HOW PROFESSIONAL CODING ENGAGES WITH BETH ISRAEL LAHEY HEALTH (BILH) PROVIDERS

PROFESSIONAL CODING & EDUCATION

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Agenda

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- Professional coding department mission
- Documentation requirements for evaluation and management services (E/M)
- Shared/Split Visit

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Professional Coding Department Mission

Professional Coding Department Mission

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- To provide quality professional coding services in the most compliant and timely manner for all areas of professional services at BILH Health
- To maintain a continuous coding program with dedicated coders committed to quality and compliance while assisting in the capture of the maximum revenue and optimizing technology
- To continually educate ourselves, providers, and other colleagues as necessary on coding guidelines and regulations
- To continually improve clinical documentation to prevent denials and capture the resources utilized for patient care and severity of illness

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Documentation Requirement for Coding/Billing

Documentation Requirement for Coding/Billing

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- Documentation must be created for every patient encounter
- This documentation must clearly depict the level of disease severity, comorbidities, underlying disease and other factors that contribute to the level of complexity for the patient encounter
- Diagnostic coding determines the level of risk in selecting the procedure (CPT Code) for the patient encounter
- **For Example:**
- **Moderate risk is equivalent to**
  - **one or more chronic illness with mild exacerbation or side effects of treatment.**
  - **Two or more stable chronic illness**

Documentation Requirement for Coding/Billing

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- **High risk is equivalent to**
  - One or more chronic illness with severe exacerbation, progression or side effects of treatment
  - One acute or chronic illness or injury that posses a threat to life or bodily function
- **Low risk is equivalent:**
  - Two or more self –limited or minor problems
  - One stable chronic illness
  - One acute, uncomplicated illness or injury
  - One stable acute illness
  - One acute uncomplicated illness or injury requiring hospital inpatient or observation level of care

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Hcc Hierarchical Condition Categories

What is HCC?

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- The center for Medicare and Medicaid Services (CMS) created the Hierarchical Condition Categories (HCCs) risk adjustment model for Medicare Advantage managed care plans
- Every patient enrolled with the health plan is assigned a risk score which rises if they have a condition(s) or disease(s) included in risk adjusted HCC
- Diagnosis coding and demographic information are the basis on which risk is determined
- **Examples of diagnosis with a risk score**
  - **Diabetes, end stage renal disease, congestive heart failure, chronic obstructive pulmonary disease, malignant neoplasm and some acute conditions**
- Payments made are adjusted upwards for high risk patients i.e. patients with higher than average expected healthcare expenditure

Documentation Requirement

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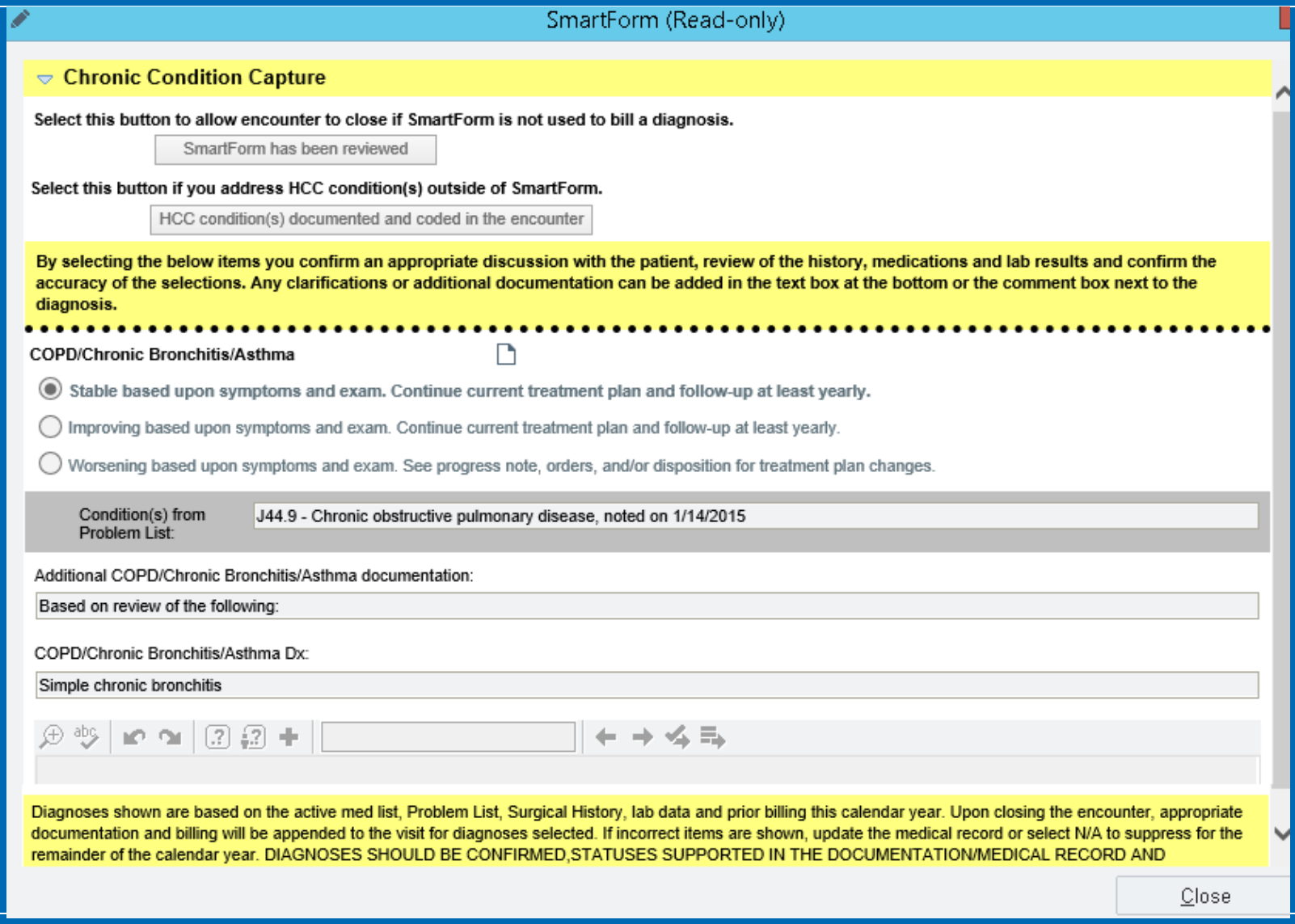
- Specificity in diagnosis documentation is critical for risk adjustment because ICD-10-CM diagnosis codes are used to establish accurate risk score for patients
- Documentation must accurately reflect:
  - **Document the diagnosis to the highest level of specificity**
  - **Document all diagnosis that are part of the medical decision making**
  - **Status of each chronic condition**
  - **Comorbid conditions as secondary diagnosis as they impact risk adjustment**
- As a provider, you will use the smart form to capture these HCC conditions and close the patient's gap
- The risk score ties to the budget that and subsequently impacts overall performance with value-based contracts with payers


SmartForm (Read-only)
Chronic Condition Capture
Select this button to allow encounter to close if SmartForm is not used to bill a diagnosis.
SmartForm has been reviewed
Select this button if you address HCC condition(s) outside of SmartForm.
HCC condition(s) documented and coded in the encounter
By selecting the below items you confirm an appropriate discussion with the patient, review of the history, medications and lab results and confirm the accuracy of the selections. Any clarifications or additional documentation can be added in the text box at the bottom or the comment box next to the diagnosis.
COPD/Chronic Bronchitis/Asthma
Stable based upon symptoms and exam. Continue current treatment plan and follow-up at least yearly.
Improving based upon symptoms and exam. Continue current treatment plan and follow-up at least yearly.
Worsening based upon symptoms and exam. See progress note, orders, and/or disposition for treatment plan changes.
Condition(s) from Problem List:
J44.9 - Chronic obstructive pulmonary disease, noted on 1/14/2015
Additional COPD/Chronic Bronchitis/Asthma documentation:
Based on review of the following:
COPD/Chronic Bronchitis/Asthma Dx:
Simple chronic bronchitis
Diagnoses shown are based on the active med list, Problem List, Surgical History, lab data and prior billing this calendar year. Upon closing the encounter, appropriate documentation and billing will be appended to the visit for diagnoses selected. If incorrect items are shown, update the medical record or select N/A to suppress for the remainder of the calendar year. DIAGNOSES SHOULD BE CONFIRMED,STATUSES SUPPORTED IN THE DOCUMENTATION/MEDICAL RECORD AND
Close

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New Versus Established Patient

New Versus Established Patient

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- A new patient is defined as one who has not been seen by the provider or another provider of same group/specialty or an NP/PA within the past 3 years

➢ **Example:**

➢ All existing patients that has been seen within the specialty by any provider within the past 3 years will be coded as an **"established"** patient.

➢ If a patient presents to the office and has never been seen by anyone in the specialty within the past 3 years it will be coded as a new patient

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Evaluation & Management Services (E/M)

E/M Services

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- Documentation of all evaluation and management services is be based on either

  1. Medical decision making

  - **Or**

  2. Time

- The provider's documentation of history and physical examination elements will not be factored in when selecting the level of E/M
- The provider is still required to document medical appropriate history and exam for the continuity of care of the patient.

- ***NOTE: Time is not a description component for the emergency room evaluation and management***

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Medical Decision Making (MDM)

What determines medical decision making (MDM)?

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- The level of the Medical Decision Making (MDM)is determined by 3 elements
- **1. The number and complexity of problem(s) that are addressed during the encounter.**
- **2. The amount and/or complexity of data to be reviewed and analyzed.**
- **3. The risk of complications and/or morbidity or mortality of patient management .**
- Note: The provider is still required to document only the medically appropriate history and examination

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MDM Table

LEVEL OF MEDICAL DECISION MAKING (MDM)

Straightforward and Low MDM

	Elements of Medical Decision Making		
Level of MDM (Based on 2 out of 3 Elements of MDM)	**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**
Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable **chronic** illness; or • 1 acute, uncomplicated illness or injury **or** • **1** stable **acute** illness; **or** • **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**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** *Examples only:* • Over the counter medication • Minor procedure • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy

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LEVEL OF MEDICAL DECISION MAKING (MDM)

Moderate MDM

	Elements of Medical Decision Making		
Level of MDM (Based on 2 out of 3 Elements of MDM)	**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**
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

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LEVEL OF MEDICAL DECISION MAKING (MDM)

High MDM

	Elements of Medical Decision Making		
Level of MDM (Based on 2 out of 3 Elements of MDM)	**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**
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 or escalation of hospital level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

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Documentation Based on Time for Evaluation and Management Services

Documentation Based on Time

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- Documentation of the total time spent on the visit includes:

- **Time spent reviewing charts, previous test, films, etc.**
- **Counseling and educating the patient, family members, caregivers, etc.**
- **Interpreting results**
- **Communication with other providers**
- **Ordering of tests or procedures**
- **All pre, intra and post service time**
- **Note:**
- **The clinical staff time is not included on this time**

Prolonged service based on time

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- For prolonged evaluation and management services on the date of an inpatient or outpatient clinic visit should be coded using below codes
- 99418 - **Prolonged inpatient or observation evaluation and management** service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (**List separately in addition to codes 99223, 99233, 99555 for inpatient evaluation and consultation)**
- 99417- **Prolonged office or other outpatient evaluation and management** service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time **(List separately in addition to codes 99205, 99215, 99245 for outpatient evaluation and consultation**

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E/M Codes Table with Time

E/M MDM Table: Inpatient (Initial and Subsequent)

Inpatient/Observation: Initial admission				
E/M Code	**History**	**Exam**	**MDM**	**Time**
99221	Appropriate Medical history and/or Physical exam		Straightforward or Low	40 minutes
99222			Moderate	55 minutes
99223			High	75 minutes
Prolonged (99223+99418)				90 minutes

Inpatient/Observation: Subsequent visit				
E/M Code	**History**	**Exam**	**MDM**	**Time**
99231	Appropriate Medical history and/or Physical exam		Straightforward or Low	25 minutes
99232			Moderate	35 minutes
99233			High	50 minutes
Prolonged (99233+99418)				65 minutes

E/M MDM Table: Inpatient Consultation

Consultation: Inpatient				
E/M Code	**History**	**Exam**	**MDM**	**Time**
99252	Appropriate Medical history and/or Physical exam		Straightforward	35 minutes
99253			Low	45 minutes
99254			Moderate	60 minutes
99255			High	80 minutes
Prolonged (99255+99418)				95 minutes

E/M MDM Table: Outpatient (Consult and Office visit)

Consultation: Outpatient				
E/M Code	**History**	**Exam**	**MDM**	**Time**
99242	Appropriate Medical history and/or Physical exam		Straightforward	20 minutes
99243			Low	30 minutes
99244			Moderate	40 minutes
99245			High	55 minutes
Prolonged (99245+99417)				70 minutes

E/M: Outpatient - New				
E/M Code	**History**	**Exam**	**MDM**	**Time**
99202	Appropriate Medical history and/or Physical exam		Straightforward	15-29 minutes
99203			Low	30-44 minutes
99204			Moderate	45-59 minutes
99205			High	60-74 minutes
Prolonged (99205+99417)				89 minutes

E/M: Outpatient - Established				
E/M Code	**History**	**Exam**	**MDM**	**Time**
99212	Appropriate Medical history and/or Physical exam		Straightforward	10-19 minutes
99213			Low	20-29 minutes
99214			Moderate	30-39 minutes
99215			High	40-54 minutes
Prolonged (99215+99417)				69 minutes

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Shared/ Split Visit

Shared Visit

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- A split/shared visit E/M is an E/M visit provided in the facility setting by a physician and an NPP in the same group
- The visit is billed by the physician or practitioner who provides the substantive portion of the visit
- The substantive portion of the visit is defined as more than half of the total time spent
- A **face-to-face encounter is not required by the billing provider**
- Note:

➢ **Split/shared visit can only be billed in any facility setting, including the emergency department and skilled nursing facilities**

➢ **Each provider must document the portion of the service that they performed.**

➢ **Two separate notes that uniquely state what each provider did.**

AP Shared Visit Code (AP, Outpatient)

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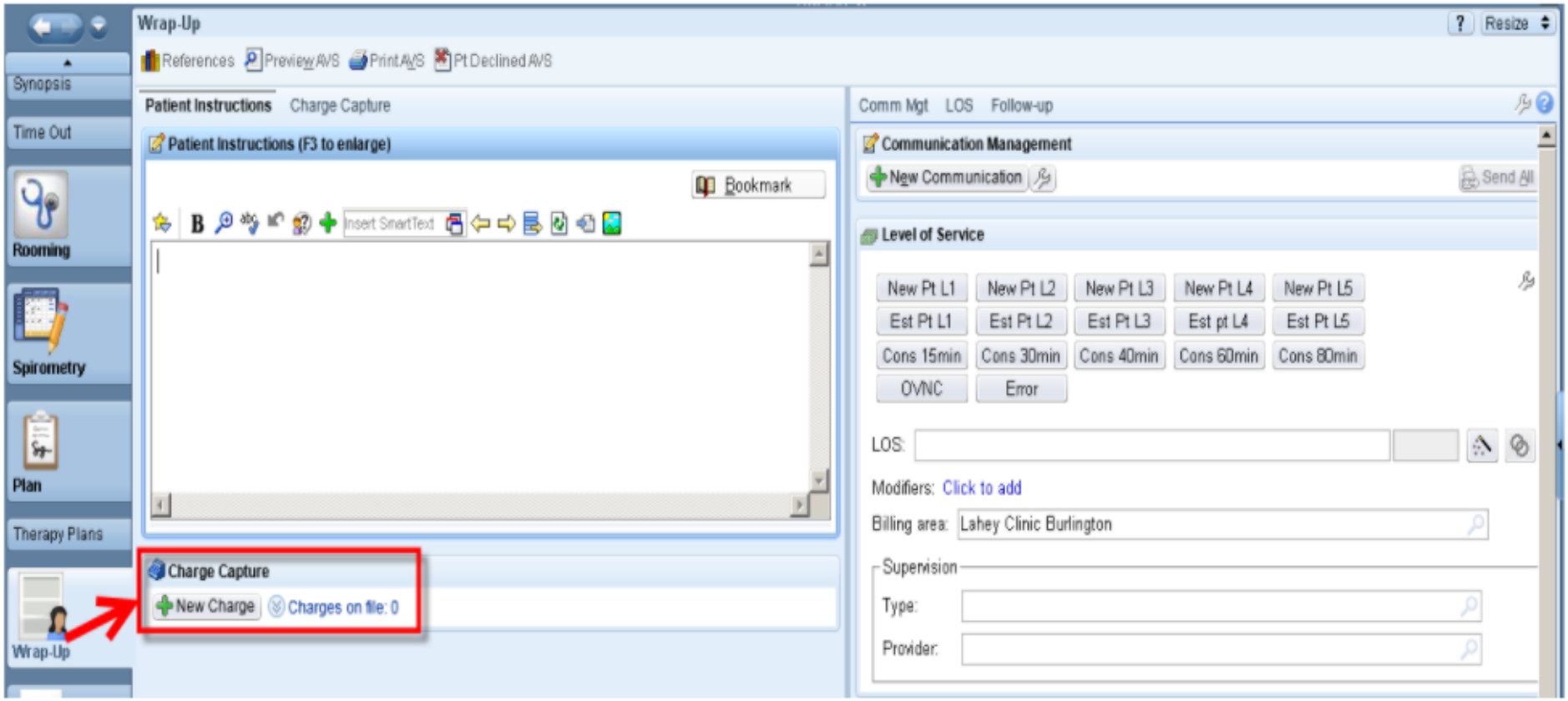

More on AP selecting shared visit code

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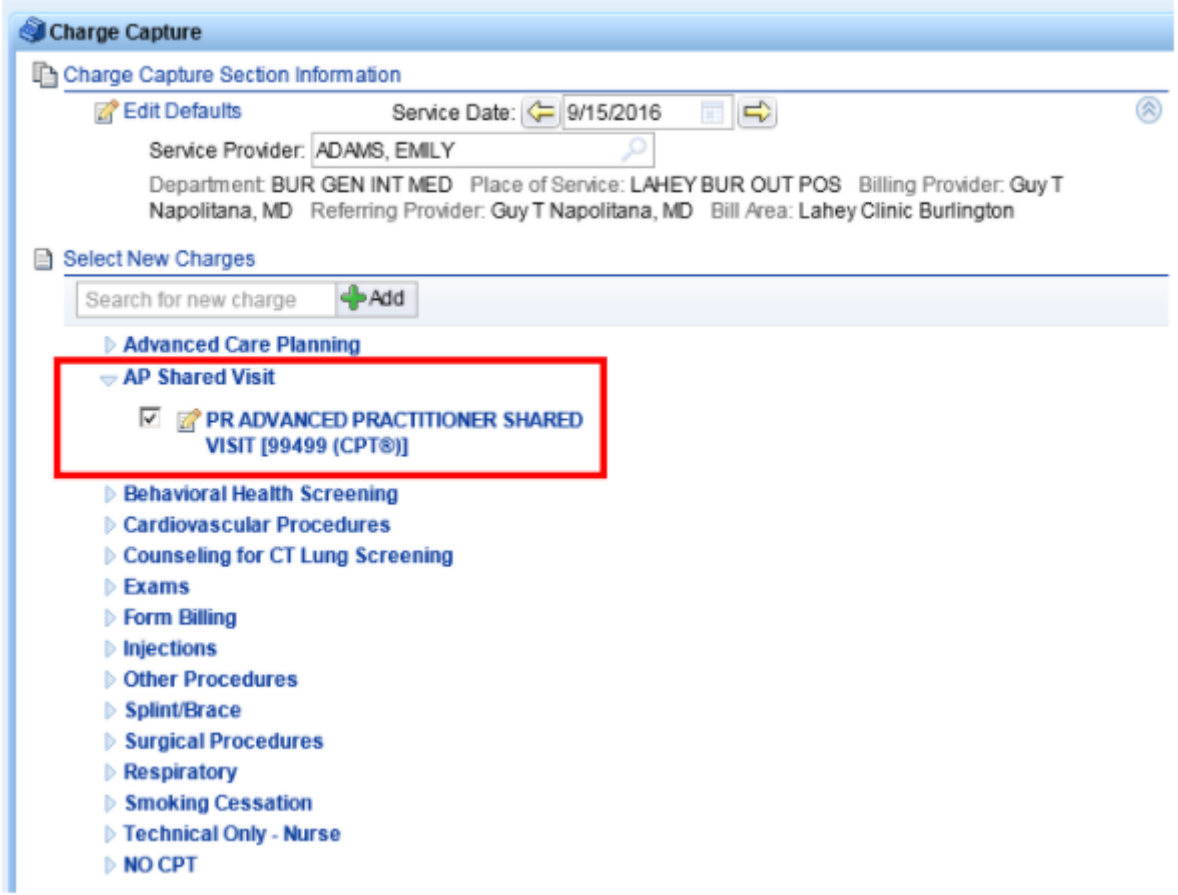

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Independent Billing By An AP

Ambulatory AP Charge Submission Workflow

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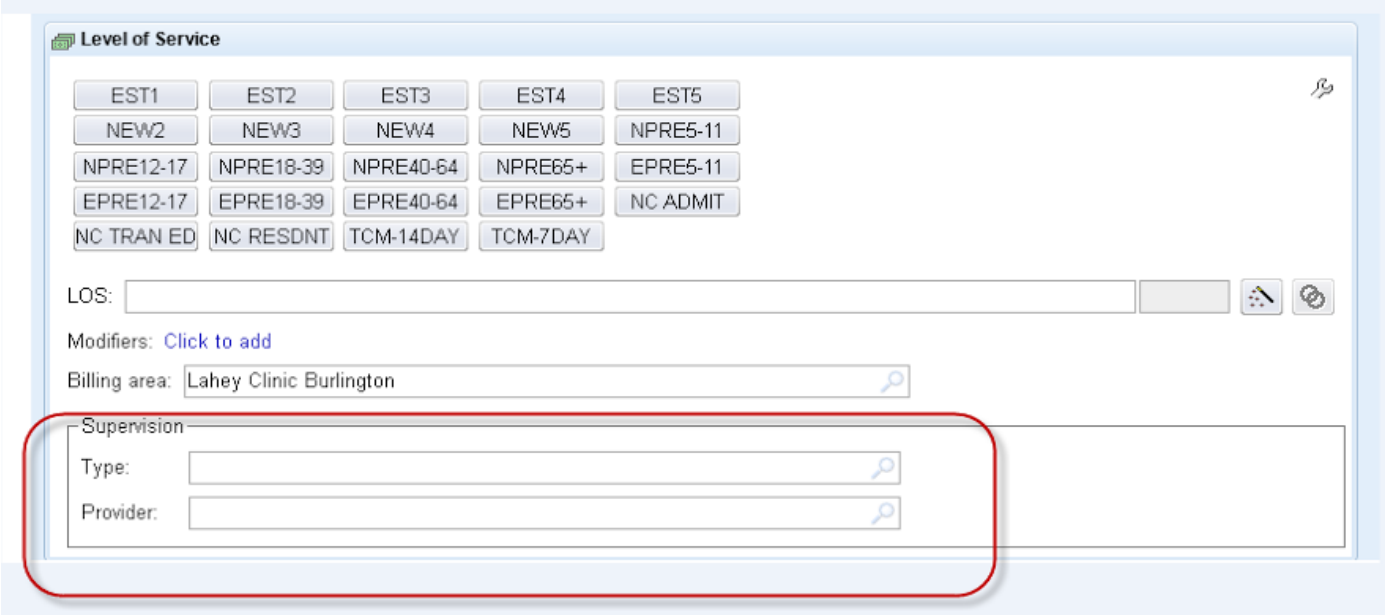
- For **ALL** outpatient visits where the Advanced Practitioner (AP) is seeing and billing for the patient visit independently (AP = encounter provider), the "Supervision" section must be COMPLETED
- It should be filled out as **"INDIRECT SUPERVISION"** with the supervising physician for that particular patient (i.e. physician identified by division-specific established process, such as Doctor of the Day) named directly



Inpatient Independent AP Billing

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- AP creates/writes note and signs it
- AP is taken to charge screen automatically **EVEN IF CO-SIGN BUTTON IS CHECKED**
- AP submits charge and writes supervising physician name in **COMMENT** section
- AP clicks on “accept” and makes sure charges are “filed”
- **NOTE:**
- There are a few Epic note types that do not automatically take the provider to the charge screen upon signing; the AP must go to the charge “tab” on the left and complete the charge process

Area to write the supervising physician name

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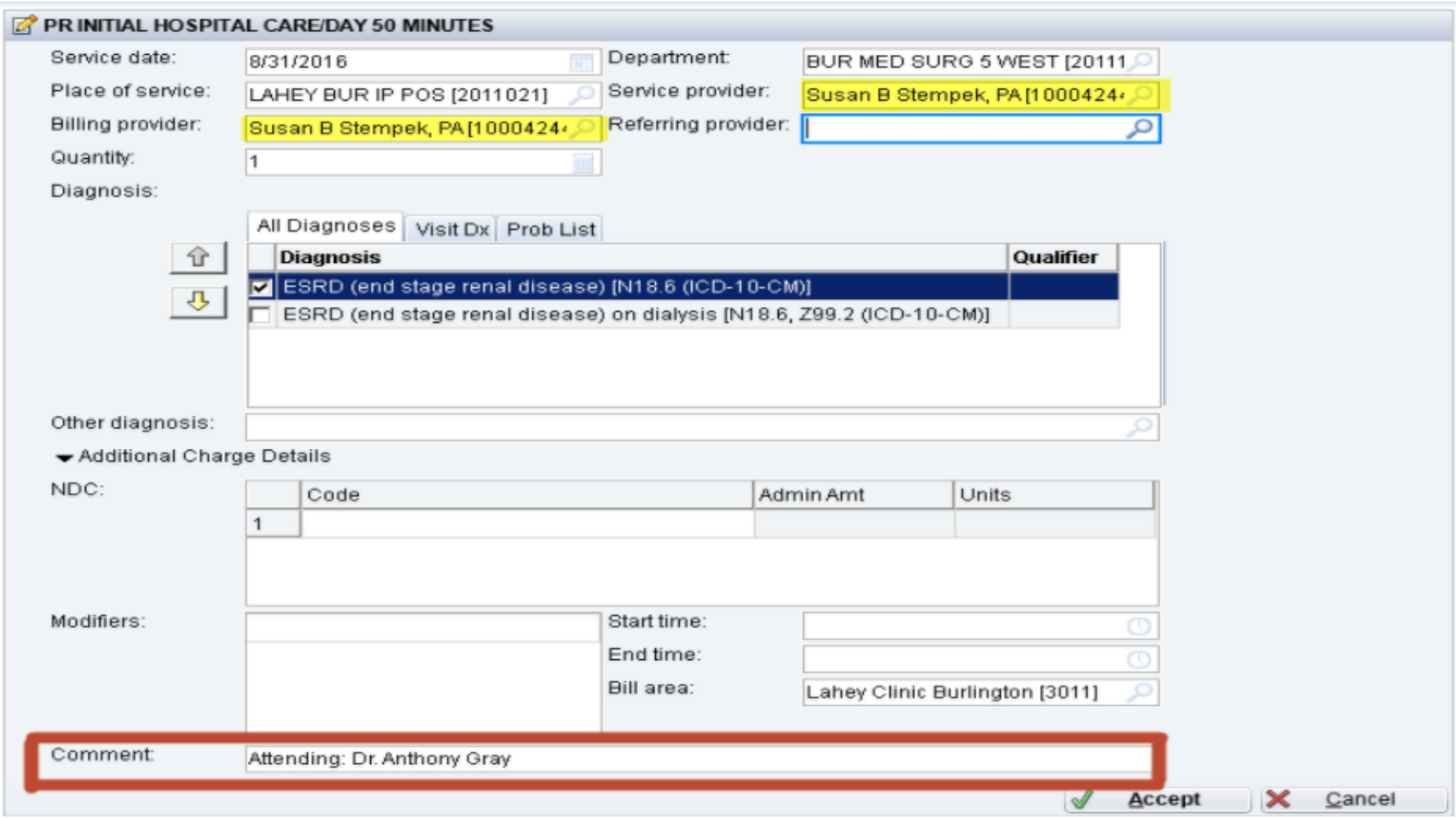

Things to Remember

Documentation requirement

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- Document either based on Medical decision making (MDM) or time
- For MDM, refer to the MDM table
- For time it is pre, intra and post service time
- For HCC coding use the smarform
- Document all diagnosis that is impacting the patient care
- On MassNet (Lahey intranet) under Helpful Links use **“ Ask the Coder**” link to send any coding questions

Questions?

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- **Oby Egbunike CCS-P, COC, CPC, CRC, CPC-I**
- **Director Professional Coding and Education**
- **obiageli.c.egbunike@lahey.org**

- **On MassNet under Helpful Links “Ask the Coder”**