



Introduction to Coding

Todd W. Frieze, MD, FACP, FACE, ECNU, CEC
Member, AACE Socioeconomic &
Member Advocacy Committee

Disclaimer

Please note that any AACE proprietary information or intellectual property may not be shared with any third party or utilized in any manner without the expressed written consent of AACE.

All medical coding must be supported with documentation and medical necessity.

**While this department represents our best efforts to provide accurate information and useful advice, we cannot guarantee that third-party payers will recognize and accept the coding and documentation recommendations. As CPT®, ICD-9-CM and HCPCS codes change annually, you should reference the current CPT®, ICD-9-CM and HCPCS manuals and follow the "Documentation Guidelines for Evaluation and Management Services" for the most detailed and up-to-date information.

This information is taken from publicly available sources. The American Association of Clinical Endocrinologists cannot guarantee reimbursement for services as an outcome of the information and/or data used and disclaims any responsibility for denial of reimbursement. This information is intended for informational purposes only.

Current Procedural Terminology (CPT©) is copyright and trademark of the 2011 American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT©. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

Rationale for Medical Coding

- ✦ Physicians & qualified staff perform services & procedures, and provide medications, supplies, & equipment during pt encounters
- ✦ Determine definitive diagnoses & treat sxs/sxs
- ✦ Services captured on permanent medical record
- ✦ Computers correlate specific numbers and letters with canned text, on which payment is ultimately based

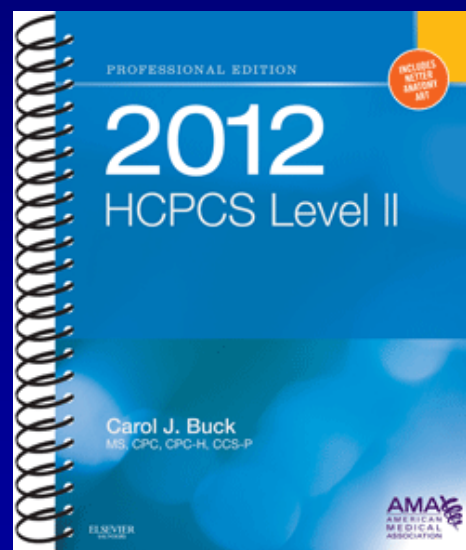
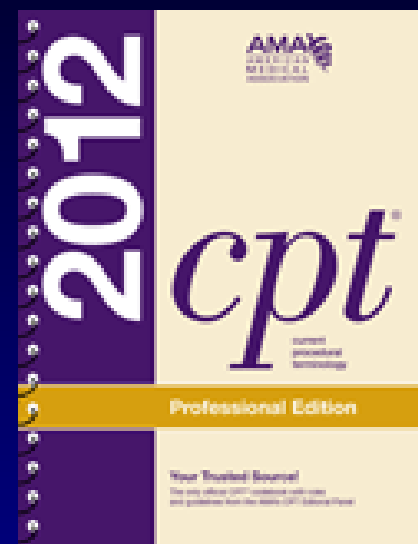
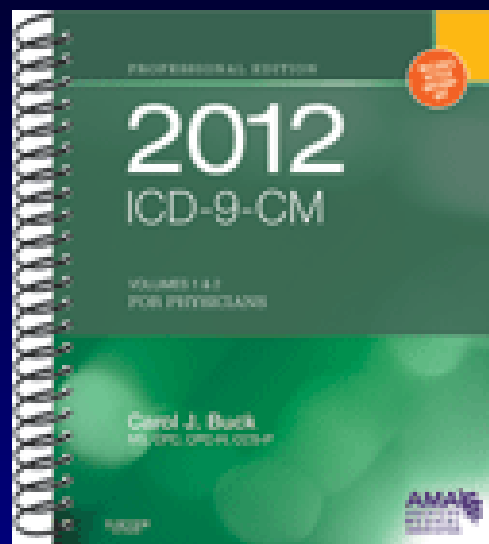
Principles of Medical Coding

- ✦ If it's not documented, it wasn't done
- ✦ If you don't submit internally consistent codes for services provided, you won't get paid!

Principles of Medical Coding

- ✦ Read the introductions for each section
- ✦ Understand the underlying premises to use system correctly
- ✦ Good understanding → maximal reimbursement
- ✦ Poor understanding → penalties
 - ✦ Not billing at appropriate level (under or over-charging)
 - ✦ Not billing for provided services as unaware of existence of separate code

Tools Your Practice Will Need



International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM)

- ✦ Based on official version of WHO's 9th revision
- ✦ National Center for Health Statistics (NCHS) & Centers for Medicare & Medicaid Services (CMS) are the US government agencies responsible for overseeing changes & modifications
- ✦ Code updates, deletions, changes, & revisions are published & effective each October 1st

Organization of ICD-9-CM

- ✦ 3 volumes
- ✦ Volumes 1 & 2 used to report diagnostic information for physicians, inpts, & outpts
- ✦ Volume 3 use by hospital for procedures
 - ✦ Used for Medicare Part A
 - ✦ Part of the DRG calculation
 - ✦ NOT used to bill physician services

Volume 2 – Alphabetic Index

- ✦ Presented first as this is where to look when identifying diagnosis codes
- ✦ 3 sections
 - ✦ Section 1: *Alphabetic Index to Disease* (contains many diagnostic terms not in Volume 1)
 - ✦ Section 2: *Table of Drugs & Chemicals*
 - ✦ Section 3: *Index of External Causes*
- ✦ Select tables in alphabetic place in index

Volume 1 – Tabular List

- ✦ Found behind Volume 2
- ✦ Lists diseases found in alphabetic index
- ✦ 3 sections
 - ✦ Section 1: *Classification of Diseases & Injuries*
 - ✦ Section 2: *Supplementary Classification (V & E codes)*
 - ✦ V codes: problem or circumstance influencing health status, but not current illness or injury
 - ✦ E codes: describe the circumstance causing an injury, not the nature of the injury
 - ✦ Section 3: *Appendices*

ICD-9-CM Specifics

- ✦ Numerous symbols, tables, abbreviations, etc. that you must understand to use correctly
- ✦ Conventions: general guidelines & rules for all settings unless otherwise specified
- ✦ Chapter Specific Coding Guidelines: specific guidelines within each chapter regarding diseases process, sequencing, & other pertinent coding instruction

Chapter 3 = Endocrine, Nutritional, Metabolic

Steps to Correct ICD Coding (1)

- ✦ Review documentation & determine reason for service
- ✦ Look up main term in alphabetic index (Vol 2)
 - ✦ Do not use “possible”, “rule out”, etc.
 - ✦ If no definitive diagnosis, code signs or symptoms
- ✦ Review all notes, sub-terms, & modifiers listed
- ✦ Interpret any abbreviations, cross references, symbols, or brackets

Steps to Correct ICD Coding (2)

- ✦ Select a code from Volume 2
- ✦ Find the code in the tabular list (Vol 1)
- ✦ Review all instructions such as “includes”, “excludes”, & “code first” guidelines
- ✦ Determine the correct code & choose the code with highest specificity
- ✦ Report additional & co-existing conditions after primary diagnosis

ICD-9-CM Coding Guidelines

- ✦ Use both the alphabetic index & tabular list
- ✦ **Never code from the alphabetic index alone**
 - ✦ Ensures proper coding
 - ✦ Choose a code supporting highest specificity level
- ✦ Always follow instructions in either Volume
- ✦ Use all diagnosis codes at their highest # of digits available (5th digits not optional)

Current Procedural Terminology (CPT®)

- ✦ “Listing of descriptive terms & identifying codes for reporting medical services & procedures performed by physicians. The purpose ... is to provide a uniform language that will accurately describe medical, surgical, & diagnostic services ...”.
- ✦ National coding standard for all electronically submitted health care transactions
- ✦ Proprietary product of AMA (primary source of income for AMA)

CPT[®] Book

- ✦ Index organized by main terms in 4 categories
- ✦ Main Sections: Evaluation and Management Services (E&M), Anesthesia, Surgery, Radiology, Pathology & Laboratory, Medicine
 - ✦ Each section with initial guidelines necessary to interpret & report procedures & services
 - ✦ Further subsection or code-specific guidelines
- ✦ Appendices

Finding the Correct CPT[®] Code

- ✦ Identify significant terms in documentation
- ✦ Use alphabetic index to find terms & code(s)
- ✦ Refer to CPT[®] code or code range
- ✦ Do not select code that approximates
- ✦ Always read section, subsection, code-specific instructions
- ✦ Interpret any symbols or abbreviations
- ✦ Use unlisted code only if no descriptive code

Modifiers

- ✦ Provide way to report services &/or procedures that have been altered by some circumstance without their definition or code changed
- ✦ May report professional or technical services, multiple services, increased or reduced service/procedure, an adjunctive service, or that unusual events occurred
- ✦ If no modifier, “global” charge is being billed
Physician covers all cost and interpretation

Modifiers of Interest

- ✦ -25: Separately identifiable E&M service by same physician on same day as procedure
Office visit on same day as FNA, DXA, etc.
- ✦ -26: Professional component (physician work)
Interpret study done by others (e.g. DXA)
- ✦ -TC: Technical component
- ✦ -59: Distinct procedural service — FNA on ≥ 2 nodules
- ✦ -90: Reference (outside) lab — billing payer for purchased test done outside your office (non-Medicare)

E&M Coding

- ✦ Almost all encounters will include an E&M code
- ✦ CPT® book contains tables outlining process
 - ✦ Copy for reference use
 - ✦ Must understand definitions of terms used to code properly
- ✦ Each level has specific code based on place/type of service, content of service, nature of presenting problem, or time required

E&M Classification

- ✦ Location
- ✦ New or established pt
- ✦ Consultation
- ✦ Observation
- ✦ Initial or subsequent visit
- ✦ Face-to-face or not
- ✦ Time
- ✦ Based on age (preventive, newborn)
- ✦ Care plan oversight

New Vs. Established Pts

- ✦ New Pt: has not received any professional services from the physician or another physician of same specialty who belongs to the same group practice, within the past 3 years
- ✦ Established Pt: has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years

E&M Component Levels

- ✦ History*
- ✦ Examination*
- ✦ Medical Decision Making*
- ✦ Counseling
- ✦ Coordination of Care
- ✦ Nature of presenting problems
- ✦ Time

*Key Components

E&M History

- ✦ Chief complaint (CC)
- ✦ History of Present Illness (HPI)
 - ✦ Multiple elements
 - ✦ Ranges from Problem focused to Comprehensive
- ✦ Review of Systems (ROS)
 - ✦ Certain systems recognized
- ✦ Past Medical, Surgical, Family, &/or Social Hx

E&M History

Type of History	HPI	ROS	PFSH
Problem Focused	Brief	N/A	N/A
Expanded Problem Focused	Brief	Problem Pertinent	N/A
Detailed	Extended	Extended	Pertinent
Comprehensive	Extended	Complete	Complete

E&M Examination

- ✦ Two sets of guidelines from 1995 and 1997
- ✦ Range from problem-focused to comprehensive examination
- ✦ Focus on body areas or organ systems which are distinctly defined

E&M Medical Decision Making

- ✦ 3 pertinent elements
 - ✦ Number of diagnoses &/or management options
 - ✦ Amount &/or complexity of data
 - ✦ Risk of Complications, Morbidity, &/or Mortality
- ✦ 2 of 3 elements must be met for correct use
- ✦ Tables of risk determination and selection present for use (see handout)

E&M MDM Table

Selecting the type of decision making: Indicate below the level of each element of the decision making from the tables above. If at least two elements are met or exceeded in a certain level of decision making, then select that level. If a different level is indicated for each element, then select the level that is in the center of the three indicated.

Type of medical decision making	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Diagnosis and/or management options	0-1	2	3	4 or more
Amount and complexity of data	0-1	2	3	4 or more
Overall risk	Minimal	Low	Moderate	High

Choosing an E&M Code

- ✦ First determine level of history
- ✦ Second, determine the extent of the exam
- ✦ Third, determine the complexity of the MDM
- ✦ For ER, admission, and new pts, decision based on all 3 components
- ✦ For subsequent care or established visits, code based on 2 of 3 components

Level of Service Based on Time

- ✦ For encounters dominated by counseling &/or coordination of care (>50%), time may become the key element
- ✦ If elects to report on this basis, total length of time of encounter should be documented & record should describe counseling &/or activities to coordinate care

“This 45 minute visit was spent counseling the pt regarding ... and discussing the treatment options available”

Healthcare Common Procedure Codes (HCPCS)

- ✦ Used to identify supplies, products, & services not included in CPT[®] codes
- ✦ Level II (alpha numeric characters)
- ✦ Includes services such as non-physician procedures, ambulance services, DME, supplies, and injectable drug administration
- ✦ Book organized with index, tabular list, then appendices

Selected HCPCS Subsections

- ✦ A codes: Transportation Services, Medical & Surgical Supplies, Administrative, Miscellaneous & Investigational
- ✦ B codes: Enteral & Parenteral Therapy
- ✦ E codes: Durable Medical Equipment
- ✦ G codes: Procedures/Professional Services (Temporary)
- ✦ J codes: Drugs Administered other than Oral Method

Choosing a HCPCS Code

- ✦ Identify service or procedure provided
- ✦ Look up service or procedure in index
- ✦ Choose a preliminary code
- ✦ Turn to appropriate service and locate code(s)
- ✦ Read narrative of all codes before choosing
- ✦ Check all notes & references
- ✦ Review Appendices for all other references & other guidelines
- ✦ Determine if any modifiers should be used

Final Coding Caveats

- ✦ Just because code exists does NOT mean service will be eligible for payment
- ✦ Different payers may interpret same code differently & require different code submission for same service in order to be paid
- ✦ Talk to your billing/collection staff frequently – do not write off charges w/o your knowledge
- ✦ Get trained appropriately ...

Upcoming AACE Courses

Bridge the Gaps in Endocrine Coding

June 12-13, 2012- Richmond, VA

July 19, 2012 – Atlanta, GA

Fundamentals and Advanced Endocrine Coding Course

June 29-30, 2012- Gainesville, FL

November 9-10, 2012 – Philadelphia, PA

These courses are designed for you and your staff. Contact Vanessa Lankford at vlankford@aace.com or 904-353-7878 for additional information. Cancellations must be received in writing to the AACE office 48 hours in advance of the course in order to receive a full refund. No-shows or cancellations received after this time are not eligible for a refund. AACE reserves the right to cancel the course with a minimum 48-hour notification. Participants will have the option to attend in an alternate course (if available) or request a full refund.

AACE Coding Involvement

- ✦ Many of the codes that are endocrinology-specific did not exist before 1991
- ✦ Desperate need for these codes to allow us to get paid was one of the principle reasons for the creation of AACE
- ✦ Represented on AMA CPT[®] and RUC

AACE Contact Information

Anita Henderson-Sumpter, MHA, MBA, CHC, CPC, CMOM

Director of Socioeconomics & Member Advocacy

(904) 353-7878 ext. 142

asumpter@aace.com

Vanessa Lankford, CMCO, CPC, CMOM, AACE-CEC

Socioeconomics Coordinator

(904) 353-7878 ext. 123

vlankford@aace.com

ICD-10-CM Overview

- ✦ Diagnostic coding system
- ✦ Developed by WHO in 1993 to replace ICD-9-CM
- ✦ Used in most countries except USA
- ✦ Will be required by Medicare effective October 1, 2013
- ✦ New proposal to be effective October 1, 2014

Why The Change from 9 to 10

- ✦ ICD-9-CM is out-of-room for more codes
 - ✦ Organization is classified scientifically
 - ✦ Can only be 10 subcategories for each 3 digit category
- ✦ Disease patterns and outcomes of treatment can be better analyzed
- ✦ Provides a clearer view of diagnosis

ICD-9-CM vs. ICD-10-CM

ICD-9-CM

- ✦ Up to 5 characters
- ✦ Mostly numeric
- ✦ E and V codes only alphanumeric
- ✦ Valid codes may be 3, 4, or 5 digits
- ✦ ~ 13,600 codes

ICD-10-CM

- ✦ Up to 7 characters
- ✦ All codes alphanumeric
 - ✦ 1st character always alpha
 - ✦ 2nd character always numeric
 - ✦ 3rd-7th characters can be mix
- ✦ Valid codes may be 3,4, 5, 6, or 7 characters
- ✦ ~69,000 codes

ICD-10-CM Overview

- ✦ Single codes can report a disease and current manifestation
- ✦ Higher specificity (e.g. diseases of the ovary can be reported with ICD-10-CM as unspecified ovary, right ovary, left ovary, or bilateral; ICD-9-CM only specifies disease of ovary)
- ✦ Requires more detailed documentation
- ✦ 2 year transition allowance
 - ✦ Systems will need to access both ICD-9-CM and ICD-10-CM

ICD-10-CM Chapter IV

Endocrine, nutritional and metabolic diseases

- ✦ E00-E07 Disorders of thyroid gland
- ✦ E10-E14 Diabetes mellitus
- ✦ E15-E16 Other disorders of glucose regulation & pancreatic internal secretion
- ✦ E20-E35 Disorders of other endocrine glands
- ✦ E40-E46 Malnutrition
- ✦ E50-E64 Other nutritional deficiencies
- ✦ E65-E68 Obesity and other hyperalimentation
- ✦ E70-E90 Metabolic disorders

E&M Table of Risk

This table is compiled by the AMA and CMS and is used to illustrate risk factors of morbidity /mortality associated with common diagnoses and treatments provided by physicians

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	<ul style="list-style-type: none"> *One self-limited or minor problem, e.g., cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> *Laboratory tests requiring venipuncture *Chest X-rays *EKG/EEG *Urinalysis *Ultrasound, e.g., echocardiography *KOH prep 	<ul style="list-style-type: none"> *Rest *Gargles *Elastic bandages *Superficial dressings
Low	<ul style="list-style-type: none"> *Two or more self-limited or minor problems *One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH *Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> *Physiologic tests not under stress, e.g., pulmonary function tests *Noncardiovascular imaging studies with contrast, e.g., barium enema *Superficial needle biopsies *Clinical laboratory tests requiring arterial puncture *Skin biopsies 	<ul style="list-style-type: none"> *Over-the-counter drugs *Minor surgery with no identified risk factors *Physical therapy *Occupational therapy *IV fluids without additives
Moderate	<ul style="list-style-type: none"> *One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment *Two or more stable chronic illnesses *Undiagnosed new problem with uncertain prognosis, e.g., lump in breast *Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis *Acute complicated injury, e.g., head injury with brief loss of consciousness 	<ul style="list-style-type: none"> *Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test *Diagnostic endoscopies with no identified risk factors *Deep needle or incisional biopsy *Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization *Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> *Minor surgery with identified risk factors *Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors *Prescription drug management *Therapeutic nuclear medicine *IV fluids with additives *Closed treatment of fracture or dislocation without manipulation
High	<ul style="list-style-type: none"> *One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment *Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure *An abrupt change in neurologic status, e.g., seizure, TIA, weakness, or sensory loss 	<ul style="list-style-type: none"> *Cardiovascular imaging studies with contrast with identified risk factors *Cardiac electrophysiological tests *Diagnostic endoscopies with identified risk factors *Discography 	<ul style="list-style-type: none"> *Elective major surgery (open, percutaneous or endoscopic) with identified risk factors *Emergency major surgery (open, percutaneous or endoscopic) *Parenteral controlled substances *Drug therapy requiring intensive monitoring for toxicity *Decision not to resuscitate or to de-escalate care because of poor prognosis