

Coding Webinar 1

Coding Outpatient Pediatric Visits: Terminology and Rules

Laura Brey, Training Director, NASBHC

Loretta Jenkins, Research Analyst, OSHD

brey@nasbhc.org

919-866-0920

loretta.l.jenkins@state.or.us

971-673-0246

Laura Brey, MS Training Director, NASBHC

- *32 year career in public health and nonprofit administration, management, consultation, and training .*
- *Joined NASBHC staff in 2000*
- *Manages NASBHC'S technical assistance and training initiatives, and the annual convention*
- *Has sixteen years of experience school-based health experience at the state and national levels*
 - *Training Director, NASBHC*
 - *Clinical Service Coordinator for the NC Division of Public Health, Making the Grade in NC,*
 - *Project Director for the American Medical Association's GAPS in School-Based Health Centers Initiative*



Loretta Jenkins, Research Analyst, OSPHD

- *16 year career working with children and adolescents in clinical and research-based environments. .*
- *Joined OSPHC, State SBHC Program Office in 2004*
- *As the State SBHC Program Office Research Analyst,*
 - *Focuses on data collection, management and analysis, and program evaluation*
 - *Responsible for generating data-driven content for standard and special reports*



Objectives

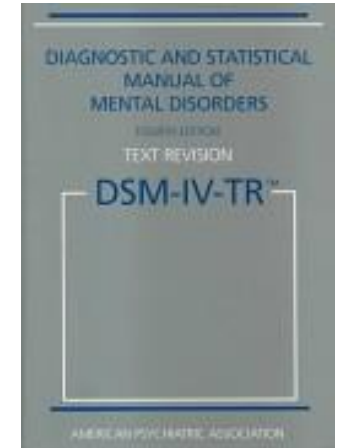
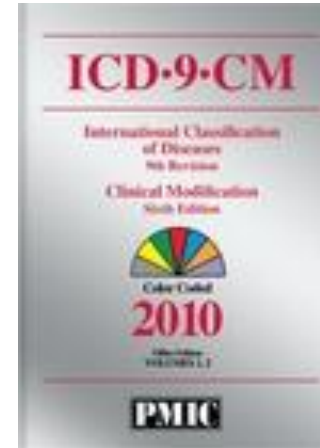
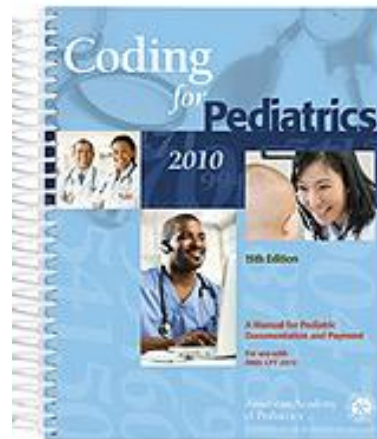
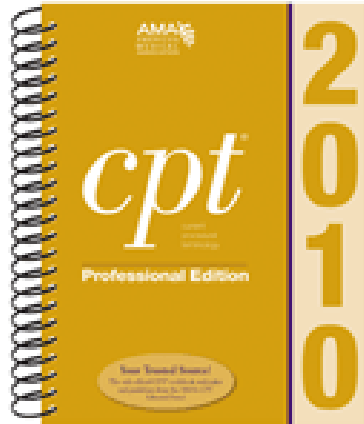
- ✓ **Define** CPT, ICD 9, and DSM 4 Coding
- ✓ **Explain** the reasons why appropriate coding and documentation is so important in SBHC settings.

Coding Background and Terminology

Coding Definition

- Coding is an alphanumeric system used to translate medical procedures and services into data

Types of Coding



- Current Procedural Terminology (CPT)
- International Classification of Diseases (ICD-9 Clinical Modification - CM)
- Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR)

Coding Is Not The Same As Billing



Coding is Medicare Drive

- Pediatrics was not considered in original coding guidelines, so some of the things we do in SBHCs may not fit well

SBHC Coding

- There is no difference between coding in a SBHC and any other setting – the coding assumptions are the same.
- You provide the same level of care regardless of the location.

Why Code Correctly?

- Reimbursement depends on it.
- Codes describe the services you provide
- Codes justify these services
- Services not documented “never happened”

PS: Never code for the purpose of getting more money

The Coding Process has 2 Parts

1. “What you did” = CPT
2. “Why you did it” = ICD-9 or DSM-4 TR

YOU MUST ALWAYS USE BOTH
a what and a why
(NO EXCEPTIONS)

When a provider is under-coding they tell the wrong story

This wrong story is:

- ✓ SBHC Providers are seeing very few patients with multiple problems.
- ✓ SBHC Providers should see more patients since they are not seeing complicated patients.
- ✓ The SBHC should decrease the number of physicians and add more mid-level providers.

There Are Two Coding Guidelines - 1995 & 1997

- Both 1995 and 1997 guidelines are approved for use by CMS
- Agencies may specify use of 1995 or 1997 guidelines
- 1997 guidelines are more specific than 1995 in the examination portion (they are more computer friendly)
- New guidelines have been proposed, but have not yet been accepted

Coding Guidelines 1995 vs. 1997

This lecture is based on the 1995 guidelines because they are 15 pages long vs. 57 pages of the 1997 version.

www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf

Fraud

- ***Intentional*** deception or misrepresentation
 - Deliberately billing for services not performed
 - Unbundling of services
 - Intentionally submitting duplicate claims

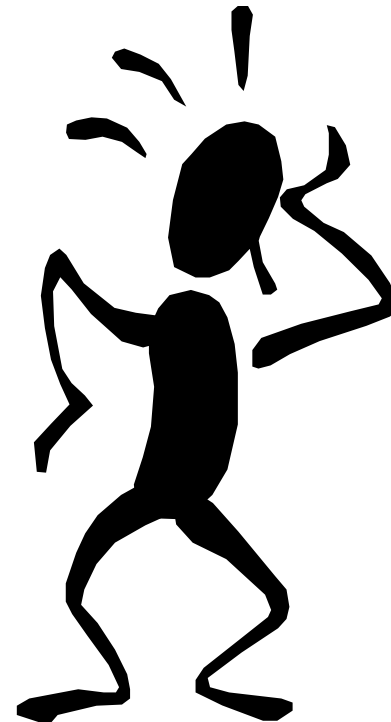
Abuse

- Improper billing practices
 - Billing for non-covered services
 - Misusing codes on a claim form



Errors

- Accept it, you will make them.
- Your best defense is having a plan for your coding and being able to explain it.



Over-coding and Under-coding

- CPT and ICD-9 codes must always relate
- The first ICD-9 code you use drives the relationship to the CPT code

Coding Does Not Equal Good Medicine

Coding



But - Coding is Good Documentation



Questions ?

CPT Codes document:

- Level of Service
- Procedures Provided

Examples of CPT codes

Evaluation & Management

99211

99212

99213

99214

99215

Preventive Health

99391

99392

99393

99394

99395

99397

99397

ICD-9 and DSM4 Codes document:

The **reason** behind the visit

(They must support the CPT codes)

General Coding Principles

- Coding gets you paid for your services
- Coding can be used to justify the need for services to your funders

Coding with ICD-9

- ICD-9 codes have 3, 4 or 5 digits
 - The greater the number of digits, the higher the specificity
 - Use a 5-digit code when it exists
 - Use a 4-digit code only if there is no 5-digit code with the same category
 - Use a 3-digit code only if there is no 4-digit code within the same category

PS: Omitting the required 4th or 5th digit will result in the denial of a claim. Do not add any additional digits, even zero

ICD-9-CM Codes

Range from 001.0 to V82.9

- They identify:
 - Diagnoses
 - Symptoms
 - Conditions
 - Problems
 - Complaints
 - Other reason for the procedure, service, or supply provided

ICD-9-CM Codes

- Three volumes
 - Volume 1 Tabular List of Diseases
 - Notes all exclusive terms and 5th-digit instructions
 - Volume 2 Alphabetic Index of Diseases
 - Does not contain detail – Do Not code from this volume
 - Volume 3 Procedures
 - Used almost exclusively for hospital services

PS: (All 3 Volumes are generally found in one binding)

“V” Codes

- For circumstances other than disease or injury
- Three categories:
 - **Problem** – Could affect overall health status, but is not a current illness or injury
 - Ex.: V14.2 Personal history of allergy to sulfonamines
 - **Service** – Circumstances other than illness or injury
 - Ex.: V68.1 Issue of a repeat prescription
 - **Factual** – Certain facts that do not fall into the “problem” or “service” categories

“V” Codes

- Can be used as a:
 - Solo Code
 - Principal code
 - Secondary code
- May represent check-ups, screenings, administrative requests, prescription refills

Questions ??

Rules for Coding Outpatient Visits

Determine Type of Office Visit

- **Evaluation and Management**

New Patients vs. Established Patients

- **Preventive Health Visits**

New Patients vs. Established Patients

- **Counseling Visits**

Medical Visit – talker only

- **Mental Health Visits**

New Patients vs. Established Patients

Definition of a new patient:

- It is the patient's first visit to the provider
- The patient has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice, within the past three years.

PS: Any time a patient is seen in an Emergency Room they are considered a new patient

If your patient does not
meet the definition of a
New Patient,
then they are an
Established Patient

Determine Medical Necessity

- Services are reasonable and necessary for the diagnosis and treatment of illness or injury.
- All payors define necessity differently
- Clinical rationale must be documented through coding.
- You cannot write more, to get paid more.

Determine Chief Complaint

- The reason for the patient's visit
 - S of a SOAP note
- Codes used must relate to chief complaint or they are invalid
- And, the chief complaint must be documented in the chart

Evaluation and Management Services

Evaluation/Management (E / M) Services

- Used for acute care visits
- Five levels of service
- Seven components within the levels
 - Key components – history, exam and medical decision making
 - Contributory components – counseling, coordination of care, nature of presenting problem, and time

Evaluation/Management (E / M) Services

- Beginning information about coding deals with the three key components:
 - History
 - Examination
 - Medical Decision Making

E/M Office Visit Services

There are 5 different levels of service

New Patient	Established Patient
N/A	Level 1: 99211 – Minimal
Level 1: 99201 – PF; PF; SF	Level 2: 99212 – PF; PF; SF
Level 2: 99202 – EPF; EPF; SF	Level 3: 99213 – EPF; EPF; LC
Level 3: 99203 – D; D; LC	Level 4: 99214 – D; D; MC
Level 4: 99204 – C; C; MC	Level 5: 99215 – C; C; HC
Level 5: 99205 – C; C; HC	N/A

- The numbers for “new” vs. “established” visits do not match for the level of service.
- The history & exam are classified as Problem Focused (PF); Expanded Problem-Focused (EPF); Detailed (D) and Comprehensive (C).
- The level of medical decision making is ranked as Straightforward (SF); Low Complexity (LC); Moderate Complexity (MC) and High Complexity (HC).

E and M Visits with $\geq 50\%$ of Time Spent in Education/Counseling

New Patients

10 minutes 99201
20 minutes 99202
30 minutes 99203
45 minutes 99204
60 minutes 99205

Established Patients

5 minutes 99211
10 minutes 99212
15 minutes 99213
25 minutes 99214
40 minutes 99215

Questions ???

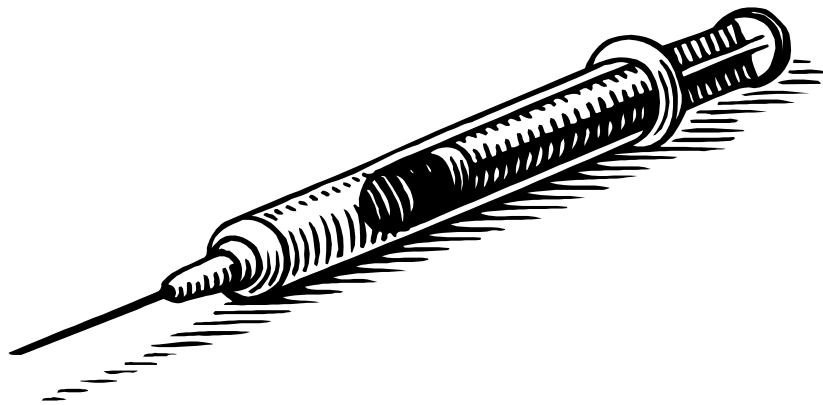
Preventive Services

Preventive Services

- These visits include a comprehensive history and examination, as well as appropriate counseling/anticipatory guidance/risk factor reduction, interventions, and the ordering of age-appropriate laboratory/diagnostic procedures.

Preventive Services

- “Comprehensive” in a preventive service examination is not synonymous with a “comprehensive” E/M examination.



Preventive Service Codes

Age	New	Established
< 1	99381	99391
1-4	99382	99392
5-11	99383	99393
12-17	99384	99394
18-39	99385	99395
40-64	99387	99397
65+	99387	99397

Preventive Services

Appropriate ICD-9 codes would be:

- **V20.2** for a **Routine Infant or Child Health Check**
- **V70.3** for a **Sports Physical**

Preventive Services

- Additional services provided at the time of the visit should be reported with their specific CPT codes listed separately:
 - Examples:
 - Snellen Test
 - Laboratory
 - Immunizations
 - Administration of Immunizations

Oregon Medicaid Sliding Fee Schedule

- http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml

Questions ?????