

**COMMUNITY HEALTH PLAN**  
of Washington

*Committed to your health.®*

## **Provider Education Webinars**

Course 9:

Coding Quality and Continuity Of Care

# Housekeeping Items

## **Technical Difficulties**

If you experience technical difficulties, please

- utilize the “Chat” feature of the GoToWebinar application to let us know what kind of problem you’re having
- exit the application and try re-establishing your internet and phone connections
- call 1-888-206-2266 and enter Conferee pin number that came with your invitation/registration (if you cannot establish a webinar connection, this number will allow you to follow along with the conference using your handout). If you have to fall back on this method, please email us at the below email address and let us know what kind of problem you’re having.

## **Webinar Questions**

For questions concerning the content of this webinar, CHP has a dedicated email address:

[Providereducation@chpw.org](mailto:Providereducation@chpw.org).

## **Questions about Specific Coding Scenarios**

If you have questions about particular documentation and coding questions (specific coding scenarios) please email it to us at [Providereducation@chpw.org](mailto:Providereducation@chpw.org).

## **Questions about Claims**

If you have questions about specific coding/claims processing issues, please use your usual route for claims queries (the webinar project isn’t set up to be the best forum to access claims information).

## **Continuing Education Credit**

At the end of each webinar, there are instructions detailing how to request Continuing Medical Education and/or Continuing Education Units, by using the dedicated email address that CHP has established for this activity: [Providereducation@chpw.org](mailto:Providereducation@chpw.org).

# Welcome

Welcome to this presentation of Community Health Plan's Provider Education Webinar, Course 9: Coding Quality and Continuity Of Care.

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\*\*\*

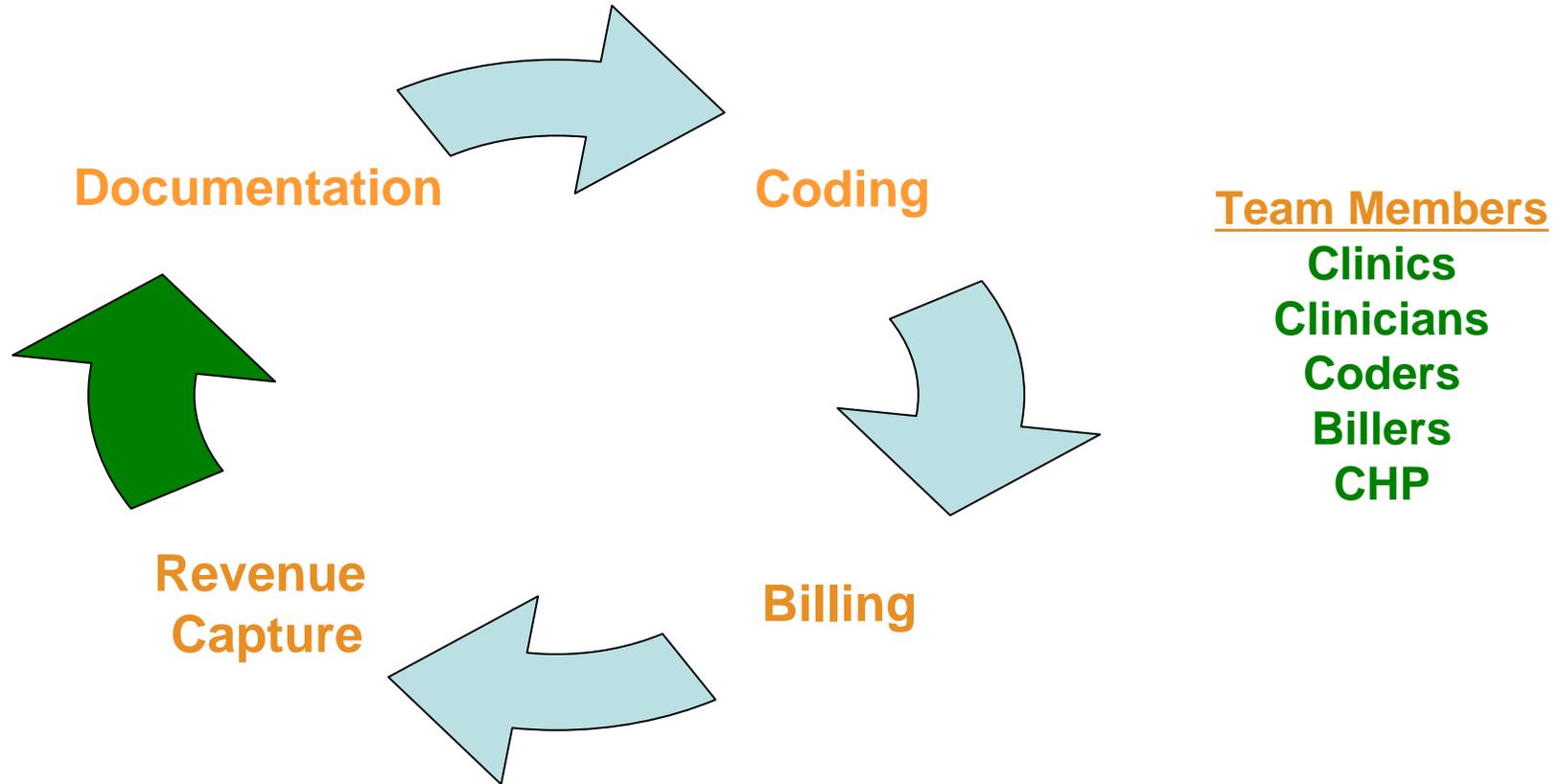
Courses and Self-Assessments must be completed to earn the CME/CEU credit.

\* American Academy of Family Physicians

\*\* American Academy of Professional Coders

\*\*\* American Health Information Management Association

# A Comprehensive Approach to Optimizing Documentation & Coding



## **Our Role – Clinical Components**

- Deliver timely comprehensive care....
- Document the care you deliver....
- Code the care you document....
- Capture the codes you document...

**Community Health Plan - Medicare Advantage**  
**Member HCC Report**



HEALTH CENTER - Clinic Name

Run Date: 10/27/2008

Patient Name: Doe, John  
 Address: 1234 Main Street, Anytown, US 98765  
 Phone: (555) 555-5555

Member ID: HP1000000000

**How To Use This Report**

Step 1: Please review the diagnoses (ICD9 codes) and conditions (Hierarchical Condition Categories (HCC Codes)) listed in Sections 1 and 2. If you believe that a diagnosis/condition listed here is not relevant to this patient, please circle the diagnosis/condition.

Step 2: After reviewing, please sign below and fax this form to our confidential fax: 206-652-7024, Attn: Member HCC Report.

Step 3: At your next visit with this patient, please check for the presence of these diagnoses/conditions and document each currently present diagnosis/condition accordingly in your visit note.

**Section 1 - Conditions (HCCs) Reported in Current Year**

(Reported diagnoses may come from multiple care settings, including primary care, specialty care and hospital providers. Only one HCC per patient is shown, with highest documented ICD9 code.)

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
250.00	Dmii Wo Cmp Nt St Uncntr	19	Diabetes without Complication	0.2

**Section 2 - Additional Conditions (HCCs) Reported in Prior Years**

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
291.81	Alcohol Withdrawal	51	Drug/Alcohol Psychosis	0.353
303.90	Alcoh Dep Nec/Nos-Unspec	52	Drug/Alcohol Dependence	0.265
780.39	Convulsions Nec	74	Seizure Disorders and Convulsions	0.269
428.0	Chf Nos	80	Congestive Heart Failure	0.417
		16	Diabetes with Neurologic or Other Specified Manifestation	0.552
		71	Polyneuropathy	0.268

*I have reviewed the diagnoses/conditions listed on this page, along with the medical history of this patient. With the exception of those codes that are circled, I attest that these diagnoses/conditions are present in this patient's medical history as available to me beginning \_\_\_\_\_ (mm/yyyy).*

\_\_\_\_\_  
 Printed Name & Credentials

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

# Community Health Plan of Washington Provider Education Webinar

## Course 9:

### Coding Quality and Continuity Of Care

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Cost Reimbursement and Research Analyst

Kate Parman, CPC, CCS, CCS-P, MCS-P  
Cost Recovery Analyst

# Learning Objectives

## Webinar Learning Objective:

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

## Course 9:

Coding Quality and Continuity Of Care

## Learning Objective:

To focus on proper documentation to optimize the quality of care and optimize use of ICD-9, CPT, & HCPCS codes.

## Participants' learning objectives for Course 9:

- Understand the relationship between record documentation and quality coding
- Learn how accurate documentation enhances Patient care and how inadequacies in documentation can jeopardize continuity of care
- Recognize how quality in documentation leads to proper coding, which in turn leads to proper reimbursement, avoiding underpayments and overpayments

# Documentation, Coding, and Billing and their role in preserving Continuity of Care

What is Continuity of Care?

Various types of healthcare Providers

In various settings where healthcare is delivered

Would easily and smoothly communicate with each other

And work as a team

To insure that the Patient's care journey

Is seamless.

# Follow-Up VS Status ICD-9 Code Example 1

Date of Service: 07/23/08

Reason for visit:

Follow up microdiscectomy.

History:

Patient returns today for follow up, and is doing very well. He states he has absolutely no pain in his leg whatsoever.

Orthopedic Physical Examination:

On examination the Patient has normal strength in the iliopsoas, quadriceps, EHL, dorsiflexors and Plantar flexors. The Patient ambulates without antalgia. Patient says he has a little stiffness first thing in the morning after getting up. SLR and bowstring signs are normal.

Plan:

We discussed the do's and don'ts, things that could happen in the future and I encouraged the Patient not to do any heavy lifting, bending, twisting or carrying for several months.

# Follow-Up VS Status ICD-9 Code Example 2

Date of Service: 07/23/08

## Reason for Visit and History:

Follow up microdiscectomy. I performed a L4 laminotomy on 04/21/08 for displacement of lumbar intervertebral disc without myelopathy. Patient returns today and is doing very well.

## Review of Systems:

Today is post-op day 93. He states he has absolutely no pain in his legs whatsoever.

## Orthopedic Physical Examination:

On examination the Patient has normal strength in the iliopsoas, quadriceps, EHL, dorsiflexors and Plantar flexors. The Patient ambulates without antalgia. Patient reports a little stiffness first thing in the morning after getting up. SLR and bowstring signs are normal.

## Impression and Plan:

We discussed the do's and don'ts, things that could happen in the future and I encouraged the Patient not to do any heavy lifting, bending, twisting, or carrying for several months. Follow up in 6 months or sooner if needed.

# Global Care Coding and Continuity of Care

Questions to ask when coding services rendered in a global surgical period:

- For the service being coded, does a global period apply?  
Some services have no global period, such as endoscopy.
- For the service being coded, how long is the global period?  
The number of days after the procedure that the global period lasts, usually 10, 30, 60, or 90 days.
- Is the service being coded related to the global-period service?  
If related, modifier 58 or 78 needs to be appended to the CPT code that applies to the related service.
- Is the service being coded unrelated to the global-period service?  
If unrelated, modifier 24 or 79 needs to be appended to the CPT code that applies to the unrelated service.
- Is the service being coded a complication of the global-period service?  
Services rendered in the global period for complications cannot be coded unless the Provider has documented that the condition is a complication of the previously performed global service.

# Common Documentation Inadequacies

The following elements need to be present on the medical\_record. This prevents compromising continuity of care and creating reimbursement 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
- Omitted Date of Service
- 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.

The quality of the actual medical care proposed or performed (quality of care) is not what Coders are looking for or able to capture from medical record documentation. Only the services and diagnoses documented can be captured and 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.

# Don't Report A Qualified Diagnosis

A qualified diagnosis is a working diagnosis that is not yet proven or established. This includes diagnoses that are stated as possible, rule-out, differential, versus, potential, maybe, probably, probable, etc.

Incentive for not reporting a qualified diagnoses resulted from the Missouri case of *Stafford v. Neurological Medicine Inc.*, 811 F.2d 470 (8<sup>th</sup> Cir.1987)

In this case, the diagnosis stated in the physician office chart was "rule out brain tumor." The claim submitted by the office listed the diagnosis code for "brain tumor," although test results proved that a brain tumor did not exist. The physician assured the Patient that although she had lung cancer, there was no metastasis to the brain. Sometime after the insurance company received the Provider's claim, it was inadvertently sent to the Patient. When the Patient received the claim, she was so devastated by the diagnosis that she committed suicide.

Her husband sued and was awarded \$200,000 on the basis of "negligent paperwork" because the physician's office was responsible for reporting a qualified diagnosis.

<http://cases.justia.com/us-court-of-appeals/F2/811/470/205958/>

# Patients' Access To Medical Documentation

Many Patients are now able to access their records through several online record databases, and the number of Patients that will be able to do so in the near future is increasing.

Google and Microsoft (and other companies) are piloting online health record databases for consumers of health care that will allow the Patient to approve the secure transfer of any number of records—from lab results to known allergies to other medical conditions and procedures—to the online system, allowing Patients to take their medical records to another doctor or have them available while traveling.

<http://www.google.com/intl/en-US/health/about/>

<http://www.healthvault.com/PERSONAL/INDEX.HTML>

# H1N1 & Avian Flu Virus: New ICD-9-CM Codes

Today, Providers are reporting H1N1 influenza (also known as “Swine Flu”) with ICD-9 Code 487

Effective October 1, 2009, two new codes have been added:

"Influenza due to identified avian influenza virus" will be reported with ICD-9 Code 488.0

“Influenza due to identified novel H1N1 influenza virus" will be reported with 488.1.

Please note the word “identified” in the code description.

# When to Report an Office Visit with a Procedure

## Examples

1. If a Patient comes in with a new complaint, and doesn't know what the problem is or what treatment (if any) should be pursued, and after evaluation and discussion, the Provider and Patient decide together to proceed with a particular procedure at that visit, the Provider should document, code, and bill for an Office Visit (E/M code) in addition to the Procedure. Be sure to add the Modifier 25 to the office visit code.

Example: Patient A comes in with a complaint of severe left sided knee pain - and is evaluated by Dr. M-who determines that an arthrocentesis is necessary, and can be done at this same visit. Proper coding would be for the office visit (99213-25), the arthrocentesis (20610), and the HCPCS supply code for the injectable (i.e. betamethasone). If an anesthetic supply is used (i.e. lidocaine) it is not reported separately (as anesthesia is included in the procedure code).

2. If the Patient comes in knowing they are going to have the procedure done - then code and bill only for the procedure. Why? At a previous encounter, the Provider already reported the visit making the decision to do the procedure, and the procedure scheduled for a later date. It is not appropriate to again bill for another E/M visit in addition to the procedure.

Example: Let's look at the same Patient from above, but lets say Dr. M decided to have the Patient take some NSAIDs and schedule the arthrocentesis at a later date, 4 days later. You would code and bill the E/M for the first office visit, when Dr. M prescribed the Patient NSAIDs. Then, when the Patient comes back 4 days later, you would bill only for the arthrocentesis (20610) and the injectable supply.

3. If the Patient comes in knowing they are going to have the procedure done but they also have a new complaint, you would bill for an office visit and the procedure in this scenario. Again, you must be sure to add a modifier 25 to the office visit.

Example: Patient A has come back to the office as instructed in scenario 2 (4 days later) and now in addition to her knee hurting she has also noticed some pain with urination. Through evaluation it's determined that Patient A has a UTI and she also has the arthrocentesis done. Code for the office visit (99213-25), for the UTI, and the arthrocentesis (20610) for the knee, and the HCPCS supply for the injectable (usually a J-code).

# Another Type of Continuity of Care Problem

Continuity of Care problems come from all sources, not merely from coding errors. Here is an example of an electronic medical record (EMR) issue causing a Continuity of Care problem:

- AIDS Patient admitted to hospital with shortness of breath
- Diagnosed with *Pneumocystis jiroveci* pneumonia (PCP)
- Started on appropriate antibiotic therapy
- Patient also had multiple flat purple skin lesions on the left thigh and several perianal lesions
- The medical team wanted to rule out Kaposi's sarcoma and human papillomavirus (HPV) infection
- Biopsies of both lesions were taken
- Patient was slowly improving
- Three days later, Patient's primary Doctor (not directly caring for the Patient in the hospital) visited Patient
- noted the PCP diagnosis in the record before seeing the Patient
- Also noted three biopsy results showing three separate cancers
- The primary care Doctor met with the Patient and recommended that the Patient begin hospice care
- He told the Patient that with "cancer in three places" the overall prognosis was poor
- Later, the hospital medical team found the errors
- The biopsy results belonged to a different Patient
- But were entered into this Patient's medical record in error
- The Team and the primary care Doctor met with the Patient and disclosed the mistake
- But clearly the error had caused the Patient tremendous pain, mental trauma, and anguish

What happened: the software program used to track and report biopsy results electronically "dumped" the results into the hospital's EMR. But the department Physicians and Staff didn't have access to the hospital's EMR. In fact, when called and asked if they had seen the error in X (the name of the EMR), the Pathologist responded, "What is X?"

Eventually, it was found that all of the incorrect biopsy results were entered into the pathology software under the wrong Patient identifier and then uploaded into the hospital's EMR.

# Signs That Your Clinic May Have A Problem

- Claims denials due to non-specific ICD-9 codes
- Claims denials due to lack of medical necessity
- Delays in posting services
- Report from billing staff of diagnosis code errors
- Deleted diagnosis codes still on encounter forms/superbill
- Multiple requests for supporting documentation from payers
- “Coders” ICD-9-CM, CPT, and HCPCS knowledge does not extend beyond the cheat sheet you gave them 3 years ago
- Computer’s coding software or database not updated yearly
- Using outdated coding books

# Building a Bridge, and Using it

## Ethical Responsibility

Guessing about where to find rules that apply to documentation and coding questions is not necessary, is unethical, and wastes your valuable time and energy.

CHP is here to help you build a foundation for understanding this valuable career skill, and to assist you with official references when questions about proper documentation and coding arise.

## Feedback about the Webinar

Community Health Plan chose this enterprise-wide, long-term approach of online training to serve our Providers, achieve our training objectives, and optimize the delivery of this information (which ultimately benefits the Patients, the Providers, and the Plan).

To that end, CHP has created a dedicated email address for our Providers and their Staff to send questions and comments about this training: please email us at: [Providereducation@chpw.org](mailto:Providereducation@chpw.org). CHP encourages our Providers to give us feedback about this educational webinar, so that it may be continuously improved.

# Continuing Education Credit Requirements

CHP has arranged to award CMEs (through AAFP) and CEUs (through AAPC and AHIMA) for Participants who:

- attend this webinar
- are counted as present
- complete a brief Self-Assessment and Quality Survey at the end of the webinar
- request the continuing, education credit in the manner described in the steps in the next slide.

# Obtaining Continuing Education Credits

1. Send an email to [Providereducation@chpw.org](mailto:Providereducation@chpw.org) with “Continuing Education Credit Request” in the subject line.
2. Be sure to let us know which organization/s you’re requesting continuing education credit from, and
3. Include your contact information in the body of the email.
4. A *brief* Self-Assessment will be emailed to requesters. The brief Self-Assessment is evidence of learning objectives met (and is a requirement of the continuing education granting organizations), and
5. Upon completion of your Self-Assessment, email it back to CHP at the above email address.
6. CHP will process and send the continuing education certificates to the Participants at the contact information provided in Step 3 (above).
7. As always, it’s the responsibility of the Participant to submit and/or make available proof of continuing education credit earned (CME/CEU certificates) to the AAFP, AAPC, and AHIMA on demand. CHP doesn’t submit certificates to these organizations on behalf of webinar Attendees.

Additional Resources: much of the information in the Webinar is available in a more comprehensive form at CMS’s website: <http://www.cms.hhs.gov/MLNGenInfo/> and click on the Web-Based Training Modules. There are additional CMS web-based training courses there as well.

# 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.

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.

Send an email to [Providereducation@chpw.org](mailto:Providereducation@chpw.org) with "Continuing Education Credit Request" in the subject line.

We cannot address specific, individual claims processing queries. There are other resources available for specific claim reimbursement questions, and the usual route for claims questions should be used for them.

The Provider Education Team is looking forward to delivering the next course in this webinar series, and it will reinforce the concepts and complement the content of this course.