Provider's Condensed Resource for Revenue Cycle, Coding Tools, and More

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A cyclone of regulatory requirements for providers has officially touched down in the United States. The Affordable Care Act (ACA), Medicare Access and CHIP Reauthorization Act (MACRA), patient-centered medical home (PCMH), and value-based purchasing (VBP) initiatives are contributing to dramatic changes to the healthcare infrastructure for clinical practices of all shapes and sizes.

Providers are leaving paper health records behind as they work toward being proficient with electronic health records (EHRs). Patients appreciate the window to their health and the health of loved ones that portal access provides. Consumers also check provider reviews found on the Internet before switching from one practice to another, in essence shopping around for a provider that aligns with their own needs. With the volume of aging Baby Boomers on the rise—and an increase in the diagnosis of chronic comorbid diseases such as diabetes, heart disease, and obesity—comes an urgent need for an efficient coordination of care between specialists to help keep chronic diseases in check.

In addition to the aforementioned challenges, providers have undergone the rigorous transition to ICD-10-CM/PCS, which has its own unique set of learning curves. Whether utilizing paper or electronic records, current documentation and coding practices should be assessed. Multiple specialists within a shared EHR increase the complexity of the documentation and challenges of consistency within the documentation. This increases the challenge for accurate reporting of a patient's true severity of illness and risk of mortality. Providers must accurately and adequately document in order for diagnoses to be complete, regardless of which staff member is responsible for final code assignment.

This Practice Brief will review the important ICD-10-CM and Current Procedural Terminology (CPT) coding guidelines for provider practices, as well as coding edits, tools, and templates in EHRs, the use of copy and paste, and more.

Coding Guidelines in a Provider Practice

The following is a summary of the important coding guidelines provider practices should understand.

National Correct Coding Initiative (NCCI)

NCCI is a system of edits developed by the Centers for Medicare and Medicaid Services (CMS) to help prevent improper payments. NCCI edits are applied prior to the bill being submitted, and identify improper pairs of Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes submitted together on the same claim. The edits consist of two columns on a spreadsheet labeled column 1 and column 2. If a code in column 1 is submitted with a code from column 2, the code from column 1 is eligible to be paid and the code from column 2 is denied. If both codes are clinically appropriate, the code in column 2 may be submitted with an appropriate modifier. Documentation should support the modifier assignment. Mutually Exclusive Code (MEC) pairs should not be submitted together, even with a modifier. CMS considers it unreasonable for the provider to perform them on the same anatomical site during the same encounter.

The NCCI tables include a column that identifies which codes can be billed with an appropriate modifier and when it is not allowed (Modifier: 0 = not allowed, 1 = allowed, 9= not applicable).

In addition to the pair edits, NCCI also includes medically unlikely edits (MUEs). MUEs limit the units of service (UOS) allowed for a HCPCS/CPT code performed by a provider for a single date of service for a single beneficiary. Not all services are subject to MUE edits. Modifiers may not be used to override MUE edits.

Services denied for NCCI edits may not be billed to Medicare beneficiaries even if an Advanced Beneficiary Notice of Noncoverage (ABN) is obtained. NCCI tables are updated quarterly. Hospital outpatient NCCI tables are updated the quarter

following the Part B tables. For more information visit www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/.

Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)

NCDs and LCDs are developed by Medicare and its local contractors to ensure items and services provided to Medicare beneficiaries are reasonable and necessary. NCDs cover all Medicare beneficiaries. Local Medicare Administrative Contractors (MACs) develop LCDs when there is no NCD or to further detail coverage. CMS and the MACs offer weekly updates via e-mail for any interested party that registers on their website.

CMS provides a database on its website for anyone to search for NCDs and LCDs. Providers or patients can search to determine the coverage parameters for services prior to the service being provided. Because this information is easily available, CMS expects all providers to be aware of the parameters prior to submitting claims to CMS. The database provides a variety of ways to search for determinations including local regions, CPT, and ICD-10 codes. NCDs and LCDs can be located at www.cms.gov/medicare-coverage-database.

ICD-10-CM Official Guidelines for Coding and Reporting

The complete ICD-10-CM Official Guidelines for Coding and Reporting can be found on the National Center for Health Statistics (NCHS) website. The ICD-10-CM coding guidelines differ between inpatient and outpatient settings. The outpatient coding guidelines apply to all outpatient settings, including provider practices.

There are several sections of the coding guidelines applicable to provider practices, including (but not limited to): Section I.A, Conventions for ICD-10-CM; Section I.B, General Guidelines that apply to the entire classification; Section I.C, Chapter specific guidelines in the classification; and Section IV, Reporting guidelines for outpatient services.

Section I.A: The conventions are general rules for coding use when assigning ICD-10-CM codes to health record documentation. These are incorporated into both the Alphabetic Index and Tabular List as instructional notes. This section provides specific information regarding the format and structure of the classification and included here are abbreviations, punctuation, and use of seventh characters.

Section I.B: This section of the guidelines provides general coding guidelines related to locating a code in ICD-10-CM, use of the entire classification, signs and symptoms, and multiple coding for a single condition. Review of this section provides coding guidance for general questions related to the classification.

Section I.C: These guidelines are for specific diagnoses and/or conditions in the classification. These guidelines apply to all healthcare settings, unless otherwise indicated.

Section IV: This final section of the guidelines provides comprehensive information specific to the outpatient setting, including provider practices. Significant highlights of this section include the following:

- The term "first-listed diagnosis" is used in lieu of principal diagnosis.
- In determining first-listed diagnosis, the coding conventions—as well as the general and disease-specific guidelines—take precedence over the outpatient guidelines.
- The most critical rule involves the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List.
- Uncertain diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty should not be coded. Code the condition(s) to the highest degree of certainty for that encounter/visit, such as signs, symptoms, abnormal test results, or other reasons for the visit.

1995/1997 Documentation Guidelines

The 1995/1997 Documentation Guidelines (DG) for Evaluation and Management Services (E/M) provide guidance to providers in determining the appropriate service to bill for their E/M services. The 1995/1997 DGs are published by CMS. There is an Evaluation and Management Services Guide available to providers on the Medicare Learning Network (MLN).

The Evaluation and Management Services Guide consists of three main parts: Medical Record Documentation, Evaluation and Management Billing and Coding Consideration, and Reference Section. The guide provides information on choosing the patient type and the correct service type setting. The Reference Section includes the 1995 and 1997 DG. The 1995 and 1997 DG can be found at www.cms.gov. The provider can use either version of the documentation guidelines when choosing the appropriate level for the patient encounter. However, they cannot use both. The DGs provide guidance on what elements need to be included and information needed to support the history, examination, and medical decision making (MDM). Each section in the DGs provides additional examples and guidelines.

The 1995/1997 DGs assist providers with selecting the appropriate E/M level of service. Providers should review the 1995/1997 DGs to determine which set of guidelines is advantageous to them. Once they have selected the appropriate set of guidelines, they should become familiar with the components for the different elements of a particular visit.

History: The patient history is made up of four elements. The four elements include the Chief Complaint (CC); History of Present Illness (HPI); Review of Systems (ROS); and Past, Family, and/or Social History (PFSH). The information provided will assist in determining the type of history: problem-focused, expanded problem-focused, detailed, and comprehensive.

Examination: The Examination section is where significant differences are seen between the 1995 and 1997 DG. Either version of the DG can be used, but a provider cannot use a combination of both. The types of exam for both DGs are problem-focused, expanded problem-focused, detailed, and comprehensive.

In the 1995 DG, the examination can be documented by either body areas or organ systems. To achieve a comprehensive exam, a general multi-system exam or complete examination of a single organ system is required. Additionally, the DG explains what is needed to document "abnormal," "negative," and "normal," and what is included in the general multi-system examination.

The 1997 DG is made up of either general multi-system examination or a single organ system examination. The single organ system examinations are listed in the Table of Contents. A general multi-system examination or single organ system examination each contains its own additional details about the required elements of a physical examination. Bullet points are the key component used to determine the type of examination in the 1997 DG. The bullet points are described in each type of examination.

Medical Decision Making: The MDM is comprised of three components: number of diagnoses or management options; amount and/or complexity of data to be reviewed; and risk of complications and/or morbidity or mortality. The different types of MDM are straightforward, low complexity, moderate complexity, and high complexity. The E/M level must be medically necessary for the documented condition. Details are described in the DG.

Medicare vs. Commercial Guidelines

Coding and billing staff in provider practices need to be aware of the different billing and reporting requirements/guidelines of each insurance plan. Coding specialists and billers cannot assume that by following Medicare guidelines they are accurately completing claims for all insurance plans. Each plan may have different billing rules, coding rules, or quality reporting requirements mandated in their contracts. A complete understanding of each plan's specific contractual obligation is necessary to protect the practice financially and contractually.

Teaching Provider Guidelines

CMS publishes guidelines pertaining to the clinical services performed by teaching providers, residents, interns, fellows, and medical students. These guidelines are often referred to as the Providers at Teaching Hospitals (PATH) regulations. CMS, along with the Office of Inspector General (OIG), monitors compliance with the PATH regulations through nationwide reviews. Clinical documentation must support the teaching services performed.

The teaching provider guidelines are published by CMS and are divided between teaching programs that are furnished within and outside of an approved program. The general guidelines are that payments will be made by CMS for provider services within a teaching setting through the Medicare Provider Fee Schedule (MPFS) if the services state:

- Personally furnished by a physician who is not a resident
- Furnished by a resident when a teaching physician is physically present during the critical or key portions of the service
- Furnished by a resident under a primary care exception within an approved graduate medical education program

The teaching provider is paid through the MPFS for his/her involvement with the patient care and there is no payment provided by CMS directly to the physician for the teaching portion. This payment is made directly to the hospital as a part of the Accreditation Council for Graduate Medical Education.

Although the documentation guidelines for E/M services must be followed, there are specific modifiers that must be appended to the E/M service that defines who is providing the service for proper reimbursement to be issued:

- GC: Service performed in part by the resident under the direction of a teaching provider.
- GE: Service performed by a resident without the presence of a teaching provider under the primary care exception.

Additionally, specific documentation requirements must be noted by the teaching provider to identify involvement in the services rendered. An excellent resource that details these requirements is the Medicare Claims Processing Manual, Chapter 12, Section 100. There are clinical examples and sample statements which display the documentation requirements for teaching providers and the proper billing for these services in a variety of specialties, such as primary care, surgery, anesthesiology, radiology, and psychiatry.

EHR Enhancements: Templates and Macros

A high percentage of EHRs use templates to assist providers with documentation. A number of EHR vendors also employ macros (blocks of text) that can be stored and imported into the record as needed. Templates, and to a lesser degree macros, may address history and physicals, progress notes, operative notes, office procedure notes, nurses' notes, and other documentation scenarios. They may be designed to address the documentation needs of an entire clinical note, from the chief complaint to the assessment and plan. They may also be structured to represent a specific component of the note (i.e., HPI or physical examination) or even a subset of a component of a section of the record (i.e., subcomponent of the HPI template specific to a diabetic follow-up visit).

Templates are often developed to meet specific documentation scenarios tailored to a practice setting. For example, a headache template in primary care may be significantly different than one developed for a neurology practice. They may also be customized for new versus follow-up visits. In order to speed documentation, templates may have fully formatted sentences that include drop-down menus or other tools that allow for the users to choose the most appropriate item. For example, a HPI sentence in a template may read: "The patient presents with LOCATION OF PAIN that has started DATE/TIME TOOL." The LOCATION OF PAIN drop-down menu might list several anatomic sites (i.e., low back pain, hip pain, mid-back pain, etc.).

Templates often initiate E/M coding elements, ICD-10-CM codes, HCPCS codes, and non-E/M CPT codes. For example, the drop down menu titled "LOCATION OF PAIN" would be mapped to the HPI element for location and the "DATE/TIME TOOL" would be mapped to the HPI element for duration of symptoms. The same is true of the past medical history, review of systems, physical examination, assessment, and plan. Each section contains information that may be mapped to specific E/M coding elements that are then summarized and used to suggest an E/M code.

In the assessment section of the note, the templates may have embedded ICD-10-CM codes that can be chosen as diagnoses for the encounter. The template may also have embedded CPT and HCPCS codes that can be chosen by the provider when ordering tests, procedures, and devices.

Template defaults help to improve the efficiency of documentation, but if not used carefully may put the user at risk for inaccurate documentation from a medicolegal and coding compliance perspective. This often occurs when an ROS that has default negative values is imported into a note and the default negative is in conflict with the HPI findings. EHR users need to carefully review any templated default values to ensure that the information is clinically accurate. Coding professionals should become directly involved with template development and quality control to ensure that the embedded billing codes are accurate and that the templates allow the users to provide adequate supporting documentation.

EHR and Coding Quick Reference Guides (QRG)

There are many different types of QRGs when it comes to the EHR and documentation. QRGs may be helpful for use when learning a new EHR or serve as reminders about the particular system being used.

An EHR QRG would contain a listing of shortcut keys on how to do a particular function within the EHR. Each EHR is unique and providers may find this helpful when going to a new facility.

QRGs may be a listing of smart phrases that a provider can type into an EHR or speak into software to assist with finding orders or to serve as a reminder for shortcuts to quicker documentation. An example may include: if the provider types or says "PFSH" the system knows to type out "past medical, family, and social history." Some of these shortcuts may even be particular to a region referring to different facilities or providers.

Coding professionals often keep coding rules, tips, and advice on a QRG that they have ready access to that can help them with their coding. A coding QRG may have high-level categories such as the level of the visit, labs, diagnoses, and a few procedures that are common within the practice or specialty that the coding specialist is responsible for coding.

There are also many other uses for QRGs such as to serve as reminders to providers of documentation needed for different programs from the federal government. Some of those reminders may provide assistance to review what is needed for the Provider Quality Reporting System (PQRS) or measures in which the provider is participating.

A coding QRG may be of use in the office setting. There are a few types of coding QRGs, both for the diagnosis portion and for the E/M levels, described below.

A QRG for diagnosis may assist providers in choosing the diagnosis needed for medical necessity, preauthorization for procedures, and assignment of the diagnosis for the visit. The QRG should be related to the specialty of the provider. Diagnosis coding QRGs should be reviewed annually for each code set update for accuracy. It is important to note that diagnoses should not be limited to those referenced on the QRG. The notes related to the codes should also be reviewed when the codes are updated to be aware of includes notes, inclusion notes, etc.

A QRG for the E/M portion may assist in determining the appropriate level of service for the medical care provided. There are several QRGs available on the Internet to assist providers. The sections in the QRGs will assist with determining the type of history, examination, and medical decision making. One important item to review with QRGs is the use of a point system in medical decision making. There is no official point system for medical decision making in the 95 and 97 Documentation Guidelines. When using this one should check to see if the provider's Medicare Administrative Contractor has guidelines related to the use of a point system for medical decision making.

Copy and Paste Functionality

Copy/paste functionality refers to the ability of EHR users to be able to copy sections of text from one source to another such as to "paste" text into the clinical record for a patient encounter or procedure. This obviously improves efficiency and in some cases may improve documentation. However, users frequently copy and paste material and do not review it carefully. This introduces significant errors in the clinical record that could represent a patient safety concern and may result in denials of claims.

Copy/paste functionality has been an area of significant concern for OIG and other government and payer entities. CMS has referred to this practice as the "cloning" of records. Some auditing bodies have been using plagiarism detection software to identify copy and paste between patient records and within the same patient record. Clear evidence of copy/paste behavior may be considered fraudulent in some instances. It is generally used to deny payment or to seek repayment for prior services.

EHRs allow users to "pull forward" notes from previous visits. This creates an exact copy of some, or all, of the patient's last visit. In some cases this adds clinical value, as the provider is reviewing the document from the previous visit while they are evaluating the patient and creating the new document. In this setting their attention may be drawn to items in the record that they would otherwise have not addressed (i.e., persistent cough that was not mentioned during the current visit).

Unfortunately, some practitioners do not carefully review documents that have been pulled forward, resulting in records containing information that is irrelevant or inaccurate.

Another source of copied information can be derived from templates, as described previously. Large bodies of text can be imported into the record in the form of a template or macro. These should be reviewed and modified with the same level of diligence as information that is entered into the records through copy/paste.

Coding specialists should remain alert to the possibility of inappropriate use of copy/paste technology and report any findings to their leader. Periodic internal audits looking for evidence of copy/paste should also be conducted.

Guideline Awareness More Important than Ever

With regulatory requirements impacting a provider's practice now more than ever, it is important for an astute practice leader, provider, and coding professional to be aware of the changing guidelines and requirements that may change current practices. Understanding the importance of medical necessity, coding guidelines, EHR, copy/paste, and a coding quick reference guide are a few of many opportunities to help keep a practice on track for correct reimbursement and compliance.

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