Physician Coding **TOOLKIT**

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American Health Information Management Association



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FOREWORD

The provider practice setting can present unique challenges for the health information (HI) professional, particularly in medical coding. The healthcare industry is in a constant state of flux, adding to the already complex demands for operations of this setting. Value-based purchasing, quality reporting, and new reimbursement models have pushed provider practice into its next generation.

There are many resources available for coding and reporting on facility claims. This toolkit is intended to be for the non-facility practice and has been created to provide guidance and reference tools for provider practice coding.

INTRODUCTION

The complexity of the United States healthcare system requires providers and other healthcare professionals to continually update information and resources to ensure the accuracy of coded data and appropriateness of codes reported for reimbursement. This continual change presents significant challenges to provider practices.

A healthcare provider is any person or organization who furnishes, bills, or is paid for healthcare services provided in the normal course of business.¹ A provider is any of the following types of professionals that are legally authorized by the state to practice medicine:

- Doctors of medicine or osteopathy (MD, DO)
- Doctors of dental medicine (DMD) or dental surgery (DDS)
- Doctors of podiatric medicine (DPM)
- Doctors of optometry (OD)
- Chiropractors

The definition of a non-provider practitioner is a nurse midwife (CNM), nurse practitioner (NP), or physician assistant (PA) licensed by the state within which the individual practices.²

According to data received by the Federation of State Medical Boards, there were about 1 million licensed providers in the United States in 2016.³ As of 2013, there were approximately 600,000 providers in an office practice and 200,000 providers in a hospital-based setting.⁴ Due to multiple factors, the traditional provider practice has been changing, and fewer providers are in privately owned small group practices. More providers are employed with a practice owned by a healthcare system. Furthermore, emerging practice models, including boutique and telemedicine, are beginning to take hold.

These various practice models face common challenges including, but not limited to, continuously changing government regulations, evolving reimbursement

methodologies, varying insurance contractual reporting requirements, and reporting on multiple quality indicators. In addition, healthcare reform in the U.S. is driving emerging value-based and risk-adjusted reimbursement models that require providers to continually assess documentation and coding practices. Multiple specialists working within a shared electronic health record (EHR) increases the complexity of the documentation, and therefore raises the likelihood of inconsistency within the documentation. This increases the challenge for accurate reporting of a patient's true severity of illness and risk of mortality. Providers must accurately and adequately document in order for coded data to be complete, regardless of which staff member is responsible for final code selection.

This provider practice coding toolkit is a valuable resource for any type of provider, and for provider practices of any type or size. The tools and resources contained herein are equally relevant for a single provider or a large multi-specialty practice or network, for example.

The toolkit provides multiple tools and resources to help providers and their staff successfully navigate challenges associated with accurate coded data. While information contained in this toolkit is comprehensive, it is not an all-inclusive list of resources. The resources were current at the time of publication; however, URLs change frequently and may require an additional search for the referenced item.

The content contained within this toolkit includes defining the various code sets used in provider practice; a summary of applicable coding guidelines; the impact of EHR documentation templates on coding compliance; introduction to typical coding workflows; best practices for coding audits; coder training; and more. The purpose of this toolkit is to help address and provide guidance on the most common coding-related issues found in provider practices today.

SECTION I: CLASSIFICATIONS, CODE SETS, AND TERMINOLOGIES IN PROVIDER PRACTICE

Multiple classification systems, code sets, and clinical terminologies are used to capture and report the clinical services rendered in provider practices. The code sets used for reimbursement are regulated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Transaction & Code Sets Standards. The HIPAA-mandated code sets include the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM); Current Procedural Terminology – 4th Edition (CPT®-4); Healthcare Common Procedure Coding System (HCPCS); Current Dental Terminology (CDT); and National Drug Codes (NDC). An additional code set, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), is used by mental health professionals. An overview of each of these code sets is provided in

this section of the toolkit.

This section also provides an overview of Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT), which is a clinical terminology standard for entry of structured data in certified EHR systems and is a required standard in interoperability specifications in the U.S. Lastly, this section provides an introduction to reimbursement schemas and categories including relative value units (RVUs) and hierarchical condition categories (HCCs).

Each system explored in this section includes a description of the purpose and structure of the system, how it is used in provider practices, an example (current as of the date of publication), and references to obtain additional details.

INTERNATIONAL CLASSIFICATION OF DISEASE, TENTH REVISION, CLINICAL MODIFICATION (ICD-10-CM)

The International Classification of Disease (ICD) is owned and copyrighted by the World Health Organization (WHO). ICD is used worldwide as a standard diagnostic tool for epidemiology, health management, and clinical purposes.

With permission from the WHO, the United States created a modified version of the tenth version of ICD (ICD-10) for reimbursement. The current version used in the United States is the International Classification of Disease, 10th Revision, Clinical Modification (ICD-10-CM).

ICD-10-CM codes are alphanumeric codes used to represent diagnoses. This code set includes approximately 72,000 codes to represent diseases, disorders, injuries, infections, and symptoms. The codes are grouped into classes and organized intentionally by body system. The alphanumeric codes may contain a minimum of three and a maximum of seven characters. Each code describes a particular diagnosis in detail. Below is an example of some of the ICD-10-CM codes for diabetes. Notice how characters are added to the ICD-10-CM code as the diagnoses become more specific.

*ICD-10-CM	ICD-10-CM Code Description
Code	
E11.10	Type 2 diabetes mellitus with ketoacidosis
	without coma
E11.11	Type 2 diabetes mellitus with ketoacidosis with
	coma
E11.8	Type 2 diabetes mellitus with unspecified
	complications
E11.9	Type 2 diabetes mellitus without complications

*ICD-10-CM 2022

ICD-10-CM defines specific coding conventions and instructions imbedded within the code set. In addition, the ICD-10-CM Official Guidelines for Coding and Reporting are included as part of the designated code set standard. Coding guidelines are discussed in the next section of this toolkit.

The National Center for Health Statistics (NCHS) is responsible for the development and use of ICD-10-CM. This is done by the ICD-10 Coordination and Maintenance Committee. The ICD-10 Coordination and Maintenance Committee is a federal interdepartmental committee. Suggestions for code modifications come from both the public and private sectors. Information about submitting a code update proposal, public meeting information, meeting materials, and submitted proposals is available on the ICD-10 Coordination and Maintenance Committee website <u>https://www.cdc.gov/nchs/icd/icd10_maintenance.htm.</u> Updates to the ICD-10-CM code set are published each fiscal year, effective on April 1 and October 1.

ICD-10-CM diagnosis codes demonstrate the medical necessity for services reported on provider claims. Third-party payer coverage determinations often define specific diagnoses that justify services for payment. Medicare national and local coverage determinations are discussed in the next section of this toolkit.

CURRENT PROCEDURAL TERMINOLOGY (CPT)

The CPT code set is owned and copyrighted by the American Medical Association (AMA). CPT codes were developed to describe medical services and procedures performed by healthcare providers. CPT is part of a larger coding system called the Healthcare Common Procedure Coding System, which contains both CPT codes (HCPCS Level I) and HCPCS National Codes (HCPCS Level II). HCPCS Level II is commonly referred to merely as "HCPCS" and is discussed next.

CPT is composed of three types of codes: category I, category II, and category III. All CPT codes are five characters in length. CPT category I codes are numeric and represent distinct services commonly performed. Category II codes are alphanumeric codes with an "F" in the fifth position. They are supplemental tracking codes used for performance measurement. Category III codes are temporary alphanumeric codes with a "T" in the fifth position. They are used to describe emerging technologies that do not yet qualify for a category I code. Below are examples of each type of CPT code.

CPT Category	Use/Purpose	*Code Examples
Category I Codes	Common distinct services	69209 Removal impacted cerumen using irrigation/lavage, unilateral

Category II Codes	Supplemental tracking codes for performance measurement	0518F Falls plan of care documented (GER)⁵
Category III Codes	Emerging technologies	0071T Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue

*AMA CPT 2022

Evaluation and management codes are CPT codes and are discussed in more detail in the next section. CPT defines specific coding conventions and instructions embedded within the code set. In addition, CPT® Assistant is a supplementary publication that provides expanded descriptions and coding guidance for use with CPT codes. CPT® Assistant is published monthly and is available for purchase from the AMA.

Modifiers may be appended to CPT (or HCPCS) codes to further describe clinical services or to qualify the relationship between separate procedures. Modifiers are typically two-digit numeric or alphanumeric codes; however, ambulance origin and destination modifiers are one numeric digit. Payer-specific guidelines must be followed to ensure that modifiers are appended when appropriate. The CPT code set includes modifier definitions and examples of appropriate use in the CPT code book Appendix A. Below are examples of CPT codes with modifiers.

*CPT Code with Modifier	*Code Description
99213-25	Office or other outpatient visit for the evaluation and management of an established patient, which requires: a medically appropriate history and/or examination and a low level of medical decision making; significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service.
69209-50	Removal impacted cerumen using irrigation/lavage, bilateral

Changes to the CPT code set are released in the fall and updated January 1 each year. The code set is available in print or electronic data file through numerous vendors.

In a fee-for-service provider reimbursement model, CPT procedure codes reported on healthcare claims determine provider reimbursement. Therefore, each CPT and HCPCS code submitted for payment consideration must be supported by clinical documentation. Submitting a claim for services that were not performed and documented is illegal and fraudulent. Third-party payers have explicit guidelines for correct reporting of CPT codes. Medicare's National Correct Coding Initiative is an example that is addressed in more detail in the next section of this toolkit.

HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

HCPCS Level II codes are alphanumeric codes maintained by the Centers for Medicare and Medicaid Services (CMS). The primary purpose of HCPCS codes is to meet the operational needs of the Medicare and Medicaid reimbursement programs. HCPCS Level II codes identify "products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)."⁹ Below are examples of HCPCS Level II codes.

HCPCS	HCPCS Code Description
Code	
E0110	Crutches, forearm, includes crutches of various materials,
	adjustable or fixed, pair, complete with tips and handgrips
J0120	Injection, Tetracycline, up to 250 mg
L0130	Cervical, flexible, non-adjustable, prefabricated, off-the-shelf (foam collar)
L3250	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each

* HCPCS 2022

A list of current HCPCS codes and pertinent data can be found on the CMS website. HCPCS level II series Q, K, and G are temporary national codes. These may be converted to permanent codes in a subsequent update, or they may remain for more than one update cycle. Local codes may be requested if a HCPCS level I or II code does not exist for the service. If assigned, the code will appear in the W, X, Y, or Z series. HCPCS Level II codes are updated quarterly and available in print or electronic data file through numerous vendors.

NATIONAL DRUG CODES (NDCs)

The Federal Food and Drug Administration (FDA) published the National Drug Code (NDC) listing as required by the Drug Listing Act of 1972. The Drug Listing Act required all manufacturers, repackagers, and labelers to list with the FDA prescription drug products manufactured, prepared, propagated, compounded, or processed for commercial distribution in the US. The list was subsequently expanded to include over-the-counter drugs and veterinary drugs. NDCs are a drug product identification system that facilitate official identification of drug products commercially marketed in the US. NDCs are also used in prescribing, dispensing, and administering drugs by healthcare professionals, and they may be used to identify drug products for coverage, billing, payment, and reimbursement. The NDC must be entered on the claim form for certain medications.

NDC codes are 10 digits divided into three segments that identify the labeler, product, and package type of drug products. The NDC code is included on drug labels, including any prescription drug container furnished to a consumer. It may be embedded in a linear bar code or within a product identifier. An 11-digit format of the NDC codes was adopted as the HIPAA designated standard for reporting drugs and biologics, referred to as the HIPAA NDC or NDC11. The NDC11 is created from a 10-digit NDC code by adding a leading zero to one of the three NDC segments.

NDC Package	Proprietary	Strength	Dosage	Nonproprietary name
code	name		Torm	
50580-730-01	Children's	5 mg/5	Syrup	Cetirizine Hydrochloride
	Zyrtec	mL		
67414-608-06	Tylenol PM	500 mg/1,	Tablet, film	Acetaminophen,
		25 mg/1	coated	Diphenhydramine
				Hydrochloride
67296-1156-5	Amoxicillin	500 mg/1	Capsule	Amoxicillin
55154-7704-0	Coumadin	5 mg/1	Tablet	Warfarin Sodium

The National Drug Code (NDC) Directory is a public repository of NDC codes and related drug product information. This directory is owned by the FDA and distributed by the Department of Health and Human Services (HHS). It currently includes over 120,000 drug products and is updated each weekday. Firms marketing products in the U.S. are required to update their FDA drug listing as necessary, but at least two times per year (in June and December).

CURRENT DENTAL TERMINOLOGY (CDT)

The CDT code set is the standard dental procedural code reference for dentists practicing in academic and clinical settings. CDT was developed and is published by the American Dental Association (ADA). In 1999, CMS licensed the code set from the ADA, and since then it has been included in the HCPCS Level II code set. HIPAA subsequently designated CDT as the federally mandated code set for reporting dental services on electronic claims. However, the ADA still retains ownership and authority to make code changes. Maintenance and development of the CDT code set is the responsibility of the Code Maintenance Committee (CMC) established by the ADA's Council on Dental Benefit Programs (CDBP). CDT is published annually.

The primary purpose of CDT codes is to accurately represent dental procedures in claims to third-party payers. CDT codes, similar to HCPCS Level II codes, are fivedigit alphanumeric codes. CDT codes begin with the letter D followed by four numerals. The code set includes an alphabetic index as well as a numeric index. The ADA publishes a CDT Coding Companion that provides principles and guidelines for using CDT codes.

CDT	CDT Code Description
Code	
D0210	Intraoral – complete series of radiographic images
D7220	Removal of impacted tooth – soft tissue; requires mucoperiosteal
	flap elevation
D7210	Extraction, erupted tooth requiring removal of bone and/or
	sectioning of tooth, and including elevation of mucoperiosteal
	flap if indicated
D2950	Core Buildup, including any pins

* CDT 2022

DIAGNOSTIC STATISTICAL MANUAL (DSM-5)

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is the standard classification of mental disorders used by mental health and medical professionals throughout the U.S. DSM-5 contains the ICD-10-CM codes for mental disorders, criteria for making specific diagnoses, assessment measures, and other helpful text. It is developed and published by the American Psychiatric Association (APA). The primary purpose of DSM-5 is to assist trained clinicians in the diagnosis of mental disorders. It is an authoritative guide used by practicing psychiatrists, clinical psychologists, and clinical social workers as well as other providers. It provides a common language and standards to assist in making psychiatric diagnoses. DSM-5 is divided into three sections. Section I describes the revision process and changes to the manual. Section II contains the diagnostic criteria, related ICD-10-CM codes, and descriptive text for mental disorders. Section III includes several assessments and measures to rate the severity of diagnoses. Mental disorders in the DSM-5 classification include the corresponding ICD-10-CM code from the ICD-10-CM mental disorders chapter, but also include additional subtypes, specifiers, and coding notes unique to DSM-5. In this manner, DSM-5 is compatible with ICD-10-CM.

The following excerpt from DSM-5 (page 162) provides an example of coding and recording procedures for Major Depressive Disorder.

Coding and Recording Procedures

The diagnostic code for major depressive disorder is based on whether this is a single or recurrent episode, current severity, presence of psychotic features, and remission status. Current severity and psychotic features are only indicated if full criteria are currently met for a major depressive episode. Remission specifiers are only indicated if the full criteria are not currently met for a major depressive episode. Codes are as follows:

Severity/course specifier	Single episode	Recurrent episode
Mild	F32.0	F33.0
Moderate	F32.1	F33.1
Severe	F32.2	F33.2
With psychotic features	F32.3	F33.3
In partial remission	F32.4	F33.41
In full remission	F32.5	F33.42
Unspecified	F32.9	F33.9

In recording the name of a diagnosis, terms should be listed in the following order: major depressive disorder, single or recurrent episode, severity/psychotic/remission specifiers, followed by as many of the following

Specify:

With anxious distress (p. 184).

With mixed features (pp. 184-185).

With melancholic features (p. 185).

With atypical features (pp. 185-186).

With mood-congruent psychotic features (p. 186).

specifiers without codes that apply to the current episode.

With mood-incongruent psychotic features (p. 186).

With catatonia (p. 186). Coding note: Use additional code 293.89 (F06.1).

With peripartum onset (pp. 186-187).

With seasonal pattern (recurrent episode only) (pp. 187-188).

SNOMED CT

SNOMED Clinical Terms (SNOMED CT) is a reference terminology with comprehensive coverage of diseases, clinical findings, etiologies, procedures, and outcomes used by providers, allied health professionals, veterinarians, and others. It is a clinical terminology with comprehensive, scientifically validated clinical content that enables consistent, digestible representation of clinical content in electronic health records. It provides a standardized way to represent clinical phrases captured by clinicians and enables automatic interpretation to facilitate better communication, interoperability in electronic health record exchange, and clinical decision support functionality. SNOMED CT is one of the designated standards for use in health information exchange, and is named by the Office of the National Coordinator for Health Information Technology (ONC) as one of the standards for structured data in certified EHR systems. SNOMED CT is owned and maintained by SNOMED International.

SNOMED CT includes concepts that are structured according to logic-based representations of meaning. Each concept has a unique concept identifier that is a machine-readable string of digits. The minimum length is six digits, and the maximum length is 18 digits, though most concept identifiers are eight to nine digits. Other SNOMED CT components also have unique identifiers; however, the concept identifier has a specific role as the code used to represent the meaning in clinical records, documents, messages, and data.

Concept	SNOMED CT ID
Nausea (finding)	422587007
No nausea (situation)	162056003
Nausea and vomiting (disorder)	16932000
Postoperative nausea (disorder)	64581007
Postoperative nausea and vomiting (disorder)	1488000

SNOMED CT has been implemented in a variety of ways within EHR systems. For example, it is commonly used as the standard to codify problem list entries. It's also used to electronically record and report patient smoking status, one of the core measures under the guidelines for CMS Meaningful Use Stage 2.

RELATIVE VALUE UNIT (RVU)

Each CPT code is assigned a relative value unit (RVU). The RVU is made up of three values: provider work, practice expense, and malpractice. The provider work portion of the RVU is based on wage data and provides a measure of the physician work involved with performing the service or procedure represented by the CPT code. The work RVU represents physician labor, considering technical skill, physical effort, mental effort, judgement, and stress. It includes pre-service work, intra-service work, and post-service work. The work RVU is specified for each CPT code and includes total work as well as a measure of the approximate time involved with delivering the service. The practice expense portion of the RVU accounts for non-physician clinical and non-clinical labor of the practice, as well as expenses for building space, equipment, and office supplies. The malpractice portion of the RVU accounts for RVU

The data for developing the original work RVUs came from a Harvard University study in the late 1980s, where physicians reviewed vignettes and estimated the comparable work involved. CMS is responsible for maintaining the physician fee schedule and has continued to modify and refine the original RVUs. The American Medical Association's Specialty Society Relative Value Scale Update Committee (RUC) provides advice and recommendations for this maintenance process.

In the 2021 Medicare Physician Fee Schedule, work RVUs range from 0.1 for CPT code 70300 (Radiologic examination, teeth; single view) to 108.91 for CPT code 39503 (Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia). The RVU for a particular service is determined relative to other services and procedures. For example, removing a foreign body from the eye is relatively less work than performing a minor eye wound repair. Thus, the former is assigned a lower work RVU than the latter.

CPT Code	CPT Code Description	Work RVU
65205	Removal of foreign body, external eye; conjunctival superficial	0.49
65270	Repair of laceration; conjunctiva, with or without non-perforating laceration sclera, direct closure	1.95

Under the Resource-Based Relative Value Scale (RBRVS) payment model, the RVU, multiplied by the conversion factor and geographical adjustment, creates the compensation level for a particular service represented by the CPT code. Medicare uses this RBRVS fee-for-service approach to determine reimbursement for professional services under Medicare Part B, for example. The RVU is also commonly used in physician compensation models since it correlates with physician work, and is generally accepted as a measure of physician productivity. Accurate documentation and CPT code assignment are key to capturing accurate RVU data.

HIERARCHICAL CONDITION CATEGORY (HCC)

Hierarchical condition categories (HCCs) are used in risk-adjustment payment models. Risk adjustment is a statistical process that considers the underlying health status and health spending of patients when examining their healthcare outcomes or healthcare costs. The hierarchical condition category (HCC) model ranks diagnoses into categories that represent conditions with similar cost patterns. Higher categories represent higher predicted healthcare costs, resulting in higher risk scores.

Each HCC is mapped to the relevant ICD-10-CM code(s) that reflect the chronic conditions associated with the category. Long-term conditions such as morbid obesity, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), chronic kidney disease, and diabetes will "risk adjust" or fall within an HCC; whereas acute illnesses and injuries will not, because acute conditions are not reliably predictive of ongoing healthcare costs. To factor into risk adjustment, a diagnosis must be based on clinical documentation from a face-to-face encounter, documented at least once per year, and coded according to the ICD-10-CM guidelines.

CMS HCC	Description	Weight
136	Chronic kidney disease, stage 5	0.289
137	Chronic kidney disease, stage 4	0.289
138	Chronic kidney disease, moderate (stage 3)	0.069

Risk scores are applied, for example, to adjust capitated payments made for beneficiaries enrolled in Medicare Advantage plans (i.e., Medicare Part C). Different patients may have different payment rates, based on each patient's risk score representing the predicted level of risk (e.g., the expected cost to maintain the patient's health). Accurate documentation, coding, and reporting of ICD-10-CM codes for chronic conditions is key to accurate HCC capture, accurate risk scores, and ultimately appropriate payment rates.

SECTION II: CODING GUIDELINES IN PROVIDER PRACTICE EVALUATION AND MANAGEMENT SERVICES

Evaluation and management services, as the name implies, are those cognitive services provided by physicians and other qualified healthcare providers to evaluate and manage the health of a patient. The concept of evaluation and management (E/M) codes was first introduced in 1992. Major changes to office and other outpatient coding took effect in 2021. Other sites of service will be changing in 2023. We will first discuss the rules previously established, followed by the 2021 changes in office and other outpatient codes.

1995/1997 DOCUMENTATION GUIDELINES

The 1995/1997 Documentation Guidelines (DGs) for Evaluation and Management Services provide guidance to providers in determining the appropriate service to bill for their evaluation and management services. The 1995/1997 DGs are published by CMS. A part of the information that is available to providers is the Evaluation and Management Services Guide on the Medicare Learning Network (MLN).

The Evaluation and Management Services Guide consists of three main parts: Medical Record Documentation, Evaluation and Management Billing and Coding Consideration, and Reference Section.

The guide provides information on choosing the type of patient and determining the setting of the service. The Reference Section includes the 1995 and 1997 DGs. The 1995 DGs can be found at <u>https://www.cms.gov/Outreach-and-</u>Education/Medicare-Learning-Network-

<u>MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf</u>. Documentation guidelines for 1997 are found at <u>https://www.cms.gov/Outreach-and-</u> <u>Education/Medicare-Learning-Network-</u>

<u>MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf.</u>The provider can use either version of the documentation guidelines when choosing the appropriate level for the patient encounter. The DGs provide guidance on what elements need to be included and information needed to support the history, examination, and medical decision making (MDM). Each section in the DGs provides additional examples and information.

The 1995/1997 DGs assist providers with selecting the appropriate E/M level of service. Providers should review the 1995/1997 DGs to determine which set of guidelines is advantageous to them. Once they have selected the appropriate set of guidelines, they should become familiar with the components for the different elements of a particular visit.

History

The patient history is made up of four elements. The four elements include the chief complaint (CC), history of present illness (HPI), review of systems (ROS), and past, family, and/or social history (PFSH). The information provided will assist in determining the yype of history: Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive.

Examination

The Examination Section is where significant differences come in between the 1995 and 1997 DGs. Either version of the DGs can be used; however, a provider cannot use a combination of both. The types of exam for both DGs are Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive.

In the 1995 DG, the examination can be documented by either body areas or organ systems. To achieve a Comprehensive Exam, a general multi-system exam or complete examination of a single organ system is required. Additionally, the DG explains what is needed to document "abnormal", "negative," and "normal," and what is included in the general multi-system examination.

For example, the 1997 DG is made up of either a general multi-system examination or a single organ system examination. The single organ system examinations are listed in the DG table of contents. Each contains its own additional detail about the required elements of a physical examination. Bullet points are the key component used to determine the type of examination in the 1997 DG. The bullet points are described in each type of examination.

Medical Decision Making

MDM is made up of three components: number of diagnoses or management options; amount and/or complexity of data to be reviewed; and risk of complications and/or morbidity or mortality. The different types of MDM are straightforward, low complexity, moderate complexity, and high complexity. Details are described in further detail in the DG.

Office and Other Outpatient Services

In the Physician Fee Schedule Proposed Rule for 2019, CMS proposed changes to office visit payments and documentation requirements. In response to this, the American Medical Association convened a special workgroup to consider changes to the code descriptions themselves. The stated goals of this workgroup were:

- 1. To decrease the administrative burden of documentation and coding.
- 2. To decrease the need for audits.
- 3. To decrease unnecessary documentation in the medical record that is not needed for patient care.

4. To ensure that payment for E/M is resource-based and that there is no direct

goal for payment redistribution between specialties. (AMA, 2019)

Beginning in 2021, the following changes were made to the office visit codes:

- Visits will be coded based either on total physician time on the date of service, or
- Medical decision making as defined in a new table.

• History and examination will be documented as medically appropriate but will not affect the level of service.

The 2021 MDM table is included in the CPT code book beginning with the 2021 version. It is also available on the AMA website at <u>https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf</u>

The AMA has announced that similar changes will be made to all other sites of evaluation and management services in 2023. Until then, the 1995/1997 documentation guidelines apply to all E/M code categories, except for Office and Other Outpatient Services.

SURGICAL SERVICES

Surgical services are reported using codes from 10000 to 69990. A coding professional would review the medical record documentation of the procedure to assign the appropriate code or codes. Bundling edits and the use of modifiers with surgical procedure codes is discussed in a later section.

In the CPT code book, the surgical procedures performed include certain services that are considered part of the procedure, are designated as the surgical or global package, and are covered by a single fee. These include the following:

- The surgical procedure
- Any local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia
- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical)
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
- Evaluation of the patient in the post-anesthesia recovery area
- Typical postoperative follow-up care

CMS has established a slightly different surgical package. The CMS surgical package includes any complications that do not require a return to the operating room. This surgical package lasts for the period of time established for the particular code and will be either zero, 10, or 90 days, depending on the complexity of the procedure.

Maternity care is also coded based on a package concept. The physician is able to use one code rather than multiple codes to bill for the prenatal, delivery, and postpartum follow-up care of the pregnant patient. The CPT Manual describes the components of the maternity package. Additional visits and services beyond these are coded separately with E/M codes or other appropriate procedure codes. If the physician does not perform the entire package, then they may report only the codes for the services they provided.

DIAGNOSTIC SERVICES

Diagnostic radiology services are coded from the 70000 series of codes. These codes represent services such as X-rays, ultrasound, magnetic resonance imaging (MRI), and computed tomography (CT). It is acceptable to code multiple procedures performed at the same session using individually appropriate codes. There must be a separate interpretation and report, signed by the interpreting physician. It is not appropriate to code separate codes for multiple studies when a code is available that describes the complete study.

Laboratory services are coded from the 80000 series of codes and include various laboratory tests such as urinalysis and blood work, as well as pathological examinations such as frozen sections and Pap smears. Codes within this section are assigned based on variables such as specimen type (urine, blood, sputum, and others), the type of testing method used (commercial test kit versus reagents), type of equipment used (manual versus automated), and the number of tests completed (single tests versus multiple tests in a panel). It may be helpful to consult with the laboratory specialists within the physician practice to assist in determining the appropriate code(s) for the services provided.

MODIFIERS

Modifiers are two-digit extensions to the main CPT or HCPCS code. Modifiers can be alphabetic, alphanumeric, or numeric. They do not alter the basic definition of the code, but rather specify circumstances surrounding the particular procedure being coded. A comprehensive list of CPT modifiers is found in Appendix A of the CPT code book, and examples are included in Section I of this toolkit. HCPCS Level II modifiers are usually found as an appendix in the HCPCS code book. Modifiers can be classified by the intended effect of their use. Some modifiers are used to identify circumstances that would bypass bundling edits; these are discussed in the section below. Other modifiers are used to indicate that a service is not part of the normal global surgical package. A special set of modifiers is used with anesthesia services to indicate the provider of the service and the supervision provided. Modifiers may affect the payment to be received for the service, or they may be informational only.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

NCCI is a system of edits developed by CMS to help prevent improper payments. NCCI edits are prepayment and identify improper pairs of HCPCS/CPT codes submitted together on the same claim. The edits consist of comprehensive codes and component codes. These are labeled column 1 (comprehensive) and column 2 (component). If a code in column 1 is submitted with a code from column 2, the code from column 1 is eligible to be paid and the code from column 2 is denied. If both codes are clinically appropriate, the code in column 2 may be submitted with an appropriate modifier. The applicability of a modifier is indicated in a separate column. Indicator 0 specifies that a modifier is not allowed, while indicator 1 notes that a modifier is allowed if there is appropriate supporting documentation. The medical record documentation should support the appropriateness of the modifier assignment. Mutually exclusive code (MEC) pairs should not be submitted together, even with a modifier, because CMS considers it unreasonable for the provider to perform them on the same anatomical site during the same encounter. Note that the edit table includes an effective date and in some cases a deletion date. If the date of service falls in the span of dates between effective and deleted, the edit would still be applicable.

In a separately available table, NCCI also establishes medically unlikely edits (MUEs). MUEs limit the units of service (UOS) allowed for a HCPCS/CPT code. MUEs may be date of service or claim line edits. Claim line edits may in some cases be bypassed with an appropriate anatomical modifier. While there is a HCPCS modifier -GD to indicate that the service is medically necessary, CMS does not recognize this modifier. If the documentation supports that the number of units exceeding the MUE are medically necessary, an appeal may be appropriate.

Services denied for NCCI edits may not be billed to Medicare beneficiaries even if an Advanced Beneficiary Notice of Noncoverage (ABN) is obtained. NCCI tables are updated quarterly. Hospital outpatient NCCI tables are updated the quarter following the Part B tables.

MEDICARE NATIONAL COVERAGE DETERMINATIONS (NCDs) AND LOCAL COVERAGE DETERMINATIONS (LCDs)

NCDs and LCDs are developed by Medicare and its local contractors to ensure items and services provided to Medicare beneficiaries are reasonable and necessary. NCDs cover all Medicare beneficiaries. Local Medicare Administrative Contractors (MACs) develop LCDs when there is no NCD, or to further detail coverage. Updates to NCDs and LCDs occur continuously throughout the year. CMS and the MACs offer weekly updates via email for any interested party that registers on their website.

CMS provides a database on its website for anyone to search for NCDs and LCDs. Providers or patients can search to determine the coverage parameters for services prior to the service being provided. Because this information is easily available, CMS expects all providers to be aware of the parameters prior to submitting claims to CMS. The database provides a variety of ways to search for determinations, including local regions, CPT, and ICD-10 codes.

NCDs and LCDs can be located at <u>http://www.cms.gov/medicare-coverage-database</u>.

ICD-10-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING

The complete ICD-10-CM Official Guidelines for Coding and Reporting can be found on the NCHS website. The guidelines should be carefully reviewed and kept for future reference. The ICD-10-CM coding guidelines differ between inpatient and outpatient. The outpatient coding guidelines apply to all patient settings, including provider practices.

There are several sections of the coding guidelines applicable to provider practice:

- Section I.A Conventions for ICD-10-CM
- Section I.B General guidelines that apply to the entire classification
- Section I.C Chapter-specific guidelines in the classification
- Section IV Reporting guidelines for outpatient services
- Sections II and III apply to the inpatient setting

Section I.A

The conventions are general rules for use of the classification. These are incorporated into both the Alphabetic Index and Tabular List as instructional notes. This section provides specific information regarding the format and structure of the classification, including abbreviations, punctuation, and use of seventh characters.

Section I.B

This section of the guidelines provides general coding guidelines related to locating a code in ICD-10-CM, use of the entire classification, signs and symptoms, and multiple coding for a single condition. It also discusses coding guidance for general questions related to the classification.

Section I.C

In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. These guidelines apply to all healthcare settings, unless otherwise indicated.

Section IV

This final section of the guidelines provides comprehensive information specific to the outpatient setting, including provider practice. Significant highlights of this section include the following:

- The term "first-listed diagnosis" is used in lieu of principal diagnosis.
- In determining first-listed diagnosis, the coding conventions, as well as the general and disease-specific guidelines, take precedence over the outpatient guidelines.
- The most critical rule involves the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List.
- Uncertain diagnoses documented as "probable," "suspected," "questionable," "rule out," "compatible with," "consistent with," or "working diagnosis" or other similar terms indicating uncertainty should not be coded. Code the condition(s) to the highest degree of certainty for that encounter/visit, such as signs, symptoms, abnormal test results, or other reasons for the visit.

While these examples above highlight only a few of the ICD-10-CM coding guidelines specific to the provider setting, all guidelines should be carefully reviewed to ensure correct code assignment.

MEDICARE VERSUS COMMERCIAL GUIDELINES

Coding and billing staff in provider practices need to be aware of the different billing and reporting requirements and guidelines of each insurance plan. Coders and billers cannot assume that by following Medicare guidelines, they are accurately completing claims for all insurance plans. Each plan may have different billing, coding rules, or quality reporting requirements mandated in their contracts. A complete understanding of each plan's specific contractual obligation is necessary to protect the practice financially and contractually.

TEACHING PROVIDER GUIDELINES

CMS publishes guidelines pertaining to the clinical services performed by teaching providers, residents, interns, fellows, and medical students. These guidelines are often referred to as the providers at teaching hospitals (PATH) regulations. CMS, along with the Office of Inspector General (OIG), monitors compliance with the PATH regulations though nationwide reviews. However, clinical documentation must support the teaching services performed.

The teaching provider guidelines are published by CMS and are divided between teaching programs that are furnished within and outside of an approved program. The general guidelines indicate that payments will be made by CMS for provider services within a teaching setting through the Medicare Provider Fee Schedule (MPFS) if the services are:

- Personally furnished by a provider who is not a resident.
- Furnished by a resident when a teaching provider is physically present during the critical or key portions of the service.
- Furnished by a resident under a primary care exception within an approved graduate medical education program.

The teaching provider is paid through the MPFS for their involvement with the patient care, and there is no payment provided by CMS directly to the provider for the teaching portion. "The services of the resident are payable through either the direct GME payment or reasonable cost payments made by the FI."⁶ This payment is made directly to the hospital as a part of the Accreditation Council for Graduate Medical Education (GME).

Although the documentation guidelines for evaluation and management services must be followed, there are specific modifiers that must be appended to the evaluation and management service that define who is providing the service for proper reimbursement to be issued:

- GC: This service has been performed in part by the resident under the direction of a teaching provider.
- GE: This service has been performed by a resident without the presence of a teaching provider under the primary care exception.

Additionally, specific documentation requirements must be noted by the teaching provider to identify involvement in the services rendered. An excellent resource to detail these requirements is the Medicare Claims Processing Manual, Chapter 12, Section 100. There are clinical examples and sample statements which display the documentation requirements for teaching providers and the proper billing for these services in a variety of specialties, such as primary care, surgery, anesthesiology, radiology, and psychiatry.

SECTION III: EHR AND DOCUMENTATION ENHANCEMENTS

TEMPLATES AND MACROS

A high percentage of EHRs use templates, which are customizable forms to assist providers with documentation. A number of EHR vendors also employ macros, i.e., blocks of text, that can be stored and imported into the record as needed. Templates, and to a lesser degree macros, may address history and physicals, progress notes, operative notes, office procedure notes, nurses' notes, and other documentation scenarios. They may be designed to address the documentation needs of an entire clinical note, from the chief complaint through to the assessment and plan. They may also be structured to represent a specific component of the note (e.g., HPI or physical examination) or even a subset of a component of a section of the record (e.g., subcomponent of the HPI template specific to a diabetic follow-up visit).

Templates are often developed to meet specific documentation scenarios tailored to a practice setting. For example, a headache template in primary care may be significantly different than one developed for a neurology practice. They may also be customized for new versus follow-up visits. In order to speed up documentation, templates may have fully formatted sentences that include drop-down menus or other tools that allow the user to choose the most appropriate item. For example, an HPI sentence in a template may read: "The patient presents with LOCATION OF PAIN that has started DATE/TIME TOOL." The "LOCATION OF PAIN" drop- down menu might list several anatomic sites (e.g., low back pain, hip pain, mid-back pain, etc.).

Templates often initiate E/M coding elements, ICD-10-CM codes, HCPCS codes and non-E/M CPT codes. For example, the drop-down menu titled "LOCATION OF PAIN" would be mapped to the HPI element for location, and the "DATE/TIME TOOL" would be mapped to the HPI element for duration of symptoms. The same is true of the past medical history, review of systems, physical examination, assessment, and plan. Each section contains information that may be mapped to specific E/M coding elements, which are then summarized and used to suggest an E/M code.

In the assessment section of the note, the templates may have embedded ICD-10-CM codes that can be chosen as diagnoses for the encounter. The template may also have embedded CPT and HCPCS codes that can be chosen by the user when ordering tests, procedures, devices, and more.

Template defaults help to improve the efficiency of documentation, but if not used carefully, may put the user at risk for inaccurate documentation from a

medicolegal and coding compliance perspective. This often occurs when an ROS that has default negative values is imported into a note and the default negative is in conflict with the HPI findings. EHR users need to carefully review any templated default values to ensure that the information is clinically accurate. Coding professionals should become directly involved with template development and quality control to ensure that the embedded billing codes are accurate and that the templates allow the users to provide adequate supporting documentation.

Charge Orders

With one of the core measures of the CMS Meaningful Use guidelines being computerized order entry, the use of electronic order sets has become standard. Charge orders are most commonly utilized in the ambulatory hospital setting and are an extension of electronic order sets.

Charge orders allow for services that are placed as an electronic order such as a lab test, drug administration, or radiology services to convert to a charge code upon completion of service. This is commonly referred to as charge on administration (COA). This functionality allows for drug and supply utilization monitoring as well as prior authorization for planned procedures and tests, and it also provides accurate and efficient charge capture of services rendered. Charge orders should be reviewed and revised annually with annual code changes.

SHORT LISTS/LONG LISTS

The terms "short lists" and "long lists" may have different meanings in different settings. In this context they represent drop-down lists in EHRs that are used to facilitate choosing a diagnosis, order, medication, device, or other commonly used term or object. Short lists contain a small subset of data that may be designed to represent the information needed for a specific type of encounter, such as an evaluation of abdominal pain. Long lists may be a list of ICD-10-CM codes that are used by a specific specialty. Short lists are often used to remind providers of the differential diagnosis when they are evaluating a common problem. Some providers have reported that these lists have helped them think of additional potential causes of a patient's condition, and in some cases lead to the correct diagnosis.

These lists often contain codes such as ICD-10-CM, CPT, and HCPCS codes. This help users find the terms they need quickly without having to do a search of an entire coding database.

Coding professionals benefit from being aware of this clinical content because it represents a source of billing codes that needs to be reviewed and updated. Providers will choose menu items from these lists that will be included in the documentation. The associated codes are sent from the EHR to the practice management system. For this reason, these lists can be a source of coding errors. By no means should these lists be considered all-inclusive. According to AHA Coding Clinic[®], it is not appropriate for a provider to pick from a list and only use a code number in lieu of a written diagnosis.⁷

There may also be situations where items on the short and long lists are appropriate for one payer and not another. Some applications may allow for notes to be provided with each item. In this situation, it may be feasible to provide coding guidance to the provider, allowing them to choose the most appropriate codes for a specific payer.

Short and long lists should be reviewed annually to coincide with code changes.

CODING CHEAT SHEETS

There are many different types of cheat sheets when it comes to the EHRs and documentation. Cheat sheets may be helpful for use when learning a new EHR, or may serve as reminders about the particular system you are using.

An EHR cheat sheet would contain a listing of shortcut keys on how to do a particular function within the EHR. Each EHR is unique, and providers may find this helpful when going to a new facility. Some examples of this might be Control F12 opening up a new documentation template on the patient. Control F11 opens a quick text box of preset standards that are used for normals that a provider would like inserted into a document.

Cheat sheets may be a listing of "smart phrases" that a provider can type into an EHR or speak into software such as Dragon to assist with finding orders, or to serve as a reminder for shortcuts to quicker documentation. For example, if the provider types or speaks "PFSH," the system knows to type out past Mmedical, family, and social history. Some of these shortcuts may even be particular to your region, referring to different facilities or providers.

Coding professionals often keep coding rules, tips, and advice on a personal cheat sheet that they have ready access to that can help them with their coding. A coding cheat sheet may have high-level categories such as the level of the visit, labs, diagnoses, and a few procedures that are common within the practice or specialty that the coding professional is responsible for coding.

There are also many other uses for cheat sheets to serve as reminders to providers of documentation needed for different programs from the federal government. Some of those reminders may provide assistance to review what is needed for the Provider Quality Reporting System (PQRS) or measures the provider is participating in, such as CMS's Meaningful Use.

Coding cheat sheets may be of use in the office setting. There are a few types of coding cheat sheets, both for the diagnosis portion and for the evaluation and management levels.

Cheat sheets for the diagnosis portion may assist providers in choosing the diagnosis needed for medical necessity, preauthorization for procedures, and assignment of the diagnosis for the visit. Cheat sheets should be related to the specialty of the provider. Diagnosis coding cheat sheets should be reviewed with each code set update for accuracy. It is important to note that diagnoses should not be limited to those referenced on the cheat sheets. The notes related to the codes should also be reviewed when the codes are updated to be aware of changes in the ICD-10-CM code book includes notes, inclusion notes, exclusion notes, etc.

Cheat sheets for the E/M portion may assist in determining the appropriate level of service for the medical care provided. There are several cheat sheets available on the internet to assist providers. The sections in the cheat sheets will help with determining the type of history, examination, and medical decision making. When utilizing cheat sheets for E/M services, you want to be in alignment with the 1995, 1997, and the 2021 Office and Outpatient E/M documentation guidelines. For additional guidance, see AHIMA's Copy Functionality Toolkit in the References section.

COPY/PASTE

Copy/paste functionality refers to the ability of EHR users to be able to copy sections of text from another source and then place this text into the clinical record for a patient encounter or procedure. This obviously improves efficiency and, in some cases, may improve documentation. However, users may frequently copy and paste material and not review it carefully. This introduces significant errors in the clinical record that could represent a patient safety concern and may result in denials of claims.

Copy and paste has been an area of significant concern for the Office of the Inspector General of HHS and other government and payer entities. CMS has referred to this practice as the "cloning" of records. Some auditing bodies have been using plagiarism detection software to identify copy and paste between patient records and within the same patient record. Clear evidence of copy-and-paste behavior may be considered fraudulent in some instances. It is generally used to deny payment or to seek repayment for prior services.

EHRs allow users to "pull forward" notes from previous visits. This creates an exact copy of some, or all, of the patient's last visit. In some cases, this adds value clinically, as the provider is reviewing the document from the previous visit while they are evaluating the patients and creating the new document. In this setting, their attention may be drawn to items in the record that would have otherwise not been addressed (e.g., persistent cough that was not mentioned during the current visit). However, a number of practitioners do not carefully review documents that have been pulled forward, resulting in records containing information that is irrelevant or inaccurate.

Another source of copied information can be derived from templates, as described previously. Large bodies of text can be imported into the record in the form of a template or macro. These should be reviewed and modified with the same level of diligence as information that is entered into the records through copy and paste.

Coding professionals should remain alert to the possibility of inappropriate use of copy-and-paste technology and report any findings to their leader. Periodic internal audits looking for evidence of copy and paste should also be conducted.

PROBLEM LISTS

According to the Meaningful Use EHR Incentive Program, providers need to maintain an updated problem list of current and active diagnoses. According to the program, a problem list is defined "as current and active diagnoses as well as past diagnoses relevant to the current care of the patient."⁸

In the AHIMA practice brief "Best Practices for Problem Lists in an EHR," a problem list is defined as "a compilation of clinically relevant physical and diagnostic concerns, procedures, and psychosocial and cultural issues that may affect the health status and care of patients. This information should identify the date of occurrence or discovery and resolution, if known."⁹

Problem lists facilitate continuity of patient care by providing a comprehensive and accessible list of patient problems in one place. Problem lists used within health records are a list of illnesses, injuries, and other factors that affect the health of an individual patient, usually identifying the time of occurrence or identification and resolution. They are an important communication vehicle used throughout the entire healthcare continuum.

A problem list must be maintained in order to ensure the integrity of the list. In problem lists, current problems should be documented, and the resolved problems should be easily identified. Administration and maintenance of problem lists can present challenges, and most organizations struggle to define content, responsibilities, and accountability for maintaining an accurate, updated problem list.

There are differing opinions about who should be authorized to add entries to the problem list. Separate lists for providers, nurses, or other care providers (e.g., social workers, therapists, pharmacists) may be a help or a hindrance depending on the specific organization and its use of the problem list. More people adding entries contributes to more complex maintenance. Providers should review and sign off on these types of documentation when added by other care providers.

A concise list is necessary to enhance readability and usability. Problem list

accuracy is of paramount importance in order to take full advantage of safety measures, document encounters precisely, and maximize informatics opportunities.

Coding professionals use the problem list to confirm or clarify documentation found in other parts of the health record. To address billing needs, the problem list may be used as a source of diagnostic information. Problem list entries may be linked or integrated with other parts of the EHR to minimize duplication and improve documentation. Key information about a patient (e.g., drug-seeking behavior or other pertinent facts affecting care or treatment) may be added to the problem list as a means of communication to all providers, since the problem list is intended to be reviewed at every patient encounter.

AHIMA has several references available that relate to problem lists regarding policies and procedures, use in the EHR, uses beyond the incentive program, and best practices.

TIMELINES

There are several factors that affect timelines in health record documentation. One of them is claims submission for payment of services. Providers may not submit a claim to Medicare until documentation is complete. According to Chapter 12 of the Medicare Claims Processing Manual, "documentation should be done during or as soon as practicable after the service is provided in order to maintain an accurate medical record."¹⁰

It is important to note different payers have different requirements when it comes to submitting claims in a timely manner. Commercial payers have stricter timelines for submitting claims than Medicare. Commercial payers' timelines may range from 90 days to 180 days; this will depend upon a contract with a particular payer. Claims to Medicare must be submitted within 12 months from the date of service.

SIGNATURES

Signatures in the EHR should follow these guidelines: Signatures must be dated and

documented in a timely fashion.

Documentation must contain enough information to determine the date on which the service was performed or ordered. If the entry immediately above or below the entry is dated, medical review may reasonably assume the date of the entry in question. The progress notes must specify what tests were ordered. A note stating "Ordering Lab" is not sufficient.¹¹

If an office is using a hybrid EHR, signatures must be either handwritten or electronic. The use of rubber stamps is not acceptable unless the author can provide proof of his/her inability to sign due to a physical disability. If using a hybrid health record, it is required that the organization maintain a signature log that can be used to compare handwritten signatures with those on the signed record.

According to CMS, "Systems and software products must include protections against modification, and you should apply administrative safeguards that correspond to standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information being attested to. Providers are encouraged to check with their attorneys and malpractice insurers in regard to the use of alternative signature methods. Part B providers must use a qualified electronic prescribing (e-prescribing) system. Prescriptions for drugs incident to durable medical equipment (DME) must be made via a qualified e-prescribing system."¹²

Also according to CMS, "Orders for some clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub.100-02 chapter 15, §80.6.1 state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation (e.g., a progress note) by the treating provider that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature."

Depending on payer requirements, it is advised that signatures be attached to all orders, and coding professionals should review orders to ensure that signature requirements have been addressed. In addition to documents and orders, it is recommended that discrete components of the record also have individual signatures (e.g., flow sheets).

SECTION IV: PROVIDER CODING WORKFLOW

ELIGIBILITY VERIFICATION, PRIOR AUTHORIZATIONS, AND CERTIFICATIONS

Verification of a patient's eligibility and insurance coverage is a key first step in the provider's office coding workflow. Understanding a patient's coverage prior to services being rendered can avoid downstream issues with continuity of care and payment for services. It is important to note if there are limitations to coverage, prior authorizations required, and/or any patient financial responsibility.

Prior authorization, or certification, may be required to facilitate coverage for the service(s) by the patient's insurance. When required, obtaining the prior authorization helps to minimize payer denials and unnecessary loss of reimbursement for services. A few key pieces of information are needed when initiating the request for prior authorization, including:

- Patient diagnosis: Diagnosis codes play a key role in the approval of prior authorizations or certification requests. The diagnosis is used to support the medical necessity of the service being requested. The ICD-10-CM code(s) for the medical diagnosis will be required.
- Requested procedure: The procedure is the service that is expected to be rendered to the patient requiring the prior authorization. The appropriate CPT/HCPCS code(s) will be required. In some cases—surgery, for example—the main procedure code is used to generate the approval, with the understanding that during the operative session there may be medically necessary additional procedures that will be billed on the final claim. Submit all planned procedure codes at time of prior authorization.
- Submission procedure: Every payer will have its own process for submitting a prior authorization request. Some of the options include a phone-based process, a fax-in process, or a web-based process. Certain prior authorizations can be obtained by phone by discussing the details of the request with a representative. More intricate or complicated services may require a fax-in or internet-based submission to include relevant medical records. There are some challenges that should be considered and planned for as well.
- Authorization delays: Many payers offer options for emergent prior authorizations, but for regular services, a quick decision may not be possible. Errors in the submitted information or missing elements may cause a delay. Incorporating a follow-up process with the payer will help minimize the opportunity for delay.
- Patient care delays: A delay in the receipt of a prior authorization may also delay the patient's care. It can be a source of frustration for both the patient and the provider. Communicating with and educating the patient can minimize this burden.
- Denials: Denial tracking and review is necessary to spotlight opportunities for education and documentation improvement.
- Preparedness: It is critical to know the coding and documentation details for each practice, along with each payer contract and their respective coverage guidelines.
 Provider and prior authorization staff education on documentation issues, new coverage determinations, and guidelines are essential to a successful prior authorization workflow.

PAPER-BASED VERSUS ELECTRONIC

Prior to the vast implementation of electronic health records, the provider's office functioned in an entirely paper-based world. The daily provider schedule was printed along with the associated encounter forms, also known as fee sheets or superbills, and was used to monitor and track the day's patients. These encounter forms were comprised of the most common office visit codes, procedure codes, and diagnosis codes that the provider performed. Once the patient visit was completed, the provider would use the encounter form to identify the services rendered along with orders and diagnoses, which would facilitate any in-office labs, medications, injections, referrals, future appointments, and finally the billing. The day's encounter forms would be compiled and then processed either by submission to the coding/billing office, or by the individual provider's designated coder/biller. Providers documented their patient visits by handwritten progress notes or by using a form of dictation, which could delay the availability of final progress notes.

Once the encounter forms were received by the coder/biller, they were reviewed to ensure all required items had been identified. A CPT code, E/M and/or procedure code, and an ICD-10-CM diagnosis code are the minimum required elements in order to bill for in-office visits and services. Discrepancies or missing elements would require a follow-up to the provider and likely a review of the medical record. Completed and finalized encounter forms were entered into the practice management or billing system to facilitate the creation of the claims, which were sent to the payers for payment.

This paper-based coding and billing process could take several days to complete depending upon the provider's documentation habits, the physical location of the coder/billers, access to the patient's medical record, and validation of charges. Some other notable challenges in the paper-based process included reconciliation of encounter forms to patient visits, tracking communications for corrections to encounter forms, data entry errors, and the storage of all billing-related documents.

With the implementation of the EHR, the paper-based processes and documents can be eliminated. EHRs allow for a coder/biller work queue with an automated encounter form that provides the procedure(s) and diagnosis codes based on completed services and fulfilled on orders entered into the patient's EHR. For example, as the provider is documenting, the EHR template is collecting the elements to facilitate the appropriate E/M code for the visit; or when the provider enters an order for an injection, once the medical assistant or nurse administers that service and documents it in the EHR, the assigned procedure code passes to the coder/biller queue. In addition, the provider can enter an order for a patient visit, for example, that is associated with an E/M. The provider also has the added functionality software in place of dictation should they prefer that method over the point-and-click template, which eliminates the waiting period for returned dictation progress notes. The EHR eliminates many of the notable challenges that paper-based coding and billing processes presented.

COMPUTER-ASSISTED CODING (CAC)

As provider reimbursement continues to decline and the pressure to enhance

revenue performance mounts, provider practices are looking for alternatives to increase the efficiency and effectiveness of the documentation, coding, and billing processes. Before a claim can be generated for billing, diagnosis codes—which justify medical necessity for a service rendered—must be applied to the claim. This is a critical piece of the billing process that can delay getting a claim out the door and ultimately the time it takes to get reimbursed. With the ever-evolving world of reimbursement, provider practices small and large are finding it more challenging to keep up with the documentation requirements, coding changes, quality measures, and billing rules thus finding it a daunting task to code their encounters accurately and timely for services rendered. As a result, providers and practice administrators have started exploring various options to address the issue. CAC is the process of generating codes from clinical documentation. AHIMA defines CAC as the process of extracting and translating dictated and then transcribed free-text data (or dictated and then computer-generated discrete data) into codes (ICD-10-CM/PCS and/or CPT/HCPCS codes) for coding and billing purposes.¹³ Natural language processing (NLP) is the backend technology used to translate the data. While some may think CAC would eliminate the need for a coding professional, the reality is that it is intended to assist and facilitate more accurate coding outcomes for the coding professional to review. The ability to automate the coding process can teach the system how to read documentation specific to your organization and translate repetitive data for an initial period of time after implementation. The role of a coder will eventually look more like an auditor as CAC reduces the amount of time it takes to code an encounter. The CAC application not only has the potential to increase coding productivity, but it can also improve a coder's accuracy in code selection, reduce accounts receivable, and aid in identifying documentation deficiencies.

If a practice is considering CAC, there are a few things to consider, such as cost, EHR compatibility, implementation, and post-implementation maintenance. There are a variety of published resources available to assist with this selection and implementation process.

SECTION V: Coding Compliance and Auditing

There are many reasons a provider practice may decide to perform an audit of their records. One of the foundations of auditing is understanding the purpose of the audit and understanding the results that are expected. Compliance audits are typically performed to evaluate the compliance with a guideline or a policy. Compliance audits can be internal, external (completed by a party outside of the organization), or regulatory (compliance with billing guidelines). Audits can be performed for research or clinical purposes; perhaps a review is needed to identify outcomes after a procedure or a particular medication treatment. Reimbursement

validation is a very common reason to audit documentation compared to payment. Audits are often utilized when an expected payment is not received, or to ensure proper and compliant payment was received as compared to billing guidelines and/or payer contract. Quality initiatives or quality of care concerns may prompt a review of provider documentation. Internal audits may evaluate operational efficiencies or identify opportunities for further education. A review of benchmarks may prompt an audit if operating metrics are not aligned with comparative benchmark data.

Depending on the reason for the audit and the type of the audit, codes assigned may or may not be included in the audit. Coding validation audits are often done within the provider setting to validate reimbursement (accurate, expected, and received), benchmarking, research, statistics, regulatory, compliance, education, development of documentation and/or coder, or provider code assignment. Coding validation audits should be done to validate the presence of documentation to support accurate and specific code assignment. Audits should ensure all providers, coders, and codes assigned are reviewed for each of the various types of records generated (e.g., new patient versus established patient, well visit versus sick visit, hospital visit versus office visit).

Defining the focus of the audit is essential during the planning phase. The details of what is being measured should be clearly defined. The audit should not be too narrow or too broad; for example, only looking at one provider and the CPT codes assigned, or only looking at overall coding accuracy rate are not ideal. A standardized audit tool is recommended to ensure all records and elements are reviewed consistently. In some audits, the preliminary findings are returned to the coder or the provider for review and rebuttal, or agreement. Once the results are tallied, a summary of the findings as well as highlighting areas of opportunity and strengths should be documented. Performance improvement plans may be warranted based on results.

Once the reason or focus for the audit is understood, the audit process can then be designed. The goals should be clear, measurable, and attainable. There must be identification of the elements to be reviewed and an understanding of how those elements are measured. For example, is the audit intended to identify the presence or absence of something specific, or is the expected result an accuracy rate of the element? Define the criteria of what encounters will be included in the audit: for example, all patient visits versus a subpopulation of specific types of visits. What is included and what is excluded? Answering these questions will assist with determining the sample size. Consider the dates of the records reviewed, as standards, guidelines, and code sets are ever changing. Frequency of the audit is an important variable. Newer processes should likely have audits performed frequently in the beginning and should taper off as users become familiar with the process. If a follow-up audit is needed, ensure enough time is left between the result delivery, education provided, and new dates of service processed prior to the follow-up audit

beginning.

After the audit has been completed and tabulated, the scores or rates are reviewed as well as the detailed findings to identify any patterns or trends. Lower-than-target accuracy scores likely need a deeper dive into the data to identify shortcomings. If, for example, there are many recommendations to add modifiers, it is possible the provider or coder is not aware of when to add the modifier. This could be a system issue if there are rules set up to auto-assign certain modifiers.

Now that the data has been analyzed, patterns and trends noted, and root causes identified, what is next? Action plans or activities to improve in the identified opportunity areas should follow an audit, but this task is not always completed. If action plans are not implemented and completed, the next audit is likely going to reveal the same or similar findings and scores. Often, simple solutions or an education session will yield an uptick in scores. An uptick in scores will potentially result in accurate financials, compliance with guidelines, improved patient outcomes, and more.

SECTION VI: PROFESSIONAL DEVELOPMENT

CODER EDUCATION

Coding for professional services requires a unique set of knowledge and skills. In addition to a coder's foundational education and on-the-job training, there is a need for continuous development of job-related knowledge.

General education:

Coding and health information management-related education can be obtained through many sources, such as webinars, online courses, or live training opportunities offered by various organizations, including professional associations. Employee education is critical to the medical billing and coding profession.

Basic knowledge and experience for entry-level coding professionals should include:

- Anatomy and physiology
- Medical terminology
- Pathophysiology, disease process, and pharmacology related to the specialty
- Basic coding knowledge of diagnostic and procedural codes such as ICD-10-CM, CPT, and HCPCS, including the official guidelines for coding and reporting
- Application of guidelines published in the AMA's CPT Assistant
- Application of guidelines published in the AHA's Coding Clinic
- Safeguarding protected health information (PHI)
- Documentation requirements for providers and ancillary staff
- Use of computer systems
- Ability to successfully navigate the EHR

Advanced skills for coding professionals may also include:

- Reimbursement methodology: ability to analyze contracts, understand payment methodologies, and ensure appropriate reimbursement
- Intermediate or advanced ICD diagnostic/procedural and CPT/HCPCS coding
 - Knowledge of specialty-specific coding guidelines and reporting requirements
 - Clinical documentation improvement
 - Denials management
 - CMS local/national coverage determination
 - Financial tracking and reporting; for example, monitoring the payer mix and the impact of fee schedule changes
 - Data governance

Certification:

Education in support of professional certification is offered through AHIMA and other entities. Exam preparation courses are available for AHIMA certifications such as:

- Certified Coding Associate (CCA)
- Certified Coding Specialist (CCS)
- Certified Coding Specialist-Physician (CCS-P)
- Registered Health Information Technician (RHIT)
- Registered Health Information Administrator (RHIA)
- Certified Documentation Improvement Practitioner (CDIP)

Certifications expand the professional opportunities available to the individual. Hiring certified personnel ensures the individual has demonstrated competency in the particular subject matter. Visit the AHIMA Certification page to see the requirements for each specific credential: <u>http://www.ahima.org/certification</u>

Degrees in HIT/HIM:

Traditional or online educational opportunities resulting in a degree in the fields of health information and informatics are available through many community colleges and universities. The Commission on Accreditation for Health Informatics and Information Management (CAHIIM) offers a list of accredited programs.

Continuing education units:

AHIMA certifications require that the individual obtain a certain number of continuing education units (CEUs) each two-year certification cycle. CEUs may be

obtained by participating in AHIMA sponsored events, completing CE quizzes, or through other training opportunities. Many employers provide opportunities for further education by hosting educational events during work hours, or by offering financial reimbursement for educational endeavors attended outside of work.

HOW TO STAY CURRENT

For coding professionals to stay current in their profession, it is important to attend local, state, and/or national coding events. This is also a great way to network. It helps to know colleagues who may have the same situations or coding questions and can share how they handled a certain issue. It is important to keep a current AHIMA membership to have access to AHIMA's resources such as Access Communities, the HIM Body of Knowledge (BoK), and the Journal of AHIMA.

AHIMA offers free e-newsletters with open subscriptions, such as:

• Certification Connection—This quarterly publication provides certified professionals with information on certification, as well as articles on professional development, industry news, information on obtaining CEUs, featured credentials, and more.

AHIMA e-newsletters for members only:

- AHIMA Advantage—Distributed six times per year to all AHIMA members, covering AHIMA news, key HI practice issues, industry trends, and more, this newsletter is also available as a mobile app.
- AHIMA E-Alert—A 360-degree view of the HI industry, AHIMA, and government developments can be found in this weekly newsletter, as well as ways to get more involved with AHIMA and the profession, and professional development resources. The focus is on news members can use and apply immediately to their job. Members can view the most recent issue in Engage in the AHIMA community.
- AHIMA SmartBrief—Daily health information and technology news are the highlight. This newsletter includes a top story, EHR and clinical care, technology and innovations, legislative and regulatory issues, patient advocacy, big data and analytics, free eBooks and resources, and news from AHIMA.

Many healthcare payers, specialty societies, and other organizations in the healthcare industry provide relevant articles, newsletters, and tools, many of which are free. Some examples include:

- The Medicare Learning Network (MLN) Matters (includes free education on CMS programs, policies, and initiatives) <u>https://www.cms.gov/Outreach-and-</u> Education/Medicare-Learning-Network-MLN/MLNGenInfo/Index.html
- American Academy of Family Physicians (AAFP) Family Practice Management (FPM) Toolbox on Coding and Documentation <u>https://www.aafp.org/fpm/toolBox/viewToolType.htm?toolTypeId=6</u>

• Multiple free newsletters available from HCPro (e.g., Just-Coding News: Outpatient, Medicare Insider, Provider Practice insider)

The best practice to stay current on regulatory changes impacting coding and reporting is to develop a list of websites and monitor them regularly, at least monthly. The list of sites to monitor may vary by the type of practice. Suggestions to begin include:

- Monitor the CMS website: <u>https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html</u>
- Review MedLearn compliance questions published on a weekly basis: <u>https://www.medlearnmedia.com/compliance-question-week/</u>
- The Medicare Learning Network has an abundance of helpful information: <u>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html</u>
- Third-party payer and MAC websites are full of valuable information—for example, Noridian, CGS, and WPS: <u>https://www.wpshealth.com/</u>
- Review the OIG workplan: <u>https://oig.hhs.gov/reports-and-publications/workplan/index.asp</u>

GLOSSARY

Cheat sheets: According to the Merriam-Webster Dictionary, a cheat sheet is a "written or graphic aid (as a sheet of notes) that can be referred to for help in understanding or remembering something complex."¹⁴

Computer-assisted coding (CAC): The use of computer software that automatically generates a set of medical codes for review, validation, and use based upon clinical documentation provided by healthcare practitioners.

Critical or key portion: The part or parts of a service that the teaching provider determines are a critical or key portion.

Healthcare provider: Any person or organization who furnishes, bills, or is paid for healthcare services provided in the normal course of business.¹⁵

Intern or resident: An individual who participates in an approved graduate medical education (GME) program or a provider who is not in an approved GME program but who is authorized to practice only in a hospital setting (e.g., has a temporary or restricted license or is an unlicensed graduate of a foreign medical school). Also included in this definition are interns, residents, and fellows in GME programs recognized as approved for purposes of Direct Graduate Medical Education and Indirect Medical Education payments made by fiscal intermediaries or A/B Medicare Administrative Contractors. Receiving a staff or faculty appointment, participating in a fellowship, or whether a hospital includes the provider in its full-time equivalency count of residents does not by itself alter the individual's status as a resident.

Medicare provider fee schedule: The basis for which Medicare Part B pays for Provider services. This fee schedule lists the more than 7,400 covered services and their payment rates.

Natural language processing (NLP): A technology that converts human language (structured and unstructured) into data that can be translated then manipulated by computer systems; branch of artificial intelligence.

Non-provider practitioner: A nurse midwife, nurse practitioner, or provider assistant licensed by the state within which the individual practices.¹⁶

Physically present: When the teaching provider is located in the same room as the patient (or a room that is subdivided with partitioned or curtained areas to accommodate multiple patients) and/or performs a face-to-face service.

Primary care exception: An exception within an approved GME program that

applies to limited situations where the resident is the primary caregiver and the faculty provider sees the patient only in a consultative role (i.e., those residency programs with requirements that are incompatible with a physical presence requirement). In such programs, it is beneficial for the resident to see patients without supervision to learn medical decision making.

Student: An individual who participates in an accredited educational program (e.g., medical school) that is not an approved GME program and who is not considered an intern or resident. Medicare does not pay for any services furnished by these individuals.

Teaching hospital: A hospital in which residents train in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

Teaching provider: A provider, other than an intern or resident, who involves residents in the care of their patients. Generally, for the service to be payable under the Medicare PFS, they must be present during all critical or key portions of the procedure and immediately available to furnish services during the entire service.

Teaching setting: Any provider, hospital-based provider, or non-provider setting in which Medicare payment for the services of residents is made by the fiscal intermediary or A/B Medicare Administrative Contractor under the Direct Graduate Medical Education payment methodology, or on a reasonable cost basis to freestanding skilled nursing facilities or home health agencies.

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