

TPR Spotlight

7th Edition

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2009 is off to a great start and full of many changes and other exciting events. First and foremost, Nutri-West and the Brimhall team held an amazing seminar at the end of January which has proven to be instrumental in aiding practices in proper implementation, proper training of nutritional protocols as well as the other 6 Steps to Wellness protocols.

Total Practice Resources is very excited to announce the completion of the website and other web services. Please be sure to visit www.totalpracticeresources.com to learn more about us! Additionally, the TPR webinars are being recorded (audio/video) and loaded once per month. Each webinar has guest speakers and important messages for your practice development and success. The entire 2009 webinar schedule is loaded onto the site for your convenience.

Coding and Documentation

By popular request from the Nutri-West/Brimhall Homecoming seminar, TPR is making available the important details from the Coding and Documentation session presented by Brandy Beeson of Total Practice Resources. This article will outline much of that information for you. The following bullets highlight much of the presented program. Please note that the details below do not contain 100% complete requirements as that is far too much data to translate. The data below lists only some helpful information and tips for Coding and Documentation only

Utilize Your Resources

*Follow your state and local Medicare carrier guidelines to be abreast of special circumstances or changes

*State Associations/Councils & Medicare carriers have websites where information is posted and usually e-newsletter updates can be registered for as well

Important Rules of Coding

*For CPT coding, you must use the code that most accurately defines the service being provided

*Doctor should also be aware of his/her intent during treatment & so therefore is in the best position to know (and is required) to determine the best and most accurate code to use

*The provider is in the best position to know what services is being rendered to the patient

*CPT code describes WHAT is being done with the patient. The diagnosis code tells WHY it is being done.

- *You must support your services with diagnosis
- *Diagnosis pointers should be used on claim forms

Proper Diagnosis Coding

- *For injuries/accidents, the 800 series diagnosis codes may be more applicable as they are specific to injuries
- *Additional guidelines are in place for proper Medicare diagnosing, when payment is expected. Know these requirements for your state or locality.
- *Always diagnose to the highest level of specificity.
- Diagnosis have either 4 or 5 digits. More digits in a diagnosis is more specific.
- *The provider must diagnose for his/her services. Office staff is not qualified nor allowed to make this determination
- *All relevant codes should be documented
- *Codes should not appear on a claim form that are not clear on documentation
- *Do not diagnose symptom/condition if uncertain or unconfirmed

What are HCPCS Codes

- *HCPCS Procedure codes are temporary codes for services that are not described or not clear in the standard CPT code section
- *HCPCS also consist of specific supply codes which may be more specific than the standard 99070 supply code
- *HCPCS codes are covered under insurances depending upon insurance policy benefits & limitations
- *Not all payers are aware of or use HCPCS codes
- *Common examples of HCPCS are:
 - G0283: more specific for E-Stim and is required by UHC & possibly other payers in place of the more common 97014 or 97032 CPT
 - S8948: Low Level Laser, 15 minutes
 - A9150: Non-prescription drugs (OTC Nutraceuticals)
 - E0190: Positioning cushion/pillow/wedge
 - L3030: Custom foot insert, each
- *Modifiers that apply for HCPCS codes are the same as those for standard CPT codes

Modifiers

- *Allows for more specific description of special circumstances for specific procedure codes
- *Increases communication between provider and payers
- *Modifier use or lack of may impact reimbursement from payers
- *Generally, two digit numeric modifiers apply for insurance claims and should be used when applicable
- *Some payers do not recognize the use of modifiers
- *It is the responsibility of the provider to confirm this with individual payers
- *Medicare requires the use of alphabetic modifiers to indicate special circumstances and detail with Medicare treatment

Proper Coding for Timed Services

- *Most insurance companies follow a policy in which 8-23 minutes = 1 full unit, 24-38 minutes = 2 units, etc
- *Less than one full unit would require a 52 modifier to be appended to service code
- *When service is performed in more than one region the time should be bundled

Evaluation & Management New Patients & Established Patients

*E&M codes can be used when the services is completely separate from the primary service(s)

*Specific required criteria for proper documentation and billing of these codes

*3 Categories of required criteria: (History, Exam, Complexity of Medical Decision Making). All 3 of 3 are required to be met or exceeded for New Patient E&M Codes and 2 of 3 categories must be met or exceeded for Established Patient E&M Codes.

Documentation (some requirements and recommendations)

- *Medical Necessity must be supported if expecting payment
- *Treatment notes should show change or improvement in patient 'function' (ADL) to help support necessity for care or continued care
- *All timed services should have an approximate time performed included in documentation (start/stop)
- *Diagnosis must be noted and should support/validate services
- *Diagnosis should NOT appear on claim forms that are not clearly indicated in documentation
- *Thorough and detailed exams and re-exams can help to support necessity, validate follow-up visits & expedite documentation for follow-up visits
- *Avoid waiting till end of the day or following days to do notes. Opportunity to forget data or confuse data is less likely.
- *Use the same style of note taking for all patient case types
- *If notes are requested and forwarded to payer or other provider, treating dr should sign and date notes
- Manual signature, electronic or stamp is generally acceptable
- *Re-injury or exacerbations should have updated history form
- *Date-of-Service must be included on note
- *Notes may not be changed or altered once completed
- *Written notes must be legible
- *Special or unusual circumstances should all be documented
- *Dr must have proof that patient was seen on all dates-of-service
- Patient sign in, finger print scan etc
- *Rule of thumb....If it's not documented, it didn't happen!

REMINDER...

There are important new service, HCPCS and diagnosis codes introduced for 2009. If you don't have this up to date information, you will need it! Through out February, TPR will pay your shipping & handling for your ChiroCode book orders.

Our Price: \$ 99

**List Price:
S & H:Paid by TPR**

Additionally, a fee schedule review should be done annually. To receive your current year zip code analysis (fees for individual services per zip code) for your records and review, please let us know. February specials for this report are available.

Our Price: \$ 37

List Price: \$47
S & H:will be shipped with book or faxed separately

****Order both for \$136****

****A \$10 fee applies for multiple zip codes.**

E-mail brandy_tpr@yahoo.com to request the order form for these materials.

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Additionally, Total Practice Resources does not make code recommendations, fee recommendations or provide any legal advice. Providers are in the best position to determine codes & fees as well as obtain other guidelines and legal requirements in their state and locality. Total Practice Resources assumes no responsibility for inaccurate or inappropriate use of materials and information.

Brandy Beeson
Total Practice Resources