Provider Coding and Documentation

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Introduction

About S4CH

Since 2007, Solutions 4 Community Health (S4CH) has focused on management solutions to meet the complex needs of our clients in response to the constant changing healthcare landscape. S4CH's expertise is in Strategic Consulting, Practice Transformation, Revenue Cycle Enhancement, Analytics, HEDIS and Risk Contracting Performance Improvements.

S4CH focuses its work primarily federally qualified health centers (FQHCs) and health care organizations that serve predominantly low-income, uninsured, and at risk populations.

S4CH Revenue Cycle Management

We optimize & maximize revenue, ensure accurate billing and coding, and streamline the financial processes within organizations. We utilize the use of automation to help optimize revenue cycle processes. We work hand in hand with our clients to ensure timely and efficient billing practices.

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CHCANYS Billing & Coding Webinar Series in Partnership with S4CH

1. ~~Basics of FQHC Billing 11/6/2024~~
2. ~~Mastering Medicaid Billing in FQHCs 12/4/2024~~
3. ~~Navigating Medicare Billing in FQHCs 1/8/2025~~
4. ~~Provider Coding and Documentation 3/5/2025~~
5. Effective Claim Denial Management 3/26/2025

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Outline- Provider Coding and Documentation

- ✓ Evaluation and Management Coding
  - ✓ Time Based
  - ✓ Medical Decision Making
- ✓ Separately Identifiable Services or Procedures
- ✓ Diagnosis Coding
  - ✓ ICD-10
  - ✓ Social Determinants of Health
  - ✓ Hierarchical Condition Category (HCC) Coding
- ✓ Medicare Specific Coding
- ✓ Preventive Visits
- ✓ Behavioral Health Coding
- ✓ Telehealth Coding
- ✓ Modifiers
- ✓ Common Coding Errors
- ✓ Tips to Improve Coding
- ✓ Useful Links

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Accurate Coding Importance

- Compliance (Internal & External Audits)
- Revenue/Reimbursement
- HEDIS (Healthcare Effectiveness Data and Information Set)
- RVU's (Relative Value Units) impacts reimbursement
- Specific ICD-10 codes improve cost estimates in risk contracts
- Patient responsibility

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Evaluation & Management Introduction

Steps to Determining Proper Evaluation and Management Code:

1. Are you coding based on Medical Decision Making or Time?
2. Is this a New Patient Visit or Established Patient Visit?
3. If based on Medical Decision Making, what components are being met- Straightforward, Low, Moderate, or High?
4. If based on Time- Is the documentation supporting time requirements?

CPT	New 99202	Established 99212	New 99203	Established 99213	New 99204	Established 99214	New 99205	Established 99215
Time (min)	15	10	30	20	45	30	60	40
MDM	Straightforward		Low		Moderate		High	
History	Medically appropriate		Medically appropriate		Medically appropriate		Medically appropriate	
Exam	Medically appropriate		Medically appropriate		Medically appropriate		Medically appropriate	

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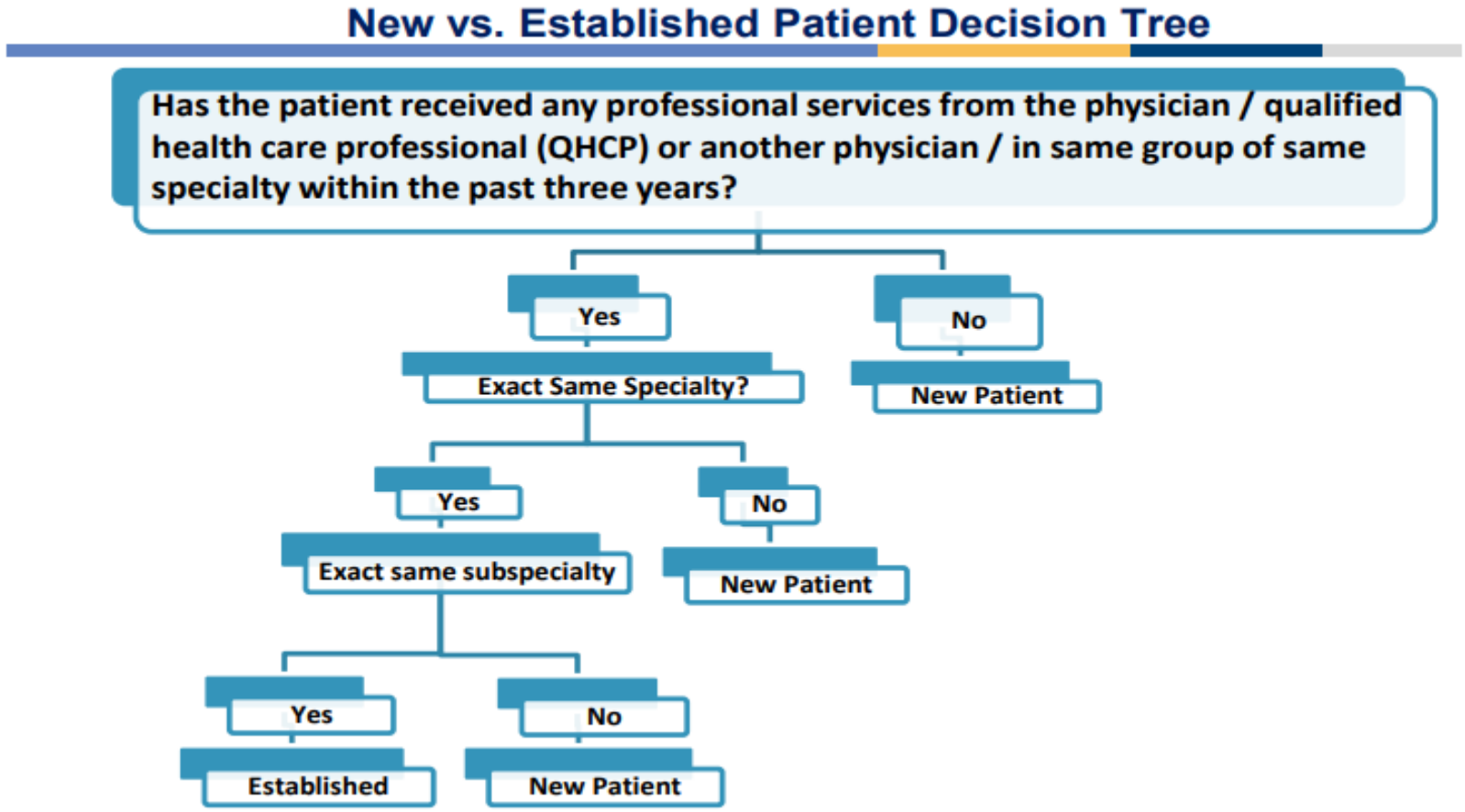
Determining New Patient vs. Established Patient



**** Medicare New Patient vs. Established Patient:** If the patient has received any professional services from a provider (regardless of specialty) in the same group- they are an Established Patient with the FQHC.

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Medical Decision Making

To qualify for a level of MDM, two of the three elements for that level must be met or exceeded.

The three elements of Medical Decision Making:

1. Problem: Number and complexity of problems addressed during the encounter

2. Data: Amount and/or complexity of data to be reviewed and analyzed (Test results/orders)

3. Risk: Risk of complications, morbidity, and/or mortality of patient management decisions at the visit, associated with a patient's problem, diagnostic procedure, or treatment

Types of Medical Decision Making

- Straightforward- 99202, 99212
- Low Complexity- 99203, 99213
- Moderate Complexity- 99204, 99214
- High Complexity- 99205, 99215

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Required Components for Medical Decision-Making Based Coding

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed** **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

Full MDM Grid on AMA website-
https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management

99204
99214
	Moderate	**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
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s) **or**
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or**
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				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**
		• **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
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s) **or**
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or**
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				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

MDM-Problem, Data and Risk

Example:

- ✓ Established Patient presents with cough, congestion and body aches; no fever reported.
- ✓ Ordered rapid flu and Covid 19 tests
- ✓ Tests were negative. Diagnosed with a cold. Patient was advised to go home, rest and drink lots of fluids.

2 or more self limited minor problems	S	(L)	M	H
2 unique lab tests	S	(L)	M	H
Minimal Risk of Morbidity with treatment or testing	(S)	L	M	H

MDM = Straightforward CPT 99213

2 of the 3 MDM elements need to be met or exceeded in order to select the level

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Documentation Tips

- You can only bill what your documentation supports.
- The documentation needs to justify the level of service provided.
- Document all patient detail in clear specific language.
- Ensure progress notes are completed in a timely manner.
- Use of customized templates in EMR system.
- Documentation must be consistent.

*Example: Chief Complaint-sore throat

•Review of Systems

•ENT: denies sore throat

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Time Based Coding

What ***can*** be counted in total time?

- Prepare for the visit – for example, review test results.
- Obtain or review a patient history.
- Perform a medically necessary examination.
- Educate the patient, a family member or a caregiver.
- Write orders for tests, medicine, additional services.
- Refer/communicate with other health care professionals.
- Enter clinical information in the patient's record.
- Interpret and share test results with the patient.
- Coordinate patient care.

What ***cannot*** be counted in total time?

- Time performed by clinical staff members; such as taking the patient's vitals, asking health questions, obtaining family, social and personal history, etc. is not allowed. The guidelines state that activities that are normally performed by clinical staff are not used to calculate time.
- Time spent on services that are separately reportable should **not** be included in total time calculations.

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Time Requirements

CPT Code	**Total time on date of encounter to meet or exceed (minutes)**
99202	**15**
99203	**30**
99204	**45**
99205	**60**
99212	**10**
99213	**20**
99214	**30**
99215	**40**

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Example of Time-Based Documentation

The physician documents the following activities on the day of a patient's visit:

- Talking to the patient's primary care provider about the patient's condition: **Seven minutes**.
- Reviewing the patient's history: **Two minutes**.
- Examining the patient: **Eight minutes**.
- Discussing treatment options with the patient: **Six minutes**.
- Writing prescriptions for the patient: **Three minutes**.
- Ordering diagnostic tests: **Three minutes.**
- Updating the patient's record: **Five minutes.**

above time entries are examples; only the total time should be listed with the reviewed components.

The total time equals 34 minutes. If the physician provided complete documentation for each activity, the coder would report 99203 for a new patient and 99214 for an established patient.

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Reporting a Separately Identifiable Procedure or Service

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately but ***cannot*** be counted in total time.

The separate service must be reported separately.

Example:

Time spent giving patient an injection would be billed with 96372 and not reported in total time of e/m service.

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Common Separately Identifiable Procedures or Services

- Counseling (99401-90412)
- In House Labs (8000 series Codes)
- Vaccines and Administrations 90460-90474
- Injections (J codes) and Administrations 96372
- Venipuncture 36415, Cap Blood Draw 36416
- Audiometry Testing 92551
- Behavioral Assessment Questionnaire 96127
- Visual Acuity Screening 99173
- Electrocardiogram 93000
- Q0091 Pap Smear Handling

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Diagnosis Coding

- **ICD-10 Structure**
  - 3-7 alpha-numeric codes
    - Digit 1 is alpha
    - Digit 2 is numeric
    - Digit 3-7 are alpha or numeric
    - A decimal is used after the third character
      - Examples:
        - R05-cough
        - J45.90-unspecified asthma
        - J45.901-unspecified asthma with an acute exacerbation

Diagnosis Coding

- The primary diagnosis is the condition that most significantly contributed to the patient's visit.
- All diagnoses addressed during a patient encounter should be reported on the claim.
- Diagnosis codes need to match the services provided and support medical necessity.
- Combination codes represent a single code used to classify two diagnoses, a diagnosis with an associated sign or symptom or a diagnosis with an associated complication.
  - Example- E11-Type 2 diabetes mellitus
    G60.9-Neuropathy
    E11.21-Type 2 diabetes with diabetic neuropathy
- Use and report diagnosis codes at the highest level of specificity.
- If a definitive diagnosis hasn't been established by the end of the encounter, report codes for either signs or symptoms, or both, instead of a definitive diagnosis

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Social Determinants of Health (SDOH)

- Social determinants of health are non-medical factors that have a major impact on people's health, well being and quality of life. Includes access to food, transportation, housing, education, etc.
- ICD-10 Code categories Z55-Z65 identify SDOH. The ICD-10 codes describe factors influencing health status. These codes allow health providers, health systems and payers to better track patient's needs and identify solutions to improve the health of communities.
  - Z55.0-Z55.9 - Problems related to education and literacy
  - Z56.0-Z56.9 – Issues related to employment and unemployment
  - Z57.0-Z57.9 – Occupational exposure to risk factors
  - Z58-Z58.89 – Problems related to the physical environment
  - Z59.0-Z59.9 – Problems related to housing and economic circumstances
  - Z60.0-Z60.9 – Problems related to social environment
  - Z61.0-Z61.9 – Problems related to negative life events in childhood
  - Z62.0-Z62.9 – Problems related to upbringing
  - Z63.0-Z63.9 – Other problems related to primary support group, including family circumstance
  - Z64.0-Z64.4 – Problems related to certain psychosocial circumstances
  - Z65.0-Z65.9 – Problems related to other psychosocial circumstances

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Hierarchical Condition Category (HCC) Coding

- HCC (Hierarchical Condition Category) coding is a risk-adjustment model originally designed to estimate future health care costs for patients.
- HCC helps communicate patient complexity and paints a picture of the whole patient. That in turn helps predict future reimbursements and contracts with certain Healthcare plans.
- Always code to the most specific ICD10 possible
- Common HCC Codes:
  - **HCC 19**: Diabetes without complications
  - **HCC 12**: Cancers and tumors of the breast, prostate, and other organs
  - **HCC 18**: Diabetes with chronic complications
  - **HCC 79**: Seizure disorders and convulsions
  - **HCC 96**: Specified heart arrhythmias
  - **HCC 85**: Congestive heart failure
  - **HCC 23**: Other significant endocrine and metabolic disorders
  - **HCC 111**: Chronic obstructive pulmonary disease
  - **HCC 59**: Major depressive, bipolar, and paranoid disorders
  - **HCC 22**: Morbid obesity

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Documenting For HCC

The MEAT criteria is a set of guidelines for documenting a patient's condition to support Hierarchical Condition Category (HCC) coding. MEAT stands for Monitor, Evaluate, Assess, and Treat.

What does MEAT stand for?

- **Monitor**: Observe signs and symptoms, disease progression, and disease regression
- **Evaluate**: Use test results, medication effectiveness, and response to treatment
- **Assess**: Review records, discuss the condition, and document the patient's condition level
- **Treat**: Use medications, surgery, or other therapies, or refer the patient to a specialist

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HCC V24 vs. V28

The main differences between HCC V24 and HCC V28 are:

- **Number of HCC categories**: V24 has 86 categories, while V28 has 115
- **Number of HCC codes**: V24 has 9,797 codes, while V28 has 7,770
- **Weightings**: Some weights changed-

  Examples- ICD10 E66.01 Obesity 0.25 vs. 0.186

  ICD10 E11.9 Type 2 diabetes mellitus 0.105 vs. 0.166
- **Hierarchies**: Some hierarchies were changed or eliminated
- **Data accuracy**: V28 is designed to capture more accurate data about patients' health status

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Medicare Federally Qualified Health Center (FQHC) Guidelines

G0468- FQHC Annual Wellness Visit (AWV)
G0466- FQHC New Patient Visit
G0467- FQHC Established Patient Visit
G0469- FQHC New Behavioral Health
G0470- FQHC Established Behavioral Health
G2025- any CMS approved telehealth service, including PPS FQHC qualifying visits that are part of the traditional FQHC PPS reimbursement, as well as for non-PPS visits

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Medicare Wellness Visits

Initial Preventive Physical Exam (IPPE)

- Review of medical and social health history and preventive services education.
- New Medicare patients within 12 months of starting Medicare coverage.
- Coding:
  - G0402- Initial preventive physical examination
  - G0468- Federally qualified health center (FQHC) visit

Annual Wellness Visit (AWV)

- Visit to develop or update a personalized prevention plan and perform a health risk assessment.
- Covered once every 12 months (except first 12 months of Medicare coverage)
- Coding:
  - G0438- Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
  - G0439- Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
  - G0468- Federally qualified health center (FQHC) visit

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Adult Preventive Exams

Age	Initial Patient Exam	Established Patient Exam
18-39 years	99385	99395
40-64 years	99386	99396
65 years-older	99383	99393

The ICD-10 codes for preventive exams include:

- **Z00.00**: A general adult medical exam without abnormal findings.
- **Z00.01**: A general adult medical exam with abnormal findings.
- **Z01.411**: A routine gynecological exam with abnormal findings.
- **Z01.419**: A routine gynecological exam without abnormal findings.

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Adolescent Preventive Exams

Age	Initial Patient Exam	Established Patient Exam	ICD 10
0 – 1 year	99381	99391	Dependent on Patient Age- see below**
1 – 4 years	99382	99392	Z00.121 or Z00.129
5 – 11 years	99383	99393	Z00.121 or Z00.129
12 – 17 years	99384	99394	Z00.121 or Z00.129

** Only for age 0-1 (99381 or 99391)
Z00.110- Health exam for newborn under 8 days old
Z00.111- Health exam for newborn 8 to 28 days old
Z00.121- Encounter for routine child health exam with abnormal finding for child over 28 days old
Z00.129- Encounter for routine child health exam without abnormal finding for child over 28 days old

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Behavioral Health Coding

- **Psychiatric Diagnostic Testing:**
  - Used to evaluate a patient's mental health conditions.
  - May include communication with family and other sources and review and/or ordering of diagnostic studies.
  - Used for the diagnostic assessment or reassessment and do not include psychotherapy. Psychotherapy services may not be reported on the same day.

  - **Documentation:**
    - A complete medical and psychiatric history (including past, family and social)
    - Mental status examination
    - Establishment of an initial diagnosis
    - Evaluation of the patient's ability and capacity to respond to treatment
    - Initial plan of treatment

  - **CPT Codes:**
    - 90791-Psychiatric diagnostic evaluation
    - 90792-Psychiatric diagnostic evaluation with medical services (MD,DO or NPP)

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Behavioral Health Coding cont.

- **Psychotherapy**
  - The treatment of mental illness and behavioral disturbance in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personal growth.

  - **Documentation:**
    - Time
    - Modalities and frequency if applicable
    - Clinical notes that summarizes:
      - Diagnosis
      - Symptoms
      - Functional Status
      - Focused mental status examination
    - Treatment plan, prognosis and progress

  - **CPT Codes:**

****Time Based CPT Codes**

CPT Code	Total time on date of encounter to meet (minutes)
90832	16-37
90834	38-52
90837	53 or longer

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Behavioral Health Coding cont.

- **Interactive Complexity**
  - Refers to specific communication factors that complicate the delivery of psychiatric care.
  - List this code separately in addition to the code for primary procedure
  - Factors are typically present with patients who:
    - Have other individuals legally responsible for their care (minors or adults with guardians)
    - Request others to be involved in their care during the visit (guardians, interpreters, translators etc.)
    - Require the involvement of third parties (child welfare agencies, parole, probation, school etc.)
- **Documentation**
  - Patients with high anxiety, high reactivity that complicates the delivery of care
  - Patients that have not developed or lost communication skills to explain his/her symptoms and response to treatment or understand the health care professional treatment information or guidance
  - Use of play equipment or other physical devices
  - Use of translator to overcome language barriers
  - Use of interpreter for deaf patients

- **CPT Code**
  - 90785 (add on code)
    - Can only be used with;
      - 90791 or 90792 (Psychiatric Diagnostic Evaluation)
      - 90832, 90834 or 90837 (Psychotherapy)
      - CAN NOT be used with Crisis Therapy, Family Therapy or an E/M

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Telehealth Coding

- **Must document:**
  - Modality of visit (audio-only or audio-video)
  - Patient consent for the telehealth visit
  - Patient's location
  - Provider's location
  - Ensure documentation is largely similar to an in-person visit, capturing the reason for the telehealth visit, and time spent during the encounter; specific rules may vary depending on the payer and state regulations.

- **Modifiers:**
  - **95-** is for use with real-time, audio-video visits.
  - **FQ-** A telehealth service was furnished using real-time audio-only communication technology.

- **Article 28 telehealth:**
  - If both patient and provider are offsite, use 4012 rate code.

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Modifiers

- **25-** indicates a significant and separately identifiable evaluation and management (E/M) service was performed.
- **95-** is for use with real-time, audio/visual visits.
- **FQ-** A telehealth service was furnished using real-time audio-only communication technology.
- **GN, GO, GP, KX, CO, CQ-** Therapy modifiers
- **GC, GE-** Resident/Preceptor modifiers

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Common Coding Errors

- Missing Medicare payment codes
- Preventive care coded as an Office Visit (E/M CPT)
- Sick visit coded as Preventive care
- Unlinked Diagnosis
- New patient coded as established patient
- Incorrect or Invalid primary diagnosis
- Use of deleted or expired ICD’s and CPT’s

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Tips to Improve Coding

- **Coding Audits**
- **Provider Training**
- **Staff Training**
- **Certified Professional Coder (CPC) Certification**
- **Utilize Edits in Electronic Medical Record (EMR) and Clearinghouse**
- **Update systems with updated CPT's and ICD 10 diagnosis codes**
  - CPT- Updates annually on January 1st
  - ICD-10- Updates annually on October 1st

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Useful Links

- ✓ https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf
- ✓ https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf

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Thank You

Questions

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