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SVT Medical Pre-Audit

February 2023
Meri Harrington CPC, CEMC

BCA
Revolutionizing Your Revenue Cycle

SVT Health&Wellness
Your Community Health Center!

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Training Agenda

01 UDS

02 E/M and Time-Based Coding

03 Additional Services

04 Diagnosis Coding Overview

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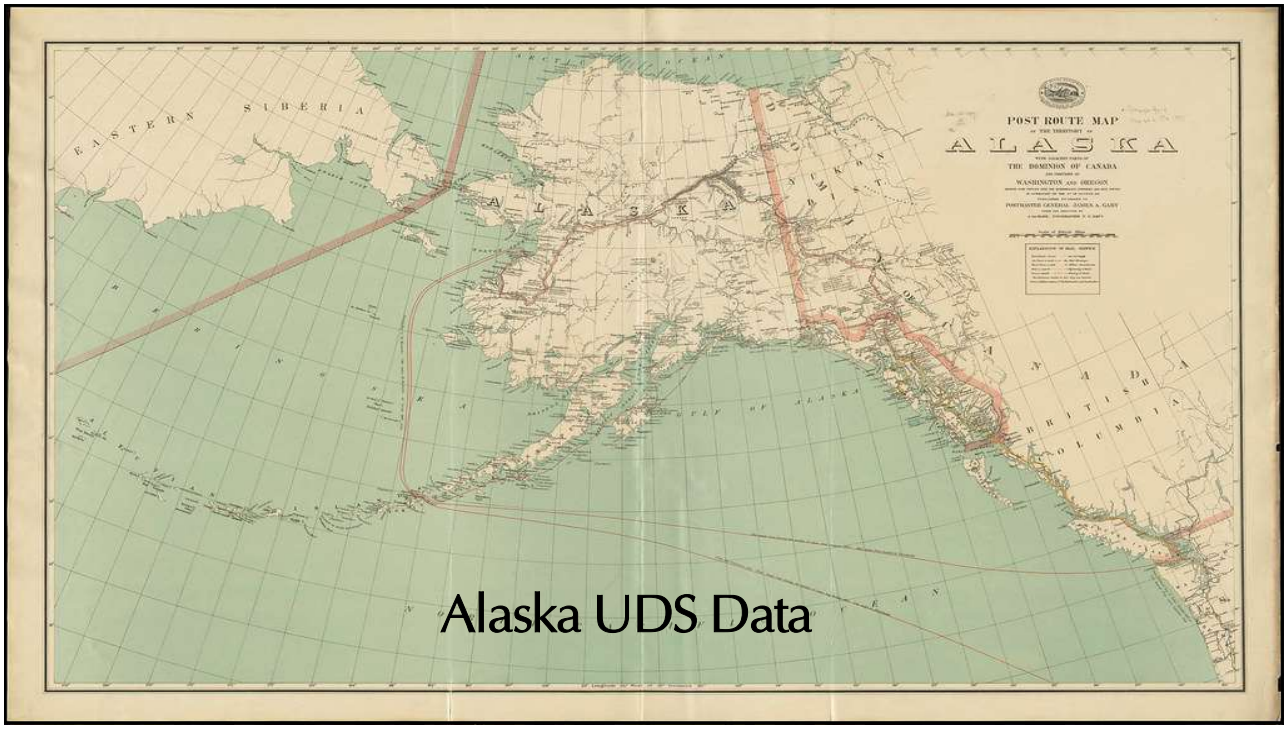

Alaska UDS Data

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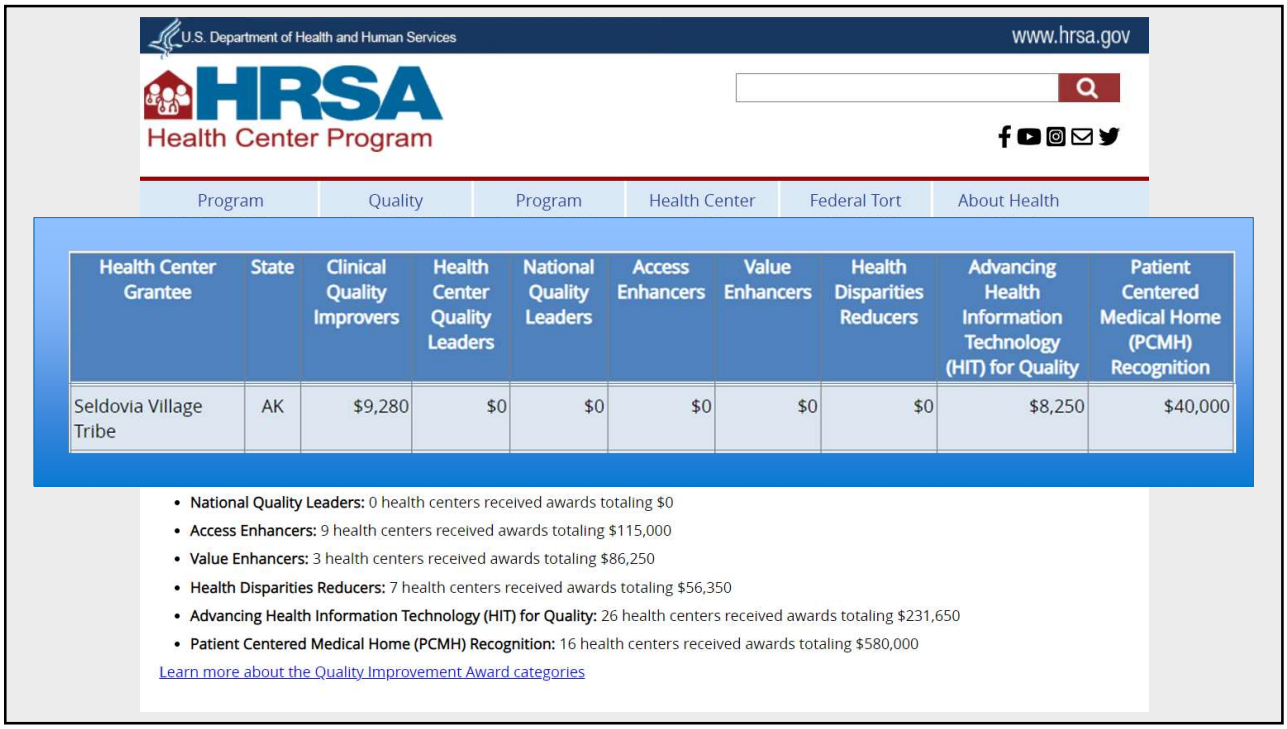

Health Center Grantee	State	Clinical Quality Improvers	Health Center Quality Leaders	National Quality Leaders	Access Enhancers	Value Enhancers	Health Disparities Reducers	Advancing Health Information Technology (HIT) for Quality	Patient Centered Medical Home (PCMH) Recognition
Seldovia Village Tribe	AK	$9,280	$0	$0	$0	$0	$0	$8,250	$40,000

- **National Quality Leaders:** 0 health centers received awards totaling $0
- **Access Enhancers:** 9 health centers received awards totaling $115,000
- **Value Enhancers:** 3 health centers received awards totaling $86,250
- **Health Disparities Reducers:** 7 health centers received awards totaling $56,350
- **Advancing Health Information Technology (HIT) for Quality:** 26 health centers received awards totaling $231,650
- **Patient Centered Medical Home (PCMH) Recognition:** 16 health centers received awards totaling $580,000

Learn more about the Quality Improvement Award categories

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Components of UDS Data

Statistical Information

01 Number of visits, by type (medical, behavioral, dental)

02 Number of unique patients

03 Number of providers (FTEs)

Special Populations					
% Homeless Patients	-	0.55 %	2.50 %	1.29 %	1.08 %
Total Homeless Patients	-	**17**	**74**	**34**	**30**
% Total Agricultural Workers or Dependents		0.00 %	0.00 %	0.00 %	0.00 %
Total Agricultural Workers or Dependents		**0**	**0**	**0**	**0**
% Public Housing Patients		0.00 %	0.00 %	0.00 %	0.00 %

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Components of UDS Data

Demographic Information

- Race/Ethnicity
- SOGI
- Income Level
- Special Populations

Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site		**0**	**0**	**0**	**0**
% School-Based Health Center Patients		0.00 %	0.00 %	0.00 %	0.00 %
School-Based Health Center Patients		0	0	0	0
% Veterans Patients	6.54 %	6.42 %	6.06 %	5.57 %	7.06 %
Veterans Patients	208	198	179	147	197

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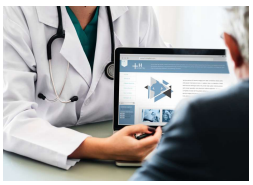
Components of UDS Data

Diagnosis and Services

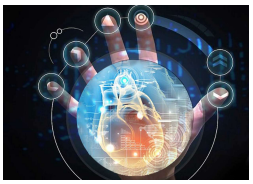
Prevention/Screening

- Weight/BMI
- Tobacco Use and Counseling
- Preventive Statin Therapy
- Cancer
- HIV
- Depression
- Dental Sealants in Children

Selected Diagnoses



Early Prenatal Care



Childhood Immunizations

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Components of UDS Data

Health Outcomes

- Delivery and Birth Weight Data
- Control of Hypertension
- Control of Diabetes
- Disparities

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Components of UDS Data

Costs/Revenue

01 **Costs**

- Staffing
- Lab and X-ray costs
- Donations

02 **Revenue**

- Patient related revenue
- Other revenue
  - Grants
  - COVID-19 Supplementation

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A Closer Look – Childhood Immunizations

Childhood Immunization Status	0.00 %	0.00 %	-	-	-	
Number of Children Under Age 3 Who Received Appropriate Childhood Immunizations	0	0	-	-	-	

Numerator: Column C

- Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday

Measure Description

Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three Hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one Hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Childhood Immunization Status: Children will be less likely to contract vaccine-preventable diseases or to suffer from the sequelae of these diseases if they receive their vaccinations in a timely fashion.

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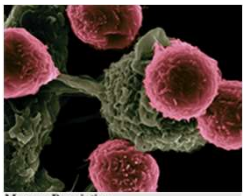
A Closer Look – Cervical Cancer Screening

Cervical Cancer Screening	44.37 %	51.34 %	30.86 %	38.42 %	42.06 %	3
Number of Cervical Cancer Screening Patients	272	344	237	282	331	



Measure Description

Percentage of women 21*–64 years of age who were screened for cervical cancer using **either** of the following criteria:

- Women age 21*–64 who had cervical cytology performed every 3 years
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

Cervical Cancer Screening: Early detection and treatment of cervical abnormalities can occur and women will be less likely to suffer adverse outcomes from cervical cancer if they receive Pap tests as recommended.

Include documentation in the medical record of a cervical cytology and HPV tests performed outside of the health center with the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the test or a copy of the lab test.

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A closer look – Colon Cancer Screenings

Colorectal Cancer Screening	30.64 %	30.79 %	36.27 %	36.96 %	33.93 %	3
Number of Patients Screened for Colorectal Cancer	205	234	301	299	305	

Measure Description

Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer

Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any *one* of the following criteria:

- Fecal occult blood test (FOBT) during the measurement period
- Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA) during the measurement period or the 2 years prior to the measurement period
- Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period
- Computerized tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period
- Colonoscopy during the measurement period or the 9 years prior to the measurement period

Colorectal Cancer Screening: Early intervention is possible and premature death can be averted if patients receive appropriate colorectal cancer screening.

There are two FOBT test options: Guaiac fecal occult blood test (gFOBT) and the immunochemical-based fecal occult blood test (iFOBT).

Lab tests (FOBT and FIT-DNA) performed elsewhere must be confirmed by documentation in the chart: either a copy of the test results or correspondence between the clinic staff and the performing lab/clinician showing the results.

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A Closer Look – Weight Assessment and Counseling

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	44.99 %	0.00 %	13.37 %	46.46 %	40.94 %	4
Number of Children Age 3-16 with Weight Assessment and Counseling for Nutrition and Physical Activity	166	0	54	164	165	

Measure Description

Percentage of patients 3–17 years of age who had an outpatient *medical* visit and who had evidence of height, weight, and body mass index (BMI) percentile documentation ***and*** who had documentation of counseling for nutrition ***and*** who had documentation of counseling for physical activity during the measurement period

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: The likelihood of obesity and its sequelae will be reduced if clinicians ensure their patients' body mass index (BMI) percentile is recorded and if patients (and parents) are counseled on nutrition and physical activity (regardless of the patient's weight).

Children and adolescents who have had:

- their BMI percentile (not just BMI or height and weight) recorded during the measurement period ***and***
- counseling for nutrition during the measurement period ***and***
- counseling for physical activity during the measurement period

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UDS Data for BP control

Controlling High Blood Pressure	68.77 %	57.32 %	73.39 %	73.62 %	69.12 %	1
Number of Patients with Hypertension (HTN) Whose Blood Pressure (BP) was Controlled (< 140/90 mmHg)	207	188	342	240	244	

Measure Description

Percentage of patients 18–85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period

Denominator (Universe): Columns 2a and 2b

- Patients 18 through 84 years of age who had a diagnosis of essential hypertension overlapping the measurement period with a *medical* visit during the measurement period

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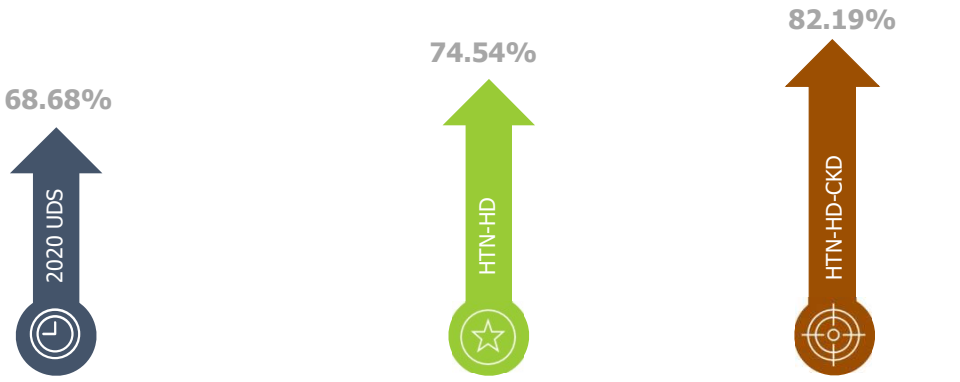
UDS and Hypertension

Simple changes to your diagnosis coding can improve your quality measures!



4441 Controlled	4441 Controlled	4441 Controlled
6466 HTN	5958 HTN-HD	5403 HTN-HD-CKD

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FQHC New vs. Established Patients

A new patient is one who has not received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within the past three years prior to the date of service.

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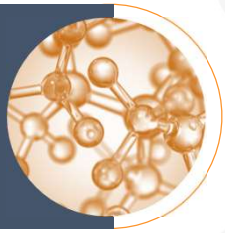
2023 E/M Guideline Reminders



CPT Codes
Now applies to all places of service

Choice
Choose visit on time or MDM

Time
Time includes all clinician time devoted to patient care on the date of service that is not separately billed

History/Exam
History and exam still expected

Services
Don't count x-rays, EKG's, etc. towards MDM if the clinic bills for them

Deleted
Observation Codes

Emergency Room
Time may not be used for code selection

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Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:
Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited *(Must meet the requirements of at least 1 of the 2 categories)* Category 1: Tests and documents • Any combination of 2 from the following: ▪ Review of prior external note(s) from each unique source*; ▪ review of the result(s) of each unique test*; ▪ ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate *(Must meet the requirements of at least 1 out of 3 categories)* Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: ▪ Review of prior external note(s) from each unique source*; ▪ Review of the result(s) of each unique test*; ▪ Ordering of each unique test*; ▪ Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive *(Must meet the requirements of at least 2 out of 3 categories)* Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: ▪ Review of prior external note(s) from each unique source*; ▪ Review of the result(s) of each unique test*; ▪ Ordering of each unique test*; ▪ Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

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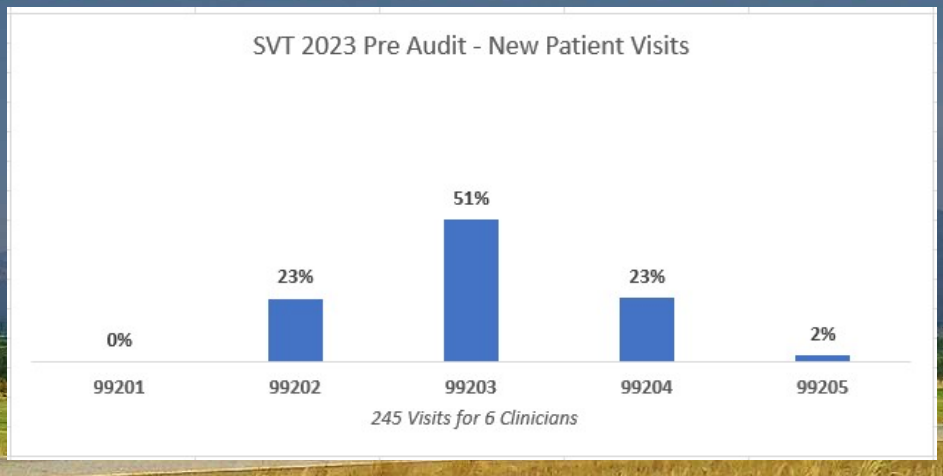
E/M Production: New Patients



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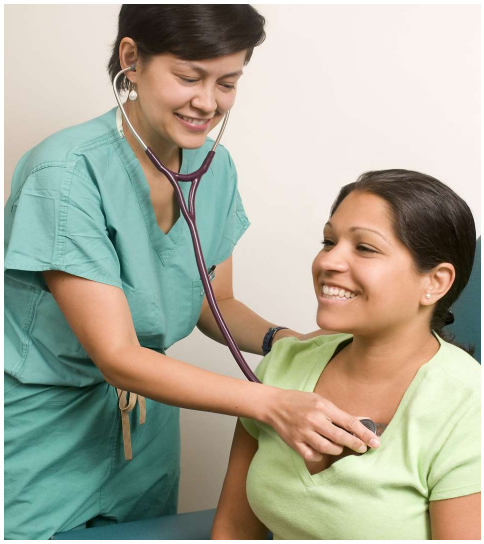
Reasons a provider would report 99203

Most patients present with an acute, uncomplicated problem or a single, stable chronic illness.

Preparing to see the patient, actual evaluation time and time spent documenting are under 45 minutes.

Problem management options are of low complexity.

Provider not informed of reimbursement rates or importance of coding resulting in lack of accuracy



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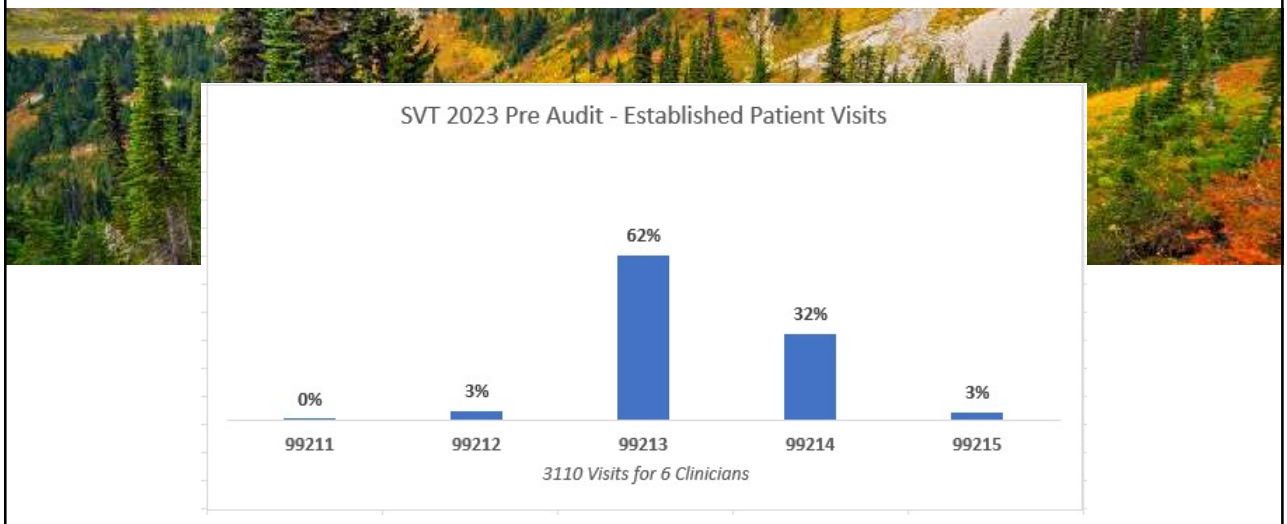
E/M Production: Established Patients



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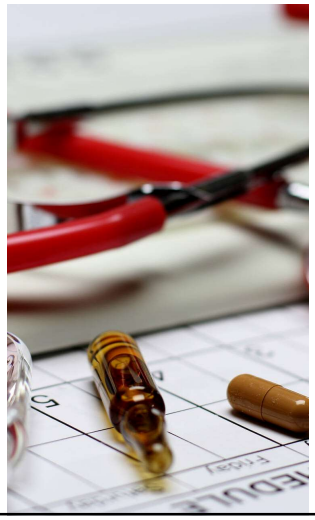
99213 vs. 99214

99213

Office or other outpatient visit for the evaluation and management of an established patient:

- Low complexity medical decision making
- When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter



99214

Office or other outpatient visit for the evaluation and management of an established patient:

- Moderate level of medical decision making
- When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter

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Good Reasons to Report 99213

01 Mgmt of an acute uncomplicated illness with OTCs or ABX

02 Mom with significant concerns/anxiety, needs reassurance, total time spent today on pt care is 20-29 minutes

03 Mgmt of an acute uncomplicated injury with a splint, OTCs, PT

04 Patient requests birth control, options discussed, method decided upon

05 Mgmt of a chronic illness at goal, just needs refills/couple of labs

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Good Reasons to Report 99214

Two chronic illnesses (both at goal) with review of notes from specialist and ordering of two labs or prescription drug mgmt.	Significant problem requiring surgery
Acute illness with systemic sxs needing IV Abx and sx mgmt.	Lots of counseling needed, total time on pt care today 30-39 mins
One chronic illness in exacerbation, needs rx mgmt.	Hospital follow-up with lots of pre and/or post-visit work on pt's behalf

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Medical Decision Making (MDM)

Problems

Number/Complexity of Problems

- A problem is addressed or managed when evaluated or treated at the encounter by the clinician
- Notation that another clinician manages problem doesn't count
- Clarify why or how a condition affects your care today

Data

Amount/Complexity of Data

- Tests, documents or independent historian
- Independent interpretation of tests
- Discussion of management or test interpretation

Risk

Risk of Complication

- Minimal, Low, Moderate or High Risk

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Problems Defined

What qualifies as a problem addressed?

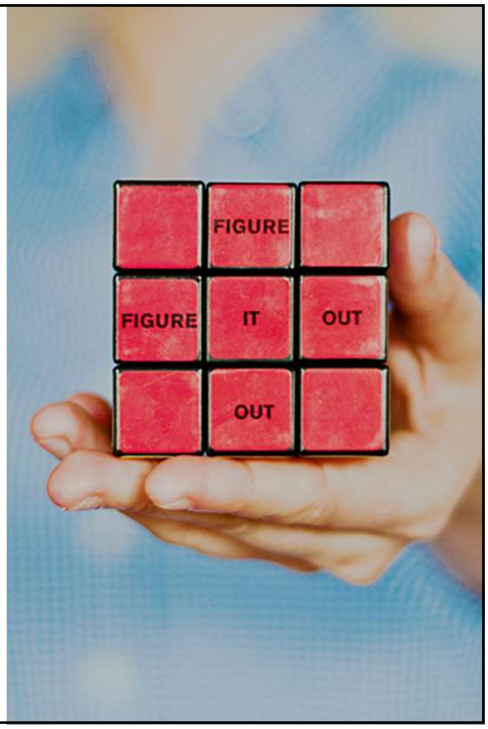
When it is evaluated or treated at the encounter by the clinician

Further testing or treatment is considered, whether or not it is pursued

What doesn't qualify as a problem addressed?

Noting that another provider manages the problem without additional assessment or care coordination documented.

Referral without evaluation (history, exam, dx study, consideration of tx)



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MDM Components

Number/Complexity of Problems

Only count problems addressed today

Notation that another provider manages condition doesn't count

Referral without evaluation or consideration of treatment doesn't count

If a condition affects your care today, clarify why or how

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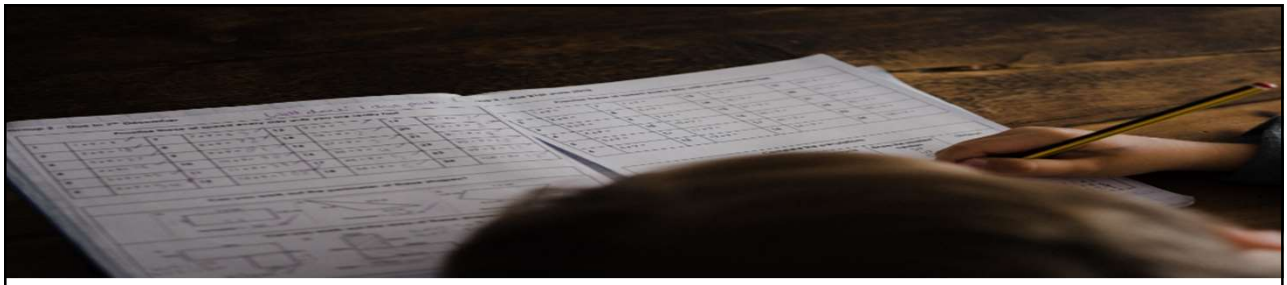

Revisions to Number/Complexity

The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.

Therefore, presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition.

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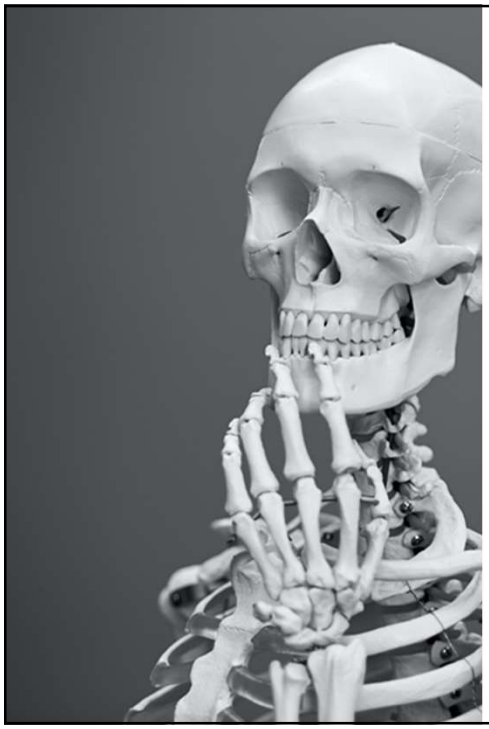

MDM Components

Amount/Complexity of Data
Three Data Categories to Consider

Category 1:Tests, documents or independent historian(s):

Any combination of 3 from the following:

- Review of prior external notes from each unique source
- Review of results of each unique test
- Ordering of each unique test *(CMP = 1 test)*
- Assessment requiring an independent historian

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MDM Components

Amount/Complexity of Data - Three Data Categories to Consider (Continued)

Category 2: Independent interpretation of tests

Independent interpretation of a test performed by another physician/other qualified heath care professional (not separately reported)

Category 3: Discussion of management or test interpretation

Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source

Appropriate source examples:
- Lawyer
- Parole Officer
- Case Manager
- Teacher
- (Not family or informal caregivers)

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Risk Defined

The probability and/or consequences of an event

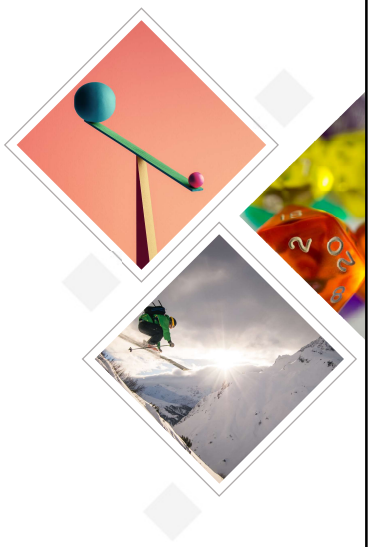
Assessment of level of risk is affected by the nature of the event under consideration

Definitions based on usual behavior and thought processes of clinicians in the same specialty

Clinicians are trained on these levels of risk and don't need quantification

For MDM, level of risk is based upon consequences of the problems addressed when appropriately treated

Also includes MDM r/t need to initiate or forego further testing, treatment or hospitalization



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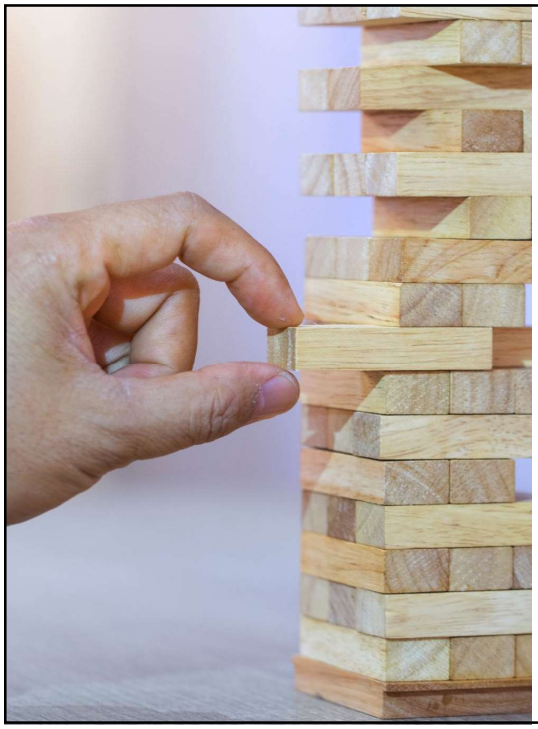

Risk Considerations

Morbidity: State of illness or functional impairment expected to be of substantial duration during which

- Functioning is limited
- Quality of life is impaired
- Organ damage that may not be transient despite treatment

Social Determinants of Health: Economic and social conditions that influence the health of people and communities.

- Food insecurity
- Homelessness
- Insufficient social insurance and welfare support
- Many others

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Risk Considerations (Continued)

Drug therapy requiring intensive monitoring for toxicity: a therapeutic agent that has the potential to cause serious morbidity or death.

Monitoring is performed for assessment of these, not primarily for therapeutic efficacy

Should be monitoring that is generally accepted practice for the agent

May be patient specific in some cases if not generally accepted practice

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E/M INITIAL AND SUBSEQUENT HOSPITAL AND OBSERVATION					
CODE	MDM	NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED	RISK OF COMPLICATIONS AND/OR MOBIDITY OR MORTALITY OF PT. MGMT.	TIME
99221 99234	Low Can also be used for straight forward MDM	Low: • 2 or more self-limited or minor problems • 1 stable or chronic illness • 1 acute uncomplicated illness or injury • 1 stable acute illness • 1 acute uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: tests and documents Any combination of 2 of the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test OR Category 2: Assessment requiring an independent historian(s)	Low Risk of morbidity from additional diagnostic testing or treatment	40 mins.
99231	Low Can also be used for straight forward MDM	SAME AS ABOVE	SAME AS ABOVE	SAME AS ABOVE	25 MINS
99222 99235	Moderate	Moderate: • 1 or more chronic illnesses with exacerbation • 2 or more stable chronic illnesses • 1 undiagnosed new problem with uncertain prognosis • 1 acute illness with systemic symptoms • 1 acute complicated injury	Moderate (Must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring independent historian(s) Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate Risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health	55 mins.
99232	Moderate	SAME AS ABOVE	SAME AS ABOVE	SAME AS ABOVE	35 MINS
99223 99236	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet the requirements of at least 2 out of 3 categories Category 1: Tests, documents, or independent historian(s) Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring independent historian(s) Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High Risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major procedure with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances	75 mins
99233	High	SAME AS ABOVE	SAME AS ABOVE	SAME AS ABOVE	50 MINS

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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

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Allowable Activities for Time

01
Preparing to see the patient & Results review

02
Obtaining and/or reviewing separately obtained history

03
Performing a medically appropriate exam and/or evaluation

04
Counseling and educating the patient/family/caregiver

05
Ordering medications, tests, or procedures

06
Referring and communicating with other health professionals*

07
Documenting clinical information in electronic or other health record

08
Independently interpreting results* and communicating results to the patient/family/caregiver

09
Care Coordination*

**Do NOT count time spent performing separately reported services*

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New Times for Code Selection

Total time spent on the date of the encounter

New Patient E/M Codes	Established Patient E/M Codes
99202: 15-29 minutes (was 20)	99212: 10-19 minutes (was 10)
99203: 30-44 minutes (was 30)	99213: 20-29 minutes (was 15)
99204: 45-59 minutes (was 45)	99214:30-39 minutes (was 25)
99205: 60-74 minutes (was 60)	99215:40-54 minutes (was 40)

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A Few Rules for Time-Based Coding:

DO: Count all time spent by the clinician dedicated to this patient on the date of service, both face-to-face and non-face-to-face.

DON'T: Count time spent performing separately reimbursable services, e.g., administration of tests, etc.

DON'T: Apply this method to all visits – reserve for time-consuming encounters

Examples:

- Hospital follow-ups
- Complex illnesses
- Extensive prescription work

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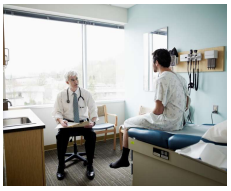
Code Assignment Considerations for Outpatient Services

Applies to 99205-99215 only

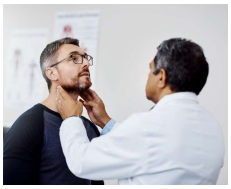
Time-Based Coding Revisions to, "Countable Time":



Total time spent on date of service dedicated to the patient

Only one clinician's time may be counted

Includes face-to-face or non-face-to-face time personally spent by clinician or other QHCP



Clinical staff time is not counted

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AMA Points

Don't count time for these

- ✓ The performance of other services that are reported separately
- ✓ Travel

- ✓ Teaching that is general and not limited to discussion that is required for the management of a specific patient

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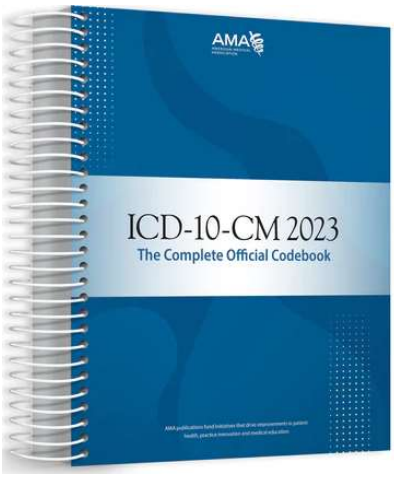
ICD-10-CM Coding and Reporting

Steps Toward Reporting Proficiency



BCA's Diagnosis Coding Booklet

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BCA
Revolutionizing Your Revenue Cycle

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Correct Coding

UDS
Quality Awards

Value-based Reimbursement
Fewer healthcare dollars translating to better patient outcomes

Lift Off!
All driven by excellent claims data

Risk Adjustment
Increased capitated payments

Performance Measures
Proving meaningful application

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Excellent Diagnosis Coding Detail checks all the boxes!

- Justification of Medical Necessity
- Risk Adjustment Score Capture
- Development of Care Algorithms
- UDS Data Collection

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HIPAA MANDATED ICD-10 GUIDELINES – NO MATTER WHERE YOU WORK

Five Basic Diagnosis Coding Rules

1. The 1st listed dx identifies condition requiring the greatest work-effort as determined by the clinician and supported in the medical record.
2. Document all conditions that require/affect care.
3. Document reasons for all studies.
4. Code to the highest level of specificity known.
5. Do not use "rule out" or unconfirmed diagnoses; instead, report known signs and symptoms.

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First-listed diagnosis

List first
The diagnosis representing the greatest level of clinician work during encounter. List additional codes that describe coexisting condition(s).

Outpatient Surgery
Code reason for surgery, even if the surgery is not performed due to a contraindication.

Observation Stay
- When patient is admitted for a medical condition, assign code for condition as first-listed Dx.
- If patient presents for outpatient surgery and develops a complication requiring admission to Observation, code the reason for surgery as first-listed followed by the code for the complication.

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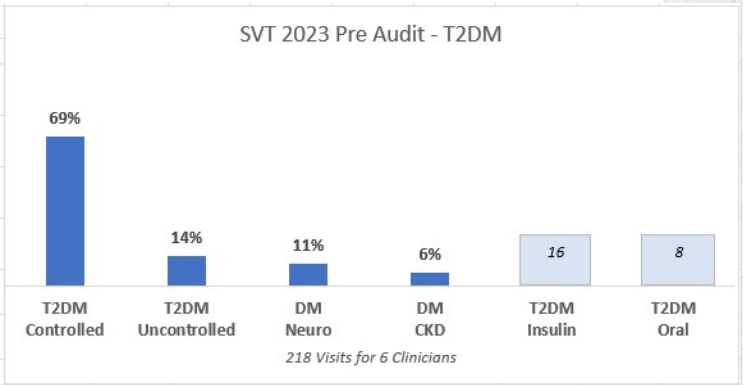
Your Type 2 Diabetes Data

Opportunities for Improvement:

- Only 24 encounters have treatment type documented
- Always code to highest known specificity
- Always code conditions that support specificity



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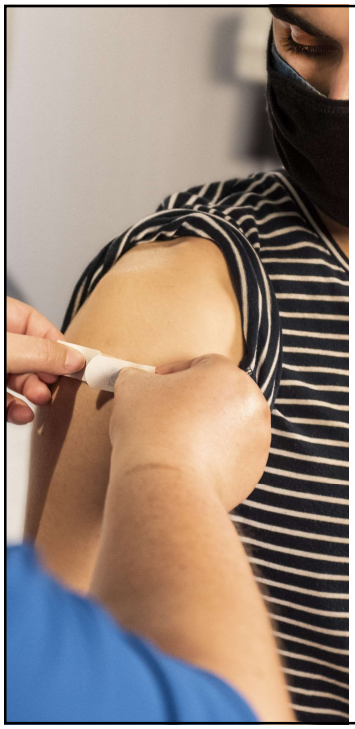

Type 2 Diabetes Mellitus

Coding Instruction as of 10/1/2021

Assign an additional code for each type of long-term medication prescribed

- Z79.4 Long-term (current) use of insulin
- Z79.85 as LT (current) use of (injectable non-insulin) antidiabetic drugs
- Z79.84 Long-term (current) use of oral hypoglycemic drugs

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E11.9: Type 2 Diabetes Mellitus *without complications*

E11.9 is a commonly used code and is easily overused. This code should only be used for patients whose diabetes is well-controlled and without complications. It should be used in conjunction with the Z describing their treatment type, Z79.4 or Z79.84

E11.65: Type 2 Diabetes *with hyperglycemia*

E11.65 is the correct code to use for patient's whose diabetes is not well-controlled and has resulted in a higher-than-normal A1c. This code should also be used in conjunction with the Z code that describes their treatment type, Z79.4 or Z79.84.

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Diabetes – Complicating Systems

DM w/o Complications

Neurologic

Circulatory

Renal & CKD

Type 2 Diabetes without complications		Code
DM controlled and without complications	*HCC 19*	E11.9
DM uncontrolled w/ hyperglycemia	*HCC 18*	E11.65
DM uncontrolled w/ hypoglycemia, w/o coma	*HCC 18*	E11.649
hypoglycemia, with coma	*HCC 17*	E11.641
Always code for DM2 patient on insulin	*HCC 19*	+Z79.4
Long-term use oral hypoglycemic med *(code both when true)*		+Z79.84
DM with complication of neurological system, specifically;		
polyneuropathy	*HCC 18*	E11.42
mononeuropathy	*HCC 18*	E11.41
gastroparesis (autonomic polyneuropathy)	*HCC 18*	E11.43
DM with unspecified neuropathy *(avoid)*	*HCC 18*	E11.40
DM with neuropathic arthropathy	*HCC 18*	E11.610
If the DM is not in control assign *also*	*HCC 18*	+E11.65
Diabetes w/complication of circulatory system, specifically;		
DM with peripheral angiopathy, no gangrene	*HCC 18 & 108*	E11.51
DM w/peripheral angiopathy, w/ gangrene	*HCC 18*	E11.52
DM with other circulatory complication	*HCC 18*	E11.59
If the DM is not in control assign *also*	*HCC 18*	+E11.65
DM with diabetic nephropathy	*HCC 18*	E11.21
DM with proteinuria or microalbuminuria: E11.29 and R80.9		
DM w/complication of CKD *(code also stage CKD)*	*HCC 18*	E11.22
CKD stage 1 GFR >90 (Glomerular Filtration Rate)		+N18.1
CKD stage 2 GFR 60-89 (Mild)		+N18.2
CKD stage 3 unspecified (Moderate)		+N18.30
CKD stage 3a GFR 45-59 (Moderate)		+N18.31
CKD stage 3b GFR 30-44 (Moderate)		+N18.32
CKD stage 4 GFR 15-29 (Severe)	*HCC 137*	+N18.4
CKD stage 5 GFR <15	*HCC 136*	+N18.5
End Stage Renal Disease (ESRD)	*HCC 136*	+N18.6
If the DM is not controlled, assign also	*HCC 18*	+E11.65

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DM2 and Medication

	Type 2 Diabetes without complications		Code
1.	**DM controlled and without complications**	*HCC 19*	E11.9
2.	**DM uncontrolled** w/ hyperglycemia	*HCC 18*	E11.65
	DM uncontrolled w/ hypoglycemia, w/o coma	*HCC 18*	E11.649
	hypoglycemia, with coma	*HCC 17*	E11.641
3.	**Always code for DM2 patient on insulin**	*HCC 19*	+Z79.4
4.	**Long-term use oral hypoglycemic med** *(code both when true)*		+Z79.84

- DM2 controlled & on Insulin
- DM2 uncontrolled & on Insulin
- DM2 uncontrolled & on oral meds
- DM2 uncontrolled, on Insulin & oral Metformin

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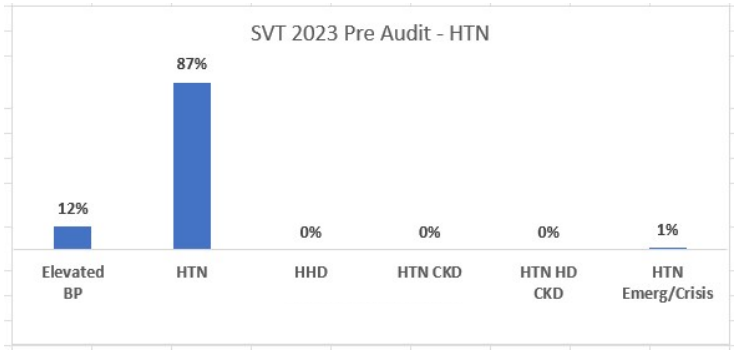
Your Hypertension Data



- Great Job documenting HTN, but don't forget to code to highest known specificity and consider presumable causal relationships.

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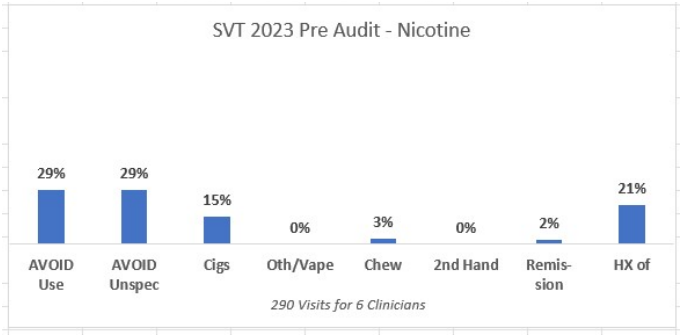
Your Nicotine Data



ICD-10-CM Guidelines require that a patient's relationship to nicotine must be documented for certain conditions including (but not limited to) : respiratory conditions and COPD. Be aware of code choices for nicotine use, abuse, dependence or history of nicotine dependence.

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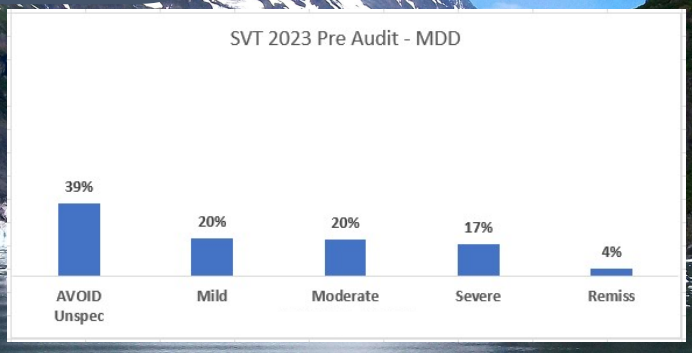
Your MDD Data



39% of encounters are missing specificity.

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The "Severity" Specifiers

Mild, Moderate, & Severe

Mild:

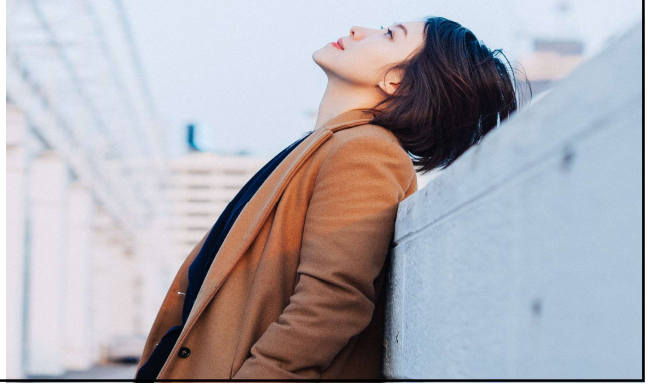
Currently, few, if any symptoms (beyond the DSM req. of 5-9) are present. Intensity of symptoms is distressing, but manageable.
Symptoms result in minor impairment in social or occupational functioning. See Details in DSM-5, page 188

Moderate:

Number and intensity of symptoms and/or functional impairments are between those identified as "mild" and "severe."
See Details in DSM-5, page 188

Severe:

At this time, the number of current symptoms is substantially in excess of the 5-9 required for diagnosis. The intensive of symptoms is seriously distressing and unmanageable, symptoms markedly interfere with social and/or occupational functioning. DSM-5 page 188
Note: When the severity level is "severe," provide further detail indicating whether or not symptoms of psychosis are present.
DSM-5 page 188 & ICD-10-CM



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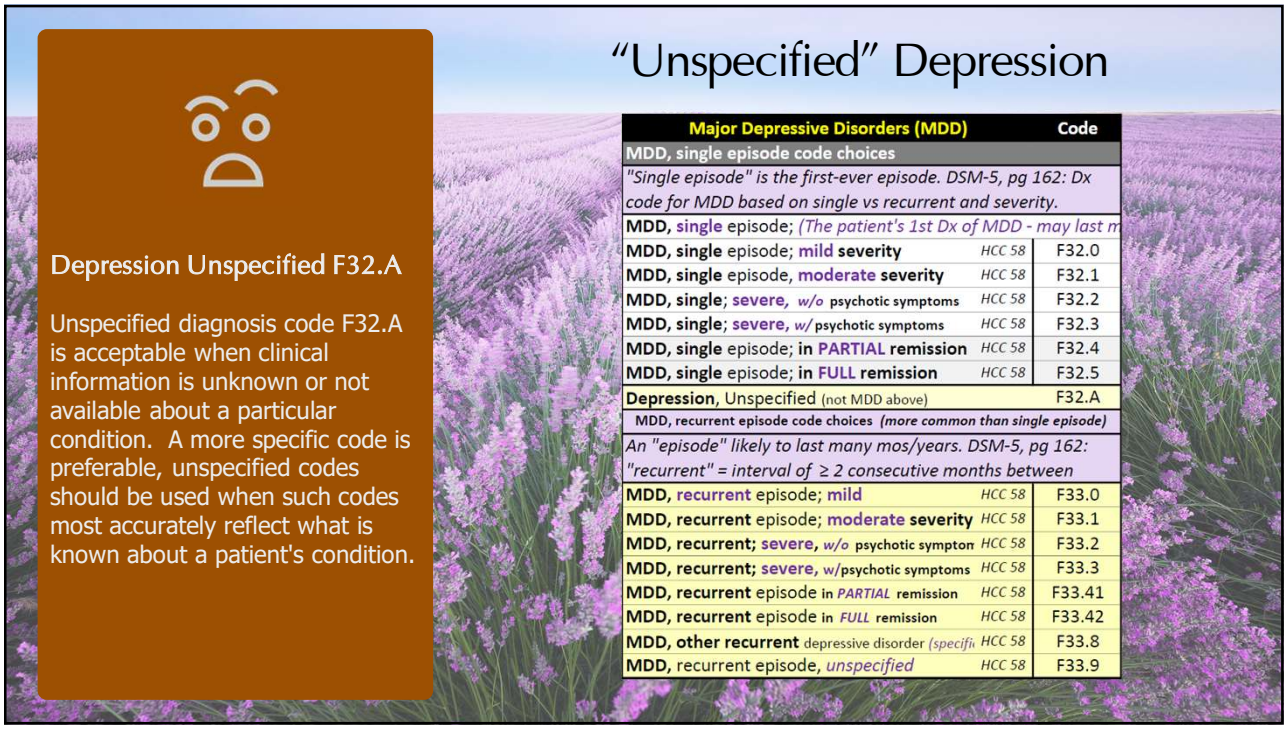
"Unspecified" Depression
Depression Unspecified F32.A
Unspecified diagnosis code F32.A is acceptable when clinical information is unknown or not available about a particular condition. A more specific code is preferable, unspecified codes should be used when such codes most accurately reflect what is known about a patient's condition.
Major Depressive Disorders (MDD) Code
MDD, single episode code choices
"Single episode" is the first-ever episode. DSM-5, pg 162: Dx code for MDD based on single vs recurrent and severity.
MDD, single episode; (The patient's 1st Dx of MDD - may last m
MDD, single episode; mild severity HCC 58 F32.0
MDD, single episode, moderate severity HCC 58 F32.1
MDD, single; severe, w/o psychotic symptoms HCC 58 F32.2
MDD, single; severe, w/ psychotic symptoms HCC 58 F32.3
MDD, single episode; in PARTIAL remission HCC 58 F32.4
MDD, single episode; in FULL remission HCC 58 F32.5
Depression, Unspecified (not MDD above) F32.A
MDD, recurrent episode code choices (more common than single episode)
An "episode" likely to last many mos/years. DSM-5, pg 162: "recurrent" = interval of ≥ 2 consecutive months between
MDD, recurrent episode; mild HCC 58 F33.0
MDD, recurrent episode; moderate severity HCC 58 F33.1
MDD, recurrent; severe, w/o psychotic sympton HCC 58 F33.2
MDD, recurrent; severe, w/psychotic symptoms HCC 58 F33.3
MDD, recurrent episode in PARTIAL remission HCC 58 F33.41
MDD, recurrent episode in FULL remission HCC 58 F33.42
MDD, other recurrent depressive disorder (specifi HCC 58 F33.8
MDD, recurrent episode, unspecified HCC 58 F33.9

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SVT 2023 Pre Audit - Preventive
82%
3%
10%
4%
0%
Adult w/o Abnormal
Adult w/ Abnormal
WCC w/o Abnormal
WCC w/ Abnormal
Newborn Wt/Color Chk
118 Visits for 6 Clinicians
Your Prevention Data

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The Preventive (Wellness) Encounter

The clinician selects the appropriate code according to CPT Guidelines:
- New or Established Patient
- Patient Age

Time Guidelines do not apply

Code immunizations/ procedures separately

Do NOT code Risk Factor Reduction/Behavior Change Intervention Services separately

Service does not include management of illness(es)

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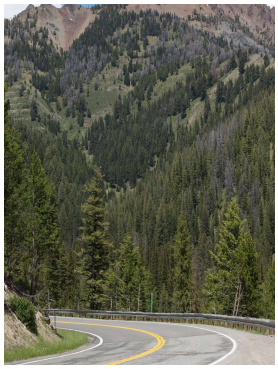
MAWV HCPCS vs CPT Preventive E/M

Not covered by Medicare
May be covered by MAOs
Check payer guidelines

MAWV: HCPCS Codes

G0402 Welcome to Medicare
G0438,G0439 Annual Wellness Visits
✓Comprehensive history
✓Some required exam
✓Risk-factor reduction
✓Counseling
✓Referrals



Preventive CPT E/M 99391-99387

✓Ordering screening services
✓Preventive counseling
✓Age specific, periodic comprehensive evaluations
✓Comprehensive history
✓Comprehensive exam
✓Risk-factor reduction

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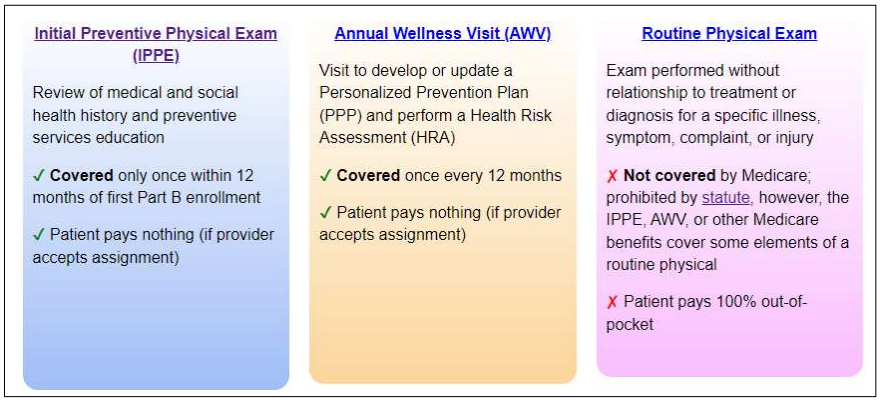
Three Medicare Wellness Visits



https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

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Wellness vs. Illness

Wellness Encounter

- Patient presents to confirm wellness; results in confirmation of wellness
- Includes Age/Gender appropriate History, Exam, anticipatory guidance, risk factor reduction, counseling
- Includes ordering of labs and studies
- Diagnosis indicates reason for wellness examination

Illness Encounter

- Patient presents with chief complaint and provides HPI
- Results in problem solving
- Includes problem-pertinent History, Exam and Medical Decision Making
- May involve extra time, nursing services, procedures and plans
- Diagnosis is related to the findings

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Wellness + Illness on the Same Date

If illness is evaluated and treated during a wellness service and it's significant enough to require additional work of problem evaluation and management, report a wellness E/M and an illness E/M:

99395 - Wellness – with abnormal findings Z00.01
99213-25 - Illness - acute bronchitis, rx w/abx - J20.9
Assign illness code based on MDM complexity, not on total time.
Modifier 25 must be appended to the illness E/M
Don't assign an additional illness E/M code for evaluation of a minor problem or a problem that does not require additional work of the key components.

If it's worth an extra code, it's worth an extra paragraph!

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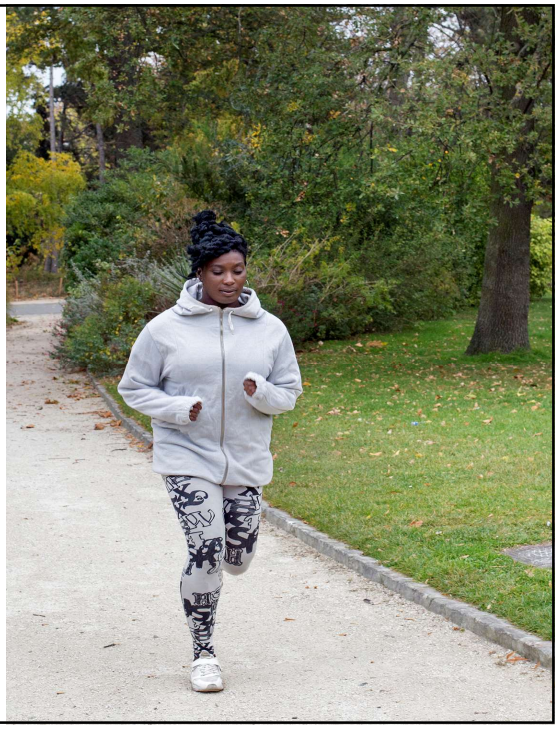
Report All Conditions That Affect/Require Care

Examples of commonly omitted conditions:

- Alcohol use/abuse/dependence disorders
- MDD
- Long-term medication use (Z79.899)
  - Use for meds that require frequent monitoring or have mod-high risk of side effects
- Social Determinants of Health



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ZIP Code likely has more effect on health outcomes than DNA Code

Z59.01 Sheltered homelessness
Z62.22 Institutional living
Z59.4 Lack of food/water
Z59.6 Low income
Z59.5 Extreme poverty
Z60.3 Acculturation difficulty
Z60.4 Social rejection
Z62.2 Upbringing away fm parents
Z63.32 Absence of family member
Z62.8XX Hx of abuse/neglect
Z65.8 Psychosocial problems
Z65.3 Legal circumstances

Social Determinants of Health

Problems related to:

- Education and Employment
- Housing and Social Environment
- Support Group and Psychosocial Circumstances

Impact on Outcomes:

- Payer Programs
- Complexity of MDM Data Integrity

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- Z55 Problems related to education and literacy
- Z55.5, less than a high school diploma
- Z56 Problems related to (un)employment
- Z57 Problems related to occupational exposure
- Z58.6, inadequate drinking-water supply
- Z59 Problems related to housing and economics
- Z59.00, homelessness, unspecified
- Z59.01, sheltered homelessness
- Z59.02, unsheltered homelessness
- Z59.41, Food insecurity
- Z59.811, housing instability, housed with risk of homelessness
- Z59.812, housing instability, housed homelessness in past 12 months
- Z59.819, housing instability, housed unspecified
- Z59.89, other problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Problems related to support group
- Z64 Problems related to psychosocial circumstances

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October 2022 ICD-10-CM SDoH Additions

More SDoH codes relating to transportation and economic stressors

Z59.82 Transportation insecurity

Includes Excessive transportation time, Inaccessible transportation, Inadequate transportation, Lack of transportation, Unaffordable transportation, Unreliable transportation, Unsafe transportation

Z59.86 Financial insecurity

Includes Bankruptcy, Burdensome debt, Economic strain, Financial strain, Money problems, Running out of Money, Unable to make ends meet
Excludes 2: Extreme poverty (Z59.5) Low Income (Z59.6) Material hardship NOS (Z59.87)

Z59.87 Material hardship

Includes Material deprivation, Unable to obtain adequate childcare, Unable to obtain adequate clothing, Unable to obtain adequate utilities, Unable to obtain basic needs
Excludes 2: Extreme poverty (Z59.5) Financial insecurity, NOS (Z59.86) Low income (Z59.6)

Z59.89 Other problems related to housing and economic circumstance

Includes foreclosure on lone, Isolated dwelling, Problems with creditors

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Problem Lists

A Well-Maintained Problem List Serves Many Roles

Important communication tool

- Identifies chronic conditions
- Identifies status information
- Informs other providers of all comorbidities

Helps with organization-wide responsibility

- Lean on all specialties to maintain

Assist in coordinated management

- Address gaps in care
- Determine need for chronic care mgmt. services

Minimize frustration

- Bypass search tools for complex illnesses

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A Final Thought

"The main purpose of documentation is to support care of the patient by current and future health care team(s)."
- CPT Professional Edition, 2023

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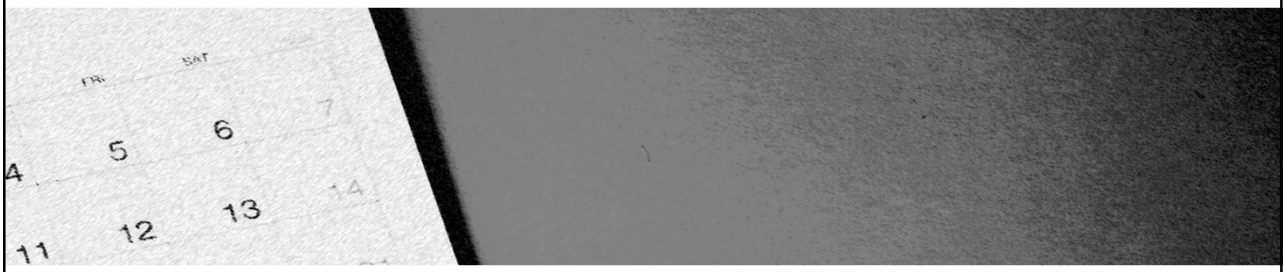
The Plan for 2023



1. Individual Audits
2. Group/Individual training as indicated
3. Ongoing support

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Questions?

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BCA
Revolutionizing Your Revenue Cycle

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NOTES

Meri Harrington, CPC, CEMC began her healthcare career with 12 years of coding and auditing experience in a multispecialty rural health clinic that led the way in the rural residency training program. She was responsible for writing the E&M coding policy for the organization, as well as conducting multiple clinician and peer audits and education sessions. She has also assisted with internal audits to assure Meaningful Use implementation and attestations.

Meri and the BCA team perform documentation quality and coding compliance audits and develop customized clinician and coder training. She has spent multiple hours working alongside clinicians and peers on projects aimed at improving the user-friendliness of electronic medical record programs.

Meri has a special interest in data analysis and training related to the intricacies of appropriate ICD-10-CM diagnosis codes and chronic care coding with expertise related to HCCs. She has had the opportunity to work alongside third-party payers with a focus on appropriate diagnosis coding as a risk-based measurement instrument.

Meri's knowledge and study of contemporary "quality" healthcare concerns coupled with her understanding of MACRA, MIPs and other quality-based federal reimbursement plans, has positioned Meri to guide BCA in such a manner that we are able to incorporate emerging physician documentation requirements in current coding and documentation training. For several years, Meri has served as the director of BCA's six-month *Comprehensive Coding Education Program* which is designed to prepare coders and billers for professional national certification.

Meri also enjoys unique auditing and training services with clinics that provide focused services such as Contraceptive Management/Family Planning, and HIV services. Meri spends a great deal of her time working with Family Practice, Pediatrics, Geriatrics and OB-GYN. She is an expert with surgical coding. Now in her 20th year in the healthcare industry, Meri is pleased and excited to see Behavioral Health, for which she is considered a subject matter expert, receiving the recognition it deserves as a medically necessary aspect of the whole-body health of patients.

Historically, Meri's education includes several years volunteering as an EMT in her local community. Meri attended the Community Colleges of Spokane – Colville IEL. Meri has developed multiple educational programs including the *BCA Transition Mission* training series, which was extensively utilized by clinics throughout the US as a tool for ICD-10-CM Implementation.

Jen Kuehn, CPA, CGMA, CPB is the managing partner of BCA and joined the team in 2019. She maintains an active Idaho Certified Public Accountant license, is a Chartered Global Management Accountant through the AICPA, and holds the Certified Professional Biller designation through the AAPC. She is a member of the AICPA and AAPC. Jen has served as the Chief Financial Officer and Compliance Officer for several Federally Qualified Health Centers throughout her 20-year career in finance. She brings a unique offering to BCA with her billing, finance, operations, and management knowledge.

Jen's focus is in two areas, management training and revenue cycle optimization. Her prior experience as a CFO revealed that training and support is vital to effective management in health care. Jen serves as a resource and provides support to boards of directors, executives, and management through strategic, tactical, and analytical assistance to strengthen cash flow. Additionally, Jen is a resource for the variety of compliance and audit requirements that are an integral part of health care today. She is also committed to provide quality training to billing and front office staff to deepen their understanding of the revenue cycle within their organization. She is the designer of BCA's billing training webinar series, offering expertise in the complex nature of medical billing.

Prior to working with non-profit health centers, Jen worked in large corporate settings, working in management at a Fortune 500 company for many years. The experience she gained in this role translates well into assisting our clients with data management, system implementation, policy and procedure manuals, and corporate compliance. Additionally, her skills in building and developing teamwork and personal leadership are key in teaching others. She has also proudly served on the board for the Idaho School for the Deaf and Blind Foundation. Jen is a proud Boise State University alumnus with a Bachelor's in Business Administration – Accountancy.

Jennifer Bartlett, CPC, CCS-P joined the BCA team in 2018 and brings with her 15 years of experience in medical coding and billing. She began her career performing administrative duties, including billing for a small orthotic and prosthetic facility. She obtained her coding certification and transitioned to a large health system holding various Charge Capture positions within Revenue Cycle. Jennifer was part of a team that successfully implemented a Charge Capture department for one of the larger facilities within the health system. She and her team ensured the integrity and charging accuracy of a high volume of facility and surgical services charges.

In her time at BCA, Jennifer has been heavily involved in performing documentation quality and coding compliance audits and develop customized clinician and coder training. She and her colleagues have spent multiple hours working alongside clinicians and peers on projects aimed at improving documentation and coding processes within electronic medical records programs. She is committed to providing quality education and training to all areas of coding and revenue cycle.

Historically, Jennifer attended the College of Southern Idaho in Twin Falls, ID. She completed the HCPro Coding Certification program in 2011 and in 2019, she obtained her CCS-P certification through AHIMA.

BCA's Commitment - BCA, Inc. has provided national physician training services since 1989. BCA recognizes the increasing and constantly changing demands placed on the physician office by federal and state government, CMS, PCMH programs, value-based reimbursement projects and private insurance carriers. In addition to serving physician offices, BCA provides specialized training for various third-party payers, outpatient hospital-based clinics, and Federally Qualified Health Centers and Rural Health Clinics. BCA offers physician and staff education designed and customized to enhance quality, operations, and federal compliance.

Medical Pre-Audit Training Evaluation - BCA, Inc.

Please scan & email to aimee@bcarev.com

SVT Health & Wellness
February 22, 2023

Consultant: **Meri Harrington, CPC, CEMC**

Your Group Training Session:

Your training session was provided with emphasis on appropriate CPT and ICD-10-CM code assignments and CMS Documentation Requirements.

		Excellent	Good	Fair	Weak
1	Please rate the group training.	❑	❑	❑	❑
2	Did you find this training process valuable?	❑ **Yes**	❑ **No**		
3	Did the trainer adequately answer your questions?	❑ **Yes**	❑ **No**		
4	Do you think the training tools will be helpful?	❑ **Yes**	❑ **No**		
5	Will your coding change as a result of training?	❑ **Yes**	❑ **No**		
6	Future EM audit training can be provided in live, web-based conference sessions. Do you think follow-up evaluation and training will be helpful?	❑ **Yes**	❑ **No**		

Please note any recommendations for improvement of this training program:

Please note any comments or recommendations you may have for administration:

Please note any follow-up you are requesting from the trainer: