Coding for the Rest of Us: Why Everyone in Your Practice Needs a Basic Knowledge of Coding

There is no one, and I do mean no one, in your medical practice who does not need to know the basics of coding. Here is why:

- Providing services to patients is the business of healthcare. Every person who relies on healthcare for their living should understand something about the business they are in. This should not outweigh the fact that we are privileged to care for patients, but as the saying goes “No money, no mission.”
- It takes a team to produce care. The silos of front desk, billing, nursing and scheduling must come together to share their knowledge and produce a high-quality, reimbursable patient visit. Here are the roles each member of the team plays:
    - The patient calls for an appointment and the scheduler matches the patient’s problem to an appropriate appointment type. The scheduler finds out if the patient is **new or established** and **what the patient’s appointment is for.**
    - The patient arrives for the appointment and the front desk assures that all **current demographic and insurance information is collected**.
    - The nurse rooms the patient, taking vitals, reviewing medications and **reviewing the reason for the visit** – the chief complaint.
    - The physician or mid-level provider cares for the patient, documenting the visit and choosing the

appropriate service and diagnosis codes.

- The patient completes the visit by paying any deductibles or co-insurance due and making any future appointments needed. The checkout staff **enters the payments and/or charges** if the service codes have not already been posted via the EMR.
- The biller "scrubs" the claim, checking for any errors and **electronically submits the claim to the payer**. The hope is that the claim is clean and will be accepted and paid immediately (within 30 days.)

When staff understands how important their contribution is to the financial viability of the practice and how all the pieces fit together, they are more incentivized to perform.

"Coding" means two things: s**ervice codes** and **diagnosis codes**. Service codes describe office visits, surgery, laboratory, radiology, pathology, anesthesia and medical procedures that are provided by physicians, nurse practitioners, and physician assistants. Diagnosis codes describe signs, symptoms, injuries, diseases, and conditions. **The critical relationship between a service code and a diagnosis code is that the diagnosis supports the medical necessity of the procedure.**

Service codes are called either CPT codes or HCPCS (pronounced "hick-picks) based on the payer/insurer who uses them. Most commercial insurers use CPT (Current Procedural Terminology) codes, but Medicare and Medicaid use HCPCS (Healthcare Common Procedure Coding System.) Codes are globally grouped into Level I and Level II:

- Level I codes include the 5-digit numeric CPT (Current Procedural Terminology) codes. These were developed by the American Medical Association (AMA) in 1966 and remain proprietary to the AMA. The codes are updated in October and become effective as of the next calendar year. They are available as a printed manual or as an

electronic file.
- Level II codes are national codes developed by the Centers for Medicare and Medicaid Services (CMS) to describe medical services and supplies not covered in the CPT. They consist of alphabetic characters (A through V) and four digits.

There are two ways that patient services are coded so they can be billed to insurance companies. The first is through the use of a preprinted coding sheet, which goes by many different names: superbill, encounter form, routing sheet, patient ticket, or billing form. The physician or mid-level provider indicates which services were provided and maps specific diagnosis codes to the services.

The second is abstraction from the medical record. A coder reads the documentation provided by the physician or mid-level provider, and matches codes to the services described in the record. Computerized coding abstraction via an electronic medical record (EMR) is also an option

Here are some basic coding rules that apply to every type of practice:

- Always have the latest edition of CPT and HCPCS. Service codes change annually and it is important to use the correct code for the calendar year. Check new, revised and deleted codes annually and change your encounter form and codes in your billing system to match.
- Attend webinars or seminars annually to stay up-to-date on large-scale coding changes for your specialty or for all specialties. For instance, tobacco cessation counseling is reportable to and payable by Medicare for the first time in 2011 – see a **handy guide here** and every specialty can bill it. You may also want to subscribe to coding newsletters for your specialty or check your physician's specialty society to see what they offer.

- Utilize the National Correct Coding Initiative (NCCI) to make sure which codes are to be submitted individually versus being bundled. Many practices do not know about or use the NCCI information for the simple reason that it is complex and confusing and changes regularly. Someone in the field who offers great (free) information on the NCCI edits is Frank Cohen **here.**
- Have an in-house crosswalk for provider abbreviations to make sure that they have signed off on what their abbreviations mean. The best of all worlds is requiring the physician or mid-level provider to supply a code as opposed to a description.
- Use scrubbing software tools to check service and diagnosis code mismatches, Local Coverage Determinations (LCDs) for Medicare, any services without appropriate diagnosis codes and any diagnoses without standard accompanying services.
- Audit your documentation regularly to ensure it matches your level of service ("if you didn't document it, you didn't do it") especially if you are not documenting electronically with decision support tools. Audit yourself or hire a firm to audit for you and document lessons learned and any corrective action taken. This should be part of your practice compliance plan. Note that physician regulatory insurance is now available (Google it) for around $1500 per physician per year.
- It is always the physician or mid-level provider's ultimate responsibility to choose the codes that best correlate with what s/he did. When in doubt, always defer to the provider of the service.

Other articles of interest:

How Many Staff Do You Need?

A Perfect Day in Your Medical Practice

The Cohen Report: Analysis and “Quickinar” of the NCCI 17.1 Changes Effective April 1, 2011

There are 11,831 new edit pairs, which pushes the total for effective edits to 709,527. There were 346 terminations for a net gain of 11,485. In this release, we find that there are around 350 edit pairs that have termination and/or effective dates retroactive to an earlier period with some going as far back as October, 2001. In fact, all but 10 of the terminated edit pairs are retroactive, adding to the complexity of billing and possible targets for RAC auditors.

If you would like to get a copy of his summary report along with a couple of worksheets that detail these changes, go to www.frankcohengroup.com and click on the Download tab. There is no charge for the analysis or the worksheets.

Free Quikinar on NCCI

Frank will also be conducting a brief (free) Quickinar„¢ to go over the NCCI policies and changes for this release on March 24, 2011 from 11:00 to 11:30. To register, go to his website at www.frankcohengroup.com and click on the Quickinar tab.

If you have any questions, please feel free to contact Frank Cohen.

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The Cohen Report: Medicare Part B NCCI Update 16.2 for Providers Effective July 1, 2010

Here's your pop quiz:

The NCCI edits are:

A. pairs of services that should not be billed by the same physician for the same patient on the same day.

B. definition refinements for HCPCS codes.

C. diagnosis codes (ICD-9) that cannot be billed together on a CMS 1500 claim.

The answer is below the picture.

Image by sxyblkmn via Flickr

If you answered "A", you're on top of your game! The King of

the National Correct Coding Initiative (NCCI) quarterly analysis is Mr. Frank Cohen and he provides that analysis free of charge for all. Thank you, Frank! With his analysis, you have the opportunity to see what's changed and what's new, to tweak your system to catch the pairs, and to make sure you are providing the right care at the right time as well as maximizing your reimbursement.

The Cohen Report:

In summary, there are 16,843 new edit pairs, bringing the total number of active edit pairs to 653,718. Six of these are backdated to an effective date of January 1, 2010. The majority of these (75.17%) are associated to the edit policy "Misuse of column two code with column one code" with 12.82% associated to "Standard preparation / monitoring services for anesthesia". There are 6,042 unique Column 1 codes and 274 unique Column 2 Codes within the new edits.

There are 36 new terminated edit pairs with 12 backdated to January 1, 2010 and two backdated to April 1, 2010. The edit policies associated to these edit pairs are distributed between "Misuse of column two code with column one code" (44.4%), "CPT Manual and CMS coding manual instructions" (33.3%) and "More extensive procedure" (22.2%).
There were 413 edit pairs with modifier changes. Of these, 387 went from 0 (no modifier permitted) to 1 (modifier permitted) and 26 went from an indicator of 0 to an indicator of 1.
There are currently 1,336 duplicate entries; codes that were activated at one point then terminated and then re-activated. There are 5,318 swapped edit pairs; situations where the edit pair was introduced at one point in a specific order (column 1 and column 2), terminated and then re-activated with the edit pair in the opposite order.
I have posted my analysis worksheets for those interested in the details. Go to www.frankcohen.com and click on the Download tab.ï»¿

October 2009 NCCI Edits Analysis Just Released by Frank Cohen

For those of you who have not tapped into the amazing wealth of information generously shared by Frank Cohen, go to **his site** now and see what he has that could help you.

Most recently Frank analyzed the October 2009 NCCI Edits Release 15.3 and organized the information into meaningful categories as well as providing an executive summary.

As a reminder, the **CMS website** tells us:

> *The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs as a general reference tool that explains the rationale for NCCI edits.*

Per Frank's assessment of the 2009 changes effective on October 1:

There are 706 terminated edit pairs but once again, around half have been terminated retrospectively. Two are terminated back to last quarter (7.1.09), 357 back to April, 2009 and 27 all the way back to January, 2009. ***This means that, if you were denied payment on edit pairs that are part of this last over the past few quarters, you should be able to resubmit and get paid.*** *The big hitters for terminated codes in both column 1 and column 2 fell within the surgical code category (520 and 513, respectively).*

For more information, go to **Frank's site here**, go to the Download tab and you will see the link at the top of the page.