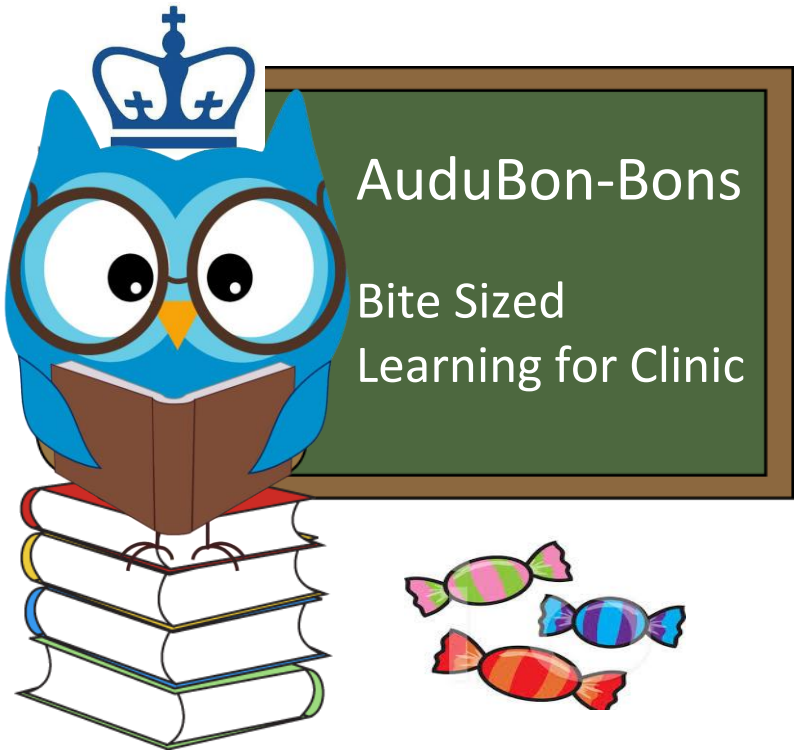
CODING AND BILLING



Week 65

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Reading Assignment:

Download **Diagnostic coding in Obstetrics and Gynecology** for your reference. https://www.acog.org/-/media/Departments/Coding/Diagnostic-Coding-Booklet-with-COVER-No-printer-marks.pdf?dmc=1&ts=20161013T1855087938

LEARNING OBJECTIVES

- To understand the basics of diagnosis coding
- To understand the importance of complete documentation in coding and billing

CODING BASICS – CPT CODES

CPT: Current Procedural Terminology

- Describe medical, surgical, diagnostic and other types of services
- Owned and maintained by AMA
- Numeric and alpha-numeric codes consisting of 5 characters
- Each code begins with a numeric character

CODING BASICS – CPT CODES

TABLE Requirements for each level of office service

- New patient outpatient encounter
- 3 of 3 elements required
- Lowest documented element determines the level of service

Code	History	Exam	Medical decision-making complexity	Typical time reported when counseling time dominates the encounter
99201	PF	PF	Straightforward	10
99202	EPF	EPF	Straightforward	20
99203	D	D	Low	30
99204	C	C	Moderate	45
99205	C	C	High	60

- Established outpatient visit
- 2 of 3 elements required; medical decision-making must be one of them
- Lowest level of these 2 determines level of service

99211	Minimal problem that may not require presence of clinician			5
99212	PF	PF	Straightforward	10
99213	EPF	EPF	Low	15
99214	D	D	Moderate	25
99215	C	C	High	40

Abbreviations: C, comprehensive; D, detailed; EPF, expanded problem focused; PF, problem focused.

CODING BASICS – ICD-10 CODES

ICD: International Classification of Diseases, 10: 10th revision

- A set of codes to report the REASON(S) for patient encounters and certain patient characteristics
- Used to convey to health insurance companies the reason for the encounter
- Maintained by an interdepartmental committee of representatives from:
  - Centers for Medicare and Medicaid Services (CMS)
  - Center for Disease Control and Prevention (CDC)
- Alpha-numeric codes of 3 – 7 characters
- Each code begins with an alpha character
- Example:
  - N76.0 Acute vaginitis
  - N95.0 Postmenopausal bleeding

CODING BASICS

- Accurate and appropriate coding for services you provide is central in the practice of medicine
  - Payment purposes
  - Documentation purposes

CODING BASICS

- Guidelines
  - Code to the highest degree of specificity
  - Code to the highest degree of certainty
  - Sequence the diagnoses
  - Code only diagnoses relevant for the clinical encounter
- Medical Necessity
  - In order to be reimbursed by an insurer, a service must be:
    - A covered benefit
    - Medically necessary
    - Supported by documentation

CLINICAL VIGNETTE #1

- Focused history
  - A 23 y.o. G0P0, LMP 3 months ago, known to your practice, presents to GYN clinic c/o LLQ abdominal pain x 6 months. She describes the pain a dull and achy in nature. She reports a h/o regular menses in the past. She is sexually active with one partner and uses condoms inconsistently for BCM. She has no significant PMHx, PSHx or FamHx.
- Exam
  - Abd: nondistended, soft, LLQ tenderness to deep palpation, no rebound tenderness or guarding, no palpable masses
  - Pelvic: NEFG, normal vagina and cervix, physiologic d/c, no CMT, uterus small, AV and nontender, + left adnexal tenderness however no masses, no right adnexal masses or tenderness
  - Bedside urine pregnancy test negative

CLINICAL VIGNETTE #1

- Assessment and Plan
  - Given patient history and clinical findings suspect left ovarian cyst vs STI
  - Order STI testing
  - Order transvaginal ultrasound to rule out ovarian cyst
  - Patient counseled on pain relief
  - Scheduled follow-up visit in 1 week

- Coding and billing
  - **How do we code and bill for this encounter?**

CLINICAL VIGNETTE #1

- ICD-10 code
  - **R10.32** Pain localized to other parts of lower abdomen, left lower quadrant pain
  - **R 10.814** Left lower quadrant abdominal tenderness
  - **N92.5** Other irregular menstruation
  - **Z11.3** Encounter for screening examination for sexually transmitted disease
- CPT code
  - **99213** Office or other outpatient visit for the evaluation and management of an **established** patient, which requires at **least 2 of these 3 key components**: An **expanded problem focused history**; An **expanded problem focused examination**; **Medical decision making of low complexity**. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, **15 minutes** are spent **face-to-face** with the patient and/or family.

CLINICAL VIGNETTE #2

- Focused history
  - A 28 y.o. G1P0010, new to your practice, presents for annual well woman exam and for preconception counseling. She has a recent h/o first trimester spontaneous abortion treated with D&C. She has no other significant PMHx or PSHx. She has never had an abnormal pap smear and has never received the Gardasil vaccination. Her mother and father both have T2DM.
- Exam
  - Vitals: BP 135/72, 178lbs, 5'4", BMI 31
  - HEENT: No adenopathy, normal thyroid
  - Breast: Symmetric, non-tender, no masses, no skin changes, no nipple changes or discharge, no LN
  - Abd: Obese, non-distended, soft, nontender
  - Pelvic:
    - Vulva: NEFG, no lesions
    - Vagina: Pink, healthy mucosa, no discharge
    - Cervix: Parous os, no lesions, no discharge, no CMT
    - Uterus: Small, AV, non-tender
    - Adnexa: No masses, non-tender

CLINICAL VIGNETTE #2

- Assessment and Plan
  - Normal pelvic and breast exams. Will obtain pap smear.
  - Preconception counseling completed.
  - Counseling regarding R/B/A of Gardasil vaccination series completed.

- Coding and billing
  - **How do we code and bill for this encounter?**

CLINICAL VIGNETTE #2

- ICD-10 code
  - **Z01.419** Encounter for gynecological examination (general) (routine) without abnormal findings
  - **Z31.69** General counseling and advice for procreative management
  - **Z71.89** Counseling for HPV vaccination
  - **Z87.59** Personal history of other complications of pregnancy, childbirth and the puerperium
  - **Z68.31** Body mass index 31.0-31.9
  - **Z83.3** Family history of diabetes mellitus
- CPT code
  - **99203** Office or other outpatient visit for the evaluation and management of a **new** patient, which **requires these 3 key components**: A **detailed history**; A **detailed examination**; **Medical decision making of low complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typic **30 minutes** are spent **face-to-face** with the patient and/or family.

CLINICAL VIGNETTE #3

- Focused history
  - A 37 y.o. G2P1001 @ 33w1d presents to your office for routine prenatal care. Her pregnancy is significant for h/o previous cesarean delivery, AMA and GDMA1. She has no complaints today and denies ctx, VB, LOF. + FM. You use todays visit to review FSG log and provide mode of delivery counseling.
- Exam
  - Vitals: BP 124/72, 152lbs, 5'6", BMI 24.5
  - Abd: Gravid, well healed pfannenstiel incision, soft, nontender, FH 33cm
  - FH: 150bpm

CLINICAL VIGNETTE #3

- Assessment and Plan
  - Reassuring fetal assessment
  - Well controlled GDMA1
  - Mode of delivery counseling

- Coding and billing
  - **How do we code and bill for this encounter?**

CLINICAL VIGNETTE #3

- ICD-10 code
  - **O09.523** Supervision of elderly multigravida, third trimester
  - **O34.21** Maternal care for scar from previous cesarean delivery
  - **O24.430** Gestational diabetes mellitus in the puerperium, diet controlled
  - **Z3A.33** 33 weeks gestation of pregnancy
- CPT code
  - **99213** Office or other outpatient visit for the evaluation and management of an **established** patient, which requires at **least 2 of these 3 key components**: An **expanded problem focused history**; An **expanded problem focused examination**; **Medical decision making of low complexity**. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the present problem(s) are of low to moderate severity. Typically, **15 minutes** are spent **face-to-face** with the patient and/or family.

USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

What are Z codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, and age.

Step 1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

Step 2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

Step 3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.[1]

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented in an individual's health care record by any member of the care team.[2]

Step 4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- **Identify individuals'** social risk factors and unmet needs.
- **Inform health care** and services, follow-up, and discharge planning.
- **Trigger referrals** to social services that meet individuals' needs.
- **Track referrals** between providers and social service organizations.

Step 5 Report SDOH Z Code Data Findings

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A **Disparities Impact Statement** can be used to identify opportunities for advancing health equity.

CMS

For Questions: Contact the **CMS Health Equity Technical Assistance Program**

[1] cms.gov/medicare/icd-10/2021-icd-10-cm
[2] aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

SDOH

USING SDOH Z CODES

Can Enhance Your Quality Improvement Initiatives

Health Care Administrators

Understand how SDOH data can be gathered and tracked using Z codes.

- Select an SDOH screening tool.
- Identify workflows that minimize staff burden.
- Provide training to support data collection.
- Invest in EHRs that facilitate data collection and coding.
- Decide what Z code data to use and monitor.

Develop a plan to use SDOH Z code data to:

- Enhance patient care.
- Improve care coordination and referrals.
- Support quality measurement.
- Identify community/population needs.
- Support planning and implementation of social needs interventions.
- Monitor SDOH intervention effectiveness.

Health Care Team

Use a SDOH screening tool.

- Follow best practices for collecting SDOH data in a sensitive and HIPAA-compliant manner.
- Consistently document standardized SDOH data in the EHR.
- Refer individuals to social service organizations and appropriate support services through local, state, and national resources.

Coding Professionals

Follow the ICD-10-CM coding guidelines.[3]

- Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for ICD-10-CM codes and information on code usage.[4]
- Coding team managers should review codes for consistency and quality.
- Assign all relevant SDOH Z codes to support quality improvement initiatives.

Z code Categories

- **Z55** – Problems related to education and literacy
- **Z56** – Problems related to employment and unemployment
- **Z57** – Occupational exposure to risk factors
- **Z59** – Problems related to housing and economic circumstances
- **Z60** – Problems related to social environment
- **Z62** – Problems related to upbringing
- **Z63** – Other problems related to primary support group, including family circumstances
- **Z64** – Problems related to certain psychosocial circumstances
- **Z65** – Problems related to other psychosocial circumstances

This list is subject to revisions and additions to improve alignment with SDOH data elements.

[3] cms.gov/medicare/icd-10/2021-icd-10-cm
[4] cdc.gov/nchs/icd/icd10cm.htm

Revision Date: February 2021

go.cms.gov/omh

SDOH

EPIC .PHRASE

.BBonCodingandBilling

Description: Billing and Time Statement

Time: I spent *** minutes preparing to see patient (including chart review and preparation), obtaining and or reviewing medical history, performing a physical exam and evaluation, documenting clinical information in the electronic medical record, independently interpreting results, communicating results to family or caregiver, and/or coordinating care.

EVIDENCE

- References

  - Coding and reimbursement 101: How to maximize your payments. OBG Manag. 2018 December;30(12):22, 24-25, 40.
  - Coding basics – physician payment. https://www.aafp.org/practice-management/payment/coding/coding-basics.html (Accessed on June 7, 2019).
  - Diagnostic coding in Obstetrics and Gynecology. https://www.acog.org/-/media/Departments/Coding/Diagnostic-Coding-Booklet-with-COVER-No-printer-marks.pdf?dmc=1&ts=20161013T1855087938 (Accessed June 7, 2019).
  - ICD-10 clinical concepts for OB/GYN. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsOBGYN1.pdf (Accessed June 7, 2019).
  - USING Z CODES: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes. https://www.cms.gov/files/document/zcodes-infographic.pdf (Accessed May 30, 2021).