CHAPTER 2-INTRODUCTION TO MEDICAL BILLING AND DOCUMENTATION

1-BIG PICTURE

Medical billing and documentation is included in one of the six competencies of ACGME, specifically within the system-based practice core competency. Despite this, it is rare for a physician to receive formal education in billing and medical documentation during residency or medical school. As a result, most attendings start their first day at the job virtually unprepared for medical billing and documentation and learn it from their colleagues along the way.

Appropriate billing and documentation is not only key to a successful private practice but also important for revenue generation in academic settings and for keeping physicians out of legal trouble.

4 different code sets are used in the healthcare system. These are ICD, CPT, HCPCS, and NDC codes. Our focus will be mostly on CPT codes. ICD codes are used for diagnosis or the reason for encounter. CPT codes are used for most professional services, vaccines, and immune globulins. HCPCS codes are used for supplies, durable medical equipment, and medications. HCPCS codes are also used for professional services when an appropriate CPT code is not available. HCPCS codes are typically used by facilities and are not further covered, as they are not frequently used by physicians. National Drug Codes (NDCs) are used for specific prescription drugs, vaccines, or insulin products. An example for each code category is given below.

CPT: 92950: Cardiopulmonary resuscitation.

ICD-10-CM: J02.0: Streptococcal pharyngitis

HCPCS: J0171: Injection, adrenalin, epinephrine 0.1mg or S06630: removal of sutures, by a physician other than the physician who originally closed the wound

NDC: 60574-4114-01: Synagis 0.5mli 1 vial, single dose

2- CPT CODES

CPT codes serve as a standardized language that replaces lengthy descriptions of medical care with concise five-digit numbers. This system streamlines communication with payers and simplifies claims processing across a wide range of services.

CPT is owned and maintained by the American Medical Association. The first edition of CPT was published in 1966. CMS's recognition of CPT as a standard coding tool in 1983 led to widespread acceptance of these codes. Initially, use of CPT codes was voluntary, but with the implementation of the 1996 HIPAA, their use for transactions involving health care information became mandatory. Today, the CPT coding system is the main system for describing healthcare services in the USA. CPT codes are updated annually by the AMA, and each year a new CPT code book is published, with mostly minor changes.

A CPT code is a 5-digit number with values ranging from 1 (00001) to 99999. Although one 100 thousand codes are possible, only around 11 thousand codes exist. CPT codes can be divided into 6 major groups in numerical sequence

1-Anesthesia

2-Surgey

3-Radiology

4-Pathology/Laboratory

5-Medicine

6-Evaluation and Management

Classification of codes into the major groups doesn't follow a set rule but is mostly based on historical usage. Surgical codes are not reserved for surgeons, and the medicine codes are not reserved for internists. For example, coronary angiography and stent placement is under medicine likely because these procedures are exclusively done by cardiologists, but many other angiographic procedures are listed under surgery. Most ultrasound studies are listed under radiology, but ultrasound of cranial vessels and duplex scan of veins for DVT are under medicine. Surgery contains many CPT codes that are used by non-surgical physicians, such as endoscopy and intubation. Most endoscopic studies are listed under surgery, but *nasopharyngoscopy with an endoscope* is listed under medicine, and this procedure is typically performed by ENT surgeons in the office setting. Although all central line placement procedures, including PICC line placement, are under surgery, Swan-Ganz catheter insertion, a more invasive procedure, is under medicine. Qualifying circumstances for anesthesia and moderate sedation are under medicine, while local anesthesia is under surgery.

CPT codes can be divided into ten-thousand blocks, which often match major groups. Paying attention to these sequences and sections helps you see the big picture and find the needed code more easily.

Now, let's look at each code group in more detail. We begin with anesthesia codes, which include the first 10 thousand, starting with either 00 or 01. Anesthesia codes are divided according to body region/organs.

Codes starting with 00: Anesthesia for head, neck, thorax, spine, Abdomen, Perineum

Codes starting with 01: Anesthesia for pelvis, extremities, radiological procedures, burn, and obstetric.

Any CPT code that starts with either 00 or 01 is an anesthesia code.

Surgery Codes: This group includes codes starting with 10 thousand to 60 thousand. Surgery codes are also divided by body region or organ. Any CPT code that starts with 1, 2, 3, 4, 5, or 6 is a surgery code.

10 thousand series: Skin, Breast procedures

20 thousand series: Musculoskeletal procedures

30 thousand series: Respiratory, cardiovascular, hematology, lymphatic system procedures

40 thousand series: Digestive system procedures

50 thousand series: Urinary, male/female genital system, maternity procedures

60 thousand series: Nervous system, eye, auditory, endocrine system procedures

Many codes in these sections are used by pediatricians, such as I&D, freezing warts, intubation, central/arterial line placements, endoscopy/bronchoscopy, circumcision, and LP.

Radiology codes (including nuclear medicine and ultrasound): This group includes codes starting with 70 thousand. Most are reported by radiologists. Any CPT code that starts with 7 (70 thousand series) is a radiological procedure.

Pathology/Laboratory: This group includes codes starting with 80 thousand. Any CPT code that starts with 8 (80 thousand series) is a pathology/laboratory procedure. In office settings, physicians can report these codes, but in inpatient settings, hospitals report them. For example, an office physician may use the code 81000 to report urinalysis performed in the office or code 87807 for a rapid RSV test.

Medicine codes: This group includes codes starting with 90 thousand. Any CPT code that starts with 9 (90 thousand series) is a medicine procedure except evaluation and management codes. There are multiple subgroups under the medicine codes. CPT codes for vaccines and vaccine administration codes are under this section

Evaluation and management (E/M) codes: This group is the only group that is not in numerical sequence. Except for newly added telemedicine codes, this group starts with 99 thousand (99202-99499), and there are medicine codes before and after evaluation and management codes. This code group applies to the evaluation and management of patients and is among the most commonly used codes by physicians across specialities and other health care workers. All sick office visits and well-child checks, inpatient admissions, follow-up/discharge care, consultations, and critical care codes are under this section.

In addition to E/M codes, which all physicians use, CPT codes a physician needs depend on their specialty. For example, gastroenterologists need to learn endoscopy codes, while intensivists need intubation and central line placement codes. Physicians should review the CPT codebook's sections and pages to find the codes relevant to their own practice.

Code descriptor

After finding the code number you are looking for, it is a good idea to look at the code descriptor. Every CPT code has a description attached next to it. Some CPT codes, like 99950, have very brief descriptions; hence, they have no specific usage or documentation requirements.

99950: cardiopulmonary resuscitation *(that is all the descriptor says).* Notice how brief the description of this code is. The code descriptor doesn't list any specific requirements but just gives the procedure name.

Code 99291 is for critical care: evaluation and management of the critically ill or injured patient, for the first 30–74 minutes. The code description is simple and has a few stated requirements. However, a closer look at the CPT book reveals several pages of rules on when and how this code is used.

Some other CPT codes have rather long descriptions and requirements.

99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low-level medical decision making. When using total time on the day of the encounter for code selection, 20 minutes must be met or exceeded.

Notice how more complex the wording/requirements of this code are. In addition to this long description, the CPT code book has several pages explaining the terms used in this code and how to report it.

Take-home message for code descriptor: make sure that you know the code descriptor well and meet its requirements before using the code.

3- ICD CODES

To request reimbursement, a physician must report 2 different codes. The first code is for the diagnosis of the patient's condition, which is reported with an ICD code. The second code is for the procedure or service performed and is reported with a CPT code. So one cannot report a CPT code without an ICD code. ICD codes are used worldwide and are maintained by WHO, whereas CPT codes are used only in the USA.

The first code/ICD tells the payer what brought the patient to the physician in the first place, and the second code/CPT tells the payer what the physician did about this problem.

Example,

Patient had ear pain/infection - - > ICD- - - - > H65.0

I evaluated the patient and prescribed antibiotics - - > CPT- - - > 99213

Selecting an appropriate ICD code is extremely important for the reimbursement process. ICD and CPT codes should align well. The CPT code you selected, which is basically the services or care you provided, should be appropriate for the patient's current problem. If you are billing higher-level E&M codes, then you should select sicker ICD codes. It's recommended that consultants choose different ICD codes from the primary attending to indicate they are managing distinct aspects of patient care.

Examples:

ENT surgeon - - > CPT code for tonsillectomy + ICD code for gastro enteritis - - - > claim will be denied

ENT surgeon - - > CPT code for tonsillectomy + ICD code severe OSA - - - > claim will be accepted

Intensivist - - - > CPT code for critical care + ICD code for knee pain - - - > claim will be denied

Intensivist - - - > CPT code for critical care + ICD code for acute respiratory failure - - - > claim will be accepted

Pediatrician - - - > highest level office CPT code + ICD code for mild URI - - - > claim may be denied

Pediatrician - - - > highest level office CPT code + ICD code for status asthmaticus - - - > claim will be accepted

4-REIMBURSTMENT PROCESS: A COMPLEX INTERPLAY AMONG MULTIPLE AUTHORITIES

Although AMA owns and describes the CPT codes for professional services, other players in the health care industry, which pay for these services, have much to say about these codes as well.

A major player in the healthcare industry is CMS (Center for Medicare and Medicaid Services). Although each payer can develop its own reimbursement regulations, it's the CMS that sets the standards for the rest of the health care industry.

Just because there is a valid CPT code defined by AMA doesn't mean that it's a covered or reimbursed service. Each payer may differ in which services are covered/reimbursed and which are not. On top of this, each payer has its own rules and regulations for reimbursing or denying reported CPT codes.

Some codes are mutually exclusive. Code 99497 (advance care planning) cannot be reported with critical care codes per CPT rules. In addition to mutually exclusive CPT codes described by CPT, payers may have their own list of mutually exclusive code lists, and when a provider reports 2 codes for the same day that are mutually exclusive to that payer, then the software program of the payer automatically denies the claim without even the involvement of a human.

Another important concept is bundle. Some codes, like critical care codes, have a certain list of other CPT codes that are bundled in the critical services by CPT. For example, pediatric critical care codes have a bundle that contains 39 different CPT codes. One of the codes in the bundle is the intubation code, so the CPT code for intubation is not reported separately when pediatric critical care codes are used. All office, inpatient hospital, consultation, and ER codes have no bundle, which means any other CPT codes may be reported separately.

Another important point is the RVU (relative value unit) of a given code. Although AMA owns CPT codes, CMS determines the reimbursement for each code by assigning each code a specific relative value unit (RVU). Other payers typically follow RVUs established by CMS.

Most billing codes are submitted via CMS Form 1500 or a similar form. Form 1500 includes more than 30 fields, including patient demographics, insurance information, charges, diagnoses in ICD codes, and services in CPT codes. This form can be submitted either on paper or electronically, and it can be filled in either automatically by software or manually by a coder. If the physician is using paper-based billing, a coder typically fills out this form manually. If the physician is using an electronic healthcare system like EPIC, EPIC will auto-populate most of the form fields in the second software, which will then send the claim to the payer. In the electronic version, there will still be some limited coder supervision. Like anything else in life, there can be errors when filling out this form; hence, it is important for physicians to know these steps so they can track their bills and ensure their billing codes are sent to payers appropriately.

5- MEDICAL DOCUM ENTATION INVOLVES MORE THAN BILLING

Appropriate medical documentation is essential for reimbursement, but medical documentation or patient note involves much more than billing. Every patient note is a potential medico-legal document, so the more detail you include, the better it is. Most legal cases are brought months, if not years, after the provision of care, so by that time, the physician's memory would not be very useful. The best defense in medical-legal cases is a well-written note that contains enough information. A well-written note is your best friend and your most important tool for protecting your license. So you can write a very short note from the billing perspective, but there are other reasons to consider for writing a longer note, especially for complex cases. Having a neutral tone, avoiding unsupported speculations, describing just the facts, documenting patient or caregivers' comments exactly as it is in quotes, giving a clear timeline of events, documenting your management rationale clearly, and sticking to professional terms and language are of utmost importance when a patient note becomes a medico-legal document.

Patient notes are also among the most important tools for communication among caregivers. A good note is not necessarily a long note. Actually, short, concise notes can be even better than the long notes. So, irrespective of the billing requirements, you may like to add a few more details to note to make it an effective communication tool and protector against potential medico-legal troubles.