

## Coding, Doing it the right way

by Tammy Martinson, CPC. CPC-I. CPMA, CEMC

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2018

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## Meet the Presenter

- Tammy Martinson CPC, CPMA, CPC-I, CEMC
- *AAPC Approved ICD.10 Trainer*
- Coding experience for over 15 years
- Auditing experience for over 8 years
- Butler Community College Adjunct - 7 years
  
- Tammy.Integrity@gmail.com

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## Disclaimer

- This presentation was developed for educational purposes for ICD 10. This presentation was designed to serve as training material. The instructor may not be held liable for any advice given or work performed by students of this course. This presentation is designed to instruct attendees on proper ICD 10 coding guidelines. The instructor cannot be held liable for how the attendee utilizes or self-interprets any of the material contained within this presentation.

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\* Documentation requirements for choosing an Evaluation & Management code.

\* The risks of "Cloning" / "Copy & Pasting"

\* Why the Medical Necessity is the overarching factor

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- General Principles of Evaluation and Management Documentation

**"If it isn't documented, it hasn't been done",**  
is an adage that is frequently heard in the health care setting.

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**Each Visit should include:**

- Reason for the encounter & relevant history, physical examination findings and prior diagnostic test results;
- Assessment, clinical impression, or diagnosis
- Medical Plan of care; and
- Date and legible identity of the provider.

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### Each visit should include (cont)

- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified;
- The patients progress, response to and changes in treatment, and revision of diagnosis should be documented

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### Other information required

- In order to receive payment from Medicare and many other insurance companies, for a service, the service must also be considered reasonable and necessary.
- Furnished for the diagnosis, direct care and treatment of the beneficiary's medical condition (i.e., not provided for the convenience of the beneficiary, provider, or supplier; and
- Compliant with the standards of good medical practice.

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### Evaluation & Management (EM)

- Patient Type: New or Established patient (New patient, not seen in last 3 yrs.)
- Setting of Service  
Office, ER, Observation, Nursing facility

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## Requirements for EM

- **History:** Includes the Chief complaint, Review of Systems and Past, Family, Social history
- **Chief Complaint:** A CC is a concise statement that describes the symptom, problem, condition, diagnosis or reason for the patient encounter. The CC is usually stated in the patient's own words.  
For example:, patient complains of upset stomach, aching joints, and fatigue.

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## History of Present Illness

Must be done by the provider

- Location (example, left hip);
- Quality (example: aching, burning, radiating pain);
- Severity (example: scale of 1-10) ;
- Duration (example: started three days ago) ;
- Timing (example: constant or comes and goes) ;
- Context (example: lifted large object at work) ;
- Modifying factors: example: better when heat is applied ; and
- Associated signs and symptoms (example: numbness in toes)

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## Example- Great documentation

- The patient is here today complaining of a cough, runny nose and sore throat for the last week. She has tried OTC tylenol cold with very little relief.

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### Example - Documentation needs a little help

- Subjective/CC:
- sitting up in bed, awaiting cath today, husband at bedside.
- What is the patients actual issue ? Why are they in the hospital ? Is it improving, stable, worse ??

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### What is the provider telling us ?

- Patient comes in today for breast lesion removal on her face & chest wall. Tibia and over wall thickening larger.
- If you use a system, like DRAGON please review the documentation. This is a perfect example.

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### Elements required for each type of history

TYPE OF HISTORY	CC	HPI	ROS	PFSH
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent 1-2	N/A
Detailed	Required	Extended	Extended 2-9	Pertinent
Comprehensive	Required	Extended	Comprehensive 10+	Comprehensive

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## Review of Systems

\* A series of questions in order to identify signs/symptoms that the patient may be experience or has experienced.

\* Clinical staff may take this information

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## ROS

- Constitutional Symptoms (e.g., fever, weight loss Ht, weight, BMI )
- Eyes;
- Ears, Nose, Mouth, Throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;

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## ROS (continue)

- Integumentary (skin and/or breast)
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic; and
- Allergic/Immunologic

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## Accepted Documentation, but not recommended

- See HPI
- I have reviewed 10 ROS and all are negative, except for what is mentioned in the HPI.
- **\*\*What 10 were reviewed ??** The pertinent positives should still be listed.
- This type of documentation, attorneys love.

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A problem pertinent ROS inquires about the system directly related to the problem identified in the HPI.

**In this example, one system – the ear – is reviewed:**

**CC:** Earache.

**ROS:** Positive for left ear pain. Denies dizziness, tinnitus, fullness, or headache.

An extended ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems.

**In this example, two systems – cardiovascular and respiratory – are reviewed:**

**CC:** Follow-up visit in office after cardiac catheterization. Patient states "I feel great."

**ROS:** Patient states he feels great and denies chest pain, syncope, palpitations, and shortness of breath. Relates occasional unilateral, asymptomatic edema of left leg

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## What if I can't get the information?

- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.  
Example: Patient unconscious, patient intubated, etc.

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### Past, Family and/or Social History

- Past History including experiences with illnesses, operations, injuries and treatments
- Family history including a review of medical events, diseases, and hereditary conditions that may place the patient at risk; and
- Social history including an age appropriate review of past and current activities (smoking, drinking, married, seat belt, etc)

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### Examination

- The difference between the Review of Systems and Examination, is the Examination is "hands on" and must be done by the provider.
- We have two different types of exams. We refer to them as 1995 or 1997

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### Always take time to read your documentation

- Ear drainage x 2 weeks, **pooping** on right side, had bleeding that required multiple Q-tips.

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**Important Points that should be kept in mind when documenting**

- Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented.
- A notation of "**abnormal**" without elaboration is not sufficient.
- Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ systems(s) should be described

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**Important Points that should be kept in mind when documenting**

- Can you defend your documentation in a court of law ?????? Will you remember what you meant in 5 years ?
- Can someone else understand your documentation ? Auditor, Coder, other physicians
- Electronic Health Records, help make documentation faster, but they also catch many mistakes and what we do and don't document.

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**Take time to read your documentation**

- The patient is at high risk for post-op pneumonia and would require pulmonary **toileting** and management.
- On exam left lower extremity has good range of motion at the knee and ankle

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## Spell check doesn't always catch errors.

- Will give trial of the toes 0.6mg subcutaneous daily
- Per her daughter, the chest is ALWAYS in the car while driving.
- Take 10mg of pregnancy in the AM & 5mg at lunch

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## Examination

- General multi-system
- Single organ system
- Areas are the same as the Review of Systems.

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Types of Exam	Description
Problem Focused	Include performance and documentation of one to five elements identified by a bullet in one or more organ system(s) or body area(s)
Expand Problem Focused	Include performance and documentation of at least six elements identified by a bullet in one or more organ system(s) or body area(s).
Detailed	Include at least six organ systems or body areas or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet is expected. Alternatively, may include performance and documentation of at least twelve elements identified by a bullet in two or more organ systems or body areas.
Comprehensive	Include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by a bullet is expected.

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## Medical Decision Making

- MDM refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the follow factors:

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## MDM Factors

- The number of possible diagnoses and/or the number of management options that must be considered
- The Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

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## Chronic conditions Mgmt

- Established diagnosis, the record should reflect whether the problem is:
  - Improved
  - Well controlled,
  - Resolving, or resolved; or
  - Inadequately controlled, worsening, or failing to change as expected.

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Is this Visit Medically Necessary ?

- A/P
- 1. DM2, controlled
- 2. HTN, stable
- 3. HLD, at goal

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Is this Visit Medically Necessary ?

- A/P
- 1. DM2, controlled, continue Metformin 500 mg daily
  - 2. HTN, stable, continue Lisinopril 20 mg daily
  - 3. HLD, at goal, continue Atorvastatin 20 mg Daily

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Assessment/Impression/Plan

- When ordering lab, radiology, EKG's, etc, the documentation **must support** the medical necessity.
- We usually say when determining the level of E& M to only count those assessments that:
  - - Have MEAT (monitor, evaluate, assess, treat)
  - - Have HPI documented
  - - Have a plan

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### Assessment/Impression/Plan

- You may have a differential diagnosis and/or a statement that you are ruling out something. The signs and symptoms must be documented for coding.
- Per ICD.10 : Rule out, possible, consistent with, probable diagnosis must be coded to the sign/symptom.

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### How to Judge if there is MEAT

- Was a med prescribed, changed or continued ?
- Was a test, procedure or therapy ordered ?
- Is there a follow-up plan like a consultation request or referral ?
- Is there a differential diagnosis such as a rule out stated ?
- Is the status of the condition stated such as worsening or new onset ?
- Are patient/nursing instructions documented ?

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### Scoring Diagnoses/Management Options

# DIAGNOSES OR TREATMENT OPTIONS	# X Pts=Results
Self limited or Minor max 2	1
Established problem; stable, improved	1
Established problem; worsening	2
New problem; no add'l workup max 1	3
New problem; add'l workup planned	4

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## Data Reviewed

Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2

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## Table of Risk

LEVEL OF RISK	PRESENTING PROBLEM	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	<ul style="list-style-type: none"> <li>One self-limited or minor problem (for example, cold, insect bite, tinea corporis)</li> </ul>	<ul style="list-style-type: none"> <li>Laboratory tests requiring venipuncture</li> <li>Chest x-rays</li> <li>EKG/EEG</li> <li>Urinalysis</li> <li>Ultrasound (for example, echocardiography)</li> <li>KOH prep</li> </ul>	<ul style="list-style-type: none"> <li>Rest</li> <li>Gargles</li> <li>Elastic bandages</li> <li>Superficial dressings</li> </ul>
Low	<ul style="list-style-type: none"> <li>Two or more self-limited or minor problems</li> <li>One stable chronic illness (for example, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH)</li> <li>Acute uncomplicated illness or injury (for example, cystitis, allergic rhinitis, simple sprain)</li> </ul>	<ul style="list-style-type: none"> <li>Physiologic tests not under stress (for example, pulmonary function tests)</li> <li>Non-cardiovascular imaging studies with contrast (for example, barium enema)</li> <li>Superficial needle biopsies</li> <li>Clinical laboratory tests requiring arterial puncture</li> <li>Skin biopsies</li> </ul>	<ul style="list-style-type: none"> <li>Over-the-counter drugs</li> <li>Minor surgery with no identified risk factors</li> <li>Physical therapy</li> <li>Occupational therapy</li> <li>IV fluids without additives</li> </ul>

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## Table of risks (Moderate)

LEVEL OF RISK	PRESENTING PROBLEM	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Moderate	<ul style="list-style-type: none"> <li>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</li> <li>Two or more stable chronic illnesses</li> <li>Undiagnosed new problem with uncertain prognosis (for example, lump in breast)</li> <li>Acute illness with systemic symptoms (for example, pyelonephritis, pneumonitis, colitis)</li> <li>Acute complicated injury (for example, head injury with brief loss of consciousness)</li> </ul>	<ul style="list-style-type: none"> <li>Physiologic tests under stress (for example, cardiac stress test, fetal contraction stress test)</li> <li>Diagnostic endoscopies with no identified risk factors</li> <li>Deep needle or incisional biopsy</li> <li>Cardiovascular imaging studies with contrast and no identified risk factors (for example, arteriogram, cardiac catheterization)</li> <li>Obtain fluid from body cavity (for example, lumbar puncture, thoracentesis, culdocentesis)</li> </ul>	<ul style="list-style-type: none"> <li>Minor surgery with identified risk factors</li> <li>Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</li> <li><b>Prescription drug mgmt</b></li> <li>Therapeutic nuclear medicine</li> <li>IV fluids with additives</li> <li>Closed treatment of fracture or dislocation without manipulation</li> </ul>

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Table of Risks (high)

LEVEL OF RISKS	PRESENTING PROBLEM	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
High	<p>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</p> <ul style="list-style-type: none"> <li>• Acute or chronic illnesses or injuries that pose a threat to life or bodily function (for example, 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)</li> <li>• An abrupt change in neurologic status (for example, seizure, TIA, weakness, sensory loss)</li> </ul>	<p>Cardiovascular imaging studies with contrast with identified risk factors</p> <ul style="list-style-type: none"> <li>• Cardiac electrophysiological tests</li> <li>• Diagnostic endoscopies with identified risk factors</li> <li>• Discography</li> </ul>	<p>Elective major surgery (open, percutaneous or endoscopic) with identified risk factors</p> <ul style="list-style-type: none"> <li>• Emergency major surgery (open, percutaneous or endoscopic)</li> <li>• Parenteral controlled substances</li> <li>• Drug therapy requiring intensive monitoring for toxicity</li> <li>• Decision not to resuscitate or to de-escalate care because of</li> </ul>

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EMR Coding Tools Do Not consider Medical Necessity

- When using the EMR coding tools, they do not consider medical necessity and as always there are gray areas.
- Sometimes the MDM is Too High
- Sometimes the MDM is Too Low

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EMR coding tools Do Not Consider medical Necessity

- Mainly the result of overdocumentation using an EMR or template
- Provider documents a comprehensive history and exam and the patient, who is established, is diagnosed with an insect bite.
  - The level of E&M should be 99212
  - Using 2/3 the EMR would suggest 99215.

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## Choosing your level

- New patients must have 3 of 3 in the same column. If they don't you go down to where all three would be
- Established patients must have 2 of 3 in the same column. Usually the MDM is one of the two.

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## More information can be found

- Evaluation and Management Services Guide on the CMS Medicare website. [www.cms.gov](http://www.cms.gov)
- EM University

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**ICD-10**



*That's one way to deal with it ...*

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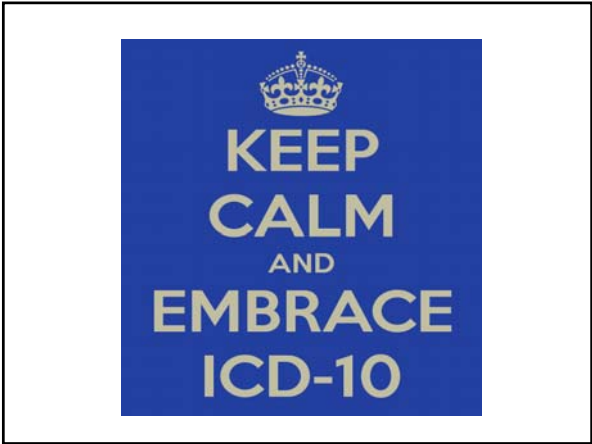
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Differences between ICD 9 and ICD10

Concept	Number of codes Impacted
Acute or chronic	1764
Open or closed	10,893
Routine healing, delayed healing, nonunion or malunion	11,290
Right or left	25,230
Initial encounter, subsequent encounter or sequela	47,223

**ICD 9 has 17 chapters compared to the 21 chapters in ICD 10.**

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**INITIAL treatment**

- Initial in CPT is DIFFERENT than Initial in ICD.10
- Initial treatment can be for more than one Date of Service, unlike Initial for CPT.

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## Guidelines

- **Code to the highest level of specificity**
- List first ICD 10 code for the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided.
- Code signs and symptoms when a definitive diagnosis has not been established by the provider.

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## Guidelines

- **Laterality** - some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified site. (section I.B.13)

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## Guidelines

- **Acute:** Abrupt onset, or short duration, usually of hrs or days in duration.
- **Chronic:** Lasting a long period of time. In medicine an illness may be considered chronic if it has lasted six months or more. It doesn't go away, but can be controlled.
- **Acute on Chronic:** A chronic condition that has had an Acute exacerbation of the chronic condition.

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## Guidelines

- Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management.

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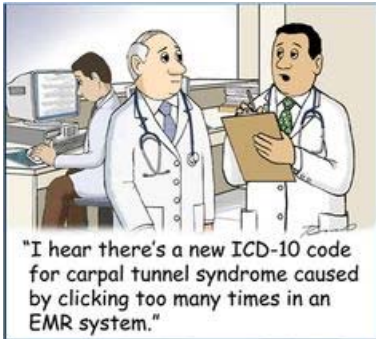
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## HELP THE CODER

**"DUE TO"**

**"RELATED TO"**

- \* Using these two words will help us code to the highest level.
- \* Is the condition DUE TO or RELATED TO another condition ?
- \* Example, Are the LE ulcers due to PVD or DM ?

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### Other Documentation

- Presence - Coronary angioplasty Implant (Stent) or graft - Z95.5
- See Z95.- for more
  
- Dependence- Wheelchair - Z99.3
- Dependence- Oxygen - Z99.81
- History of Fall- Z91.81

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### Other Documentation

- Long Term Anticoagulant - Z79.01
- Long Term ASA - Z79.2
- Interrogation, Pacemaker - Z45.018
- Interrogation, ICD - Z45.02
- Interrogation, Event / Loop recorder - Z45.09
- Presence- Pacemaker - Z95.0
- Presence- ICD - Z95.810

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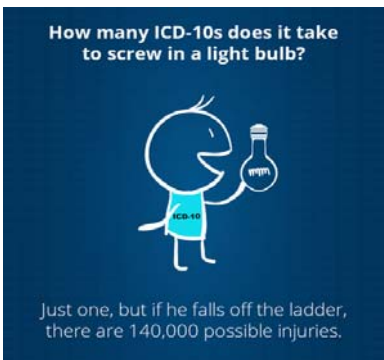
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## Guidelines

Adverse effects, Poisoning, Under dosing and Toxic Effects. (Continue)(Section 1.C.19)

- **Under dosing**-refers to taking less of a medication than is prescribed by a provider or a manufacturer's instruction. For under dosing, assign the code from categories T36-T50 (fifth or sixth character "6").

Codes for under dosing should never be assigned as principal or first-listed codes. If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, then the medical condition itself should be coded.

**Noncompliance** (Z91.12-, Z91.13-) or **complication of care** (Y63.6-Y63.9) codes are to be used with an under dosing code to indicate intent, if known.

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## Guidelines-V codes

Transport accidents (continue)

- These codes include Pedestrian injured, pedal cycle rider, motorcycle rider, other three wheeled motor vehicle, pick up, van, Other land transport, and bus are just to name a few. Please see the list of definitions of transport vehicles in the beginning of Chapter 20.
- Use additional codes to identify:
  - Airbag injury, W22.1
  - Type of street or road, Y92.4-
  - Use of cellular telephone and other electronic equipment at the time of the transport accident, Y93.C-

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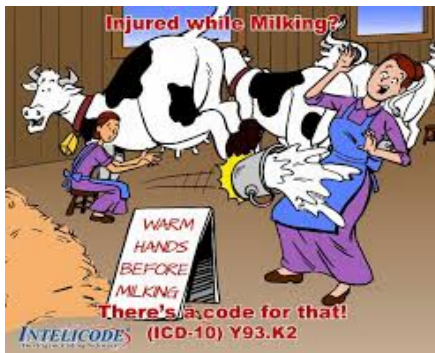
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**Struck by duck?**

**There's a code for that!**  
**(ICD-10) W61.62**

INTELCODE

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**Accidental hit or Strike by Another Person**  
**(ICD10) - W50.0XXA**

[www.medicalbillersandcoders.com](http://www.medicalbillersandcoders.com)

medicalbillers  
andcoders.com  
Call Now 888 357 3226

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ICD10code!

**Y04.1 Assault by Human Bite**

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## Guidelines - Z codes

- This area includes WCC, Physicals, WWE, **Pre-Op exams**, medical conditions that are in observation or suspected status, such as a concussion. Follow up/Aftercare for surgeries, history of a stent, Personal or family history of cancer/neoplasm, screening for a condition, Immunizations, Normal OB care, Fittings, changing of dressings, Long term codes, History of falling are to name a few.

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I THINK WE ARE DONE !

THANK YOU FOR ALLOWING ME TO  
PRESENT THE DOCUMENTATION &  
ICD.10 INFORMATION.

Tammy Martinson, CPC, CPMA, CPC-I, CEMC  
AAPC approved ICD.10 Trainer

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