WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Maximizing Billing and Coding Part 4: Wrap Up and Coding Scenarios

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STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh, and I'd like to welcome you to the Maximizing Billing and Coding Part 4, Wrap Up and Coding Scenarios webinar. This webinar is brought you by the Partnerships for Care, HIV Training, Technical Assistance, and Collaboration Center, or HIV TAC. The Partnerships for Care project is a three-year, multi-agency project funded by the Secretary's Minority Aids Initiative Fund and the Affordable Care Act.

The goals of the project are to, one, expand prevention of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department. And three, improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance, and Collaborations Center, or HIV TAC.

Our speaker again today is Stacey Murphy. Stacey is a seasoned health care professional with more than 30 years of experience. She has held positions with the Veterans Administration, Lebanon Hospital Center in the Bronx, and other private sector entities. She is an active member of the American Academy of Professional Coders and is very active with the NY MAC chapter in Queens, New York. She completed her undergraduate work in Health Administration at Saint Joseph's College in Brooklyn, New York, and obtained an executive master's degree from Baruch College in Public Administration.

She received her CPT coding designation in 1998 and is a designated ICD-10 trainer. Stacey currently teaches health information management and medical coding courses at City University, New York, School of Professional Studies. And she teaches medical terminology and other health administration courses at Saint Joseph's College. Stacey's latest achievement is as a contributor to the upcoming American Health Information Management Association's white paper, "State of Coding in Health Care Today." Please join me in welcoming Stacey Murphy.

STACEY MURPHY: Good afternoon, and thank you again, Stephen, for such a warm welcome. Now as Stephen indicated, today is our final series. And we will look at coding scenarios and bring all of the codes together that you learned from Series 1, 2, and 3.

The next slides are just a disclaimer, and I'm going to-- today's webinar as I indicated, we will review CPT codes, HCPCS codes, and ICD-10 codes that you learned in Series 1, 2, and 3. We will review coding scenarios which reflect accurate reporting of the codes for HIV and AIDS medical care, discuss the importance of proper code sequencing, and discuss the importance of proper documentation and its impact on reimbursement.

The next two slides are just the acronyms that are used in the presentation. I'm sorry, I think there are four slides that reflect the acronyms that are used in the presentation. And we are going to start, again, with our first polling question that we've been using for all of the series.

What role do you play at your health care center or facility? Are you, A, clinical staff, office manager, supervisor, front desk? That's B. C, medical biller, coder, insurance follow-up specialist, or D, other? OK, so we have quite a mix here. There's not any one area in particular. I see that 36% is biller, coder, insurance specialist, as well as other. And it looks like there are 18% physicians on the call, and 9% are office managers or supervisors.

So now, let's just recap everything that we covered in Series 1, 2, and 3. In Series 1, we did a very high level overview of your Evaluation and Management codes that are used to report your services. So this slide reflects your E&M levels 99201 through 99205. These are the codes that are used to describe the new patient encounters, for patients that come in for medical attention when they have a medical condition, or if they are coming in for care related to the AIDS or AIDS related conditions.

Your next slide is your established patient visit slides. And just to recap, your 99211 code, according to the coding guidelines, is only used for RN visits. So this particular code you would never use to report an encounter provided by a doctor. You would utilize 99212 through 99215 any time the patients are being seen by a doctor.

When the patient comes in for something very minor such as a blood pressure recheck, and the nurse is overseeing the care, that's when you will utilize the 99211. Your next slide is the preventive medicine visit, also known as your well visit codes. Your 99381 through 99387, those are your new patient visit codes. Your 99391 through 99397, those are your established patient visit codes.

And so if you'll notice, these codes are selected on the basis of the patient's age. Also, the new versus established patient for your evaluation and management, or first visit codes and your well visit codes, they follow the same guidelines. A patient is considered new if they have not been seen by a doctor in your practice within the past three years of that same specialty. And an established patient is one who has been seen within that three year time frame.

The next slide or the preventive medicine counseling visits codes. So the counseling codes are for patients that are seen by a doctor where they do not require a physical exam, and there is no history taken. So this is more for counseling and risk factor reduction or intervention. If you'll notice also on this slide, there's a note at the bottom that states that when a patient

comes in for preventive medicine visit services, that you should not be reporting the preventive medicine counseling visit codes together with a preventive medicine visit service.

Your next code is for routine blood work. In the encounters, or for patients who come in for a well visit where there is other services such as vaccines, or if they're coming in for an HIV screen, and the doctor decides to draw blood work, you would also report the CPT code 36415 for routine blood work. So this was also covered in Series 1.

The next couple of slides are the codes that describe the tests, your HIV test codes. These codes were covered in Series 2. And I believe in Series 2, someone had asked the question with regards to the oral test code-- I apologize-- the G0435 is the code that you would use for an oral rapid, and if you'll notice, it says for HIV 1 and/or HIV 2.

So if it's a swab, if the patient comes in and they have the swab test done, this would be one of the codes that you could utilize. But again, in terms of reporting, you should check with your local Medicaid state agencies as well your insurance carriers to make sure that this is the code that they want you to report.

Next slide just gives you some tidbits of information recapping the point of care. So again, your point of care tests are patients come in, and they have the HIV test performed real time. Real time results, meaning the patient's results will be available to them the same day. Here are some additional HIV test codes, also point of care tests. So again, depending on the type of tests that the physician decides he wants to perform for the patient would be the key driver in the code that you will select for the HIV test code.

The next slide just gives you some additional codes that describe your HIV tests services. Keep in mind that the rapid test codes are services that are rendered in the doctor's office at the point of care. That's why they're called point of care tests.

And then the other codes describe services where the doctor draws the blood work and sends it to a lab. In some practices, they have a lab on site that processes the specimen, whereas some other practices send the specimens off site to Quest or another lab service that will be responsible for processing the test codes.

So let's see. We have our second polling question. E&M code 99211 is used to report a follow up office visit encounter rendered by an RN. True or false? OK, so we have 60% of the webinar participants who have selected the correct answer, which is true. And we have 40% that have selected false.

Remember, according to the E&M coding guidelines, anytime a patient comes in and they see an RN, the only code that is appropriate for that RN visit for those very minor visits where there is a follow up, for example, a blood pressure recheck, or the TB recheck, or maybe they're getting a TB implanted, the RN can utilize the 99211 for those services. The physicians in that

practice should be reporting your 99212 through 99215 for the established visit codes, and the 99201 through 99205 for the new patient visit code.

In Series 1 and 2, we covered modifiers. So modifiers are two-digit, numeric and/or alphanumeric codes that indicate that a procedure or service has been altered by a specific circumstance, but that the code description has not changed. There are two types of modifiers. You have your CPT modifiers, and you have your HCPCS modifiers, but both modifiers have the ability to impact your revenue. So you have to make sure that you follow up with your local Medicaid agency to find out which modifier is appropriate in terms of the services that you're reporting.

Modifiers are never appended to ICD-10 codes. We covered ICD-10 in the last webinar series, Series 3. Modifiers are never reported alone, so a modifier has to be appended to a CPT or a HCPCS code.

Modifier 25 was covered in Series 1. And the description of Modifier 25 is significant, separately, identifiable E&M service by the same MD on the same day of a procedure, service, or other E&M service. So in terms of the Modifier 25, this modifier is only reported or appended to E&M service codes. You should not be reporting this modifier with any other CPT code in your CPT code set, and these modifiers are never appended to the lab codes.

Again, you should follow up with your local Medicaid state agency. Even though the coding guidelines may tell you to append the Modifier 25, anytime there's another service involved, some insurance carriers have specific reimbursement guidance that say that you may not need it. So the coding guidelines are there just to guide you and assist you with the appropriate way to code, but the insurance carriers provide you with the specific reimbursement and medical policy as it relates to how they pay their claims that you're submitting.

The next two modifiers were covered in Series 2. That's Modifier 92 and Modifier QW. They both have the same meaning. They both are for those lab services that designate a clear waive test. So again, in terms of the reporting of the Modifier 92 or QW, it's very important that you follow up with your local Medicaid agency to determine which modifier you should be reporting.

The Modifiers 92 and QW are only appended to your path/lab test codes. Do not report these modifiers with any other code types. In terms of a combination of waive versus Q waive, the coding guidelines state that you should not report this modifier. But again, even though the coding guidelines may provide you with one set of rules, you should follow the payer rules because those rules determine how your claims are going to be processed and whether or not you're going to be paid.

In Series 3, we covered the ICD-10 codes. So the official coding guidelines for reporting AIDS care-- some of the terminology that describes AIDS for the code B20 are located on this slide. There were very few terminology changes in the AIDS and HIV section of ICD-10.

AIDS versus HIV positive, asymptomatic HIV positive, they're not the same. Never report those together. Asymptomatic HIV and HIV positive and inconclusive HIV-- those are not the same either. So these codes should not be reported together. You should take the time to review the coding guidelines to see the very specific coding instructions that pertain to how you report the care that you're providing for patients that have AIDS or any HIV related infections.

A patient comes in from another country, and they've been diagnosed with HIV-2. The coding guidelines state that you should report the principal diagnosis for AIDS and then the secondary diagnosis for HIV-2. So the principal diagnosis is B20, and the secondary is B97.35, which we'll see in a moment on the next couple of slides.

Inconclusive HIV tests. Newborn babies are born to HIV positive moms, and the babies have the moms' diagnosis due to the antibody status. An HIV status in newborns typically lasts up to 18 months. And sometimes in that time span, the newborns are not infected. The terminology that's used to describe those newborns is called false positive.

In ICD-10 and in ICD-9, it was termed inconclusive HIV tests. And so, when a newborn has an inconclusive HIV test result, you would report the code R75, which we'll get to in a couple of slides. So these are your two common codes that you're most commonly reporting for patients that are diagnosed either with AIDS or HIV positive. So on ICD-10, you would utilize B20, and that code is the cross map for your 042 diagnosis for a patient that is diagnosed with AIDS.

And the HIV positive code in ICD-10 is Z21. Your counseling code, V65.44 in ICD-9. In ICD-10, that code is Z71.7. You're screening code, if you'll notice in ICD-9, it cross maps to two different codes in ICD-10. So the code for a patient that's coming in for an HIV screen is Z11.4.

If they're coming in for any other type of screen for a viral infection, it's Z11.59. So your false positive for your inconclusive results code is R75 in ICD-10. So again, keep in mind that this code is not only used for the newborns. It's used for anybody who's test result is inconclusive.

Your next slide is for other codes that are commonly used. So the pre-exposure prophylaxis code in ICD-10 is the 20.6. In ICD-9, you'll notice that there was one code for high risk sexual behavior, but that maps to three different codes in ICD-10. Z72.51 is for high risk heterosexual behavior, Z72.52 is for high risk homosexual behavior, and Z72.53 is for high risk bisexual behavior. There's one code for problems related to lifestyle. That's C72.89.

Your next slide is for your human T-cell lymphotrophic virus B97.34. Your HIV-2 code is B97.35. And remember, this code is never reported by itself. It's never sequenced as the principal diagnosis. The principal diagnosis is always going to be AIDS, the B20 code that we looked at in the first slide.

Some other codes encountered for procedures. Other prophylactic measure is the same description, but they changed it in ICD-10. Z41.8, encounter for screening for infectious with a predominately sexual mode of transmission, V11.3. So there are a variety of different diagnosis

codes that are used for patients that are receiving medical care related to AIDS or HIV infection, or if they're just coming in for a screening or for counseling.

Long-term use of medications-- if you notice, the ICD-10 code is a six character code, Z79.899. And I'm not sure why this diagnosis is here twice, but that's fine. Here are some additional coding instructions that were pulled from the coding book.

So if the documentation states something about the therapeutic drug levels, you have to include an additional code for that. If the patient that is being treated also has a drug abuse or a dependence, you need an additional code. In the Series 3, we spoke about the new coding guidelines for Excludes 1 and Excludes 2. In ICD-10, the Excludes 2 means that if the patient has the medical condition, you should report that as an additional code.

So for the code on this slide, if you're treating a patient that has a drug abuse or a dependence, you would, in addition to any other codes you're reporting, you would also include a code that describes that abuse or that dependent. If the patient is pregnant, you would also assign a code from the pregnancy section. The coding guidelines for patients that are pregnant stipulate that the pregnancy code is only sequenced as the principal diagnosis.

Your next slide talks about the opportunistic infections. That's this slide and the next slide. So basically, what I did is I put the most common opportunistic infections codes on the two slides. If you want a full list of the opportunistic infections, you can go to the CDC's website. And you'll need a code book so that you can ensure proper coding for those services.

The next slide is for an accidental finger stick. So if you have an employee, or a doctor, or another person that's with the patient that accidentally gets a finger stick or a puncture wound from a needle, you would also have to assign one of the codes that designates contact with a hypodermic needle or contact with a contaminated hypodermic needle. And if you'll notice, there are six different codes to choose from. Or rather, there are three codes in each code set. W46.0 series [INAUDIBLE] denotes contact with a hypodermic needle.

The "A" stands for initial encounter, the "T" stands for subsequent encounter, and the "S" is for sequela. What we covered in Series 3 is that "initial encounter" means active treatment. So as long as the patient is receiving active treatment for that finger stick, you would continue to report A for initial. Once the care is no longer considered active, then you would use the code that ends with the letter D for subsequent.

If the patient contracts some other medical problem as a result of the finger stick, then you would report this sequela code. Keep in mind that the codes on this slide are never sequenced as the principal. So these are considered your E codes in ICD-10. And this slide just gives you the description of what each character, or rather, what each digit stands for in ICD-10. We also covered well visit codes.

So your V70 in ICD-9 has two codes that it maps to an ICD-10. Z00.00 is without abnormal findings, and Z00.01 is with abnormal findings. The coding guidelines state that the definition with abnormal findings is on diagnostic test results. So if there's a lab result or if there is radiology result, then you would report the code that designates with abnormal findings.

The best example that I can give in terms of how this would be utilized is my doctors. When I called my doctor for an appointment for my well visit, they informed me to go and get my lab work done prior to my appointment so that when I come in, they will have my lab results handy so that they can discuss those with me. So for example, if I come in and my blood work is abnormal on that visit, then the principal diagnosis would be the Z00.01.

And whatever abnormal findings were discussed with me would be sequenced at the secondary diagnosis. Let's say I don't go to the appointment for the blood work on the previous encounter. And when I come for my well visit-- that's when I get my blood done. Then the diagnosis code that would be reported at the conclusion of that visit would be the Z00.00.

They have the same set of coding guidelines for your infants and adolescents. For the V20.2 there are two different codes, Z00.121 and Z00.129. The next set of codes probably would not apply in the internal medicine setting. These are more for the pediatricians. So again, in terms of the coding guidelines, there are coding instructions that say to use an additional code if there are any abnormal findings.

The next set of codes are just some generic counseling codes. So in ICD-9, the counseling code, V65.49 maps to the three different codes in ICD-10. Counseling related to sexual attitude is Z70.0. Counseling related to the patient's sexual behavior and orientation is Z70.1. Counseling related to sexual behavior and orientation of third party, such as a child, a partner, or a spouse is Z70.3.

The unspecified follow up exam code, B67.9, also maps to two codes. Rather, it maps to multiple codes. Z08 is in counsel for follow up exam after completed treatment for cancer. Any other one, Z09, is anything other than cancer. So anytime a patient is coming in for follow up, depending on what the reason is for that follow up, or if the medical condition is resolved, you have these two follow up examples.

Just some additional coding tips. Never report the code for AIDS, B20, or HIV positive when the record states suspected, suspicion of, possible, likely, rule out, questionable, consistent with, presumed to be, or appears. Instead, you have to refer back to the record and locate the presenting complaint, the chief complaint, or the signs and symptoms.

The next slide talks about active versus history of. Active translates to the current condition. So if the patient-- if the medical record says active, active HIV, then the principal diagnosis is B20. If it's active HIV positive, then it's V21. There are no codes for history of. So again, I strongly suggest you follow up with the physician to get clearer documentation because if an auditor comes in, they could possibly challenge it.

But there are no codes for history of. So you would report the diagnosis code for AIDS if the documentation says AIDS, and you've confirmed with the doctor that the patient currently has the condition. If it's HIV positive, then you will report the code as E21.

So let's look at our next polling question. According to the ICD-10 Official Coding Guidelines, AIDS related conditions are sequenced as the secondary diagnosis code. True or false? OK, so we have 70% of our webinars participants say true, and 30% say false.

So yes, the women are our participants that have selected true. The answer is true. Anytime a patient has an age related condition or an opportunistic infection, the principal diagnosis will always be AIDS B20 followed by the secondary for the opportunistic infection or the age related condition, such as Kaposi sarcoma, wasting syndrome, or candidiasis. So again, it is very, very, very important that you utilize and adhere to the coding guidelines, and that you correlate the coding guidelines to the payer guidelines, because those will determine what your reimbursement is going to be.

So now we're up to the coding scenario section. And here's where we bring everything together. The first scenario is HIV counseling without any testing. So a 17-year-old patient presents to her GYN to discuss contraception options and safe sex. Doctor attending-- the doctor's name-- counsels the patient on various methods and suggests an HIV test.

The patient agrees, but then subsequently decides that they don't want any testing. Doctor attending spends 30 minutes counseling the patient and asked her to reconsider the test at a later date. So since this was purely a counseling visit, the CPT code that you would report is 99402, and the diagnosis code for counseling is Z71.

So the next slide just gives you the rationale for the reason why we selected this code. Check with your payers. Some payers may deem the counseling codes non-reimbursable, so these may not be on your fee schedule. And they may instruct you to report the E&M codes. So again, this is totally a decision by your payers, but you should check with them before reporting either code sets.

The next example is a rapid HIV test with preventive medicine. So a patient comes in to the primary care physician's office concerned about having unprotected sex, and they request a test, an HIV test. This is a new patient. Doctor attending decides to perform a preventive medicine exam, and spends 15 minutes counseling the patient and also does a rapid HIV test.

So if you'll notice in the final answer, your principal procedure-- or your E&M-- should be sequenced as the first code. We've appended a Modifier 25 because the patient also had a rapid HIV test as part of this encounter. And code sequencing and code linkage is very important. You don't want your claims to be denied.

If you'll notice, the 99385 preventive medicine visit code, the diagnosis codes that are linked are the well visit, Z00.00, the Z11.4 the Z71.7, and your Z72.51. So you've got your well visit

diagnosis code, you've got your screening, and you have your HIV counseling, as well as your high risk behavior code. And the rapid code, the 86701, depending on your payoff would determine if you're going to append a Modifier 92 or a Modifier QW.

If you'll notice, the diagnoses codes exclude well visits. The coding guidelines say that the diagnoses must support medical necessity. So if you select the well visit diagnosis as your principal for the rapid test, that's going to deny for not medically necessary. So that's the reason why you're Z00.00 is not included with the test-- say, HIV test. And also, because this scenario doesn't state what the results are, the principal diagnosis for the well visit, Z00.00, without abnormal test findings.

The next slide gives you the rationale for this scenario. So basically, everything that I was just saying in terms of why we selected those codes is on the rationale slide. These are your diagnosis. Because there was so much content, I broke the slides out so you could see the CPT codes and your test codes, and then you're ICD-10 codes.

So here is the rationale for reporting the ICD-10 codes for this case study. So well visit, no real complaints. The well visit code is principle diagnosis. The screening code is the second diagnosis. The counseling is the third diagnosis. And the doctor made the decision to also report the unprotected sex code, Z72.51. 72.51

Then scenario three is very similar to scenario two. We're going to bypass this. This is an established patient, so basically all the diagnoses are the same. All the test code is the same. The only differences is the E&M code 99395 is for established patient versus the case study two, which was the 99385.

Your next example, case study number four, is HIV testing with counseling. So a 47-year-old male patient presents to their PCP concerned about unprotected sex. The PCP spends 35 minutes counseling the patient, draws blood, and sends the specimen to the lab for processing.

This is an established patient. Not that it matters in terms of the code selection, but actually, it would matter if your payer says, we don't accept the counseling code. So that piece about the established patient is rather important in those instances.

So if you'll notice, the 99402 has the Modifier 25, and the 36415 for the routine blood work. If the payer that you're submitting this claim to has deemed the counseling codes non-payable, then you would report your regular E&M code 99212 through 99215 for your established patients. The diagnoses were reported for this particular encounter.

Principal second and third, they're the same for both the E&M counseling code as well as for the routine blood work code. So you got your Z11.4 for your special screening, you got your counseling code Z71.7, and you got your high risk sexual behavior, Z72.51. The next two slides just give you the rationale for the reason for the code selection, and your ICD-10 rationale is on

the next slide. So your principal diagnosis, we said, was Z11.4. Z71.7 is secondary, and Z72.51 is your third one.

Your next scenario is-- again, this one is similar to the other one. The only difference is we're using an E&M service code instead of a counseling code, and the reason why is because in this scenario, the patient is HIV positive. They come in for follow up care. Patient has a history of IV drug use. The PCP spends 10 minutes counseling the patient, documents an expanded problem focused history, and draw some blood.

So there was some additional work that was a little different from the other scenario. So the E&M code, 99213 is for your established patient for this level of service with a Modifier 25 that denotes that something else was done during that encounter, which is the blood draw. And your three diagnoses are reported for both codes. Your Z21 is for your HIV positive diagnosis, the counseling is the 71.7, and the high risk IV drug use, Z72.89.

So the next slide just gives you the rationale for why we reported the code, the CPT codes. And the next slide gives you the rationale for the diagnosis code.

Scenarios six is HIV post-test counseling with negative results. So this is a counseling service. Patient comes in for their results. The physician spends 30 minutes counseling the patient on the importance of safe sex and contraceptive methods. The physician also distributes contraception and provides HIV educational literature.

So this is a counseling service, 30 minutes. The CPT is 99402. The principal diagnosis is counseling, Z71.7. Z72.51 is for the high risk behavior. And the rationale is on the next slide. So again, because of the use of the counseling code, you should check with your payers to find out if they want you to report counseling or if they want you to report the regular E&M visit codes.

For the regular E&M visit codes-- probably would not go any higher than a 99212. And the reason why is because the patient only came in for their results, and there were no other medical problems and there was no other issues that were addressed during this encounter. If you go any higher than a 99212, more than likely the claim would trigger an audit. So you don't want to trigger any type of audits on your claims.

OK, the next slide is a patient whose results are positive. And this one is a 99213. The physician councils the patient 15 minutes, discusses the importance of safe sex, dispenses prescriptions, distributes education, and there is a treatment plan. Now this one is a little different from the prior example because there are prescriptions involved, and the physician documents that there's a treatment plan.

Now this encounter is probably a 99213 depending on medication and, basically, how much time the physician spent talking with the patient, per on average, 15 minutes. If, for some reason, the physician spends more time counseling the patient, and he spends more than 50% of the time that's allotted for the code that you would have selected, if more than 50% of their

time is spent counseling the patient, then you can select the higher E&M level. But your documentation must support it.

So in terms of what you're counseling the patient on, you would just clearly document 30 minutes spent counseling the patient. And then you would list those individual items that are counseled. So the principal diagnosis is HIV positive, Z21. And the counseling code is Z71.7.

So the next slide just gives you the rationale. So you've got your E&M rationale. So the next two slides are the rationale. So the E&M code rationale is explained on this line. So because the patient's results are HIV positive, this is considered a sick visit because the patient now has a medical condition that the physician is going to manage and treat at this point.

The next slide gives your ICD-10 code, denotes that the patient is HIV positive. So that's going to be your principal diagnosis. And the next code is for the counseling Z71.7.

The next scenario is the same. The only difference now is that the patient's diagnosis is AIDS. So again, we have this patient who comes in for their results. The physician counsels the patient on the importance of safe sex, education literature is dispensed, a treatment plan is also documented in the record. And the principal diagnosis is changed in this scenario versus the other scenario. So instead of your Z21, the principal diagnosis is now B20. And the secondary diagnoses are still the same.

So the next slide just gives you the rationale. And then the next slide thereafter is your ICD-10 rationale, which is very similar to the other one. The difference is the principal diagnosis is changed.

Your next example is a patient that is diagnosed with the HIV-2 infection. So this is a counseling-- an HIV post-test counseling-- for a patient who recently relocated from another country. And so again, you have your 99213 as your E&M level.

The principal diagnosis is B20 because the coding guidelines state that when a patient is diagnosed with the HIV-2 infection that the principal diagnosis will always be HIV. And then the secondary would be the HIV-2. And then you have your counseling code.

So the next two slides give you your CPT codes. And then next slide is your ICD-10 code rationale. The next scenario is for antiretroviral therapy for a newborn.

So you have an HIV positive mom that comes to the pediatrician's office for a follow up for her two month old. Physician documents an expanded problem focused history and performs a brief exam. The lab results-- the physician makes the decision to modify the meds. And so, because there was a revised treatment plan and modification of meds, the E&M level for this one was a 99213.

If there were no changes, this would have been a 99212. But because there was a change in treatment plan, that's what makes this one a 99213. The principal diagnosis is R75, and the Z20.6 for pre-exposure.

So your next two slides give you the rationale. So you got your E&M which tells you why we selected the 99213, and then the ICD-10 codes.

We have another scenario. So this office visit is for a patient that has come down with complaints of a fever and extreme fatigue due to possible pneumonia. Physician documents an expanded problem focused history, does an exam, and dispenses a prescription for antibiotics.

The final diagnosis for this patient is AIDS and PCP. The patient is an established patient, so your coding guidelines say that anytime a patient has any of the age related conditions, that the AIDS diagnosis will always be sequenced as the principal. So that's your B20 20 and then your B59.

So your next slides just give you the rationale for that. So this is your CPT rationale. And the next slide is your diagnosis, your ICD-10 rationale.

We have another scenario, a patient with a history of AIDS and a post-op total abdominal hysterectomy comes in with complaints of nausea, vomiting, dehydrated due to chemo treatment. So there's a patient that's status quo is chemo. They also needed a prescription refill. So the physician documents a detailed history with moderate medical decision making. And the final diagnoses are noted as nausea with vomiting due to chemotherapy, dehydration due to chemo.

So you got your R11.2. You got your E86.0. This is a patient that's actively receiving chemo treatment for cancer, so that's C53.0. Because of the adverse effects of the chemo treatment, we're reporting the T45.1x5A. A is for initial encounter.

As long as the patient is being treated, or as long as the patient continues to have these symptoms and come in and for active treatment for these symptoms, the code with the alpha A will always be recorded for that particular scenario. This is a patient who came in, not because of their AIDS diagnosis, but because they had other medical issues that were being addressed. So the final diagnosis is AIDS, B20.

Now because the patient had a lot of medical issues and a lot of problems that the physician had to address, if you have noticed, the E&M level is a little higher than what we've been looking at in other scenarios. So that's your 99214. And then the next slide gives you the rationale for all of the diagnoses that were selected for this particular scenario.

I think we're getting to the end. There's another scenario. This is for a pregnant patient, 20 weeks pregnant. Comes in with a history of AIDS, but they are there for their OB appointment complaining of severe cramping and heavy bleeding.

The physician documents a comprehensive history. High medical decision making includes the patient put on IV meds to stop the bleeding, and then they transfer the patient to the hospital labor and delivery department.

So you have your 99215 because this was an established patient. The coding guidelines say that pregnant patients, depending on the situation, the pregnancy codes are sequenced as the principal diagnosis in every scenario. So your threatened abortion code, that's an O, as in Oscar, 20.0.

The patient's secondary code is O as an Oscar, 98 712 because of the AIDS infection. And then you have to assign the code that describes what that infection is. We're not using any of this O 98 code series, so that's your B20.

Now in terms of the E&M 99215, your patients that are in your office-- and you make the decision to administer something like, oh, let's say your patient has asthma, and you give them albuterol, or you have to give them oxygen, or you send them off to the hospital. Those are, typically going to be your 99214, 99215 CPT codes that you would assign for those cases.

So the next slide are just a rational. So this is the E&M rationale for this particular patient, and in the next slide is your diagnosis rationale. Again, the coding guidelines stipulate that patients that are pregnant, those diagnoses codes are sequenced as the principal over other diagnosis codes.

The last scenario for today's webinar is an office visit for a patient that is actually an employee that works in the office. A medical office assistant accidentally punctures their finger with a needle after drawing blood from an AIDS patient. So the office manager completes all the necessary workplace injury forms while the physician treats the patient.

There is a detailed history in our problem focused exam. And the medical decision making includes blood work and a 48 hour supply of post-exposure prophylaxis. And they counsel the patient.

The final CPT code so this is 99213 with a Modifier 25. We're presuming this is a new patient because there was nothing in here that said it was anything otherwise. But really and truly, the documentation must be very clear and concise. So I would have probably gone back to the doctor and said, could you please document that this is a new patient just because you want to make sure that your documentation is very clear for an auditor.

They did blood work, 36415. And the diagnoses, our principle, is Z11.4 for the screening. The pre-exposure prophylaxis code, Z20.6. The counseling code and contact with a contaminated hypodermic needle initial encounter, W46.1. In ICD-9, it says accident, but they changed the terminology in ICD-10 to read "contact with contaminated hypodermic needles."

So your next two slides just give you the rationale. So here's your E&M rationale, and then the next slide is your ICD-10 rationale.

So in closing, you want to take away some tidbits of information. HIV testing or preventive care, report the new preventive medicine visit code or the established patient visit code based on the documentation of whether it's new or established. If it's counseling, you report your counseling code, but you cannot report the two together. It's either preventive medicine or the counseling code.

Post-test results. Again, you should check with your payers to determine whether you should be using the counseling code, or whether you should be using the E&M codes. The 99211 is here because in some of the practices that I've done the training, they allow the nurses to do the follow up visits for the patients that are different results and negative. So that's why the 99211 is here on the slide. But if the physician is doing the follow up care for those services, you should not be using the 99212 codes.

HIV pre-testing with preventive care. Make sure you're using the appropriate modifiers. Check with your payers to find out what modifiers are appropriate for those scenarios. The next couple of slides just talk about the point of care testing.

So again, depending on whether you're doing a point of care test or you're doing the blood screenings will determine which codes you would assign. The confirmatory testing is processed by pathologists. So if your patients are coming in for a confirmatory HIV test, but you're sending those out to the lab, then this wouldn't apply to you. So we'll skip that slide.

In today's society, physician's income was historically driven by the procedures that were documented, and not the diagnosis. But now things have changed. There's been a shift. Everything is risk based. The diagnosis is the driver and the reimbursement.

So it's important that all of the diagnoses that the providers are treating should be documented. And all of those diagnoses that are documented should be picked up by the coders, and should be picked up by your claim representatives, especially for those patients that have the chronic conditions.

We looked at diagnosis codes, and significant chronic conditions should be reported. And they should be picked up because those impact your reimbursement, and they also impact your quality incentives. We know that there's a lot of quality driven reimbursement.

You have your HEDIS if you're on the other-- QARR is here in New York City, so it's not something that's common in other states-- so QARR and HEDIS. You got your PQRS, your PQRI. You have all of these different measure driven reimbursement methodologies that's being utilized by, not only the state Medicaid agencies, but all of the other payers. So it's very important that you are making sure that you're following and adhering to the coding guidelines and adhering to the payer guidelines as well.

Code sequencing is very important as we just discussed in diagnosis codes. And if you sequence the codes incorrectly, or you linked the codes to the wrong service, those will result in denied claims. We also spoke about principle versus secondary. So again, that ties into the code sequencing.

We spoke about the designation of the AIDS related conditions as the secondary and the AIDS condition as the primary. We also looked at coding of HIV and AIDS and the documentation that denotes that a patient has suspicion of, suspected, possible, is not coded, in the outpatient setting.

Active versus history of, we spoke about. Active translates to HIV positive, and that's Z21. Or AIDS or HIV infection, and that's B20. And history of, there is no such thing. So again, the documentation must very clearly state what the patient's medical conditions are.

If you're still using paper charts, then you're losing out on the incentives that the government is giving for utilizing an electronic medical record. If you're still using paper charts, make sure that the abbreviations that you're using are standard abbreviations, acronyms, and symbols so that there is no discrepancy or medical error.

Every visit must stand on its own. So if you're documenting in a patient's record, "see previous note," and an auditor comes in and reviews that, they will make the decision to retroactively take the money back because every visit my stand on its own. If the patient presents for follow up care for pre-exposure prophylactic, or diabetes, or hypertension, or some other medical condition that must be clearly stated in the record.

Problem lists. CMS mandates that an evaluation of each medical condition be documented. I've noticed in some records, doctors are documenting medical conditions in the problem list, but they're not stating the status of those problems. So your documentation should say something like, HIV positive, stable on meds, diabetes with neuropathy, meds adjusted. So it has to be very clear and concise. The patient's medical conditions that you're managing, that's on the problem lists.

So medical record documentation must support the services, not only submitted to the local Medicaid agencies, but to all of your insurance carriers. Documentation is important because those documentation inaccuracies can result in sanctions, fines that could ultimately lead to jail time, which is the final bullet point on this slide.

So we are now at the very end. And I apologize for going over. OK, great. We were supposed to take the bottom half off. So this was our final polling question. And the question was the ICD-10 principal diagnosis is hypertension. And we forgot to take the answers off.

So here are the answers in the interest of time. The answer is false. The principal diagnosis is AIDS. If you read the scenario, the patient returns for their test results. And they test results were the patient had the AIDS infection.

So the principal diagnosis is B20. The secondary diagnosis was for counseling. The patient also needed a refill of their hypertension meds, I10. And the prescription refill code for prescription refills is Z67.0.

So now we're wrapping up. These are your web resources. For the coders that are on the line, please take the time to go to the AAPC's website or AHIMA's website if you want information on becoming certified or maintaining your certification in your CEUs.

These are the other resources that were utilized during the presentation-- the CPT code book, the HCPCS coding book. And that's the end of my presentation. I'm going to turn it back over to Stephen now.

STEVE LUCKABAUGH: OK, thanks a lot. We do have one more polling question I'd like to pull up here. All right, so the question is, how many people are you viewing today's webinar with? We know some folks log in and listen alone, and some listen with others or even in a group.

And we're very interested in knowing just how many people are actually listening with you. So if you could take a minute to answer this poll. And if you select the 5 plus choice, please enter the actual number of people that are with you in the questions pane. So if you are with six or seven, just put the six or seven or whatever the actual number is.

And while we're waiting for you to respond to that, we would like to take some questions. So if you have any questions, please enter them in the questions pane at the Go To Webinar toolbar.

And also a reminder that the slides for today's presentation are available in the handout section. We know we had a lot of material covered today, and we went through really fast. So I know you're going to want to look back at that stuff.

So that's in there, the slides for today as well as the slides for the first three parts of the series. So you can grab all four of them right now, and you could also grab them on the website later once they're put up there. But now is probably the best chance to get them.

OK, so mostly individuals. That's good to know. OK, if you have any questions, please enter them now.

We did get one question. It reads, I understand you never report a counsel visit with a preventive medicine code. But would you ever code it with a modifier with a problem E&M visit code?

STACEY MURPHY: So, well, let me see if I can read it through. The preventive counseling visit codes-- if a patient presents for a medical problem, then you shouldn't be reporting the counseling codes, because most payers are not going to reimburse for a patient that has a medical problem, as well as for a patient that has a medical problem where you're going to treat that problem and counsel them. You should be using the E&M service code, and you

should document what you counseled the patient in, and determine whether or not your counseling was 50% or more of whatever is allotted in that particular CPT code.

So let's say, for example, a patient comes into your practice, and they're just coming in for their results. And maybe the patient also has some other medical problems that you're managing. And initially you were going to report one of the counseling codes, but because the patient presented those other medical problems now you're going to address those. And you're going to counsel the patient, also.

When you look at the evaluation and management codes, 99213 typically-- the time spent with a patient face to face is typically 15 minutes. So if the coding guidelines say if you're going to be spending 50% or more counseling that patient-- so that would be eight minutes-- if you're going to be counseling the patient for more than eight minutes, instead of reporting a 99213, you will report a 99214 because you spent more than eight minutes counseling the patient.

The caveat is you must document those items that you counseled the patient on. So you would have to document that. It has to be very plain and clear how much time you spent counseling the patient so that in the event you get audited, they'll see that even though this was, in theory, a 99213, because you spent more than eight minutes counseling that patient, you're going to now report a 99214.

STEVE LUCKABAUGH: OK, thank you. And they say, great, thank you. That's what we wanted to know. Makes sense.

If anyone else has any questions, please enter them now. I'm not seeing any questions right now. Do you have any final thoughts before we wrap it up?

STACEY MURPHY: Thank you for the opportunity to provide the coding webinars. I hope that they were very helpful. And good luck to you in the new year.

STEVE LUCKABAUGH: OK, and thank you all for participating in today's webinar. And we hope that you're able to find the information provided useful as you continue your P4C project, and ask that you take a few moments to complete the feedback survey that you will receive when you close out of this webinar. You will also receive it via email.

Today's webinar was recorded, and audio and video versions of the entire webinar, as well as the slides from today's webinar, will be available on the P4C website within the next few weeks. Copies of all our prior P4C webinars are currently available on the website on the P4C Resource Materials page at p4chivtac.com. The audio and video for part one of the webinar is currently up on the website. You'll need to log in to access materials, and if you need login credentials, send an email to p4chivtac@mayatech.com.

Thank you once again for participating in today's webinar. And thank you, once again, Stacey, for that excellent presentation. If you have any additional questions for the P4C project or for

Stacey, please email us at p4chivtac@mayatech.com. Take care everybody, and we'll see you next time.