

WHERE DOES YOUR CHART GO AFTER IT LEAVES YOUR HANDS?

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It's been a long day but you have finally completed your last chart. For each patient you've seen and treated, you've documented the presenting problem, obtained the patient's history, performed a physical examination, and recorded your diagnosis and course of treatment. You have done your job well, and expect to receive payment for the services you've provided.

But exactly what happens to that chart from the time you complete it to the time a reimbursement check arrives (or does not arrive!) in your mailbox? This is an important question because your documentation:

- Reflects the quality of care you provided to the patient.
- Can reduce risk management and liability issues.
- Can assist in maximizing your reimbursement.

In today's medical environment, care is not considered to have taken place (and payment will not be forthcoming) until the paperwork is done. So the "life story" of a chart is a good one to know.

The first stop for the chart and accompanying forms is into the hands of a medical coder.

Typically, charts are coded either 'on-site' by coders at the practice or facility, or 'off-site' by a contracted coder. If on-site, the coder collects all of the documents relevant to the patient encounter, including the physician's documentation, which can be recorded in various forms (i.e. template, dictation, handwritten notes, etc.). In emergency medicine (my area of coding specialty), the physician's documentation typically appears in one of the various documentation templates designed by template providers. Whatever the form, the physician's documentation provides a progressive 'picture' of what happened to the patient during the encounter. The record will also typically include the patient's demographics (i.e. name, address, social security number, insurance information, etc.), the physician's orders, triage and nursing progress notes, and an admissions/transfer/discharge order.

In the off-site model, records get copied, batched, and shipped to the contracted coder (or coding operation). Usually a batch reflects a date of service, and each batch should contain all patients seen within a 24-hour period. When the coder receives the records (whether on-site or off-site), he or she examines them to make sure all the necessary documents are present. The two main sets of codes to be assigned will be:

ICD-9 © (International Classification of Disease): which *describe* the injury or illness the patient presented with.

CPT © (Current Procedural Terminology): which represent any *services* the physician provided, inclusive of evaluation and management (E/M) services, surgical procedures, diagnostics, etc.

How do physicians and coders know what guidelines to follow relevant to the evaluation and management services as represented by CPT?

Evaluation and Management

In an office visit or a hospital day charge the codes delineate the physician's *evaluation* of the problem, and the subsequent *management* he or she provided. CPT separates E/M codes by 'site of service', which can range from the doctor's office, to the ED, to the hospital, etc. The documentation and medical-decision-making (MDM) requirements can differ for E/M services by site. These differences and nuances are what good coders live and breathe every day – so that physicians don't have to and can instead focus on their patient's care.

For example, the CPT E/M codes 99281-99285 apply strictly to services provided in the emergency department, and are reflective of ranges in complexity. Code 99281 would typically be reflective of a very low acuity presentation; 99283 would typically be reflective of a moderate complexity presentation; and 99285 would typically be reflective of a high acuity presentation. As the acuity increases, so does the level of documentation required to appropriately support the code assignment.

In some instances, physicians may elect to assign their own codes rather than outsource to professional coders. Here physicians must be aware of the intricate documentation requirements that have to be fulfilled in order to assure proper code assignment. An understanding of proper coding guidelines is essential to avoiding 'over-coding' or 'under-coding.' Over-coding can lead to questions of fraud and abuse or inappropriate reimbursement, while under-coding may result in missed reimbursement opportunities.

Check and balances

How can you be assured that your coders aren't doing one or the other when it comes to E/M assignment? CPT imposes a triangle of 'checks and balances' to help ensure appropriate coding of these services. The three key elements of an E/M service include:

- History
- Examination
- Medical Decision Making (MDM)

The documentation requirements for History, Examination, and MDM must *all* be fulfilled in order to assign the proper E/M code. Even if the record reflects pages and pages of history obtained and exam performed, when the MDM is minimal, the chart will not fulfill the requirements for a higher-level E/M. The key is to *balance* these elements so that the history, examination, and medical-decision-making match the acuity level of complaint. These key elements determine the appropriate E/M code assignment.

As coders review the patient records, information in addition to ICD-9 and CPT code assignment is interpreted for consideration. Coders therefore should be familiar with medical terminology, procedural terminology, anatomy and physiology, pharmacology, pathophysiology, etc. What, on the surface, may seem to be a ‘clerical’ job now requires a greater level of sophistication as medical documentation and procedures become increasingly complex.

Generally, good coders have participated in educational curriculums that include the clinical subjects listed above, and they have some records management or insurance claims processing experiences. Nurses or others with clinical backgrounds often make good coders.

Documenting medical procedures

Complete documentation is particularly important with regard to medical procedures. In the emergency setting, we tend to see a number of ‘minor’ surgical procedures, i.e. wound repairs, incision and drainage of abscesses, foreign body removals, burn care, splint applications, etc. As an example of the detail required to document each procedure code, the CPT codes for wound repair vary relative to the size of wound, location on the body, complexity of the repair, etc.

A documentation template can assist with documentation prompts, but complete procedural notes are highly recommended for several reasons.

- A complete procedural note can assist in reflecting the standard methodology and proper execution of the procedure (i.e. in the instance of a wound repair, the anesthetic administered, irrigation performed, explored for foreign bodies, materials used in the repair, etc.).
- A complete procedure note will assist in the proper code assignment.

Without adequate documentation you could find yourself defending your course of treatment before a jury with inadequate ammunition. Or, in a less dramatic situation, you could find that the services you’re providing do not necessarily lead to the reimbursement you might be entitled to.

On to billing

Once the ICD-9 and CPT codes have been assigned, the records usually are forwarded to a billing department/billing company. The records then typically progress through insurance verification, data entry, charge posting, electronic claims filing (to the insurance carriers), etc.

Payers are known to routinely review claims and the documentation within. If they find that the code assignment is appropriate (based upon their own coverage limitations, network provider allowances, medical necessity, etc.), the claim is approved for payment, and they will send you a check.

If payment is not approved, you will receive a notice of denial, which may be tied to inaccurate coding. Two very common reasons for denial are:

- Insufficient support of a CPT code by an ICD-9 code
- The use of outdated ICD-9 and/or CPT codes.

In the former, it is a coder's goal to appropriately reflect the medical necessity for a CPT (services) code through the assignment of an appropriate ICD-9 (descriptor) code. For example, a wound repair (CPT) procedure code would need to be supported by a wound descriptor (ICD-9) code; or an EKG (CPT) code would need to be supported by a cardiac (ICD-9) code. You are likely to experience denials if the services you are submitting for reimbursement are not supported by the correlating descriptor codes.

I strongly suggest that coders keep their resource materials current to the year's publication (rather than using references that are several years old). Because ICD-9 and CPT codes are constantly being created, revised, and deleted, you are likely to experience numerous denials if you are using 2001 ICD-9 and CPT books for 2004 claims.

There are ICD-9 (descriptor) codes available for every illness, injury, or presenting problem one could imagine, plus CPT (services) codes available for any type of evaluation and management service, all diagnostic services available, and all surgical procedures performed by medical professionals. Awareness of changes and updates, plus the pursuit of continuing education, are the responsibilities of a good coder.

Remember, coding is a moving target. It's in your best interest to ensure that your coder:

- has received proper training (and perhaps even certification from a nationally recognized, professional coding organization)
- participates in continuing education
- participates in professional chart reviews (for quality assurance).

While documentation requirements can be frustrating, providing complete patient documentation to your coder will serve you well in your medical career. Your “story” as a physician is bound up in the “story” of the chart, and you want both to have a happy ending.

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