Effective Coding Practices in Reproductive Health Care

CPT Coding: Pre-Test

- 31 year old G2P, established patient seen for vaginal discharge for one week
- Pelvic exam, cervical cytology done; KOH and saline slides
- Total visit = 15 minutes
- E/M Code is:
  - 99211 Supervision
  - 99212 Focused
  - 99213 Expanded
  - 99214 Detailed
  - Can’t tell without more information
  - Don’t know

What is the Fundamental Objective of Coding?

- Provider
  - To prepare a standardized “bill” for services given to a patient
- Payer
  - To determine the amount to be paid to the provider (based on contracted rates)...
  - For medically necessary services....
  - That are a benefit of the payer’s health plan...
  - And supported by documentation

Learning Objectives

By the end of this course, you will be able to:
- Describe the use of the three key components when assigning an E/M code
- Explain the difference between using “face-to-face” time and the three key components
- Discuss how chart documentation supports the coding decisions made
- Describe coding conventions for a problem oriented visit and a procedure on the same date of service

Codes Tell A Story

What | Encounter content | Code book |
--- | --- | --- |
What | Services performed | CPT-4 |
What | Drugs, supplies provided | HCPCS II |
Why | Diagnoses | ICD-CM-9 |
Additional | Modifier | CPT-4 |
Explanation

- To establish medical necessity, for every what there must be a why
- Unusual circumstances explained with a modifier
Coding Resources

- Medical services performed: CPT
  - Visits: Evaluation and Management (E/M) CPT codes
  - Surgical procedures; diagnostic imaging; lab tests
  - Developed and maintained by AMA
- Diagnoses: ICD-9-CM
  - International Classification of Diseases – 9th Revision - Clinical Modification
  - Developed by WHO; maintained by CMS
- Procedures and supplies: HCPCS II National Codes
  - Healthcare Common Procedure Coding System
  - Developed and maintained by CMS

Office (Point of Care) Lab Tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>UA dipstick</td>
<td>81000</td>
<td>UA dipstick with microscopy</td>
</tr>
<tr>
<td></td>
<td>81002</td>
<td>UA dipstick without microscopy</td>
</tr>
<tr>
<td>Urine microscopy</td>
<td>81015</td>
<td>Urine microscopy</td>
</tr>
<tr>
<td>Urine pregnancy test</td>
<td>81025</td>
<td>Urine pregnancy test</td>
</tr>
<tr>
<td>Vaginal pH determination</td>
<td>83986</td>
<td>pH determination</td>
</tr>
<tr>
<td>Microscopic of urine and vaginal smears</td>
<td>Q0111</td>
<td>Wet prep: point of care</td>
</tr>
<tr>
<td></td>
<td>87210</td>
<td>Wet prep for infectious agent: clinical lab</td>
</tr>
</tbody>
</table>

Annual CPT Code Update

- AMA Book
- On-line
- CD ROM
- iPad, iPhone, and Android platforms

2013 CPT Codes for Contraceptive Procedures

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>57170</td>
<td>Diaphragm, cap fitting</td>
</tr>
<tr>
<td>58300</td>
<td>Insert IUD</td>
</tr>
<tr>
<td>58301</td>
<td>Remove IUD</td>
</tr>
<tr>
<td>11976</td>
<td>Remove contraceptive implant (Norplant)</td>
</tr>
<tr>
<td>11981</td>
<td>Insert non-biodegradable drug delivery implant</td>
</tr>
<tr>
<td>11982</td>
<td>Remove non-biodegradable drug delivery implant</td>
</tr>
<tr>
<td>11983</td>
<td>Removal with reinsertion of non-biodegradable drug delivery implant</td>
</tr>
</tbody>
</table>

ICD-CM Coding Rules

- Code to the highest level of specificity (xxx.xx)
- Code the most specific description available at the completion of the visit
- Don’t code a diagnosis that doesn’t apply to the visit
- If visit for other than disease or injury, use V code
ICD-CM: Principal Diagnoses

- Code assigned to the diagnosis, condition, problem, or other reason shown in the documentation to be chiefly responsible for services provided
  - Signs and symptoms may be reported if a diagnosis has not been determined
  - Do not code for rule-out diagnoses
  - Two or more diagnoses may be coequal and meet the criteria for primary diagnosis

ICD-CM: Secondary Diagnoses

- Co-existing conditions may occur at the same time
- “Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment or management
- Review official ICD-9-CM guidelines in manual
  - For example: V72.31 & V25.02 would be reported for a client receiving both an annual exam and contraceptive management

ICD-CM: Co-equal Diagnoses

- “...when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, ..., any one of the diagnoses may be sequenced first.”
- The treating provider is in the best position to determine whether conditions are coequal or if one of the conditions dominated the visit.

ICD-9-CM Contraception V Codes

Sequential Listing

- “Start a method” contraception codes
  - V 25.0 General counseling and advice
  - V 25.01 Prescription of oral contraceptives
  - V 25.02 Initiate other contraceptive method
  - V 25.03 Emergency contraception
  - V 25.04 Counseling and instruction in natural family planning to avoid pregnancy
  - V 25.09 Other family planning advice
  - V 25.1 Insertion of IUC
  - V 25.5 Insertion of subdermal cont. implant

ICD-9-CM Contraception V Codes

Sequential Listing

- V25.4 Surveillance of previously prescribed contraceptive methods
  - V 25.40 Contraceptive surveillance, NOS
  - V 25.41 OC surveillance
  - V 25.42 IUC check, removal, or reinserter
  - V 25.43 Implantable subdermal contraceptive
  - V 25.49 Other contraceptive method

Hormonal Contraceptives: V Codes

<table>
<thead>
<tr>
<th>Reason for visit</th>
<th>Code</th>
<th>ICD-9-CM description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+Start OCs</td>
<td>V25.01</td>
<td>Prescription of OC</td>
</tr>
<tr>
<td>+OC follow-up visit</td>
<td>V25.41</td>
<td>Contraceptive surveillance: Oral contraceptive</td>
</tr>
<tr>
<td>+Start Patch or Ring</td>
<td>V25.9*</td>
<td>Unspecified contraceptive management</td>
</tr>
<tr>
<td>+Start DMPA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+Patch, Ring follow-up</td>
<td>V25.40*</td>
<td>Contraceptive surveillance: unspecified</td>
</tr>
<tr>
<td>+DMPA follow-up</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Non-specific ICD-9 code, but closest fit
Reason for visit | Code | ICD-9-CM description
--- | --- | ---
Implant insertion | V25.5 | Insertion of subdermal contraceptive implant
Implant follow-up | V25.43 | Contraceptive surveillance, implant (includes removal)
IUC insertion | V25.11 | Insertion of IUC
IUC removal | V25.12 | Removal of IUC
IUC removal and re-insertion | V25.13 | Removal and re-insertion of IUC
IUC follow-up | V25.42 | Contraceptive surveillance, IUC

**LARC Methods: V Codes**

Reason for visit | Code | ICD-9-CM description
--- | --- | ---
Start barrier method | V25.02* | Initiation of other contraceptive
Barrier method follow-up | V25.49* | Cont surveillance, other method
EC visit | V25.03 | Encounter for EC
Natural family planning | V25.04 | Counseling and instruction in natural family planning to avoid pregnancy
Lactational amenorrhea | | 
Fertility awareness (FAM) | | *

**Other Contraceptive Methods: V Codes**

Reason for visit | Code | ICD-9-CM description
--- | --- | ---
HSG for Essure or to evaluate for failed TL | V26.51 | Tubal ligation status
Post-vasectomy check | V26.52 | Vasectomy status
Missing or deep implant | V45.52 | Presence of implant
Missing IUC string | V45.51 | Presence of IUC

**Evaluation of Method Status: V Codes**

Reason for visit | Code | ICD-9-CM description
--- | --- | ---
Vasovagal episode | 780.2 | Syncope and collapse
Pulmonary embolism with combined hormonal method | 415.19 | Pulmonary embolism
DVT with combined hormonal method | 453.40 | Acute venous thrombosis of lower extremity
Heavy vaginal bleeding due to contraceptive injection | 626.2 | Excessive or frequent menstruation
Perforated or translocated IUD | 996.32 | Mechanical complication due to IUD
Female sterilization; operative site infection (< 30 d post-op) | 998.59 | Other postoperative infection

**Contraceptive Complications: Examples**

<table>
<thead>
<tr>
<th>Code</th>
<th>Interim code description</th>
<th>National code description</th>
<th>Code must be billed with</th>
</tr>
</thead>
<tbody>
<tr>
<td>780.2</td>
<td>Vasovagal episode</td>
<td>Syncope and collapse</td>
<td>Contraceptive V-code</td>
</tr>
<tr>
<td>415.19</td>
<td>Pulmonary embolism with combined hormonal method</td>
<td>Pulmonary embolism</td>
<td>V25.41 or V25.40</td>
</tr>
<tr>
<td>453.40</td>
<td>DVT with combined hormonal method</td>
<td>Acute venous thrombosis of lower extremity</td>
<td>V25.41 or V25.40</td>
</tr>
<tr>
<td>626.2</td>
<td>Heavy vaginal bleeding due to contraceptive injection</td>
<td>Excessive or frequent menstruation</td>
<td>V25.40</td>
</tr>
<tr>
<td>996.32</td>
<td>Perforated or translocated IUD</td>
<td>Mechanical complication due to IUD</td>
<td>V25.42 or V25.12</td>
</tr>
<tr>
<td>998.59</td>
<td>Female sterilization; operative site infection (&lt; 30 d post-op)</td>
<td>Other postoperative infection</td>
<td>V25.2</td>
</tr>
</tbody>
</table>

**STI Screening: V Codes**

Reason for visit | Code | ICD-9-CM description
--- | --- | ---
STI evaluation | V01.6 | Contact with or exposure to VD
STI evaluation | V65.5 | Worried well
STI evaluation | V69.2 | High risk sexual behavior
STI counseling only | V65.45 | STI counseling
HIV counseling (+ test) | V65.44 | HIV counseling

<table>
<thead>
<tr>
<th>Lab requisition</th>
<th>Code</th>
<th>ICD-9-CM description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ct screen or re-test</td>
<td>V73.88</td>
<td>Chlamydia screening</td>
</tr>
<tr>
<td>Order HSV serology</td>
<td>V73.89</td>
<td>Screen for viral disease (herpes)</td>
</tr>
<tr>
<td>Order GC or syphilis screen or re-test</td>
<td>V74.5</td>
<td>Screen for bacterial STDs (GC, syphilis)</td>
</tr>
</tbody>
</table>
### Cervical Cytology Visits: V Codes

<table>
<thead>
<tr>
<th>Reason for visit</th>
<th>V Code</th>
<th>ICD-9-CM description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytology screening is only reason for the visit</td>
<td>V 76.2</td>
<td>Routine cervical Pap smear</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab requisition</th>
<th>Code</th>
<th>ICD-9-CM description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening after hysterectomy for cervical cancer</td>
<td>V 67.01</td>
<td>Vaginal Pap after hysterectomy for cervical cancer</td>
</tr>
<tr>
<td>Cytology surveillance after ASC-US or LSIL</td>
<td>V 72.32</td>
<td>Pap to confirm normal after abnormal</td>
</tr>
<tr>
<td>HPV test surveillance after HPV+ or treatment</td>
<td>V 73.81</td>
<td>HPV screening</td>
</tr>
<tr>
<td>Screening after hysterectomy for HSIL</td>
<td>V 76.47</td>
<td>Screening Pap vaginal cuff</td>
</tr>
</tbody>
</table>

### Pregnancy Test Visit: V Codes

<table>
<thead>
<tr>
<th>Reason for visit</th>
<th>Code</th>
<th>ICD-9-CM description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy test visit, no result</td>
<td>V72.40</td>
<td>Pregnancy test/exam, not confirmed</td>
</tr>
<tr>
<td>Pregnancy test visit, negative</td>
<td>V72.41</td>
<td>Pregnancy test/exam, negative</td>
</tr>
<tr>
<td>Pregnancy test visit, positive</td>
<td>V72.42</td>
<td>Pregnancy test/exam, positive</td>
</tr>
</tbody>
</table>

### Heath Screening Visits: V Codes

<table>
<thead>
<tr>
<th>Reason for visit</th>
<th>Code</th>
<th>ICD-9-CM description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive well woman visit</td>
<td>V 70.0</td>
<td>Routine general medical exam</td>
</tr>
<tr>
<td>Family planning health screening visit</td>
<td>V 72.31</td>
<td>Routine gynecologic exam</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for visit</th>
<th>Code</th>
<th>ICD-9-CM description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive counseling, no method (including sterilization discussion)</td>
<td>V 25.09</td>
<td>Other family planning advice</td>
</tr>
</tbody>
</table>

### Preconception Services

<table>
<thead>
<tr>
<th>Reason for visit</th>
<th>Code</th>
<th>ICD-9-CM description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other procreative management counseling and advice</td>
<td>V26.49</td>
<td>Other procreative management counseling and advice</td>
</tr>
<tr>
<td>Other genetic testing of female</td>
<td>V26.32</td>
<td>Other genetic testing of female</td>
</tr>
<tr>
<td>Genetic counseling</td>
<td>V26.33</td>
<td>Genetic counseling</td>
</tr>
<tr>
<td>Procreative counseling: NFP</td>
<td>V26.41</td>
<td>Procreative counseling: NFP</td>
</tr>
<tr>
<td>Unspecified procreative management</td>
<td>V26.9</td>
<td>Unspecified procreative management</td>
</tr>
</tbody>
</table>

### On The Way....ICD-10-CM

- Expand from 14,000 (ICD-9) → 68,000 codes!!!
- Official start date in U.S. is **October 1, 2015**
- Workshops are available on-line, in-person courses, and other venues

### Encounter for Contraceptive Management

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30.01</td>
<td>Encounter for initial prescription of contraceptives</td>
</tr>
<tr>
<td>Z30.011</td>
<td>Initial prescription of contraceptive pill</td>
</tr>
<tr>
<td>Z30.012</td>
<td>Prescription of emergency contraception</td>
</tr>
<tr>
<td>Z30.013</td>
<td>Initial prescription of injectable contraception</td>
</tr>
<tr>
<td>Z30.014</td>
<td>Initial prescription of IUD (not insertion!)</td>
</tr>
<tr>
<td>Z30.018</td>
<td>Initial prescription of other contraceptives</td>
</tr>
<tr>
<td>Z30.019</td>
<td>Initial prescription of contraceptives, unspecified</td>
</tr>
</tbody>
</table>
Z30.4 Encounter for surveillance of contraceptives

ICD-10 | Description
--- | ---
Z30.40 | Surveillance of contraceptives, unspecified
Z30.41 | Surveillance of contraceptive pills
Z30.42 | Surveillance of injectable contraceptive
Z30.430 | Insertion of IUD
Z30.431 | Routine checking of IUD
Z30.432 | Removal of IUD
Z30.433 | Removal and reininsertion of IUD
Z30.49 | Surveillance of other contraceptives

ICD-10 and Family Planning Visits

- “Granularity” of coding is worse than ICD-9
  - Loss of codes for barrier methods
  - Loss of codes for implants
  - Absence of codes for patch and ring
- We need definitions for...
  - Z70.014 (initial prescription of IUD...but not insertion)
  - Z30.08 (Encounter for other contraceptive mgt)
  - Z30.09 (Encounter for contraceptive mgt, unspecified)
- Track how your payers assign patch, ring, implants, barriers
- ACOG will transmit suggestions to CMS for changes in 2016

Injections, IUCs, and Implants

ICD-10 | ICD-9 | Description
--- | --- | ---
Z30.013 | V25.9 | Initial prescription of injectable contraception
Z30.42 | V25.40 | Surveillance of injectable contraceptive
Z30.014 | V25.11 | Initial prescription of IUD (not insertion!)
Z30.430 | V25.11 | Insertion of IUD
Z30.431 | V25.42 | Routine checking of IUD
Z30.432 | V25.12 | Removal of IUD
Z30.433 | V25.13 | Removal and reininsertion of IUD
Z30.019 | V25.5 | Initial prescription of contraceptives, unspecified
  - Implant prescription or insertion
Z30.40 | V25.43 | Surveillance of contraceptives, unspecified
  - Implant surveillance or removal

Encounter for Contraceptive Management

Other uses of Z30.x

ICD-10 | ICD-9 | Description
--- | --- | ---
Z30.02 | V25.04 | Counseling and instruction in natural family planning to avoid pregnancy
Z30.09 | V25.09 | Encounter for other general counseling and advice on contraception
  - No method prescribed
Z30.2 | V25.2 | Encounter for sterilization
Z30.8 | V25.8 | Encounter for other contraceptive management
  - Post-vasectomy sperm count
  - Routine examination of contraceptive maintenance
Z30.9 | V25.9 | Encounter for contraceptive management, unspecified
Level II HCPCS (Hick-Pick) Codes:
On-site Dispensing of Drugs, Devices, and Supplies

May have been (and will be) replaced by national drug codes (NDC)

HCPCS II: Contraceptive J-Codes

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>National code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1050</td>
<td>Injection, medroxyprogesterone acetate, 1 mg</td>
</tr>
<tr>
<td>J7300</td>
<td>Intrauterine copper contraceptive</td>
</tr>
<tr>
<td>J7301</td>
<td>LN-releasing intrauterine contraceptive system, 13.5 mg</td>
</tr>
<tr>
<td>J7302</td>
<td>LN-releasing intrauterine contraceptive system, 52 mg</td>
</tr>
<tr>
<td>J7303</td>
<td>Contraceptive supply, vaginal ring, each</td>
</tr>
<tr>
<td>J7304</td>
<td>Contraceptive supply, hormone containing patch, each</td>
</tr>
<tr>
<td>J7307</td>
<td>Etonogestrel implant (insertion kit and supplies)</td>
</tr>
<tr>
<td>J3490</td>
<td>Ulipristal acetate EC</td>
</tr>
<tr>
<td>J3490</td>
<td>Levonorgestrel EC (Plan B, Next Choice)</td>
</tr>
</tbody>
</table>

- J 3490: unclassified drug
- J 8499: Oral prescription drug non chemo

HCPCS II: Contraceptive Supply A-Codes

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>National Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 4266</td>
<td>Diaphragm, cervical cap</td>
</tr>
<tr>
<td>A 4267</td>
<td>Condom, male each</td>
</tr>
<tr>
<td>A 4268</td>
<td>Condom, female, each</td>
</tr>
<tr>
<td>A 4269</td>
<td>Spermicide (foam, cream, gel, jelly, suppository, film sponge), each</td>
</tr>
</tbody>
</table>

HCPCS II: Family Planning Supply S-Codes

<table>
<thead>
<tr>
<th>Interim Description</th>
<th>HCPCS</th>
<th>National Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC medications</td>
<td>S 4993</td>
<td>OCs for birth control</td>
</tr>
<tr>
<td>Lubricant</td>
<td>S 5199</td>
<td>Personal care item, NOS each</td>
</tr>
<tr>
<td>Misc drugs (for nonsurgical procedures)</td>
<td>S 5000</td>
<td>Prescription drug, brand name</td>
</tr>
<tr>
<td></td>
<td>S 5001</td>
<td>Prescription drug, generic</td>
</tr>
</tbody>
</table>

Coding Definitions: Modifiers

<table>
<thead>
<tr>
<th>#</th>
<th>Definition</th>
<th>Use for</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Prolonged E/M services</td>
<td>E/M longer than 99215 or 99205</td>
</tr>
<tr>
<td>22</td>
<td>Increased procedural services</td>
<td>Complex surgery</td>
</tr>
<tr>
<td>24</td>
<td>E/M unrelated to surgical global</td>
<td>Visit during “global” post-op period for a different problem</td>
</tr>
<tr>
<td>25</td>
<td>Distinct E/M service by same MD on same day</td>
<td>Procedure and unrelated office visit on same date of service</td>
</tr>
<tr>
<td>26</td>
<td>Professional component</td>
<td>Interpretation of imaging, NST</td>
</tr>
</tbody>
</table>
| 51 | Multiple procedures (similar operation, same body area) | • Report most significant first  
|    |                                    | • Others with –51 modifier                 |
| 52 | Reduced services                   | Procedure partially completed               |
| 53 | Discontinued procedure             | Unable to perform procedure                 |

Coding Definitions

- RBRVS: Resource-based Relative Value Scale
  - Relative work value of service provided
  - Components: cognitive, procedural, time
- RVU: Relative value units
- Medicare payment for outpatient services

Work RVU (clinician work): CPT, E/M
  + Practice expense RVU (office > facility)
  + Malpractice RVU

Total RVU x $/RVU multiplier = payment
### RBRVS: Physician Work RVUs

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Procedure</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Office visit, estab</td>
<td>0.67</td>
</tr>
<tr>
<td>99343</td>
<td>Office consultation</td>
<td>1.72</td>
</tr>
<tr>
<td>57454</td>
<td>Colpo with biopsy</td>
<td>1.27</td>
</tr>
<tr>
<td>57460</td>
<td>LEEP</td>
<td>2.93</td>
</tr>
<tr>
<td>59840</td>
<td>TAB (suction)</td>
<td>3.01</td>
</tr>
<tr>
<td>58670</td>
<td>Laparoscopic TL</td>
<td>5.80</td>
</tr>
<tr>
<td>58550</td>
<td>LAVH</td>
<td>14.19</td>
</tr>
<tr>
<td>59409</td>
<td>Vaginal delivery only</td>
<td>13.50</td>
</tr>
<tr>
<td>59400</td>
<td>Global OB (PNC, del)</td>
<td>23.06</td>
</tr>
</tbody>
</table>

### The Role of Coding in State Family Planning Waiver Programs

- Claim submission from your practice...getting paid for what you do!!
- Claims data sets (with demographic data) are used for
  - Public health projects
  - Quality improvement reports
  - Utilization management reports
  - Provider practice profiles
  - Fraud and abuse detection

### Who Is Responsible for CPT Coding?

- We have a biller who reviews charts and decides which ICD+CPT codes are best to submit to payers
- She has been to many coding courses, but she is not a certified coder
- We have a chance to check her work, but we don't
- If she makes an error on a submitted claim, who is responsible...
  - The coder?
  - The clinician who saw the patient?
  - The physician who owns the practice?

### Why Is Accurate Coding Important?

- Credit for work done
  - Fee-for-service income
  - Production-based payment/bonus
- Information collection
  - Case finding by diagnosis or procedure
  - Severity risk adjustment
- Compliance: expectation of payors
  - Services billed = Services provided
  - Avoid fraud charges

### Medicare Fraud

- Most common causes of fraud
  - Billing for services not rendered
  - Misrepresenting diagnosis to justify code
  - Unbundling, upcoding
- HIPAA Regulations: fraud penalties
  - 3 times amount claimed
  - Civil penalty: up to $10,000 per episode
- CMS (Medicare) focus areas
  - Mid-level practitioners
  - Teaching hospitals!!

### Who Is Responsible for Coding?

- Three commonly utilized models
  - Clinicians code all encounters
  - In-house coder (chart review)
  - Outsource coding (chart review)
- Office staff/professional coders should be seen as "back up" to clinicians
- In all models, billing physician is responsible for accuracy and veracity of claim
Why Must Clinicians Be Active Coders?

• Inform history and physical exam components
  – But, don’t add Hx, PE elements solely for billing
• Inform documentation
  – But, don’t document elements not performed
• Inform coding levels entered by the clinician
• Minimize errors in coding
  – Inaccurate case finding
  – Undercoding: missed income, production credit
  – Overcoding: compliance violations, fraud

Documentation Drives Coding

• Three keys to proper coding
  – Documentation
  – Documentation
  – Documentation
• If it isn’t documented (and readable), an intervention can’t be considered in coding
• Each note must stand alone

Using a Superbill (Encounter Form)

• Purposes of a superbill
  – Transmit record of interventions and diagnoses from the clinician to the biller
  – Optional use: patient acknowledgement of billable services provided
• Practices either can use the same superbill for all payers or payer-specific versions
• Provider must document all interventions performed
• Biller will submit claim for services, drugs, and supplies that are benefits of the patient’s coverage

Principles of Documentation

• The medical record should be complete and legible
  – Complete all notes within 24 hours
  – Never take charts out of the clinic
• Documentation must include
  – Reason for encounter
  – Relevant history, physical exam, lab testing findings
  – Problem list: diagnosis or impression for each problem
  – Plan for care of each problem

Using a Superbill

• Claim only those services that are
  – A benefit of insurance coverage or cash payment
  – Medically necessary and documented
  – Performed on-site
• Components of the Superbill
  – Visits: E/M code(s)
  – Procedures: CPT code(s)
  – Diagnoses: by ICD code(s)
  – Injected drugs (DMPA), devices inserted (IUC)
  – Drugs, supplies dispensed onsite (not those by Rx)
  – Optional: modifiers, explanation box, off-site tests

Principles of Documentation

• Date and legibly identify clinician; options:
  – Legible signature
  – Illegible signature + print name
  – Illegible signature + stamp
  – Illegible signature + signature file
• Rationale for ordering tests and services should be documented or easily inferred
  – Clear to a non-clinician
• CPT, ICD-9 codes reported for billing must be supported
Use of Pre-Printed Forms
- Prompts clinician for available elements
- Permits on-the-spot E/M computation
- Reduces writing
- Standardizes content among clinicians
- Improves data collection and QI auditing
- Prelude to EMR

E/M: Referral vs Consultation
Definition of Referral
- Transfer care to another clinician for
  - A known problem
  - A diagnostic evaluation
  - A specific course of treatment
- No return communication with advice is expected from the provider to the referring clinician

Documentation Checklist
- Is it complete and accurate?
- Are orders dated and signed?
- Are required times captured?
- Are charts reviewed on a regular basis?
- Are clinicians available to clarify/answer questions?
- Ensure easy access to valid codes which reflect actual services provided
  - Encounter forms, EMR, Explosion Codes

E/M: Referral vs Consultation
Consultation
- “Opinion or advice regarding evaluation or management of a specific problem is requested by another physician or appropriate source”
- Written or verbal request must be documented
- Consultant’s opinion and services provided must be documented and communicated by written report to the requesting physician
- If consultant assumes care of patient, do not use consultation codes for subsequent visits

Consultation or Referral?
- The Ob-Gyn physician in our office has lots of patients sent to her by other doctors
- For these visits, either she uses “consultation” or “new patient” E/M codes, but inconsistently
- What’s the difference between a consultation and a referral?
- How are “new” and “established” patients defined?
- Can an Ob-Gyn ask for a consultation from another specialist, or only the PCP?

E/M: Referral vs Consultation
A consultation requires the 3 R’s:
- Request (from requesting clinician)
- Rendering an opinion (by the consultant)
- Report back to the referring clinician

![Flowchart showing the process of referring and consulting between clinicians](chart.png)
Sending Patients To a Consultant

- Designate to whom is the patient being sent
  - Specific provider or any provider
  - Indicate whether request is urgent or routine
- Send the request in writing, including
  - The purpose of the consultation
  - Relevant history, exam, lab, and imaging studies
  - Preference for treatment recommendations, co-management plan, or specialist to initiate care
- Specify to whom (at your clinic) the specialist’s report should be sent

Case Study: New vs. Established Patient

- In our county health department outpatient clinics, the “Family Health Clinic” (FHC) is down the hall from the “Woman’s Health Clinic” (WHC)
- If we see a FHC patient for the first time in the WHC, is coding as a “New” or “Established” patient?

Answer

- The clinicians in each clinic must be acting as a discrete “same specialty” group
- Each specialty clinic must have its own unique provider number (National Provider Identifier)

E/M: New vs. Established Patient

- New Patient
  - “One who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past 3 years”
- Rules regarding new patients
  - Within same practice, change of insurance does not qualify as “new patient”
  - If clinician changes practices, visit by same patient does not qualify as “new patient”

How NP or PA Services Be Billed?

- In our OB-GYN practice, we have two physicians and two nurse practitioners
- The NPs see all patients from all payer classes: Medicaid, Medicare, HMO, and PPO
- Is CPT, ICD coding different for NPs and PAs?
- Is payment different for NPs and PAs than for physicians?
- Can payers have policies specifying that the physician is on-site when NPs and PAs see patients?

E/M: New vs. Established Patient

- Established patient
  - “One who has received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past 3 years”
- Rules regarding established patients
  - If a physician is covering for another, encounter is classified as for the physician who is not available
  - Prior “professional services” must be face-to-face

Medicare Regulations for NPPs

Two billing options

- “Incident to” physician services
  - Care provided by NPP is “integral, but incidental” to services provided by physician
  - Applies to care rendered by “non-physician providers” (NPPs): NPs, PAs, RNs, LVNs
  - “Incident to” billing: 100% of physician fees
- Clinician’s own PIN number
  - Care is provided independently by NPP
  - Claim submitted with PIN is paid at 85% of MD
Medicare “Incident to” Rules

- Physician must see the patient at
  - Initial visit
  - Later visits if a new problem
- NPP can do follow-up visits and screening visits
- Physician member of the practice must be on-site
  - Document in chart note (or)
  - Have attendance records available
- Applies to licensed providers only for care given within scope of practice
- Care must be billed under on-site physician’s PIN

Medicare Rules for Use of “PIN”

- Applies only to NPs, CNMs, and PAs
- Must be utilized when physician is not on site when care is provided
- Must be utilized to bill visits for new Medicare patients and those with new complaints
- Must be utilized when all services for a given patient are provided by NPP
- Must be utilized for hospital inpatient billing

Problem Oriented E/M Visits

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

Or
- TIME, when greater than 50% of time is spent in counseling

Problem Visit E/M Structure

- HPI (8 elements; 2 levels)
- ROS (14 systems; 3 levels)
- PFSH (3 areas; 2 levels)
- Single organ system OR Multiple organ sys (bullets)
- Diagnoses (4 levels)
- Data Complexity (4 levels)
- Risk of Complications (4 levels)

Non-Medicare Payer Policies for NPPs

- Commercial payers will either
  - Not pay NPPs: all care given by MDs, DOs only
  - Accept Medicare “incident to” rules
  - Be more liberal than “incident to” rules
    - Can bill 100% for NPP services if physician provides “general supervision”
- Medicaid permits NPP billing using the practice’s NPI
- Some states permit direct billing by NPs and CNMs
- Refer to contract or check payer’s policies
- Never reduce billing for NPPs; let the payer do it!

E/M Visit: History

- New Patient Office Visits

<table>
<thead>
<tr>
<th>Level</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem focused</td>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem</td>
<td>Brief</td>
<td>Pbm Pertinent</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed</td>
<td>Extended</td>
<td>2-9 system</td>
<td>Pertinent any 1 of 3</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Complexity</th>
<th>Single organ system</th>
<th>Multiple organ sys (bullets)</th>
<th>Diagnoses (4 levels)</th>
<th>Data Complexity (4 levels)</th>
<th>Risk of Complications (4 levels)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single organ system</td>
<td>Single organ system</td>
<td>Multiple organ sys (bullets)</td>
<td>Diagnoses (4 levels)</td>
<td>Data Complexity (4 levels)</td>
<td>Risk of Complications (4 levels)</td>
</tr>
<tr>
<td>Multiple organ sys</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**E/M Visit: History**

- Established Patient Office Visits

<table>
<thead>
<tr>
<th>Level</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Problem focused</td>
<td>Brief 1-3 elements</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Brief 1-3 elements</td>
<td>Pbm Pertinent (1 system)</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed</td>
<td>Extended 4+ elements</td>
<td>Extended 2-9 system</td>
<td>Pertinent any 1 of 3</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Extended 4+ elements</td>
<td>Complete 10-14 systems</td>
<td>Complete Any 2 of 3</td>
</tr>
</tbody>
</table>

**E/M Visit: Physical Examination**

- Single Organ System Exam

<table>
<thead>
<tr>
<th>Level</th>
<th>Single Organ System Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>1-5 bullet elements</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>&gt; 6 bullet elements</td>
</tr>
<tr>
<td>Detailed</td>
<td>&gt; 12 bullet elements</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Female GU exam, abdomen, constitutional, other organs</td>
</tr>
</tbody>
</table>

**E/M Visit: Single Organ Exam**

**Female Genitourinary Exam: 11 elements**

- Inspection and palpation of breasts
- Digital rectal exam
- Pelvic exam
  - External genitalia
  - Urethral meatus
  - Urethra
  - Bladder
  - Vagina
  - Cervix
  - Uterus
  - Adnexa/parametria
  - Anus and perineum

**Medical Decision Making**

<table>
<thead>
<tr>
<th>Level of MDM</th>
<th># Diagnosis Mgt Options</th>
<th>Data amount &amp; complexity</th>
<th>Risk of Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight-forward</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

To qualify for a given type of MDM, two of the three elements must either be met or exceeded.

**E/M Visit: Single Organ Exam**

**Comprehensive** Female GU Exam

- 7/11 bullets in female GU exam (previous slide)
- Constitutional
  - > 3 vital signs
  - General appearance
- Abdomen
  - Exam of abdomen; note masses or tenderness
  - Examine for hernia
  - Examine liver/ spleen
  - FOBT (fecal occult blood test) when indicated
- 1 element of each: neck, resp, CV, lymph, skin, neuro/psych

**MDM: Number of Diagnoses and Management Options**

<table>
<thead>
<tr>
<th>Diagnosis/Mgt</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>1 each (max 2)</td>
</tr>
<tr>
<td>Estab stable</td>
<td>1 each</td>
</tr>
<tr>
<td>Established worsening</td>
<td>2 each</td>
</tr>
<tr>
<td>New problem w/o workup</td>
<td>3 each</td>
</tr>
<tr>
<td>New problem, with workup</td>
<td>4 each</td>
</tr>
</tbody>
</table>

- Minimal: 1 point
- Limited: 2 points
- Moderate: 3 points
- Extensive: 4+ pts
**MDM: Amount and Complexity of Data**

- One Point each
  - Lab tests ordered/planned/done
  - Medicine CPT ordered/planned
  - Radiology CPT ordered/planned
  - Discuss test results
  - Decision to obtain old records

- Two Points each
  - Review/ summarize old records
  - Independent interpretation of image, tracing, specimen

**MDM: Risk to the Patient**

- How sick is the patient and how much work will the clinician do to determine the management plan?

<table>
<thead>
<tr>
<th>Level</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minor problem</td>
</tr>
<tr>
<td>Low</td>
<td>More problems, chronic</td>
</tr>
<tr>
<td>Moderate</td>
<td>More acute or serious</td>
</tr>
<tr>
<td>High</td>
<td>Sick; intensive work</td>
</tr>
</tbody>
</table>

**E/M Coding: Level of Visit**

New Patient Office Visit: Need 3/3 Key Components

<table>
<thead>
<tr>
<th>E/M</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>PF</td>
<td>PF</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99202</td>
<td>EPF</td>
<td>EPF</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
</tr>
<tr>
<td>99204</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Mod complexity</td>
</tr>
<tr>
<td>99205</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High complexity</td>
</tr>
</tbody>
</table>

**Medical Decision Making**

- Two of three elements must be met or exceeded

<table>
<thead>
<tr>
<th>Level</th>
<th># Diagnoses</th>
<th>Data amt/complexity</th>
<th>Risk of Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal (1)</td>
<td>Minimal</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited (2)</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple (3)</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive(4)</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

**E/M Coding: Level of Visit**

New Patient Office Visit: Need 3/3 Key Components

<table>
<thead>
<tr>
<th>E/M</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>PF</td>
<td>PF</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99202</td>
<td>EPF</td>
<td>EPF</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
</tr>
<tr>
<td>99204</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Mod complexity</td>
</tr>
<tr>
<td>99205</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High complexity</td>
</tr>
</tbody>
</table>
### E/M Coding: Level of Visit

**Established Office Visit: Need 2/3 Key Components**

<table>
<thead>
<tr>
<th>E/M</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Minimal</td>
<td>5</td>
</tr>
<tr>
<td>99212</td>
<td>PF</td>
<td>PF</td>
<td>Straightforward</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>EFP</td>
<td>EFP</td>
<td>Low complexity</td>
<td>15</td>
</tr>
<tr>
<td>99214</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Mod complexity</td>
<td>25</td>
</tr>
<tr>
<td>99215</td>
<td>Comp</td>
<td>Comp</td>
<td>High complexity</td>
<td>40</td>
</tr>
</tbody>
</table>

### E/M: Face-to-Face Time: "Midpoints"

<table>
<thead>
<tr>
<th>New</th>
<th>Time (typical)</th>
<th>Established</th>
<th>Time (typical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>≤ 15 (10)</td>
<td>99211</td>
<td>≤ 7 (5)</td>
</tr>
<tr>
<td>99202</td>
<td>16-25 (20)</td>
<td>99212</td>
<td>8-12 (10)</td>
</tr>
<tr>
<td>99203</td>
<td>26-37 (30)</td>
<td>99213</td>
<td>13-20 (15)</td>
</tr>
<tr>
<td>99204</td>
<td>38-53 (45)</td>
<td>99214</td>
<td>21-33 (25)</td>
</tr>
<tr>
<td>99205</td>
<td>&gt; 53 (60)</td>
<td>99215</td>
<td>&gt;33 (40)</td>
</tr>
</tbody>
</table>

### E/M: Face-to-Face Time

**E/M Visit: Time Factor**

- Average face-to-face times are listed for each level of E/M code as guideline
- "Face-to-face Time" supercedes key indicators if
  - > 50% of total F-to-F time is spent in counseling
    - Includes time spent with patient and/or family
    - Excludes pre- and post-encounter time
- Must document
  - Total time and face time in minutes or start/stop
  - Counseled regarding outcome, risks, benefits of...
  - Answered her questions regarding...

### Summary: Problem-Oriented E/M

1. Score History
2. Score Physical exam
3. Score Medical decision making
4. Choose E/M based on 3 key elements
5. Compute counseling as a percentage of total face-to-face time
   - If >50%, find E/M based on time factor
6. Select the E/M code that is greater of 3 key elements or face-to-face time

### E/M: Face-to-Face Time:

**Established Patient Office Visit**

The “99211” Visit

- Nurse, tech, medical assistant, counselor sees patient at clinician request
- Examples: BP check, review medications, provide injection (e.g., vaccine, DMPA), and patient education
- Used only for established patients
- Must document visit, but not key components or time
- Medicare requires that a clinician be on site (but not CPT)
**How Do I Bill for a “Check-Up” Visit?**

- In my practice, at least half of my patients are in for check-ups (aka: health screening visit, well women visit)
- However, it is very common to find a problem that needs a work-up or even an office procedure
- When I see a patient for “well woman” periodic health screening visit, which E/M should I use?
- If most of the visit is spent on risk reduction counseling, should I code based on time?
- How do I code for problem evaluation and procedures that occur during a check-up visit?

**Which Code to Use for Check-Up Visits?**

- Does the payer for this patient cover?
  - Preventive services (99394)
  - Preventive medicine counseling (99402)
- What are the comparative reimbursement rates?
- If only problem oriented visit codes (9921x) are covered, code for the higher E/M level
  - By the 3 key components, or
  - Time

**E/M Codes: Preventive Medicine Services**

- Used for periodic health screening (check-up) visits
- E/M codes 99381-99397; age specific
- **Components**
  - Comprehensive history and physical exam
  - Counseling, anticipatory guidance, and risk reduction
  - Order lab, diagnostic procedures
  - Indicate immunizations with separate codes
- If insignificant or trivial problem(s) without extra work to evaluate, do not add separate E/M
- If additional work-up for pre-existing or new problem, may add problem-oriented E/M (-25)

**Case Study**

- A 64 yo woman is seen for a “well woman” periodic health screening exam
- In history, patient noted post-coital bleeding for 4 months
- On exam, cervical polyp noted; cervical polypectomy was performed
- Questions:
  - Which CPT codes should be used?
  - Can an E/M code also be used? Modifier?
  - ICD-9 diagnosis for each CPT?

**E/M: Preventive Medicine Services**

<table>
<thead>
<tr>
<th>Age</th>
<th>New patient</th>
<th>Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-17 yrs old</td>
<td>99384</td>
<td>99394</td>
</tr>
<tr>
<td>18-39 yrs old</td>
<td>99385</td>
<td>99395</td>
</tr>
<tr>
<td>40-64 yrs old</td>
<td>99386</td>
<td>99396</td>
</tr>
<tr>
<td>65 yo or older</td>
<td>99387</td>
<td>99397</td>
</tr>
</tbody>
</table>

- Preventive medicine: individual counseling
  - 99401: 15 minutes; 99402: 30 minutes
  - 99403: 45 minutes, 99404: 60 minutes
Yet Another Problem...

- An increasing number of payers are rejecting Preventive E/M + Problem E/M at same visit!!
- Monitor EOBs (by payer) to determine if occurring
- Responses
  - Appeal each denial to the payer
  - Claim only the higher paying of the two E/M codes
  - Separate preventive and problem visits...ask patient at front desk which one she wants today
    - Expect complaints about 2 visits and 2 co-pays!!!
    - Blame it on the patient’s health plan procedures

Surgical Procedure “Packages”

- CPT code includes
  - Pre-operative evaluation (admission H&P)
  - Operation per se; local infiltration
  - Normal uncomplicated follow up care
    - 99024: Post–op visit documentation only
- CPT code does not include follow up for
  - Complications
  - Exacerbations, recurrences
  - Unrelated diseases or injuries
  - Supplies and drugs over and above those usually included in office visit

Telephone Calls

- Includes call to patient, or to other health professionals, for purpose of medical management
- May be billed, but often disallowed or zero payment
- If you are substituting phone calls for office visits in some cases, request accommodation
- ACOG: if not being paid, chart phone call and add time or content to next E/M visit
- CPT coding for telephone calls
  - 99371: simple or brief (e.g., lab results)
  - 99372: intermediate (new problem or new mgt)
  - 99373: complex or lengthy (long or complex call)

Office Surgical Procedures

- Procedure CPT includes
  - Brief focused history
  - Checking use of medications and allergies
  - Administration of local anesthesia
  - Performance of procedure
  - Post-operative observation
- Bill CPT only for visit if
  - Decision for procedure made at previous visit, or
  - E/M on same day did not require significant history, exam, or decision making

Visit and Procedure at the Same Visit

- In our practice, we don’t bill for a visit (E/M) and a procedure at the same visit
- If a need is found at a problem or check-up visit, the patient returns in a few days for a procedure
- Can E/M and CPT codes be billed the same day?
- Will I collect more with one approach or the other?
- How is the payer notified that the E/M visit and CPT procedure aren’t one and the same?

Office Surgical Procedures

- Procedure + E/M visit on same day
  - May also bill E/M if patient requires a “significant, separately identifiable” E/M service
  - Apply modifier –25 (distinct E/M services) to E/M
  - ICD-9 diagnosis codes should be different for CPT, E/M
- Payment policies
  - Some will pay both CPT + E/M, with same ICD-9 code
  - Others cover E/M only if a separate diagnosis from CPT
  - Others will pay either the E/M or the CPT
**IN SUMMARY**

**Coding is:**
- Complex
- Hard to remember
- Boring
- A pain in the ass

**But:**
- It is how you are credited for the work you do
- It is often a determinant of how you are paid
- It is how your practice collects fee-for-service $$

**Therefore, DO IT WELL**

**Always....**

- “If you didn’t write it down, you didn’t do it
- Follow coding guidelines and only code what is contained in the medical record – reimbursement will follow

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**In Closing: Improving Your Coding**

- In 2015, take an ICD-10 training course
- Buy new CPT and ICD books ANNUALLY
- Review coding issues and new developments at staff meetings
- Periodically audit colleagues charts
- Track E/M distribution for each provider

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**Coding Resources**

- ACOG web site: [www.acog.org](http://www.acog.org)
  - Quick Link → Coding
- Medicare web site: [www.cms.gov](http://www.cms.gov)
  - E/M Services Guide
  - 1997 Documentation Guidelines for E/M Services
  - 1995 Documentation Guidelines for E/M Services
  - Everything ICD-10
- AHIMA web site: [http://www.ahima.org/resources](http://www.ahima.org/resources)

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**In Closing: Improving Your Coding**

- Continuously improve your coding sheet
- Take a coding course every few years
- Read a monthly OBG coding newsletter
- If you have one, get to know your office coder on a first-name basis!

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**Disclaimer**

- The guidance and scenarios provided today are meant for education purposes only and do not represent legal or coding advice
- 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
- For each claim, you must check with the coding and coverage guidelines for a particular payer