

Fundamentals of Coding and Billing for STI Clinical Services in Local Health Departments

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IN ASSOCIATION WITH

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Family Planning Council
STD/HIV Prevention Training Center at Johns Hopkins**

Objectives

- ✓ Understand how proper documentation and coding supports compliant billing practices and efficiencies
- ✓ Understand relevant ICD, CPT and modifier terminology and codes
- ✓ Become familiar with how common STD ICD codes we use will look in ICD-10 and steps you should be implementing to get ready for the transition

Why Bill for Our Services?

- Fiscal sustainability - less funding, shrinking budgets
- Changes to certain state guidelines allowing LHD to bill for STD services
- Accountable Care Act (ACA) gives more people insurance who are willing to bill their insurance
- Many still don't have insurance and can't afford to pay for services



Who's Paying for Our Services?

- Multiple sources might provide payment for our patients' care:
 - Medicaid Fee for Service, Managed Care / HMO
 - Medicare
 - Private Commercial Insurance (aka Third Party Payers)
 - State and Federal funding
 - Self Pay – Sliding Fee Scale
- Multiple payer sources = multiple requirements making your thorough documentation and coding essential

What Can We Bill?



“Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests.”

- ✓ Services provided to the patient and documented in the Medical Record
- ✓ Services **medically necessary** for the treatment of the patient's illness or condition
- ✓ If it isn't documented – it can't be billed

What Do We Need to Bill?

- In order to bill and expect reimbursement for services, we need to:
 - ✓ Understand and follow the requirements and rules of Medicaid, Medicare and other commercial insurances
 - ✓ Understand the diagnosis & procedure codes that best represent our care
 - ✓ Have checks and balances in place to avoid unintended problems
 - ✓ Understand how each of our roles impacts the organization's Revenue Cycle and success

Why Document?

- Improves compliance
- Improves patient care
- Improves clinical data for research and education
- Protects the legal interest of the patient, facility and clinician
- Enables proper reimbursement for services performed
- *If it isn't documented – it can't be coded and ultimately billed!*

Remember...

- In order to bill for our services – we need to:
 - ✓ Document services in the Medical Record
 - ✓ Capture WHAT services we provide – **CPT / HCPCS**
 - ✓ Capture WHY we did the services - **ICD**
 - ✓ Document any special circumstances – **Modifiers**
- ✓ **Always follow coding guidelines**



CPT CODING – “WHAT”

Procedure Codes – “What”

- **CPT:** Current Procedural Terminology
 - Every service we provide relates to a CPT code including medical evaluations, procedures such as lesion / wart removals, lab tests, vaccines administrations, venipuncture and blood draws etc.
- **HCPCS:** Healthcare Common Procedure Coding System
 - Additional codes to identify products, supplies, materials such as drugs and devices (i.e.: azithromycin, BIC, IUD devices)

What is an E/M?

- “Evaluation and management” (E/M, Medical Visit)
 - Provider evaluates a patient’s condition and decides on a course of treatment to manage it
- Requires selection of CPT code that best represents:
 - Patient type (New vs. established)
 - Setting of service (Outpatient LHD clinic vs. ED or Inpatient)
 - Level of service



Patient Type



- **Per CPT: New Patient**
 - “One who has **NOT** received any professional services from the physician, or other qualified healthcare professionals (QHCP) or another physician of the **exact** same specialty and subspecialty who belongs to the same group practice, **within the past 3 years**”
- **Established Patient**
 - Within 3 years

Patient Type

- It is best if each specialty clinic within your LHD bills under a separate National Provider Identifier (NPI) to avoid potential overbilling of “established” vs. “new” E/M codes
 - One NPI number for whole LHD means less “new patients” overall
 - Reimbursement is typically higher for a new patient vs. an established E/M
 - Most payers “look back” for 3 years for any new patient E/M to see if there is an earlier claim based on the billing practice’s NPI number
 - Potential loss of reimbursement

Patient Type

- This distinction matters because reimbursement and coding rules are different
 - ✓ Based facility NPI number
 - ✓ Within same practice, patient change of insurance - “established”
 - ✓ Within your reproductive health programs, multiple clinic locations – “established”
 - ✓ Prior services must be face-to-face with the QHCP

1995 vs. 1997

E/M Documentation Guidelines

- CMS: May use either version of the 1995 or 1997 documentation guidelines, not a combination of the two, may be used for a patient encounter
- Key components of history and medical decision-making are very similar
- Exam component differs
 - 1997 focuses on bullets within a multi or single organ system such as Genitourinary (GU), eyes, cardiovascular
 - 1995 requires review of multiple body areas and organ systems
- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764.pdf

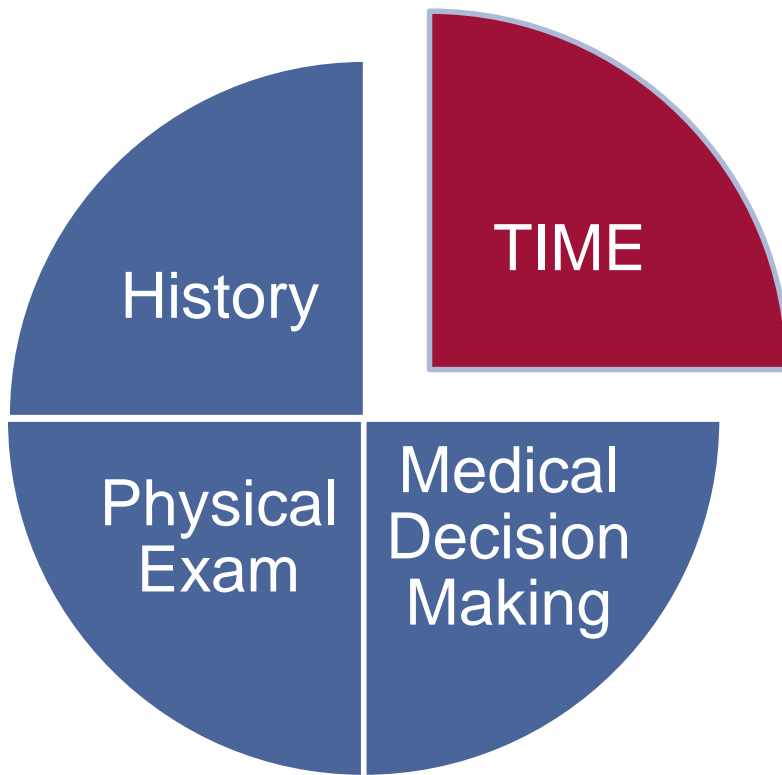
E/M: Problem-Focused Visits

- Common for STI screening visits
- Services to evaluate patients with a problem or chief complaint in the outpatient clinic setting
 - New patients 99201-99205
 - Established patients 99211-99215

Lisa, a return patient, meets with the NP to be evaluated and tested for an STI including an exam and counseling. Her visit might be reported as 99213...



2 Methods to Calculate E/M Level



- Composite of 3 key components (Hx + PE + MDM)

Or

- TIME, when greater than 50% of FTF time is spent in counseling
- 1 method does not fit all visits

Method 1 – Three Key Components

History

- Chief Complaint
- History of the present illness (HPI)
- Review of body systems (ROS)
- Past, family, social history (PFSH)

Physical Exam

- Single or multiple organ system examination

Medical Decision Making

- # of diseases and management options
- Amount and complexity of diseases
- Risk of complication

Key Component 1: History - Chief Complaint...

- Concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the patient encounter, usually stated in the patient's own words
 - Should be clearly reflected in the medical record
 - Front desk should not be filling this in prior to visit
 - Supports your diagnosis selection
 - Be specific - avoid phrases like "follow-up", "check-up" ...

Key Component 1: History of Present Illness (HPI)

- Describes the chronological development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. Includes the following elements:
 - Location, quality, duration, severity, timing, context, modifying factors, associated signs and symptoms
- Can be performed ONLY by the provider

HPI Elements

Brief (1-3)

Extended (4+)

Location	Area of body? lower back, groin, stomach
Quality	Characteristics of complaint? Is pain sharp, dull, throbbing, intermittent, stable, improving or worsening?
Severity	Discomfort – 8 on a scale of 1-10
Duration	Length of time it is present (started 4 days ago)
Timing	When is onset of pain? Constant? Or comes and goes?
Context	Circumstances of event - Is pain brought on by certain activity? Are certain situational stress factors present?
Modifying Factors	What makes it better or worse? (Better when heat is applied? OTC drugs help?)
Associated Signs and Symptoms	Problems associated with the chief complaint - weight gain, swelling in legs, mood swings and/or intense headaches?

Key Component 1: History: Review of Systems (ROS)

- Inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced:
 - 1 Constitutional (e.g., fever, weight loss)
 - 2 Eyes
 - 3 Ears, Nose, Mouth, Throat
 - 4 Cardiovascular
 - 5 Respiratory
 - 6 Gastrointestinal
 - 7 Genitourinary
 - 8 Musculoskeletal
 - 9 Integumentary (skin and/or breast)
 - 10 Neurological
 - 11 Psychiatric
 - 12 Endocrine
 - 13 Hematologic/Lymphatic
 - 14 Allergic/Immunologic
- 3 types of ROS: Problem Pertinent (1 system), Extended (2-9 systems) and Complete (10+)

Key Component 1: History: Past, Family, and Social (PFSH)

- Past Medical History
 - Experience with illnesses, injuries, operations, hospitalizations, current medications; allergies; immunizations; feeding and dietary status; compliance and treatments
- Family History
 - Medical history, including diseases that may be hereditary or place patient at risk
 - State “reviewed and found noncontributory” if there is no family history
- Social History
 - Age-appropriate review of patient’s past and current activities including, marital status; employment; drug, alcohol, and tobacco use; education; sexual history; and other relevant factors

Key Component 2: Physical Exam

For purposes of examination, the following Body Areas and Organ Systems are recognized:

Body areas:

- Head (incl. face);
- Neck;
- Chest;
- Abdomen;
- Genitalia, groin and buttocks;
- Back,
- Each extremity

Organ Systems:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Key Component 2: Physical Exam

Four levels of physical exam documentation:

- ***Problem focused***: Limited exam of affected body areas (BA) or organ system (OS)
- ***Expanded problem focused***: Limited exam of affected BA AND other symptomatic or related areas/organ systems
- ***Detailed***: Extended exam of affected body area/organ system AND other symptomatic or related areas / organ systems
- ***Comprehensive***: General multisystem exam OR complete exam of single organ system and other symptomatic or related body area(s) or organ system(s)

Key Component 3: Medical Decision Making (MDM)

Elements:

- ✓ Number of diagnosis or treatment options
- ✓ Amount and/or complexity of data reviewed
- ✓ Risk of complications and/or morbidity or mortality



Method 2 - Time Based

- Time can be used when:
 - $\geq 50\%$ of clinician's total Face-to-Face (FTF) time with patient is spent on counseling / coordination of care
- MUST document in the Medical Record:
 - Total duration of encounter and that over 50% of time is spent counseling
 - Nature and extent of the issues discussed, client questions and physician response, and recommendations or next steps
- UPDATE YOUR ENCOUNTER FORMS!!



Method 2 – Using Midpoints for Time

- 23 minutes FTF of which 18 minutes was spent counseling a new patient
 - 99202
- 20 minutes FTF of which >50% of time was spent counseling an established patient
 - 99213

New	Time (typical)	Established	Time (typical)
99201	≤ 15 (10)	99211	≤ 7 (5)
99202	16-25 (20)	99212	8-12 (10)
99203	26-37 (30)	99213	13-20 (15)
99204	38-53 (45)	99214	21-33 (25)
99205	> 53 (60)	99215	>33 (40)

Method 2 - Counseling

Discussion with a patient or their family about:

- Diagnostic results, impressions or recommended studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Summary: Problem-Oriented E/M

- ✓ Choose E/M based on scores of 3 key elements
 - History, Physical exam, MDM

- ✓ Compute counseling time as a percentage of total FTF time
 - If >50%, find E/M based on documented time factor

- ✓ Select the E/M code that is greater of 3 key elements or face-to-face time

	E/M CODE				
	99201	99202	99203	99204	99205
History					
Chief complaint	Required	Required	Required	Required	Required
History of present illness	1-3 elements	1-3 elements	≥4 elements or ≥3 chronic diseases	≥4 elements or ≥3 chronic diseases	≥4 elements or ≥3 chronic diseases
Review of systems	NR	1 system	2 systems	≥10 systems	≥10 systems
Past history/family history/social history	NR	NR	1 element	≥3 elements	≥3 elements
Examination	1 system (1-5 elements)	2 brief systems (6-11 elements)	1 detailed system + 1 brief system (≥12 elements)	8 systems or 1 complete single system (comprehensive)	8 systems or 1 complete single system (comprehensive)
Medical decision making					
Risk	Minimal	Minimal	Low	Moderate	High
Diagnosis or treatment options	Minimal	Minimal	Low	Moderate	High
Data	Minimal	Minimal	Low	Moderate	High
Time*	10 minutes	20 minutes	30 minutes	45 minutes	60 minutes
CPT, current procedural terminology; E/M, evaluation and management; HPI, history of present illness; NR, not required.					
*At least one half of total face-to-face time must involve counseling or coordination of care.					
Adapted from: American Medical Association. ⁴					

* New patients – all key components must be met.

Code based on the lowest score.

	E/M CODE				
	99211	99212	99213	99214	99215
History					
Chief complaint	Required	Required	Required	Required	Required
History of present illness	NR	1-3 elements	1-3 elements	≥4 elements or ≥3 chronic diseases	≥4 elements or ≥3 chronic diseases
Review of systems	NR	NR	1 system	2-9 systems	≥10 systems
Past history/family history/social history	NR	NR	NR	1 element	≥2 elements
Examination	NR	1 system (1-5 elements)	2 brief systems (6-11 elements)	1 detailed system + 1 brief system (≥12 elements)	8 systems or 1 complete single system (comprehensive)
Medical decision making					
Risk	NR	Minimal	Low	Moderate	High
Diagnosis or treatment options	Minimal	Minimal	Low	Moderate	High
Data	NR	Minimal	Low/Moderate	Moderate	High
Time*	5 minutes	10 minutes	15 minutes	25 minutes	40 minutes
CPT, current procedural terminology; E/M, evaluation and management; HPI, history of present illness; NR, not required.					
*At least one half of total face-to-face time must involve counseling or coordination of care.					
Adapted from: American Medical Association. ⁴					

* Established patients components must be met

Full Page handouts will be provided.

Counseling

- Used to report services provided face-to-face (FTC) by a physician or other QHCP for the purpose of promoting health and preventing injury or illness
 - Risk Factor Reduction 99401 – 99404
 - Behavior Change 99406 – 99409 (smoking and alcohol)
- Distinct from E/M
- Document time



IPV – Intimate Partner Violence Screening

- Under the Affordable Care Act (ACA), health plans must cover domestic violence screening and brief counseling at no cost to patients.
- In addition, the U.S. Preventive Services Task force (USPSTF) has officially recommended that clinicians screen women of childbearing age for domestic violence, including women who do not have signs or symptoms of abuse.
- Billable service if captured and documented
- <http://www.uspreventiveservicestaskforce.org/uspstf12/ipvelder/ipvelderfinalrs.htm>
- <http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Preventive%20Medicine%20Service%20Codes.pdf>
- http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html?s_cid=fb_vv487

IPV – Intimate Partner Violence Screening

- Potential ICD-9 codes for adult abuse when the abuse has been diagnosed:
 - 995.80 - Adult maltreatment, unspecified
 - 995.81 - Adult physical abuse
 - 995.82 - Adult emotional/psychological abuse
 - 995.83 - Adult sexual abuse
 - 995.84 - Adult neglect (nutritional)
 - 995.85 - Other adult abuse and neglect
- Not a specific ICD-9 or CPT code for domestic and interpersonal violence (DV/IPV) screening, but code V82.89 (Special screening for other conditions; other specified conditions) could possibly be reported.
- E codes may be reported in addition to the abuse diagnosis codes to provide details on the identity of the specific perpetrator. As an example, the full code description for code E967.2 is: Adult battering and other maltreatment by spouse or partner.

What About Procedures?

- Procedures have different CPT codes than E/M's
- An E/M is NOT always billed when performing a procedure – only if separate and distinct
 - Examples – lesion removals, pap smears, colposcopies

Location and Severity

- Sue is diagnosed with simple vulva lesions and returns for treatment. What code would we choose?

CPT	Description
56501	Destruction of lesion(s), vulva; simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery)
56515	Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery)
57061	Destruction of lesion(s), vagina; simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery)
57065	Destruction of lesion(s), vagina, extensive; simple (eg, laser surgery, electrocauterization, cryosurgery, chemosurgery)

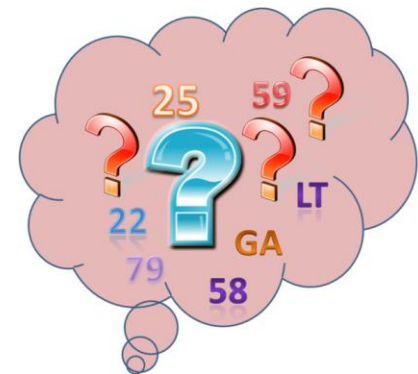
Add-on Services...

- Capture all services that may pay in addition to the main service such as:
 - ✓ Ancillary Lab Tests / Radiology – In-house vs. Send-out
 - ✓ Expanded Hours Access – Nights and Weekends
 - ✓ Interpreter Services
 - ✓ Smoking Cessation Counseling
 - ✓ Screening, Brief Intervention, and Referral to Treatment (SBIRT)
 - ✓ Vaccines / Immunizations

MODIFIERS – SPECIAL CIRCUMSTANCES

What is a Modifier?

- Two digit codes that accompany a CPT code in order to further describe a situation that may impact or modify reporting and reimbursement of services
 - Some modifiers are assigned by the clinician during the visit and some may be added during billing
 - Only certain modifiers impact payment
 - Never used on diagnosis codes
 - Payers may treat modifiers differently



Examples of Modifiers

Modifier	Description
25	Distinct Service; Same day; Same clinician
51	Multiple Procedures
53	Discontinued Procedures
59	Two separate procedures performed on the same day by the same clinician

Modifier 25: “Oh By the Way...”

- When a patient presents and has multiple issues treated, two E/M codes may be reported if:
 - Documentation clearly supports separate and distinct services provided
 - Modifier -25 is appended to the problem-oriented E/M visit
 - Provider selects the primary diagnosis for the service chiefly responsible for the services provided
 - Not all payers will reimburse 2 E/M's but good data is needed to advocate for change

ICD CODING – THE WHY

ICD-9-CM Diagnosis Codes – “Why”

- International Classification of Diseases, 9th edition, Clinical Modifications
 - Set of codes defining diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease
 - Supports **medical necessity** of services provided
 - Supported by documentation in patient’s medical record
 - Only the licensed provider determines diagnosis
 - Helps clinical staff understand prior issues and treatment when deciding a course of care

Diagnosis Selection



- Code **ALL** documented conditions that co-exist at the time of the encounter/visit and require or affect patient care, treatment or management
 - **Primary Diagnosis/First-listed Diagnosis** - Code assigned to the diagnosis, condition, problem, or other reason shown in the documentation to be *chiefly responsible for services provided*
 - **Secondary Codes** - Additional codes needed to support medical necessity and care

Diagnosis Order



- Your encounter form / superbill, on paper or electronic, should allow space for the clinician to sequence and / or mark diagnoses as co-equal
- If 2 + diagnoses are being equally monitored, and treated, and/or evaluated, the diagnoses are considered **co-equal** and the clinician may select which diagnosis is sequenced first



- *Clearly mark primary, secondary, tertiary codes....*

A Note About Documentation...

- Ensure your documentation supports the codes billed for services and captures the essential elements needed by your payers
- Be careful to not cut and paste documentation without individualizing the notes to the specific patient visit
- **More is not better – quality vs. quantity**

Coding Tips...

- A code is invalid if it has not been coded to the full number of digits required for that code (5th digit if possible)
- If diagnosis is not established, code the symptom
- Don't code for:
 - “rule-out” diagnoses
 - conditions that were previously treated and no longer exist
 - diagnosis that doesn't apply to the visit

Common ICD Codes for STI Screening

ICD-9	Description
V 01.6	Contact with or exposure to venereal diseases
V01.79	Contact with or exposure to other viral diseases (Hep, HIV)
V 65.45	Counseling on other sexually transmitted diseases
V 69.2	High risk sexual behavior
V 73.81	Special screening examination for HPV
V 73.88	Special screening examination for other specified chlamydial diseases
V 73.89	Special screening examination for other specified viral diseases (Ex: herpes)
V 74.5	Screening examination for venereal disease

Common ICD Codes - Contact with / Carrier...

ICD-9	Description
V01.1	Contact with or exposure to tuberculosis
V 01.6	Contact with or exposure to venereal diseases
V01.79	Contact with or exposure to other viral diseases (Hep, HIV)
V02.60	Viral hepatitis carrier, unspecified
V02.60	Hepatitis B carrier
V02.60	Hepatitis C carrier
V02.69	Other viral hepatitis carrier
V02.7	Carrier or suspected carrier of gonorrhea
V02.8	Carrier or suspected carrier of other venereal diseases
V02.9	Carrier or suspected carrier of other specified infectious organism

Common ICD Codes for Infection

ICD-9	Description
042	Human immunodeficiency virus [HIV] disease
054.11	Genital herpes, vulvovaginitis
054.13	Genital herpes, penis
078.11	Condyloma acuminatum
078.19	Other specified viral warts
078.88	Other specified diseases due to chlamydiae
079.98	Unspecified chlamydial infection
098.0	Gonococcal infection (acute) of lower genitourinary tract
112.1	Candidiasis of vulva and vagina
788.1	Dysuria
V08	Asymptomatic human immunodeficiency virus [HIV] infection status

Common ICD Codes for Males

ICD-9	Description
054.13	Herpetic infection of penis
078.0	Molluscum contagiosum
078.11	Condyloma acuminatum (Venereal warts)
079.98	Chlamydia infections NOS
098.0	Gonococcal infection (acute) of lower genitourinary tract
099.40	Other nongonococcal urethritis, unspecified
131.02	Trichomonal urethritis
604.90	Acute epididymitis/ orchitis
788.1	Dysuria
788.7	Urethral discharge

Be Specific

Whenever possible, avoid ICD codes that are labeled:

- NEC – not elsewhere classified
 - Indicates there is no separate specific code available to represent the condition documented. In this case, the diagnostic statement is specific, but the coding system is not specific enough.
- NOS – not otherwise specified
 - Indicates that the documentation does not provide enough information to assign a more specific code.

Coding Tip

Be careful assigning codes – Codes follow the patient long after the visit



Scenario: Male Screening

- 23-year old male presents for STD screening
- New to health department
- No symptoms
- 3 male partners in past 6 months, inconsistent condom use
- Receptive and insertive oral sex, occasional receptive anal sex, occasional anonymous partners
- No complaints, good health, gonorrhea approx. 2 years ago, tested and treated by private provider
- Recent HIV test negative 6 weeks ago - declines testing
- Is tested for GC, CT (for reported sites of exposure) and has blood drawn for Syphilis RPR test
- Face-to face counseling by clinician was > 50% of the 35 minute visit – time is documented

CPT Codes and Laboratory Test Codes

	CPT Code	LabCorp Test Code	Quest Test Code
GC Culture (urethral, cervical, rectal, pharyngeal)	87081*	008128	480X Genital: 6916R Anal: 141275R Eye: 86421A
GC NAA Genital	87591	183194** (several)	11362X* (several)
GC NAA Rectal	87591	188730	16504X
GC NAA Pharyngeal	87591	188748	70049X
GC + CT Rectal NAA	87491 & 87591	188672	16506X
GC+CT Pharyngeal NAA	87491 & 87591	188698	70051X

*If culture is positive, identification will be performed using separate CPT code(s): 87077 or 87140 or 87143 or 87147 or 87149. Antibiotic susceptibilities are only performed when appropriate (CPT code(s): 87181 or 87184 or 87185 or 87186)

** Several Lab Test Codes exist depending on the specimen source (urethral, urine, cervical)

Answer: Male Screening

	CPT code	ICD-9-CM code	ICD-10-CM Code
Procedure	None		
Supplies	None		
Drug	None		
Lab	87491 CT, 87591 GC, 86592 Syphilis*	V69.2 High-risk sexual behavior	Z72.52 High risk homosexual behavior
Specimen Collection	36415 Venipuncture (blood for Syphilis)	V69.2	Z72.52
E/M	99203 (Based on FTF counseling time being > 50% of 35 minute visit)	V69.2, (V12.09 Personal history of other specified infectious and parasitic disease (GC)	Z72.52, Z86.19 Personal history of other infectious and parasitic diseases
Modifier	None		

*Actual lab tests ordered may vary based on specimen / site of exposure / risk factors

Answer – Male Screening *con't*

- V69.2 High risk sexual behavior covers medical necessity of services
- Check Local Coverage Determinations (LCD) for lab tests and your payers to ensure additional codes are not needed. Examples of typical codes:
 - V74.5 Screening examination for venereal disease
 - V73.89 Special screening examination for unspecified chlamydial disease
 - V73.89 Screening examination for other specified viral and chlamydial diseases
 - V01.6 Contact with or exposure to venereal diseases
 - V01.79 Contact with or exposure to other viral diseases

Scenario - Contact with Gonorrhea

- Amy, a 28-year-old woman returning to the LHD, is seeking testing after learning her male partner was diagnosed with gonorrhea
 - Asymptomatic;
 - Oral and vaginal exposure – need to ask patient
 - Using NuvaRing as contraceptive method
- No abnormalities on pelvic exam
- Diagnostic tests for gonorrhea and chlamydia obtained and sent to lab
- Dispensed
 - Ceftriaxone 250 mg IM injection
 - Azithromycin 1 gm PO
- Face-to face counseling by clinician was > 50% of the 20 minute visit – time is documented

Answer - Contact with Gonorrhea

	CPT code	ICD-9	ICD-10
Procedure	None		
Supply	None		
Drug	J0696 Ceftriaxone IM NDC Azithromycin	V01.6 Exposure to STD	Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
Administration	96372 Therapeutic injection (for J0696)		
Labs	87591 GC + 87491 Ct NAAT of the throat and cervix	V01.6	Z20.2
E/M	99213 (Based on FTF counseling time being > 50% of 20 minute visit)	V01.6	Z20.2
Modifier	25 on the E/M (separate and distinct from the injection)		

- Use the V01.6 code to indicate that she was exposed to an index case
- Only code the gonorrhea after a positive lab test result

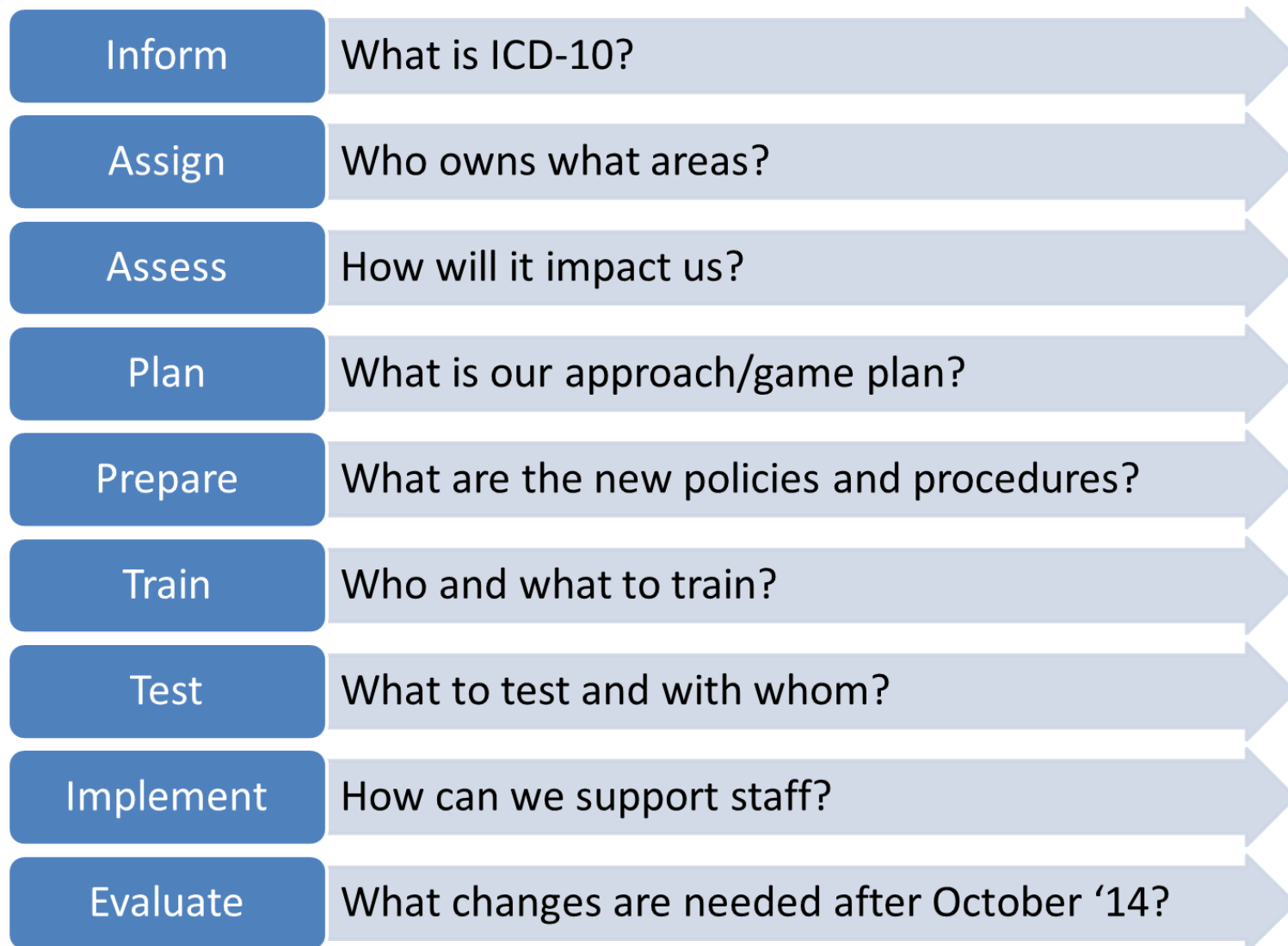
ICD-10 OVERVIEW

On The Way....ICD-10

- Implementation date in U.S. - **October 1, 2014**
- Diagnoses only for outpatient services (not procedures)
- Expands from 3-5 digits to 5-7 digits
- Not always a one-to-one match to ICD-9 codes



ICD-10 Transition...



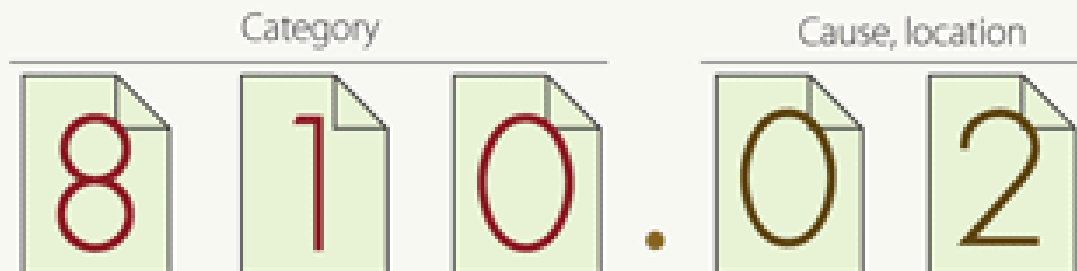
Key Differences

Features	ICD-9	ICD-10
Possible Codes	14,000	Up to 68,000
Characters	3–5	5–7
Pattern	First digit numeric	First digit alpha
Space for Growth	None	Flexible
Laterality	None	Right, left, bilateral
OB Trimesters	None	First, second, third

Layout of ICD-10 Diagnosis Code

Gross anatomy of ICD-9 and ICD-10 codes

ICD-9 structure



ICD-10 structure



Source: American Health Information Management Association

ICD-10 Code Structure...

- **First character** of the category represents the chapter the code resides in. Category is 3 digits just as it is in ICD-9.
 - A-B = Infectious / Parasitic disease
 - N = Disease of the Genitourinary system
 - R = Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
 - V-Y = External causes of
 - Z = Factors influencing health status and contact with health services
- **Fourth character** identifies the site but it can also identify a treatment or diagnostic modality
- **Fifth, sixth and seventh character** is for greater specificity

Z 0 1 4 1 1 X

Key Documentation Elements...

- Disease Acuity
- Disease or disorder site
- Laterality
- Infectious agent
- Underlying conditions and common manifestation
- Abnormal test results



Incorporating these common terms of specificity in the medical record, when applicable to the disease or disorder, will enhance quality reporting, and support reimbursement, severity of illness and medical necessity requirements

Some codes are a one to one direct match...

ICD – 9	ICD-10
V74.5 - Screening examination for venereal disease	Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission

Some codes combine...

ICD – 9	ICD-10
V73.88 Special screening examination for other specified chlamydial diseases	Z11.8 Encounter for screening for other infectious and parasitic diseases
V73.98 Special screening examination for unspecified chlamydial disease	

Some codes will require additional secondary codes...

ICD – 9	ICD-10
V70.0 - Routine medical examination	Z00.00 - Encounter for general adult medical examination w/o abnormal findings Z00.01 - Encounter for general adult medical examination abnormal findings* <ul style="list-style-type: none"><li data-bbox="625 1062 1676 1172">• Use additional codes to identify abnormal findings (R70 – R94)

054.1– Genital Herpes

- Codes are expanded but also sequenced into different groups
– be careful as you look up choices (Both Axx and Bxx)

ICD – 9	ICD-10
054.1x Genital Herpes	<ul style="list-style-type: none"> • A60.00 - Herpesviral infection of urogenital system, unspecified • A60.01 – Herpesviral infection of penis • A60.02 – Herpesviral infection of other male genital organs - new • A60.03 – Herpesviral cervicitis - new • A60.04 – Herpesviral vulvovaginitis • A60.09 – Herpesviral infection of other urogenital tract - new • A60.1 - Anogenital herpesviral infection, unspecified • B00.2 - Herpesviral gingivostomatitis and pharyngotonsillitis • B00.4 - Herpesviral encephalitis

616.10 Vaginitis and Vulvovaginitis, unspecified

- Acuity of condition and specific anatomic sites are required for accurate code selections
- Selection of code must match language in the medical record - document acute or chronic

ICD – 9	ICD-10
616.10 Vaginitis and vulvovaginitis, unspecified	<ul style="list-style-type: none"> • N76.0 Acute vaginitis • N76.1 Subacute and chronic vaginitis • N76.2 Acute vulvitis • N76.3 Subacute and chronic vulvitis <p>* Use additional code (B95-B97 Bacterial, viral and other infectious agents) to identify infectious agent</p>

Specificity Counts

ICD – 9	ICD-10
V69.2 High risk sexual behavior	<ul style="list-style-type: none"> • Z72.51 High risk heterosexual behavior • Z72.52 High risk homosexual behavior • Z72.53 High risk bisexual behavior
V69.8 Other problems related to lifestyle	<ul style="list-style-type: none"> • Z72.89 Other problems related to lifestyle (i.e. Self damaging behavior)

ICD-10 CODE

V91.12XD:

"Crushed between fishing boat and other watercraft or other object due to collision, subsequent encounter"

...WOW

ICD-10 CODE

V9733xD:

"Sucked into jet engine, subsequent encounter" ...

they survived the first time!?



ICD-10 CODE

V9107xD:

"Burn due to water-skis on fire, subsequent encounter" ...

because they just didn't learn the first time!



CAPTURING SERVICES

Clean Claims...

- “A claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that otherwise prevents timely payment being made on the claim...”
- What’s your ‘clean claim rate’?
 - Percent of money paid the first time without re-submitting?
 - When claims get denied, what happens?
 - Charts go back to clinical staff for review?
 - Internal Audits?

Lost Visits...

- There is no charge for the visit...
 - Clinician doesn't charge or under-charges
 - Pops head in for question...
 - Partners come in together-only one is charged
 - Hallway Medicine
 - How does your office handle check-outs?
- Document all services to avoid lost reimbursement

Nurse Visits – Are They Billable?

- 99211 may be billed for certain services provided by a Nurse
- Not all payers recognize this service
- Patient must be established
- Provider-patient encounter must be face-to-face
- An E/M service must be provided
 - Generally, this means that the patient's history is reviewed, a limited physical assessment is performed or some degree of decision making occurs.
- <http://www.aafp.org/fpm/2004/0600/p32.html>

Nurse Visits – Often Overbilled

- Since 99211 is an E/M code, there are some minimal documentation requirements in order to meet medical necessity for use of the code
 - There must be a face to face encounter
 - Nature of the presenting problem with a diagnosis from prior visit with a clinician
 - Brief history of the problem
 - Documentation of vital signs (sole reason for visit should not be Blood Pressure check or Blood Draw)
 - Plan of care
 - Date/signature of the nurse or other provider

Services NOT Billed as 99211

- Administering routine medications by physician or staff whether or not an injection or infusion code is submitted separately on the claim
- Checking blood pressure when the information obtained does not lead to management of a condition or illness
- Drawing blood for laboratory analysis or for a complete blood count panel, or when performing other diagnostic tests whether or not a claim for the venipuncture or other diagnostic study test is submitted separately
- Faxing medical records

Services NOT Billed as 99211 *con't*

- Making telephone calls to patients to report lab results / reschedule patient procedures
- Performing diagnostic or therapeutic procedures (especially when the procedure is otherwise usually not covered/not reimbursed, or payment is bundled with reimbursement for another service) whether or not the procedure code is submitted on the claim separately
- Recording lab results in medical records
- Reporting vaccines
- Writing prescriptions (new or refill) when no other evaluation and management is needed or performed

Confidentiality

- Privately insured patients who decline to have their insurance billed for services because of confidentiality concerns should be charged using your sliding fee scale
- * Confidentiality issues are being addressed during this Maryland legislative session – Stay tuned...

Clinic Flow

- Ensure licensed staffs' skills are maximized
- Do you need to think about patient / practitioner flow?
- Express / Fast Tract visits help clinic flow, but...
 - Are only for established patients
 - Missed opportunity for clinical assessment



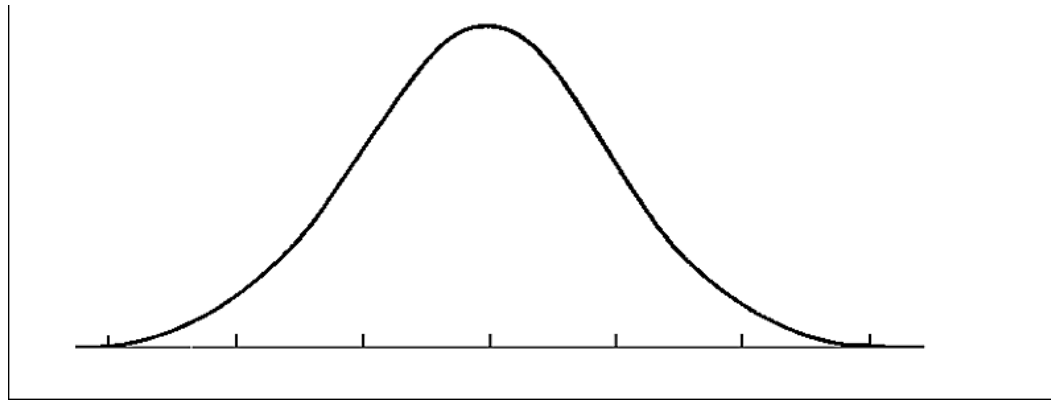
Always, Sometimes, Never...

- Aggressive vs. Timid - are you the outlier?

**Provider
Protocol**

VS.

**Medical
Necessity**



Encounter Forms / Superbills

- Communication tool between clinician and biller describing what occurred during the encounter
- Electronic or paper – includes Diagnosis, CPT, modifiers
- Be careful with EMR templates and pre-assigned codes

Is it up-to-date and reflective of all services provided?

Can clinicians sequence and note co-equal diagnosis codes?

Can modifiers be noted?

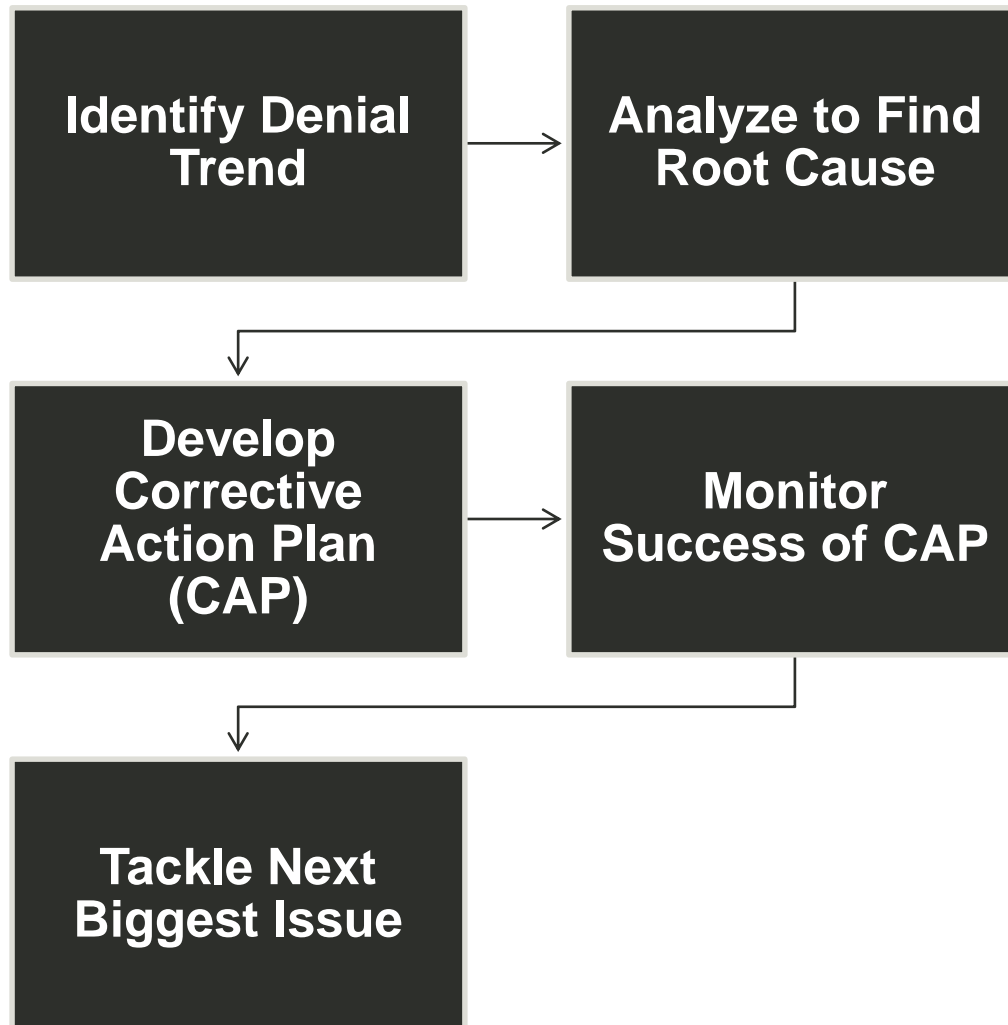
Reminder - Only the person providing the services should complete the superbill

Common Denials

- ✓ Patient not eligible
- ✓ No authorization
- ✓ Not medically necessary
- ✓ Incorrect codes
- ✓ Duplicate claim
- ✓ Non-covered
- ✓ General technical billing errors i.e. Incorrect subscriber ID, missing info on UB format, etc...
- ✓ Timely filing
- ✓ Additional data is required



Get to the Root of the Problem



Build Success...

- ✓ Be a Team - Partnership between clinical, administrative and billing staff
- ✓ Right licensed clinicians see the right patients
- ✓ Education and knowledge is key
- ✓ Updated EMR and resources
- ✓ Be supportive – be a mentor
- ✓ Communicate... Communicate...
- ✓ Embrace the Changes and Opportunities



Acknowledgements

Thank you to our consultant:

Elizabeth Menachery, MD

Medical Director, Howard County Health Department

Elizabeth Menachery is an Internal Medicine doctor by training with past experiences in both outpatient and inpatient practices at Johns Hopkins. She has been at HCHD since the end of 2007, initially as the clinician for family planning, STD, Refugee Health, Latent TB Infection, Suboxone, and Tobacco clinics. She became Medical Director in 2012 and has led HCHD in improving their billing and collection processes, merged Family Planning, STD, and Immunization Clinics at HCHD, and is currently leading their efforts to transition to Electronic Medical Records.

About Ann Finn Consulting, LLC



- Having partnered with Providers and supporting organizations for over a decade, Ann has developed a core understanding of the services provided, coding and operational issues faced over time and has established herself as a trusted colleague / confidant to many.
- AFC was started by Ann Finn in 2012 to focus primarily on reproductive health including STD and Family Planning services.
- She works collaboratively CAI Global, National Family Planning and Reproductive Health Association (NFPRHA), National Clinical Training Center (NCTC), Cardea Services, JSI Research and Training Institute (JSI), Planned Parenthoods, FPA, Local Departments of Health and many Providers across the US to improve fiscal sustainability by improving coding, billing and revenue cycle management practices.

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Disclaimer

- The guidance, interpretations, and recommendations provided today are meant for education purposes only and actual coding/billing decisions are the sole liability and responsibility of the provider(s) and respective billing staff
- Nothing herein is a specific recommendation about billing or charging of services or ICD-9, ICD-10, CPT and/or HCPCS codes – code selection and claim submission is based upon medical record documentation for services rendered and diagnoses considered for each individual encounter.
- Providers must follow all coding guidelines and check with rules of individual payers.

E/M References

- “1995 Documentation Guidelines for E/M Services”
<http://www.cms.gov/MLNProducts/Downloads/1995dg.pdf>
- “1997 Documentation Guidelines for Evaluation and Management Services”
<http://www.cms.gov/MLNProducts/Downloads/MASTER1.pdf>
- “Medicare Benefit Policy Manual” Processing Manual” (Pub. 100-04) and the “Medicare Claims Processing Manual”
<http://www.cms.gov/Manuals/IOM/list.asp>
- ICD-9-CM <http://www.cms.gov/ICD9ProviderDiagnosticCodes>
- CPT Books from AMA <https://catalog.ama-assn.org/Catalog/home.jsp>

References

CPT - American Medical Association

(AMA) <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page>

- ICD-9-CM Official Coding Guidelines

http://www.ama-assn.org/resources/doc/cpt/icd9cm_coding_guidelines_08_09_full.pdf

- ICD-10-CM Coding Guidelines

http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf

References

- **CMS QUICK REFERENCE INFORMATION: Preventive Services**

A CMS educational tool with information on Medicare preventive services: Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes; International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes; coverage requirements; and beneficiary liability for each Medicare preventive service. http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/downloads/MPS_QuickReferenceChart_1.pdf

- **CMS - Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs**
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7610.pdf>

QUESTIONS



After the webinar has concluded, feel free to send any questions to Elisabeth Liebow at:
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