



COMMUNITY HEALTH PLAN
of Washington

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Provider Education Webinars

Course 1: Coding in Health Care:
Introduction and Purpose

Community Health Plan of Washington Provider Education Webinar

Course 1: Coding In Healthcare: Introduction and Purpose

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Welcome

Welcome to this presentation of Community Health Plan's Provider Education Webinar, Course 1: Coding in Healthcare: Introduction and Purpose.

This webinar series is designed specifically for Community Health Plan's Physicians, Healthcare Professionals, and Administrative Staff who want to broaden their understanding and use of documentation and coding skills.

This webinar series consists of 10 one-hour courses.

Attendees may earn

- Continuing Medical Education (CME) through the AAFP*, and/or
- Continuing Education Units (CEU) through AAPC** and AHIMA***

Courses and Self-Assessments must be completed to earn the CME/CEU credit

* American Academy of Family Physicians

** American Academy of Professional Coders

*** American Health Information Management Association

Learning Objectives

Webinar Learning Objective:

It is Community Health Plan's goal that our Providers will apply some or all of this career training and best practices knowledge across their care spectrum, regardless of Patients' ability to pay or insurance type.

Course 1 Learning Objective:

To introduce the area of knowledge, to create a foundation for further study of Medical Documentation and Coding.

Participants' learning objectives for Course 1 are:

- Knowledge of the current medical coding classification systems,
- Basic understanding of the regulatory entities that mandate compliance with documentation and coding accuracy, and
- Awareness of resources and reference materials to assist in the pursuit of quality documentation and accurate coding of medical encounters.

Medical Coding Defined

Medical coding is:

The process of converting narrative descriptions of diagnoses, procedures, diagnostics, supplies, and services into official, standardized alphanumeric codes.

The primary data source for diagnoses and procedures is the medical record.

Achieving a high degree of accuracy in medical charting is imperative in documenting the quality and continuity of care (while successfully, ethically navigating reimbursement systems).

Medical Coding Classifications

ICD-9-CM Diagnosis Volume I & II: (International Classification of Diseases, Ninth Revision, Clinical Modification)

Volume I & II work together in the selection of diagnostic codes

ICD-9-CM Diagnosis Volume III: (International Classification of Diseases, Ninth Revision, Clinical Modification)

Volume III contains facility procedures only

CPT-4 Procedure: Current Procedural Terminology, 4th Edition

Describes medical services and procedures performed by physicians

HCPCS : (Healthcare Common Procedure Coding System)

Describes Services & Supplies

Other Classification Systems:

There are some (tumor cell type registry, dental, and medications, for example) that are not discussed in this webinar.

ICD-9-CM Medical Coding: Then & Now

- ICD-9-CM (Diagnosis) codes were first developed in 1950 by the Public Health Service and the Veterans Administration, for the purpose of hospital indexing.
- A study was undertaken in 1956 and found the classification system to be a suitable and efficient framework for indexing hospital records.
- Physicians have been required by law to submit diagnosis codes using ICD-9-CM as the designated coding classification by the Medicare Catastrophic Coverage Act of 1988.
- In 1993, the World Health Organization published the ICD-10-CM and ICD-10-PCS international classification systems which are currently in use in Canada, Australia, and the UK. Some European countries have adopted the ICD-10-CM and ICD-10-PCS systems, with the targeted implementation expected in 2011.
- Recently, there have been reports that ICD-10-CM and ICD-10-PCS systems will be adopted to replace ICD-9-CM and implemented in the U.S. However, the Final Rule has not yet been issued.*

*The proposed rule is available at the Federal Register at:
<http://edocket.access.gpo.gov/2008/pdf/E8-19298.pdf>. The comment period for this proposed rule closed October 21, 2008.

CPT & HCPCS Coding: Then & Now

- CPT (Procedure) codes were first published in 1966, with 5-digit codes introduced in 1970, replacing the older 4-digit classification.
- In 1986, the U.S. Congress mandated CPT codes be reported for outpatient hospital surgical procedures.
- In 1996, the HIPAA legislation mandated the use of CPT codes for physician services, physical and occupational therapy services, radiology procedures, clinical lab tests, and other diagnostic procedures.
- In 2004, the Medicare Prescription Drug Improvement and Modernization Act mandated that when CPT codes are updated annually on January 1, there is no grace period for reporting: the updated codes must be implemented and used for services on and after their effective date.
- In 1983, the HCPCS (Equipment, Supplies, and other Services) alphanumeric coding classification system was developed to compliment the CPT coding system to describe durable medical equipment, prosthetics, orthotics, supplies, and other services (i.e., ambulance). It was originally called the HCFA Common Procedure Coding System, and is now the Healthcare Common Procedure Coding System as of 2002.

Authorship and Maintenance of Coding Classifications and Guidelines

Below is a list of organizations that are responsible for the documentation guidelines and coding classifications. If you are unable to find an answer about the documentation guidelines and/or coding question, and you suspect that the code or guideline itself should be improved, these are the organizations to contact.

- ICD-9-CM: ICD-9-CM Coordination and Maintenance Committee and National Center for Health Statistics (NCHS)
- CPT: American Medical Association (AMA)
- HCPCS: HCPCS National Panel
- 1995 & 1997 Documentation Guidelines: AMA

Perspectives on Proper Coding

Generating quality medical record documentation and achieving accurate coding is mandated by many regulatory entities, and the proper use of coding classifications cannot be overemphasized.

Accurate documentation and coding is not performed merely to achieve optimal reimbursement: there are many perspectives to consider:

Quality of Care: Continuity of care can't be properly achieved without accurate and complete documentation of the Patient's care journey.

Research: Documentation drives Coding, which becomes part of the database which many entities utilize when devoting research dollars to certain medical conditions (i.e., the U.S. Congress, World Health Organization).

Ethics: Every Patient is entitled to the most accurate, complete, and consistent documentation of their health care journey: it's a sacred trust.

Reimbursement: Every Provider is entitled to optimal, ethical legal compensation for services rendered: not more, not less.

Claims Integrity: Coding which is not accurate can and does "flag" Providers for payment and medical necessity review (and can result in penalties) by regulatory entities and payers.

Mandates

Important reference materials and resources are listed below (not a complete listing). Proper use and reporting of medical codes is mandated by the following regulatory entities.

Regulatory Agencies

- Centers for Medicare and Medicaid Services (CMS)
- Health & Human Services Office of Inspector General (HHS OIG)
- Office of Civil Rights (OCR) HIPAA Enforcement

Regulatory References

- ICD-9-CM Official Guidelines for Coding and Reporting
- Federal Register
- Office of the Inspector General Annual Work Plan
- Federal False Claims Act
- American Medical Association (AMA) 1995 & 1997 Documentation Guidelines
- Qui Tam and Whistleblower Protection Provisions (federal and state levels)
- Washington State Medicaid False Statements and Fraud Provisions
- Risk Adjustment Requirements for Medicare Advantage Organizations
- Community Health Plan Provider/Facility/Specialist Contracts
- National Committee Quality Assurance (NCQA) Documentation Guidelines
- Health Insurance Portability and Accountability Act (HIPAA)
- Washington Administrative Code (WAC) 388-502-0020 General Requirements for Providers

Many Uses of Documentation & Coding Data

- Establish medical necessity (based on chart documentation)
- Facilitate payment of health services
- Evaluate patients use of health care facilities (utilization patterns)
- Study health care cost
- Research the quality of health care delivery
- Forecast disease progressions and health care treatment trends
- Plan for future health care needs

Common Documentation Inadequacies

Some Common Documentation Problems

- Illegibility – the record needs to be legible to someone other than the writer
- Missing authentication by the person responsible for the medical record entry (please see below for references).
- Missing Chief Complaint/Reason For Visit
- Patient's name and identifying information not present
- Rule-out, versus, probable, possible, differential, suspected, working, etc. terms relating to the diagnosis (undeveloped as yet diagnosis: awaiting further study): in these instances, code the most specific signs/symptoms, exposure to, personal or family history of diagnosis that applies.

Quality or quantity of actual medical care delivered is not what Coders are looking for or able to capture from medical record documentation. Only the services and diagnoses documented can be reported for reimbursement.

*National Committee for Quality Assurance Guidelines for Medical Record Documentation, WAC 388-502-0020, CMS 2006 Risk Adjustment Data Basic Training for Medicare Advantage Organizations Participant Guide, and American Medical Association 1995 and 1997 Documentation Guidelines.

2009 Codes Effective Dates

- The 2009 ICD-9-CM codes are effective October 01, 2008.
- The 2009 CPT-4 and HCPCS codes are effective January 01, 2009.
- Providers, Facilities, and Suppliers need to update computer systems and internal resources and documents (coding books, encounter forms, etc).
- If claims are submitted for dates of service after the code set's effective date, payers will auto-deny them if the code has been revised or deleted.

Provider's Documentation Responsibilities

Acceptable documentation demonstrates the below-listed qualities. If these criteria aren't met, quality and continuity of care, patient safety, and/or proper, timely reimbursement may be jeopardized; and a documentation improvement opportunity exists.

- Clear
- Concise
- Consistent
- Complete
- Legible

Building a Bridge, and Using it (And How to Get Your Continuing Education Credits)

Documentation and Coding Ethical Responsibility

Guessing about which rules apply when pursuing improvement in documentation and coding accuracy is not necessary, and wastes time. CHP is here to help you build a foundation that you can use as a permanent, valuable career skill to assist you when questions about proper, ethical documentation and coding arise.

Questions, Comments, and CME/CEU Requests

- CHP has created a dedicated email address for our Network Providers and their Staff to send questions and comments that pertain to this training, and we encourage participants to utilize this feature by emailing us at providereducation@chpw.org. CHP encourages our Network to give us feedback about this educational webinar, so that it may be improved.
- At the end of this course, CHP will award CMEs (through AAFP) and CEUs (through AAPC and AHIMA). Send an email to providereducation@chpw.org with “Continuing Education Credit Request” in the subject line, and be sure to include the Attendee’s contact information. A brief self-assessment will be sent to those Attendees who have attended the webinar and request continuing education credit. After completion and return by email of the Self-Assessment, Community Health Plan will process and send the CME/CEU certificates.

Conclusion of Course 1

In summary, today we discussed:

- the current and possible future medical coding classification systems,
- the regulatory agencies that mandate accurate documentation and coding (i.e. CMS, OIG, and OCR).
- some of the resource materials utilized to assist in the understanding and improvement of documentation and coding (i.e. ICD-9-CM, CPT-4, and HCPCS manuals, WAC regulations, HIPAA, and NCQA).
- how quality documentation and coding benefits all parties involved in the healthcare arena: Patients, Providers, and the Plan.

Thank You for Participating

Community Health Plan would like to thank you for taking time out of your busy schedule to participate in today's Provider Education Course 1 Webinar: Coding in Healthcare: Introduction and Purpose.

Community Health Plan has arranged for documentation and coding resources to be made available to you by email for questions about the materials covered in this webinar series. We cannot address specific, individual claims processing queries. There are other resources available for reimbursement questions, and the usual route for claims questions should be used for them.

The Provider Education Team will be sending you the invitation and access information today for the next webinar in the series, scheduled for November 4, 2008 at noon. We are looking forward to it and it will reinforce the concepts and compliment the content of this course.