Coding Tips & Tricks

DISCLOSURES:

NONE

Disclaimer

- This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational a guide and should not be considered a legal/consulting opinion.

Words Mean A Lot

- New
- Severe
- Unknown
- No Change
- Un-improved
- Complicated
- Goals
- At Goal
- Stable
- No Complaints
- Non-contributory

AMA – Stable Chronic Illness

- A problem with an expected duration of at least one year or until the death of the patient
- For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition)

Source AMA

AMA – Stable Chronic Illness

- “Stable” for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient.
- A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function.
- For example, in a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic, the risk of morbidity without treatment is significant.

Source AMA

AMA – Stable Chronic Illness

- Examples may include
  - Well-controlled hypertension
  - Noninsulin- dependent diabetes
  - Cataract
  - Benign prostatic hyperplasia

Source AMA

Number and Complexity of Problems Addressed
Minimal • **1** self-limited or minor problem
Low • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or** • **1** acute, uncomplicated illness or injury

Number and Complexity of Problems Addressed
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

Number and Complexity of Problems Addressed
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

NUMBER & COMPLEXITY OF PROBLEMS ADDRESSED	DESCRIPTION	AMA EXAMPLE
Minimal Problem	• A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211).	
Self-Limited or Minor Problem	• A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.	

NUMBER & COMPLEXITY OF PROBLEMS ADDRESSED	DESCRIPTION	AMA EXAMPLE
Stable, Chronic Illness	• A problem with an expected duration of at least one year or until the death of the patient. • For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). • "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. • A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function.	• Well-controlled hypertension • Noninsulin- dependent diabetes • Cataract • Benign prostatic hyperplasia
Acute, Complicated Illness or Injury	• Treatment requires evaluation of body system that aren't part of the injured organ, the injury is extensive, there are multiple treatment options, or there is a risk of morbidity with treatment	• Head injury with brief loss of consciousness

NUMBER & COMPLEXITY OF PROBLEMS ADDRESSED	DESCRIPTION	AMA EXAMPLE
Acute Illness with Systemic Symptoms	• An illness that causes systemic symptoms and has a high risk of morbidity without treatment. • For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness, or to prevent complications • See the definitions ***for self-limited or minor problem*** or ***acute, uncomplicated illness or injury***. • Systemic symptoms may not be general but may be single system.	• Pyelonephritis • Pneumonitis • Colitis.

NUMBER & COMPLEXITY OF PROBLEMS ADDRESSED	DESCRIPTION	AMA EXAMPLE
Acute, Uncomplicated Illness or Injury	• The problem is recent and short term. • There is a low risk of morbidity. • There is little to no risk of mortality w/tx • Full recovery without functional impairment is expected • The problem may be self-limited or minor but it is not resolving in line with a definite and prescribed course.	• Cystitis • Allergic rhinitis • Simple sprain
Acute, Complicated Illness or Injury	• Treatment requires evaluation of body system that aren't part of the injured organ, the injury is extensive, there are multiple treatment options, or there is a risk of morbidity with treatment	• Head injury with brief loss of consciousness

99204 **99214**	**Moderate**	**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 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

RISK

Office & Other Outpatient Services

- Discussion
  - This is required to be an interactive exchange
  - Must be direct and not through intermediaries (eg, clinical staff or trainees)
  - Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange.
  - The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter
  - It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Diagnosis Documentation

- What is most severe illness you are treating the patient for TODAY?
- This may change tomorrow
  - More severe or less severe diagnosis of same condition
  - Different diagnosis
- Place diagnoses in order of severity

Co-morbidities

- Document why they are affecting your care (MDM) of the patient
- Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are
  - Addressed

    AND
  - Their presence increases
    - The amount and/or complexity of data to be reviewed and analyzed
    - Risk of complications and/or morbidity or mortality of patient management

Co-Morbidities

- Just because a patient has a diagnosis does not mean it affected your care/MDM today

- Should not “just list” as done previously

Diagnoses

- Order of diagnoses
- Severity of diagnoses
- Interaction of diagnoses
- Resolution of diagnoses

What Does “History Of” Mean?

- History is the study of past events

- Watch “history of” documentation
  - Is it in the past
  - Is there no longer treatment directed at it

Don’t Give Patients Cancer

- Patient’s medical history includes
  - Hypertension
  - Colon Cancer
- Which is currently under treatment?
- Which has been treated and is now resolved and in the past?

Office and Other Outpatient Services

- Watch Chief Complaint (especially what staff writes)
  - Med refill
  - Follow-up
  - Establish care
  - No complaints
  - Follow up
  - Review labs
  - Review tests

Office & Other Outpatient Services

Don’t

- Insert pre-populated template with
  - Review of systems
  - Physical exam
- Forget to document Chief Complaint
  - In detail

Do

- Show sick patient is sick
  - Detailed history of present illness
  - Tell the story of the patient
- Indicate a clinically appropriate
  - History was taken
  - Exam was performed

Problem Lists

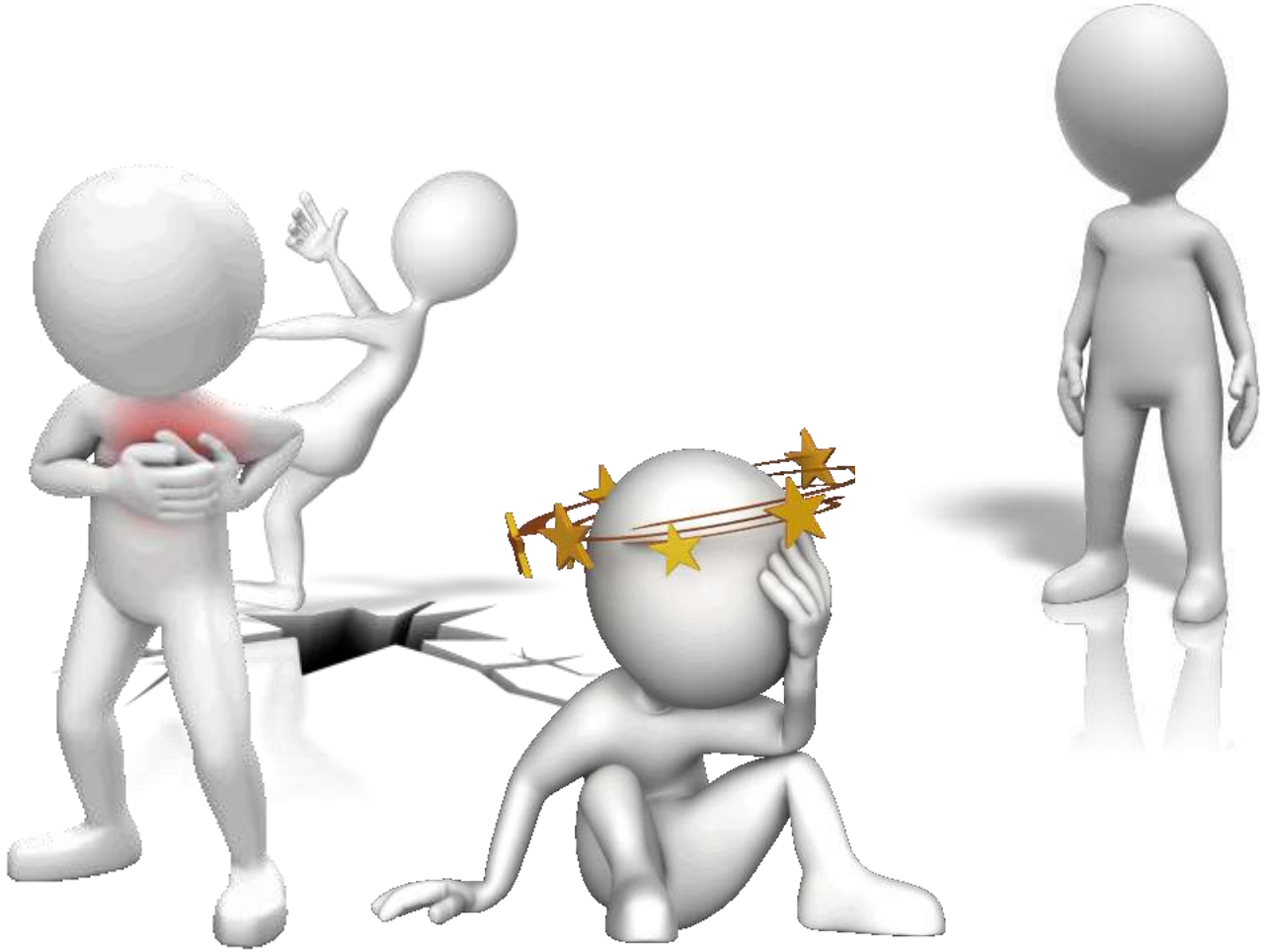
- Who maintains?
- Who revises?
- After hospitalization who updates?
- Who is responsible for accuracy?

Co-Pays – Collect at Time of Service

- Set the tone for patients
- Front desk training on how
- Don’t forget about balances

Signs & Symptoms

- Tell the story of the patient
- Show the sick patient as sick
- Document their severity



Stay Current

- New ICD-10-CM each year
  - For 2022

Depression NOS

- ICD-9-CM had a unique code for unspecified depression [311]
- Verbiage seen in medical records
- In ICD-10-CM, the default for Depression NOS is code F32.9, Major depressive disorder, single episode, unspecified
  - Determined to be clinically incorrect.
- Having an unspecified term default to major depression
  - Will prevent the true incidence of depression NOS from being captured
  - Will incorrectly increase the incidence of major depression in statistical data.
- The American Psychiatric Association (APA) has reviewed and supports this proposal.

F32 - Depressive Episode

REVISE FROM

- F32 - Major depressive disorder, single episode

REVISE TO

- F32 - Depressive episode

NEW CODE

- F32A - Depression, unspecified

  Depression NOS

  Depressive disorder NOS

R05 Cough

- Excludes1:

  Cough with hemorrhage (R04.2)

  Smoker's cough (J41.0)

NEW CODES

- R05.1 - Acute cough
- R05.2 - Subacute cough
- R05.3 - Chronic cough
  - Persistent cough
  - Refractory cough
  - Unexplained cough
- R05.4 - Cough syncope
  - Code first: syncope and collapse (R55)
- R05.8 - Other specified cough
- R05.9 - Cough, unspecified

D75.8 Other Specified Diseases of Blood and Blood-Forming Organs

D75.83 - Thrombocytosis

- Excludes1: Essential thrombocythemia (D47.3)

NEW CODE

- D75.838 - Other thrombocytosis
  - Reactive thrombocytosis
  - Secondary thrombocytosis
  - ** Code also underling condition, if known and applicable*
- D75.839 - Thrombocytosis, unspecified
  - Thrombocythemia NOS
  - Thrombocytosis NOS

R35 - Polyuria

NEW SUBCATEGORY

- R35.8 - Other polyuria

NEW CODES

- R35.81 - Nocturnal polyuria
- R35.89 - Other polyuria

  Polyuria NOS

American Psychiatric Association (APA)

- No unique code for current or history of nonsuicidal self-harm (self-injury), nonsuicidal self-mutilation, or other similar behaviors
- It is important to establish a unique code for self-harming behaviors
  - Conditions can be adequately treated and tracked in medical records and clinical databases
- New code would allow the ability to differentiated between suicidal and non-suicidal self-harm

Non-suicidal Self Injury (NSSI)

- The deliberate, self-inflicted destruction of body tissue resulting in immediate damage without suicidal intent
- The act of deliberately harming your own body
- Typically not meant as a suicide attempt
  - A harmful way to cope with emotional pain, intense anger and frustration
- Suicidal behavior and non-suicidal self-injury are both relatively common in the general population
  - Differ in terms of demographics, risk factors, and management

R45 - Symptoms & Signs Involving Emotional State

NEW CODE

- R45.88 - Nonsuicidal self-harm
  - Nonsuicidal self-mutilation
  - Code also injury, if known

Z91 - Personal Risk Factors, Not Elsewhere Classified

NEW SUBCATEGORY

- Z91.5 - Personal history of self-harm

- NEW CODE
- Z91.51 - Personal history of suicidal behavior
  - Personal history of parasuicide
  - Personal history of self-poisoning
  - Personal history of suicide attempt
- Z91.52 - Personal history of non-suicidal self-harm
  - Personal history of self-mutilation

M54 - Dorsalgia

DELETE

- M54.5 Low back pain

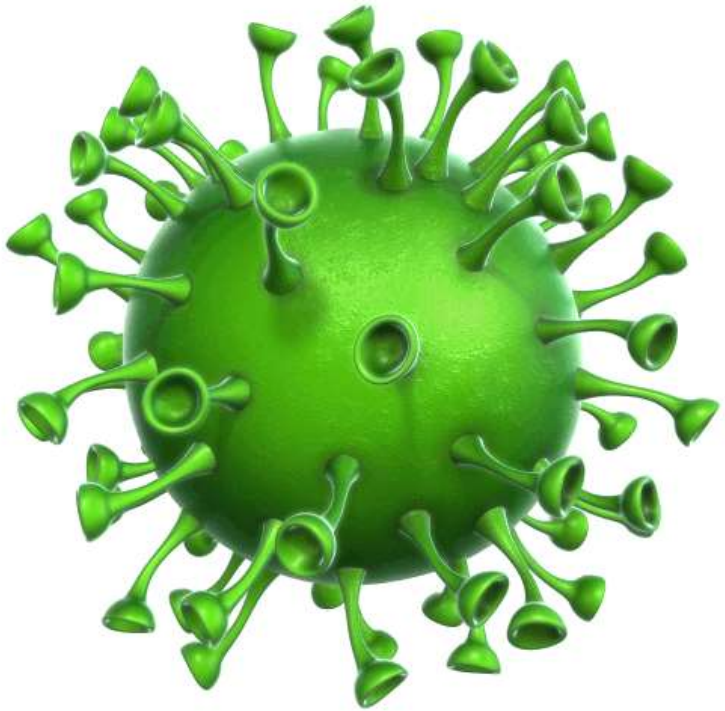
NEW CODE

- M54.50 - Low back pain, unspecified
- M54.51 - Vertebrogenic low back pain
- M54.59 - Other low back pain

Post COVID-19 Condition

- The disease COVID-19, caused by the coronavirus SARS-CoV-2
- Some people can have long term effects following infection
  - Loss of smell or taste
  - Chronic respiratory failure
  - Acute Respiratory Distress Syndrome (ARDS)

U09 - Post COVID-19 Condition



NEW CATEGORY

- U09 - Post COVID-19 condition

NEW CODE

- U09.9 - Post COVID-19 condition, unspecified

Under-Immunization Status Code for COVID-19

- Z18.310 - Unvaccinated for COVID-19
  - Patient has not received at least one dose of any COVID-19 vaccine
- Z28.311 - Partially vaccinated for COVID-19
  - Patient has received at least one dose of a multi-dose COVID-19 vaccine regimen

- For information, visit the CDC's website https://www.cdc.gov/coronavirus/2019- ncov/vaccines/.

Split Shared Visits
CMS' Final Definition of Substantive

- More than half of the total time spent by the physician and NPP performing the split (or shared) visit

Split Shared - Qualifying time -

- The following list of activities that could count toward total time for purposes of determining the substantive portion
- The CPT listing of activities that can count when time is used to select an E/M visit level, specifically the following activities, when performed and regardless of whether or not they involve direct patient contact:
  - Preparing to see the patient (for example, review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregivers
  - Ordering medications, tests, or procedures
    - Cont'd

Qualifying time

- The CPT listing of activities *(cont'd)*
  - Referring and communicating with other health care professionals (when not separately reported)
  - Documenting clinical information in the electronic or other health record
  - Independently interpreting results (not separately reported) and communicating results to the patient/ family/caregiver
  - Care coordination (not separately reported)

Qualifying time

- The finalized listing of qualifying activities will apply to all split (or shared) E/M visits, for purposes of determining the substantive portion.
  - This includes Emergency Room department visits
  - DOES NOT include Critical Care
    - They will have a different listing of qualifying activities, discussed in the critical care section

Qualifying Time – 2022

- Only for 2022 Substantive is allowed to be defined by any of the following:
  - All of History
  - All of Exam
  - All of MDM
  - More than half the total time
    - Based on activities on finalized listing
  - This includes Emergency department visits

CPT E&M Guidelines Face-to-Face

- *"The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211. A shared or split visit is a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit."*

CMS INTENT/Policy - Face-to-Face

- Only one of the practitioners **must** perform the in-person part of an E/M visit when it is split (or shared)
  - Either or both can do so
- The substantive portion can be comprised of time that is with or without direct patient contact

CMS INTENT/Policy - Face-to-Face

- CMS' final policy is that for all split (or shared) visits, **one** of the practitioners **must** have face-to-face (in-person) contact with the patient
  - Does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit
- The substantive portion could be entirely with or without direct patient contact, and will be determined by the proportion of total time, not whether the time involves direct or in-person patient contact.

CMS – Other Details - Split/Shared

- Physician or Non-Physician Practitioner is permitted to bill for split (or shared) visits
  - For both New and Established patients
  - For both Initial and Subsequent visits
- Billing of split (or shared) visits, including critical care visits, will be allowed when they are performed in any institutional setting
  - EXCEPTION - Certain SNF/NF visits are required to be performed in their entirety, directly and solely by a physician

CMS – Documentation Split/Shared

- Documentation in the medical record **must identify the two** individual practitioners who performed the visit
  - The individual who performed the substantive portion **must sign and date** the medical record
    - and bills the visit

- We recognized that this policy would necessitate the practitioners' tracking and documenting the time they spent for these visits
  - found in another section of Final rule

Substantive for Split Shared Visits– 2022

- Only for 2022 Substantive is allowed to be defined by any of the following:
  - All of History
  - All of Exam
  - All of MDM
  - More than half the total time
    - Based on activities on finalized listing
  - This includes Emergency department visits

Substantive for Split Shared Visits– 2023

- More than half of the total time spent by the physician and NPP performing the split (or shared) visit
  - Based on activities on finalized listing

Claim Identification Modifiers

- **FS -** (Split [or shared] evaluation and management visit).
- **FT -** (Unrelated evaluation and management [E/M] visit during a postoperative period, or on the same day as a procedure or another E/M visit. [Report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated]).

Discharge Summary - JUMP

- **J**ust Do It
- **U**n-cluttered version
- **M**edications
- **P**rocedures and tests

Discharge Summary

- Split Shared
  - Why?
  - Duplication of work
  - Falls into grey area of rules

Teaching Notes

- Watch “teaching time”
- Key Elements
- Critical Care

Questions?