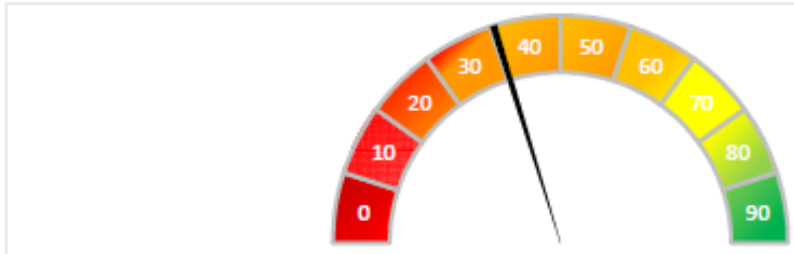
QUAL: Documentation paints a clear picture as to the reason for visits. Clinical impression and plan for next steps indicate encounters are more complex than coding patterns are reflecting.





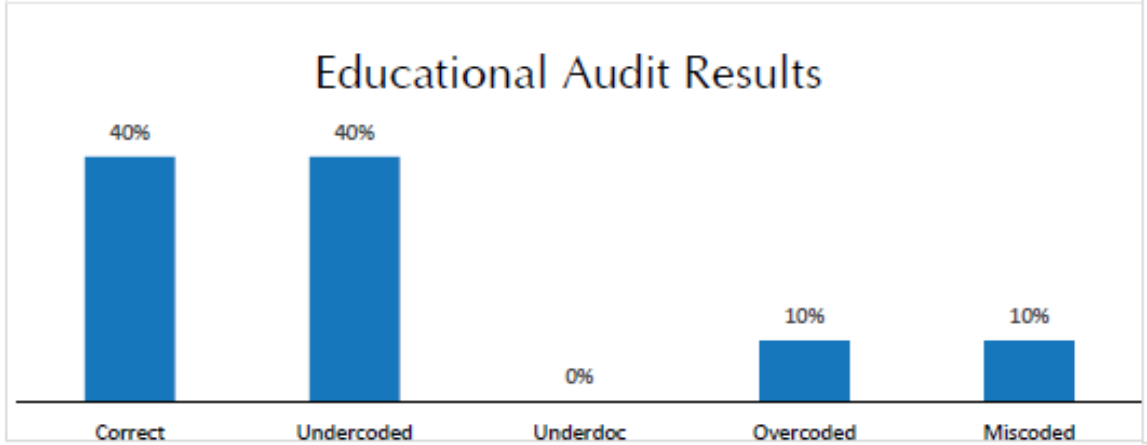


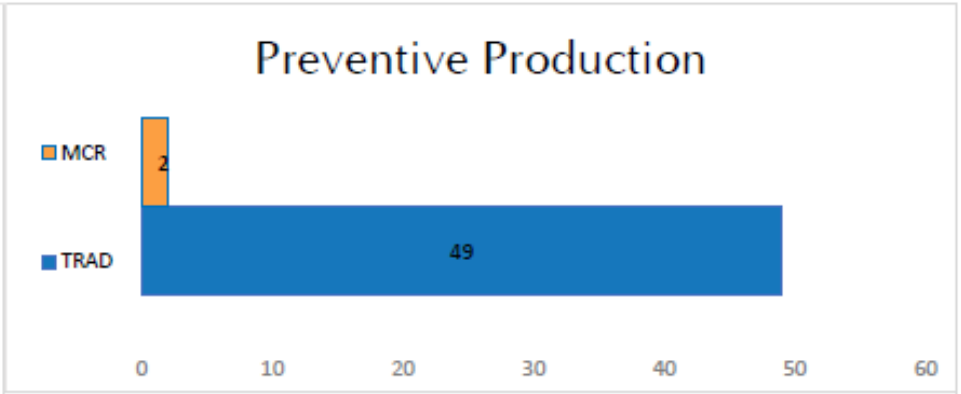


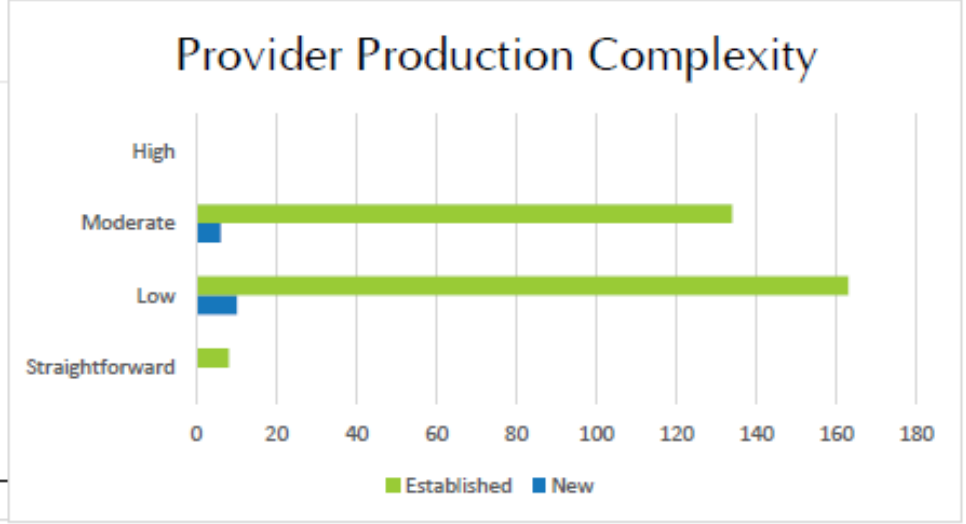


40%

Provider Audit Accuracy







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Note Sample

Assessment/Plan

1. Migraine

G43.909: Migraine, unspecified, not intractable, without status migrainosus

- Phenergan 25 mg/ml. injection solution – take 25 mg by injection route. Route: Injection Site: Buttock, Right
- Ketorolac 60 mg/2 mL intramuscular solution – Inject 2 mL by intramuscular route

2. Mixed hyperlipidemia

E78.2: Mixed hyperlipidemia

- COMP. METABOLIC PANEL (14)-322000-p – To be performed on or around 4/1/2020
- CBC WITH DIFFERENTIAL/PLATELET -005009-P – To be performed on or around 4/1/2020
- LIPID PANEL WITH LDL/HDL RATIO-235010-P – To be performed on or around 4/1/2020
- TSH+FREE T4-224576-P – To be performed on or around 4/1/2020

3. Prediabetes

R73.03: prediabetes

- HGB A1C WITH EAG ESTIMATION - To be performed on or around 4/1/2020

4. Essential hypertension

I10: Essential (primary) hypertension

- Lisinopril 20 mg tablet – Take 1 tablet(s) every day by oral route. Qty: 30 Tablet(s) Refills: 2

5. Dissociative convulsions

F44.5: Conversion disorder with seizures or convulsions

6. Osteoarthritis

M19.90: Unspecified osteoarthritis, unspecified site

- Diclofenac sodium 75 mg tablet, delayed release – Take 1 tablet(s) twice a day by oral route

7. Otitis media

H66.91: Otitis media, unspecified, right ear

- Bactrim DS 800 mg tablet – take 1 tablet(s) every 12 hours by oral route

Discussion Notes:

Phenergan and Toradol given for today's migraine. Bactrim given for right otitis. Her celebrex was switched to diclofenac at her request. She will f/u with the new neurologist as scheduled. Labs and bp were reviewed and are at goal and she will continue the lower dose of lisinopril. She will rtc in 4 months, sooner prn.

Return to Office

- To see LAB-PCC SCHEDULE for LAB 15 at PCC on or around 4/1/2020

Educational Audit Summary Report

BCA Provider Dashboard

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Baseline

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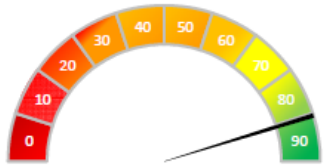
DX: A/P contains many chronic problems that appear to be pulled off of the problem list without any evaluation/management detail.

E/M: Although 90% accuracy discovered in this 10 record review, quality issues are evident. Notes appear to be driven by templates and checkboxes, creating stories that are difficult to follow. Are you managing all the problems today that are capture in the assessment? What is the plan? One overcoded encounter captures one problem being evaluated without a clinical impression or plan. RX to treat. F/U one stable problem support low MDM of 99213.

TIME: Clinician is encouraged to fine-tune clinically relevant details before persuing time-based reporting.

QUAL: Lack of clear subjective details paired with no clinical impressions for evaluated problems suggests patient presentations are not of significant concern. It appears clinician evaluates many problems during encounters, however, records lack luster and content to support complexity current production is representing. Clinician is encouraged to document their professional opinion (impression/plan) to support complexity that patient population appears to be.



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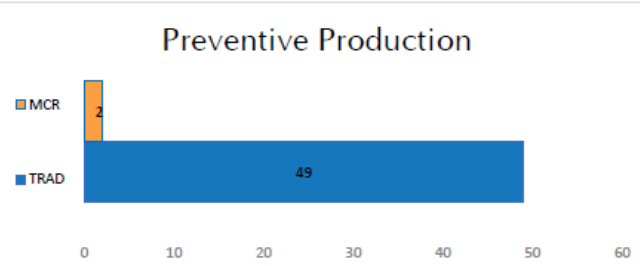

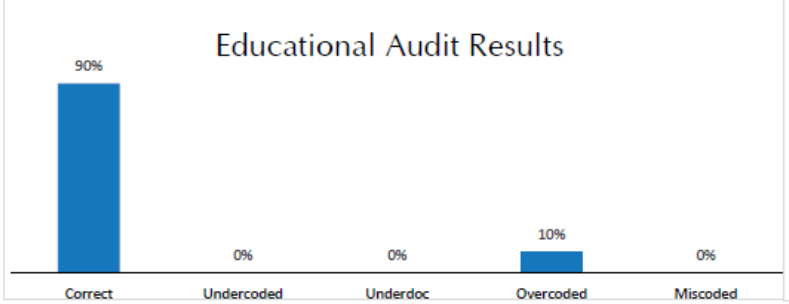

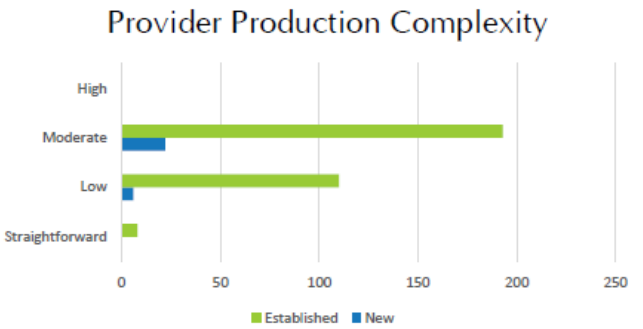

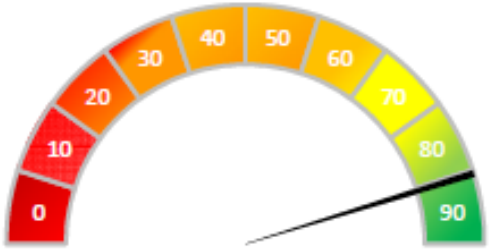

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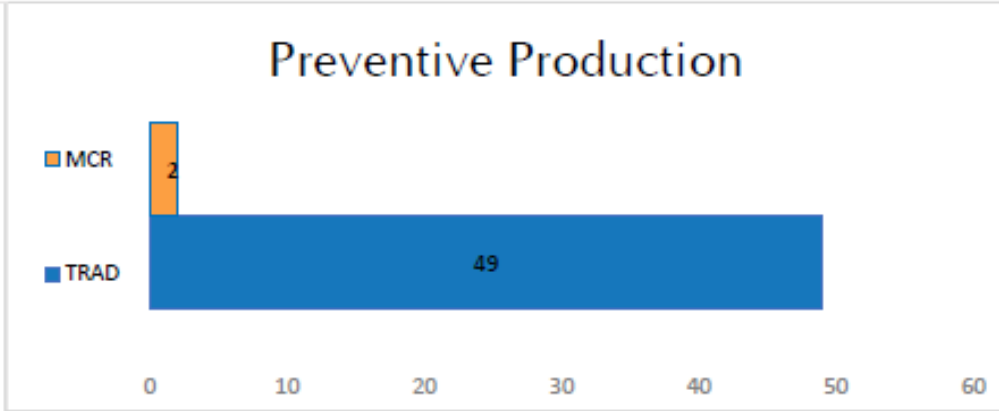

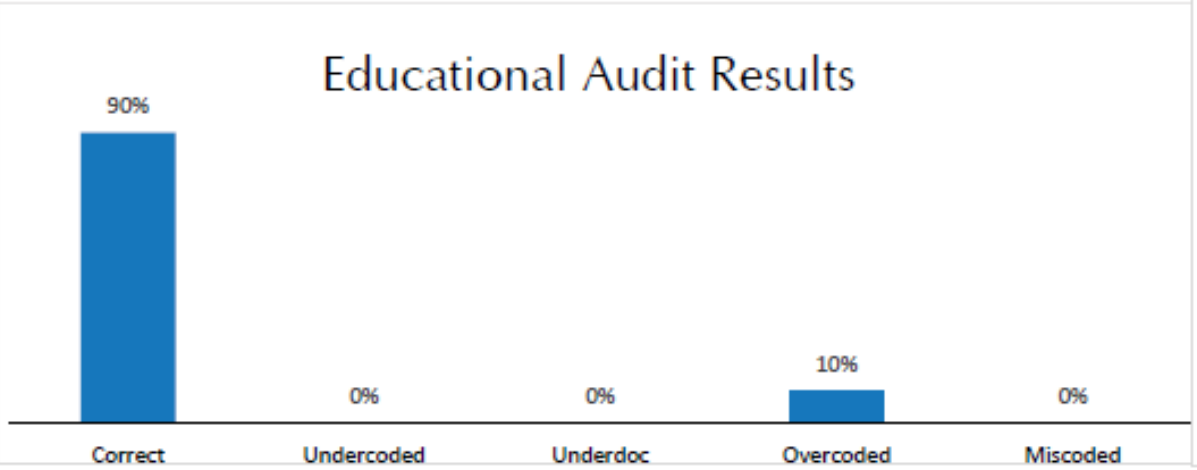

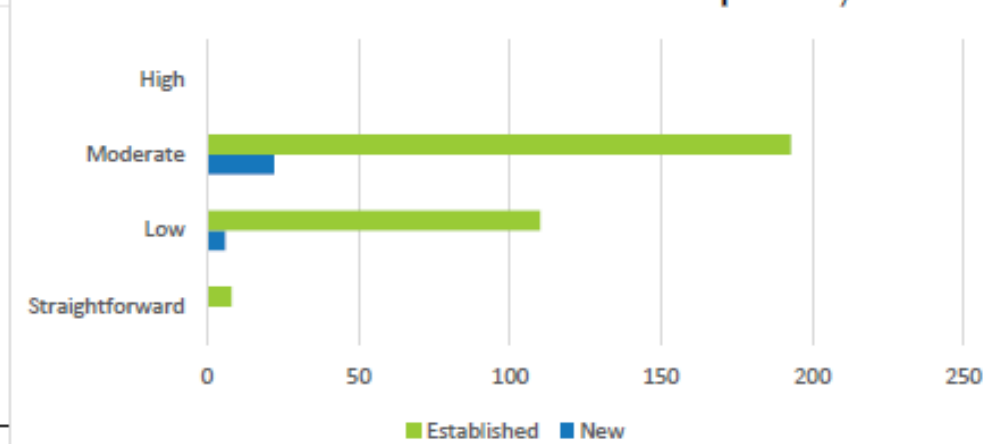

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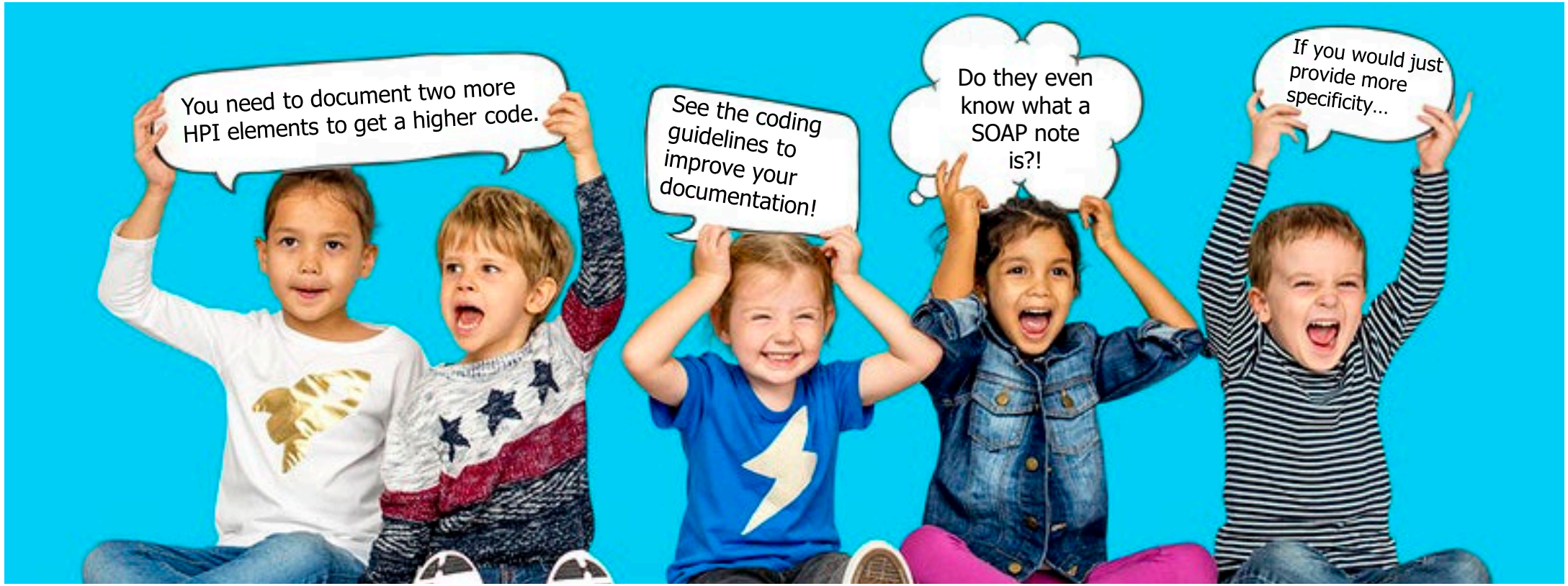
Discussion Notes:

Labs ordered, continue meds.

Say this…Not that!



Auditor agrees with moderate complexity of 99222 for this exacerbated chronic problem, however, lack of two HPI qualifiers (subjective details/incoming status) holds this to a 99221.

Lack of documenting your clinical impression undervalues the significance of the complexity involved with patient encounters.

Templated details create stories that lack luster and are difficult to follow. Auditor suspects more work was done than this record reads.

Tools to Help

AMA

CPT® Evaluation and Management (E/M)

Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes

This document includes the following CPT E/M changes,

effective January 1, 2021:

- **E/M Introductory Guidelines related to Office or Other Outpatient Codes 99202-99215**
- **Revised Office or Other Outpatient E/M codes 99202-99215**

In addition, this document has been updated to reflect technical corrections to the E/M Guidelines:

were posted on March 9, 2021 and effective January 1, 2021:

- **Medical decision making is revised in the following ways:**
  - **Clarifying when reporting a test that is considered, but not selected after shared decision making.**
  - **Providing a definition of "Analyzed" for reporting tests in the data column.**
  - **Clarifying the definition of a "unique" test.**
  - **Clarifying what is meant by "discussion" between physicians, and other qualified health care professionals and patients.**
  - **Providing a definition of major vs minor surgery.**
- **Clarification around which activities are not counted when reporting time as a key criterion for code level selection.**

All technical corrections are highlighted in blue.

Note: this content will not be included in the CPT 2020 code set release

1

Time-Based Encounters

Final E/M Code	
Established Patient	**Time Range**
99212	10-19 mins
99213	20-29 mins
99214	30-39 mins
99215	40-54 mins
New Patient	**Time Range**
99202	15-29 mins
99203	30-44 mins
99204	45-59 mins
99205	60-74 mins

Allowable Activities for Time performed on date of service

- **Pre-visit work:** Review of lab/test results, consult notes, discharge summary
- **History:** Review of separately obtained history e.g. caregiver, guardian, witness
- **Face to face:** Time spent on medically necessary exam and/or evaluation
- **Education or counseling** of patient/family/caregiver
- **Orders:** labs, xrays, other diagnostic tests or procedures, medications
- **Referral/Communicaton** with other health care professionals
- **Documentation:** clinical information documentation in the EMR/health record
- **Independent Results Interp:** results/communication to patient/family/caregiver
- **Coordination of care** not separately reported

Note: Time spent performing separately reported services, e.g., procedures, EKGs, chronic care management activities, etc. cannot be counted

Reminder: Don't count time by: Ancillary staff, Resident/student, time on another DOS or procedure time

BCA Recipe Card - Must meet TWO of THREE categories:

Final E/M Code	Problems: Number/Complexity	Data: Amount/Complexity	Risk of Complication
99202/99212 Straightforward	1 self-limited or minor problem	**None**	**None** Rest, Ice, Elevation
99203/99213 Low	•2+ Self-limited or minor illness •1 Stable chronic •1 Acute uncomplicated	**Limited: 1 of 2 data categories required** •2 Unique tests or documents **OR** •1 Independent historian assessment	**Low** OTC Meds PT, OT
99204/99214 Moderate	•1+ Progressing chronic, exacerbation or treatment SE •2+ Stable chronic •1 Undiagnosed new problem • 1 Acute illness w/systemic symptoms •1 Acute complicated injury	**Moderate: 1 of 3 data categories required** •3 Unique tests,external notes from unique source or ind historian assessment •Test interp not separately reported by clinician •Mgmt discussion or test interp w/external clinician/appropriate source	**Moderate** •Rx drug mgmt •Minor surgery/procedure decision w/patient or procedure risk factors •Major surgery decision w/o identified patient or procedure risk factors •SDoH significantly limiting dx or mgmt
99205/99215 High	•1+ Chronic illness w/severe exacerbation or treatment SE •1 Acute or chronic or injury posing a threat to life/ bodily function	**Extensive: 2 of 3 data categories required** •3 Unique tests,external notes from unique source or ind historian assessment •Test interp not separately reported by clinician •Mgmt discussion or test interp w/external clinician/appropriate source	**High** •Intensive monitoring for drug therapy for toxicity •Elective major surgery decision w/identified patient or procedure risk factors •Emergent major surgery decision •Decision regarding hospitalization •DNR or de-escalation of care d/t poor prognosis

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211).

Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, in a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic, the risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, noninsulin- dependent diabetes, cataract, or benign prostatic hyperplasia.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

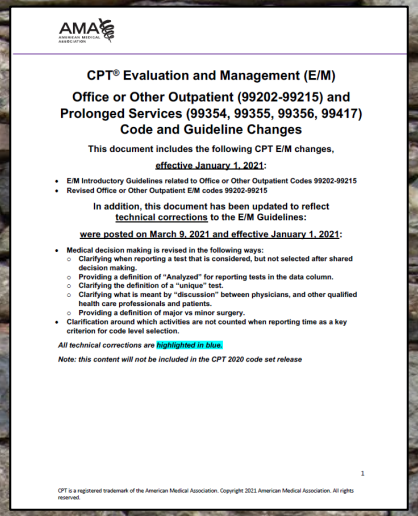
Tools to Help

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects but that does not require consideration of hospital level of care.

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. An example may be a lump in the breast.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness, or to prevent complications, see the definitions ***for self-limited or minor problem*** or ***acute, uncomplicated illness or injury***. Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.



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  - Clarifying when reporting a test that is considered, but not selected after shared decision making.
  - Providing a definition of "Analyzed" for reporting tests in the data column.
  - Clarifying the definition of a "unique" test.
  - Clarifying what is meant by "discussion" between physicians, and other qualified health care professionals and patients.
  - Providing a definition of major vs minor surgery.
- Clarification around which activities are not counted when reporting time as a key criterion for code level selection.

All technical corrections are highlighted in blue.

Note: this content will not be included in the CPT 2020 code set release

1

Queries

Documentation indicates A1C of 11.3 and that patient is underdosing, has CKD and neuropathy. Assessment shows E11.9 without comment. There is some indication of medication management.

Queries

ICD-10-CM Official Guidelines for Coding and Reporting
FY 2022
(October 1, 2021 - September 30, 2022)

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2021 version
***Italics* are used to indicate revisions to heading changes**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting. It is necessary to review all sections of the guidelines to fully understand all of the rules and instructions needed to code properly.

13. When laterality is not documented by the patient's provider, code assignment for the affected side may be based on medical record documentation from other clinicians. If there is conflicting medical record documentation regarding the affected side, the patient's attending provider should be queried for clarification. Codes for "unspecified" side should rarely be used, such as when the documentation in the record is insufficient to determine the affected side and it is not possible to obtain clarification.

Everyone's Role: Effective Listening!

- Don't talk, listen
- Prepare to listen
- Put the Speaker/Educator at Ease
- Focus on what is being said
- Empathize
- Be Patient
- Avoid Personal Prejudice
- Listen to the Tone
- Listen for Ideas
- Wait and Watch for Non-Verbal Communication

Communicating Effectively Take Homes

- Make Time
- Recognize Need/Benefits
- Use appropriate tools/methods
- Have Policies
- Be Consistent
- Be Empathetic, it's crazy out there!

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