Proper Documentation and Accurate Coding

Why is documentation so important?

- Improves patient care
- Protects the legal interest of the patient, facility and clinician
- Improves clinical data for research and education
- Enables proper reimbursement for services performed
- Improves regulatory compliance

Services provided must be documented in the Medical Record. Documentation must support codes selected for reimbursement. If it isn't documented –it should not be billed.

Proper documentation and coding supports compliant billing practices and efficiencies. The Center for Medicare and Medicaid Services has published two sets documentation guidelines to help standardize documentation of Evaluation and Management (E/M) services.

1995 Documentation Guidelines
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf

1997 Documentation Guidelines
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

What is an E/M?

- E/M stands for "Evaluation and Management" = 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

- Understand relevant diagnosis using ICD codes, CPT and modifier terminology and codes.
- Be familiar on how to select the appropriate ICD-10 codes

In order to bill and expect reimbursement for services, we need to:

- Understand and follow the requirements and rules of Medicare, Medicaid and commercial insurances.
- Understand the diagnosis and procedure codes that best represent the care provided.

- Document any special circumstances – Using Modifiers
- Have checks and balances in place to avoid unintended problems.
- Understand how each of our roles impacts the organization's Revenue Cycle and success.

What does "Patient Type" mean?

- Per CPT there are two Patient Types:

1. **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.

2. **Established Patient**
   One who HAS 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.

It is best if each specialty clinic within your LHD bills under a separate National Provider Identifier (NPI) to avoiding potential over-billing or under-billing 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.

What about procedures?

- Procedures are billed using different CPT codes (not E/M codes).
- An E/M is NOT always billed when performing a procedure – only if separate and distinct. If a procedure is performed and it is not related to the reason for the E/M, **modifier 25** would then be used with the E/M code to explain the situation.

  Modifier 25 - Modifier 25 is used to describe a "significant and **separately identifiable** Evaluation and Management service by the same physician on the same day of the procedure or other service". This modifier is used with E/M codes only and should never be used with a procedure code.

Procedure codes selected should be supported by documentation and capture all services that may pay in addition to the E/M service or procedure such as:

- Lesion removals, pap smears, colonoscopies
- 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

What are Modifiers?

Modifiers are 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 rendered.

- 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.

Modifier	Description
25	Distinct Service; Same day; Same clinician – *used only with E/M codes*
51	Multiple Procedures – *used only with procedure codes*
53	Discontinued Procedures– *used only with procedure codes*
59	Two separate procedures performed on the same day by the same clinician – *used only with procedure codes*

Modifier 25: “Oh By the Way…”

When a patient presents and has multiple issues treated, two E/M codes may be reported if:

1. Documentation clearly supports separate and distinct services provided
2. Modifier -25 is appended to the problem-oriented E/M visit
3. Provider selects the primary diagnosis for the service chiefly responsible for the services provided
4. Not all payers will reimburse 2 E/M’s but good data is needed to advocate for change

ICD-10 Diagnosis code reminders:

Be Specific whenever possible, avoid ICD codes that are labeled:

- NEC –not elsewhere classifiable. NEC represents "other specified." When a specific code is not available for a condition the Tabular List includes an NEC entry under a code to identify the code as the "other specified" code.

- NOS –not otherwise specified. NOS is the equivalent to "unspecified" or further indicates that the documentation does not provide enough information to assign a more specific code.