

HOUSE STAFF ORIENTATION

Basic Coding, Teaching Physician Guidelines and Evaluation & Management Guidelines

**Montefiore Medical Center
Billing Compliance Department
June 2007**

What is Medical Coding?

- Coding is the process of using “codes” to represent clinical information
- Codes are used to describe diagnostic information, and procedures/services and supplies provided to a patient



Coding Systems

- Three primary coding systems currently used in the United States for billing purposes:
 - 1. ICD-9-CM - International Classification of Diseases, 9th Revision, Clinical Modification
 - 2. CPT - Current Procedural Terminology, Fourth Edition
 - 3. HCPCS – Healthcare Common Procedure Coding System

"Why?" Vs "What?"



- In general, codes are used for billing purposes to describe:
 - “WHY” the patient received services (Volume I ICD-9-CM), and
 - “WHAT” services the patient received (CPT, HCPCS Level II or III, or Volume 3 of ICD-9-CM for hospital billing of inpatient procedures)

2 Reasons Why Coding is Important

- Reason # 1: Coding Drives Payment
 - Whether a claim is paid at all, and the amount paid, is based on how the claim was coded
- Reason # 2: There is Significant Potential for Abuse
 - Billing for professional medical services is generally done on the “honor system”

Evaluation & Management (E&M) Level Selection

- E&M codes are used to report service levels for Professional Services
- CPT provides approximately 130 codes for reporting of “Evaluation & Management” services rendered by physicians and other non-physician practitioners (NPP)
- E&M Codes are grouped into approximately 40 categories, based on the location and/or type of service provided

Evaluation & Management (E&M) Level Selection (continued)

- Most E&M Services are coded by selecting a code level within the applicable E&M category based on physician documentation within the medical record.
- For most E&M categories, level selection is based on the key components including:
 - Extent of HISTORY
 - Extent of EXAM, and
 - Complexity of Medical Decision Making

Evaluation & Management (E&M) Level Selection (continued)



- The CPT Manual provides guidelines on how to select E&M levels
- CMS has also developed guidelines which are more extensive than the ones found in the CPT Manual
 - 1995
 - 1997

E&M Level Selection - Compliance Issue?

- Many physicians assign E&M levels based on how difficult the case felt (to him/her), rather than applying coding guidelines.
- As a result, documentation does not always facilitate the application of coding guidelines.

Consultations and Compliance

- Why are consultations such a big compliance issue?
 - There is a misunderstanding of the difference (from a coding perspective) between a request to evaluate & treat vs a request for treatment only
 - Many physicians are not aware of the specific documentation requirements for coding consultations

What is a Consultation?



– The Rule of 3 R's...

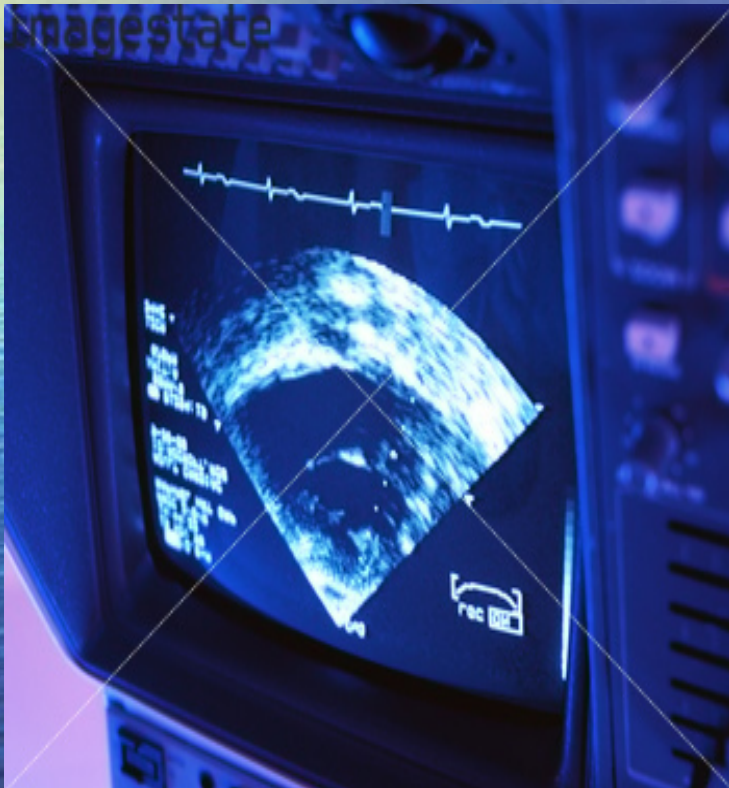
- **REQUEST** for Advice/Opinion
- **RENDERING** of Opinion
- Written **REPORT** back to the requesting MD

Coding Consultations



- It is appropriate to report a consultation when:
 - One physician has requested the advice and opinion of another physician, and
 - the “consultant” has properly documented the consultation in accordance with CPT guidelines.

Application of ICD-9-CM



- Volumes I and II
 - Used primarily to report a patient's diagnosis or condition
- Volume III
 - Used by hospitals to report procedural/surgical services, for inpatient stays
- Application of appropriate diagnosis codes validates "Medical Necessity"

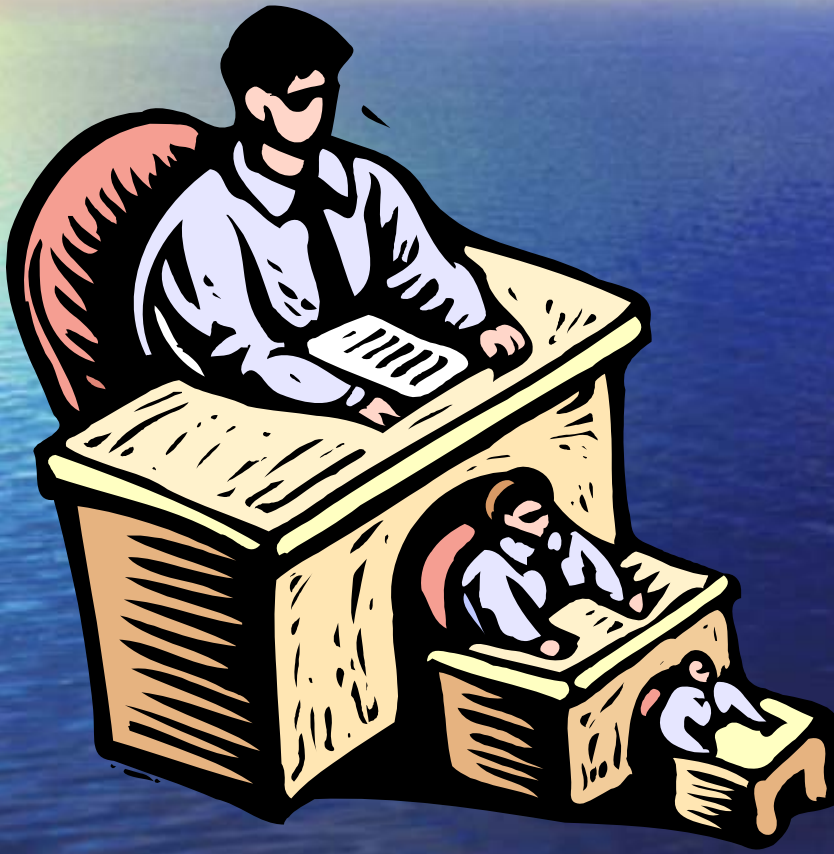
Assigning ICD-9-CM Diagnostic Codes

1. Review the clinical documentation and identify the term/terms that best describe the patient's diagnosis, disease, condition, or symptoms requiring the need for treatment
2. Look up the term or terms identified in Volume II of ICD-9-CM (alphabetic index)
3. Look up the selected code(s) in Volume I of ICD-9-CM to make the definitive code(s) selection, ensuring inclusion of all digits

Assigning ICD-9-CM Diagnostic Codes (continued)

- Many unspecified codes are not reimbursed by insurance carriers, i.e., 786.59 – Unspecified Chest
 - Try to be specific (location)/detailed
- Whenever indicated, 4th and 5th digits must be used in order to code to the highest specificity
- Until a diagnosis is confirmed, signs and symptoms should be indicated
- “Rule out” diagnosis can never be used for Professional billing purposes

Assigning ICD-9-CM Diagnostic Codes (continued)



- There will always be a primary diagnosis
- Often a secondary diagnosis
- Sometimes a tertiary diagnosis
- And so on...

V-Codes



V-codes are generally used in two ways:

1. When healthy people use a physician's service for a specific reason (administrative, screening or preventive purpose)
2. When patient's present injury or illness is influenced by a problem or circumstance which in and of itself is not a part of the current illness or injury

E-Codes

- E-Codes denote situations of accident, where and/or how they occur, and must be supported by a code for the resulting condition
 - These terms are not medical diagnoses, but describe the circumstances under which an accident or an act of violence occurred (i.e., the underlying cause or means of injury)
- An E-code is NEVER the primary diagnosis

Coding Changes

- Every year (in some instances, more frequently) there are changes to ICD-9, CPT-4, and HCPCS Level II codes.
- All code books and changes are available in October-November in order to prepare for code changes for the following year
- Encounter forms and systems must be updated to reflect changes, all changes should be effective for January of the year in question

Hot Topics in Coding Compliance

- E/M Selection
- Assignment of Diagnosis Codes
- Coding Consultations
- Reporting an E/M Code with a Procedural Service
- Teaching Physician Guidelines

Teaching Physician Guidelines

Definitions

- “Teaching Physician” – term applies to all attendings, whether employed by MMC or voluntary
- “Resident” applies to all residents, fellows, and interns. Medical Students are not considered residents as part of this policy

Teaching Physician Guidelines Evaluation & Management



- Presence Requirement:
 - Attending must be present during the portion of the service that determines the level of service billed.

Teaching Physician Documentation Requirement

- Attending must document:
 - Review of Resident's note;
 - Confirm or edit Resident's findings;
 - Document performance or participation in key components;
 - Summarize participation in the management of the patient; and
 - Date, time, signature on note

Documentation Requirement Continued

- Documentation must be in medical records and can be:
 - Dictated and typed;
 - Hand-written; or
 - Computer-generated

Documentation Requirement Continued

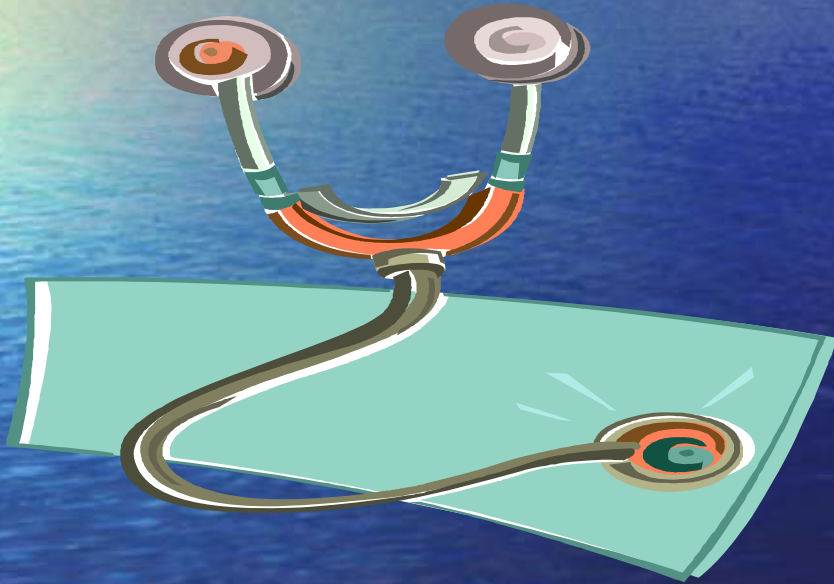
- Billing is determined based on the aggregated documentation
- Medical Students may document ROS and PFSH
- The modifier “-GC” should be attached to all encounters where there is resident involvement

Case #1 – TP performs service alone

- E/M documentation guidelines apply; teaching physician guidelines are inapplicable. E/M service billed without “GC” modifier.



Case #2 – Resident performs E/M service in the presence of, or jointly with, the TP



- E/M documentation guidelines apply to resident's note, TP guidelines apply to resident's note.

Documentation Example:

3/5/03 10:10 AM

Patient SEEN and examined with Dr. Resident. I discussed the case with the resident and agree with the findings and plan of care as documented in the resident's note above.

Dr. Teaching Physician

Case #3

- Resident performs some or all of the elements of E/M service in the absence of TP; TP independently performs some or all of the key portions of E/M service
- E/M documentation guidelines apply to resident's note; TP guidelines and E/M guidelines apply to TP's note

TP documentation - Examples

- 3/21/03 7:00 AM

I saw and examined the patient. I agree with the resident's note, except the heart murmur is louder, so I will obtain an echo to evaluate. See resident's note of 3-21-03 04:35 for more details.

Dr. Teaching Physician

Examples of Unacceptable Documentation

- “Discussed with resident. Agree”
- “Seen and agree”
- “Agree with above”
- “Rounded, reviewed, agree”
- “Patient seen and evaluated”
- Attending signature alone

Pop Quiz

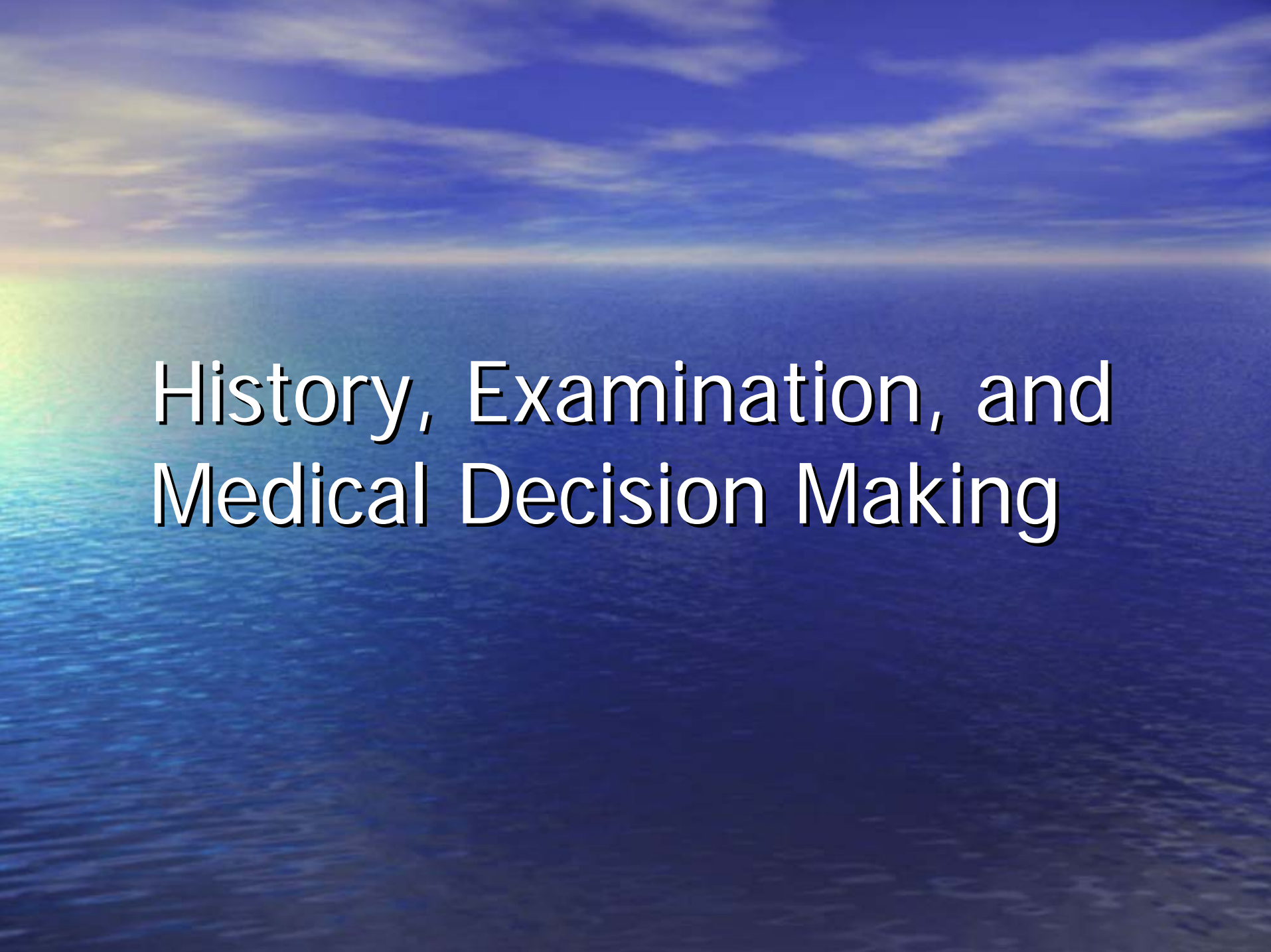
- What Level II modifier signifies that a service was performed, in part, by a resident under the direction of a teaching physician?





GC Modifier

What are the 3 “key components” of an evaluation and management (E/M) Service?



History, Examination, and Medical Decision Making

How many of the three key component must the teaching physician document to support a new patient/initial visit E/M code?

A teaching physician note should support participation or personal performance of the History and Exam, as well as participation in the Medical Decision Making.

Which of the following is an acceptable teaching physician note?

"Agree with above"

"Rounded, reviewed, agree"

"Discussed with resident"

"Seen and agree"

"Patient seen and evaluated"



NONE

Questions

