April Lewis:

Good afternoon, everyone and happy Friday. This is April Lewis, the director of health center operations and HR training here at NACHC. Thank you so much for taking time out of your schedule to join part two of our coding and documentation webinar series. Today we are answering your questions that were submitted via the survey link, and also what you emailed to me, and we grabbed all the questions that were included in the chat room on this past Wednesday where we had a very, very, very dynamic session. And I'm going to go ahead and pass it over to our presenter today, Ms. Shellie Sulzberger, who was with us on Wednesday. Again, all of these questions were sent straight from you to us, so thank you for your feedback.

April Lewis:

We included a couple of questions that, from just our work in the field, we want to make sure that we got you all answered. Now, I'll be driving the chat room, so if you do have something that comes up, please do enter it there, and if time permits, we will get to all of your questions. So, without further ado, Shellie, I'll pass the baton to you.

Shellie Sulzberger:

Thank you. Good afternoon. How's everyone today? Today, we're just going to talk about, really, the questions and answers that have come through, kind of a recap of what we talked about on Wednesday. So I will give a brief little introduction to my background, in case you were not on the call on Wednesday. So, my connection to coding and documentation is, I am a certified professional coder. I work all over the country with health centers like yours doing coding and documentation reviews, physician education, coding, and billing training. My connection to the clinical process is, I am a nurse by background. I worked in internal medicine for many years. My connection to ICD-10 is am an ICD-10 certified trainer. I work, again, across the country helping providers and coding and billing staff with ICD-10, especially as we're moving to a more value-based healthcare world with quality. And then my connection to you, as I said earlier, I work with health centers like yours all over the country.

Shellie Sulzberger:

The disclaimer really is that there is no legal advice. Again, opinions are solely the opinion of myself. If there are resources to back up or a regulatory authority to back up my answers, I've given you that as well, or I can. Otherwise, the main things are, as you're looking at things is to make sure that you check with your Medicare and Medicaid contractors as well as your commercial payers if you're changing a process or looking at anything.

Shellie Sulzberger:

So, we're going to start off with one polly question, just really quick, probably a 30, 45 seconds. I just want to know if you were able to attend to webinar on Wednesday. And so, just yes or no. That gives me a good idea of how many people were not on the webinar versus how many were.

April Lewis:

Okay, everybody. And we opened that up for just 30 seconds.

April Lewis:

(silence)

April Lewis:

Five more seconds. Thank you so much for your responses. Shellie, we had 53% attend on Wednesday, and 5% did not, and we had 30% who didn't answer. So most of the people here were with us Wednesday.

Shellie Sulzberger:

Perfect. Okay. That just gives me a good idea. Let's see. Okay, whoops, sorry. I went one too many. So, I'm just going to kind of quickly recap for those of you that were not on the call on Wednesday, or for those of you that were, just to recap what we talked about. As we move into this new value-based healthcare world, we're seeing more and more payers starting to want to risk share with health centers as well as clinics. So, we've got to make sure we have really complete, accurate, credible documentation. Our documentation is what drives the work that's performed, the risk of the patient. This helps us from a compliance standpoint to get paid correctly, mitigate liability, and really just offer good patient care.

Shellie Sulzberger:

So, when we're thinking about clinical documentation in a medical record, we want to make sure number one, it's complete. And obviously, with electronic medical record, everything is pretty legible. There are still some groups out there working off of paper charts, still, so again, if they are, make sure it's legible. Timely ... And we'll talk about timely. There was a couple of questions on timely, so we'll talk about that as well. It needs to be clear and concise. The documentation needs to be patient-centered, and we'll talk about that with cloning and templates and things like that. And the last one, it needs to be accurate. So, complete, credible, concise, patient-center, accurate, timely documentation to have what we call complete documentation.

Shellie Sulzberger:

So, one of the first questions we received was: Can a medical assistant document the HPI ... So, the History of Present Illness ... If the physician or non-physician practitioner, like a PA or an NP, review it and make a comment?

Shellie Sulzberger:

Medicare is very clear that the physician or non-physician practitioner must perform and document their own HPI. So, if the medical assistant does document that information, the provider must re-ask, re-document. The only time that this would not be applicable would be if there is a resident, because they are considered a provider at that time. The resident could document the HPI, or if you have a scribe. And a scribe is someone that is sitting in the room, typing verbatim what the provider says. And I've written Medicare on this, and they are very clear that it is a physician paid component, so the physician must document his or her own HPI in their medical record.

Shellie Sulzberger:

The second question: Can you give us the definition of MEAT?

Shellie Sulzberger:

Because when I talked Wednesday, really making sure that every diagnosis has the MEAT. So, Monitor, Evaluate, Assessment, and Treatment. So when you're thinking about ... When you're looking at the

record, if you see diabetes, we want to make sure that the providers talked about the diabetes. Did he evaluate it? Is he monitoring it? Did he assess how they're doing? And are they continued on a treatment plan? So those are things we're looking for from an auditing perspective. So it just needs to correlate all the way through. We don't want to get to the end of our documentation, and see a list of diagnoses that we can't correlate back to any pertinent diagnosis, or any history or exam.

Shellie Sulzberger:

What are the risks of having staff, not certified coders, code encounters/claims and subsequently billing them?

Shellie Sulzberger:

I'm not sure what the question actually is on this, so I probably need a little more information. I'll talk to what I think I can talk about based upon just what's here. When people ask about what coders can do, there's a lot of different terminology and different duties, and the term coders are used kind of, what I would call, loosely right now. So, some coders are actually working in the billing office, he;ping with denials, working the scrubber, because that's where we're seeing a lot of denials and rejections, or where things get stuck in the scrubbers. So, they're helping in that avenue. We are also seeing coders help code from a diagnosis perspective. So, some EMRs have where anything that's unspecified will go kind of in a bucket, and the coders are looking at them.

Shellie Sulzberger:

I'm not a fan of coders coding every E/M. I think that is something we need to teach providers. And when I say coders, you don't have to be certified. There are certified coders out there that may still need a lot of education and knowledge, where there are uncertified coders that have a lot of knowledge. So I don't think the certification really drives one way or another. I think the certification is helpful. It makes coding staff keep up their CEUs and education, but I don't think that being certified is a be-all, end-all. I think you just have to figure out what the role is, and do quality reviews whether they're certified or not certified. So whoever sent this question in, if you want more information, if I didn't answer it the way you intended it to be answered, please feel free to email April or put something in the chat box, and I can speak to that as well.

Shellie Sulzberger:

The next question was: For documentation of diagnosis being taken into consideration towards medical decision-making, should we add, for example, patient in for UTI, but had chronic kidney disease treated by nephrologist?

Shellie Sulzberger:

Would we code it as a UTI and chronic kidney disease to reflect the Medical Decision-Making for prescribing the medication and risk of assessment? Absolutely. This is where some diagnosis go hand in hand with another diagnosis, or the providers are thinking about that from a treatment perspective. So, if your providers are actually taking that into consideration about a medication they should be on, or it impacts the treatment and the patient's care and over all risk, we want to make sure that that provider includes that information. So, best practice on this one would be to ask our providers to give the stage of the chronic kidney disease. Sometimes, they will know that. However, if they're being treated by a nephrologist, they may not have the current stage of the kidney disease. So if we don't know, we would code it as unspecified. But it would be the UTI, followed by the chronic kidney disease.

Shellie Sulzberger:

If coders are changing the E/M codes because the doctor did not code correctly, is this acceptable?

Shellie Sulzberger:

From a regulatory standpoint, there's nothing in writing to say who can change things. Best practice is to talk to the provider and teach them why the code that they selected was not correct. A few things: number one, their name is on the claim form, so they are attesting to that claim form being accurate and correct. So, if we have someone in the background changing things without notifying the provider, we're changing things that they're attesting to. Number two, they're going to keep making the same mistake over and over and over again if we're not educating them. So, I don't want coders to send out things that they know are not coded and billed and documented correctly. However, I do think there should be a conversation. So my recommendation to all health centers is to develop a process in your health center, make sure you have good duties and processes outlined on what the expectations are. If coders are changing them, make sure that they're setting up time with the providers to go over them, and then also do quality reviews on your coders. You should be doing reviews on your coders as well as your providers to make sure that they're being educated, and that they're not missing anything, and everything's being done correctly.

Shellie Sulzberger:

The next question was: When a provider diagnoses a patient with an upper respiratory infection, for example, and they have a couch and fever, would that not be part of the upper respiratory infection? Is it okay for coders to remove signs and symptoms that correlate with the most definitive diagnosis? And this question also said, instead of the URI, should we code COPD with a cough?

Shellie Sulzberger:

So, you wouldn't code COPD unless the provider gives you that diagnosis. Again, coders can't take a bunch of signs and symptoms and come up with a diagnosis. Only a provider can diagnose patients. So, if the provider documents that I have an upper respiratory infection, cough, and fever, the cough and fever would be inherent to the upper respiratory infection, so we would not code those signs and symptoms. We would only code the most definitive diagnosis we know at the time. However, we wouldn't add COPD if the provider has not diagnoses the patient with COPD.

Shellie Sulzberger:

The next question was: If I can add 12 diagnoses per the visit, how many really go over through the revenue cycle to describe the complexity of this patient?

Shellie Sulzberger:

And, I apologize. I wasn't sure what this meant. A claim form can hold up to 12 diagnoses on the claim form. Again, all of those diagnoses must be monitored, evaluated, assessed, and treated, or they must correlate and go together. Each diagnosis plays a part in the medical decision-making and the risk of the patient. So you could have one diagnosis, and a very sick patient, where we're billing a higher level than we typically would bill. You could also have five diagnoses where the patient's completely stable. So, of course, the more diagnoses, the more work it takes, but I'm not really sure what this meant when it says "going through the revenue cycle to describe the complexity." The diagnosis and the documentation are

what's going to describe the complexity of the patient, and the work performed by the provider. So again, whoever sent this in, if they want more information or can reword it, they can email April as well.

Shellie Sulzberger:

When patients come in for a pregnancy test, do we need to code the positive or negative result?

Shellie Sulzberger:

We absolutely recommend coding that. You should code what you know at the time of coding. So if it's a negative, I think it's a Z32.02, and if it's a positive, I think it's Z32.01. So if you know that the result is positive or negative at the time, you should code that. If you forget to code it, I don't think payers are going to get super upset, because obviously, the reason that you're doing it should be documented, but it's a good habit to get in to. Again, this is where your IT people can write rules if that result is put in as a negative, on the back end, you could embed the negative code versus a positive. Again, if you don't have somebody in your organization that can help with writing those rules, feel free to reach out to me. I know a guy that writes a lot of rules for electronic medical records to help solve that problem on the front end.

Shellie Sulzberger:

Next question was: I recently was informed by our quality officer that my CPCs need to be adding CPT Category II codes to certain screenings, specifically A1C levels, systolic and diastolic blood pressure ranges. Is this going to be common for FQHCs in the future? None of our payers currently want this information.

Shellie Sulzberger:

Again, this is up to your payer. I already know several FQHCs that are already doing this, so I think it is a way of the future. It helps with, again, this value-based healthcare and the quality initiative, so I think it's just working with your payers. Again, best practice is to put them in, have rules on the back end, knowing that these are the payers that want them and dropping them off of the payers that don't, so you have that manual process. Anything you can automate with technology, try to do that so that you're not doing a lot of manual work on the back end.

Shellie Sulzberger:

When documenting a Well Child Exam, how many Review of Systems are required, and what classifications should be used? Example: six with toilet training, feeding habits, do they have a caregiver? Or 10 with Head, Ears, Nose, Throat, Eyes, et cetera? We have a provider that state the Review of Systems for Well Child Exams is not a requirement and the body systems to be reviewed are found in the exam section.

Shellie Sulzberger:

So, whether it is a Well Child visit or an adult visit, as long as it's not the Medicare annual wellness visit, there are not really any requirements as to what Review of Systems, or what exam components you must document. The guidelines in the case that it should be an age and gender appropriate history exam, counseling, anticipatory guidance, risk factor reduction, interventions, ordering of any kind of diagnostic or ancillary services. Typically, we would expect to see a pretty thorough Review of Systems. However, if you have a little one who's six months old, you probably aren't going to get through 10

Review of Systems, so it's really what's pertinent for that age and gender, if anything's going on. So, if the mom brings in a two-year-old and says, "They're here for their Well Child, they haven't had any problems," we may ask a few Review of Systems. They may not go through every Review of Systems. And then of course, the exam component for Well Child is going to be, of course, an unclothed exam for most Medicaids. Well Adult, again, just age and gender appropriate.

Shellie Sulzberger:

So I think this is a place internally you've got to set some guidelines on what the expectations are from a clinical perspective, and then make sure that you are consistent across the board.

Shellie Sulzberger:

Question: Could we please go over determining what complexity qualified for a 99214 instead of a 99213.

Shellie Sulzberger:

Absolutely. 99214, the detailed encounter, either history or exam, with a moderately complex patient. So, moderate risk to the patient. Some example might be a patient coming in for three chronic conditions. The three chronic conditions can be stable and continuant on medications. For something like that, we would see in our history, the patient's here today to follow up on hypertension, diabetes, COPD. The physician or non-physician practitioner has to document a status of those conditions. So, it may say something like this: "Shellie's here today for diabetes. She takes her Metformin as prescribed, she does not check her blood sugars, except when she feels like they're a little bit low." Hypertension. She hasn't had any palpitations or headaches. She takes her medications as prescribed. She does not check her blood pressure, even at the grocery store. Number three, COPD. She takes her SPIRIVA as prescribed. She can walk one block without any shortness of breath or wheezing. So that would be a status of three chronic conditions. The provider then has to have two Review of Systems. No chest pain, no shortness of breath.

Shellie Sulzberger:

Then you do the pertinent exam, and then the medical decision-making. Number one, diabetes continue Metformin as prescribed. Number two, hypertension. Whatever the plan of care is. That would qualify for a 99214. We find that in an FQHC, many times, providers are doing the work of three or more chronic conditions. However, they are not billing level fours. They're billing level threes because in their mind, they're like, "I didn't change anything." However, the guidelines say, if you're managing multiple chronic conditions with medication, that those qualify for a chronically moderate complexity patient. Other examples might be an acute abdominal pain. Patient comes in with right lower quadrant pain, the provider is trying to determine if they have a bowel obstruction, appendicitis. So the risk to the patient increases if they have appendicitis or a bowel obstruction, so you might see documentation where the provider is giving stat lab work, a CT of the abdomen, et cetera.

Shellie Sulzberger:

Patients coming in for an exacerbation of COPD or asthma, we're doing nebulizer treatments ... Those patients are moderately complex. So, one of the best ways to educate your providers is to ask them to really think about the clinical perspective. If a resident were behind you today, Dr. Jones, what's the risk if this patient comes in with a sinus infection or an upper respiratory? Your provider's going to say, most of the time, those patients are low risk. Probably nothing is going to happen between today's visit and

the next visit. However, if you get that patient with an upper respiratory or sinus infection that has COPD or emphysema, they're on oxygen, and they're still a smoker, that patient's risk just went up. So that might be a 99214, because there's a lot more that I'm concerned about between today's visit and the next visit. So if you can get your providers to start thinking clinically, that will help them with the coding, and then you can teach them how to make sure that they have the appropriate documentation based upon what they're performing in the room.

Shellie Sulzberger:

The next question is: Seeking a definition of timely or best practices for timely charting being completed by the providers.

Shellie Sulzberger:

So, if you remember, the third slide in, one of the criteria for complete documentation is timely. Medicare does not have anything in writing for physician practices or health centers. Most practices strive for 24 to 48 hours. Medicare says it must be timely, but they don't define timely on that side. Now, the conditions of participation for hospitals is 48 hours. So that's where you typically see that most practices strive, somewhere between 24 or 48, maybe 72 hours at most. The reason we don't really want to go much longer than 72 hours is because it's really hard for a provider to remember everything that they did for that specific patient. Because remember, our documentation must be patient-centered. So again, I think this is something that you have to look at in your own organization and try to determine if 24, 48, 72 hours is best practice. What works best for your practice? But if you think about it, and you let providers go weeks on end, if you said, "Gosh, Dr. Jones, last Friday, what did you have for your 2:00 snack?" Most providers are not going to remember that unless they eat the same thing every day. So again, we want to make sure that it's patient-specific, so usually 24 to 48 hours is a good rule of thumb. But again, nothing in writing for that.

Shellie Sulzberger:

Can we talk about documentation for nurse visits?

Shellie Sulzberger:

First, let's talk about Medicare, Medicaid. Medicaid, you'll have to check with your Medicaids. But Medicare, you can't have a nurse visit in an FQHC. One of the key things for you guys to think about with Medicare is, you have the G codes that have qualifying codes underneath them, so the GO466, GO467, and a 99211 is not under either of those codes. So that tells you that that is not a billable service. They do not reimburse for a nurse visit in an FQHC, so it has to be an established, qualified provider. So, physician, non-physician practitioner, licensed clinical social worker, psychiatrist, et cetera.

Shellie Sulzberger:

For payers that allow incident to billing, it has to be an established patient with an established problem, and there already has to be a treatment plan that's outlined, and you cannot deviate from that treatment plan. So, if the provider says to the patient, "Come back and see nurse Betty to have your wound dressed," and if that payer followed the incident to guidelines ... But when the patient comes in that day, they say, "Gosh, you know, I've also had this rash on my arm," that's unrelated to the wound, that breaks the incident to, so a provider would have to see that patient. So again, established patient, established problem, and you cannot deviate from the treatment plan. Everything has to be outlined. But again, for Medicare, an FQHC cannot bill a nurse visit.

Shellie Sulzberger:

Next question: What are your thoughts on using certified scribes to assist providers with extensive EHR data entry that is required in our current healthcare environment?

Shellie Sulzberger:

There are health centers starting to use scribes. Again, you just have to weigh out the cost-benefit. The scribe is truly functioning as what we call a living recorder. So, scribes have to sit and document, verbatim, what that provider says. The scribe can't translate what he or she thinks a provider means, or "Gosh, I've worked with this provider for a long time, I know when they say this, they really mean X." So, they truly are just a living recorder, documenting in real time what the provider says. So they have to be in the four walls with the provider and the patient, document verbatim. They must document that they scribed for Dr. Jones by, and their name and credentials, if they have credentials, and then the provider must review, update, change anything that needs to be changed, sign, and date as well.

Shellie Sulzberger:

Should the coder query providers if they change a diagnosis so the provider can update their patient's problem list from the change so the problem list is updated?

Shellie Sulzberger:

If the problem list is not updated, then you will continue, of course, to have the same issue every time. So again, I'm a big believer in, we need to educate providers. So, if I were in charge of your coders, what I would say is, change the diagnosis to get the bill out. Make sure it's accurate, and then set up scheduled times to meet with your providers to go over things like that. What happens in an FQHC is we bombard providers with sending things jelly beans, or an email, and they get so many that they don't update anything. They don't respond to them because they're an overload. So, instead of sending all of those all the time, it's best practice to go ahead and fix the diagnosis, go meet with the provider, help them at that same time to make sure the problem list is updated for each of those patients. And then, if you do this on an ongoing basis, then you're going to update that problem list. But if you're emailing them, you're probably not going to have them change that, so you're going to have the same issue every single time.

Shellie Sulzberger:

If a provider documents in the HPI the patient has diabetes type II with chronic kidney disease, stage three, but the provider documents diabetes type II in the assessment plan, can the coder automatically make the diagnoses change to the most specific type of diabetes with chronic kidney disease without querying the provider?

Shellie Sulzberger:

Yes, you can. From the Coding Clinic, "The subterm 'with' in the index is interpreted to be a link between the diabetes and other conditions." So one of the things that I would tell your coders is, if they get the ICD-10 book out, at the very beginning, it has official coding guidelines, and it goes through and talks about which conditions have a casual relationship between them so that you can automatically code them. So, if I see hypertension and heart disease, I know that I can change that to the appropriate, most specific code for hypertensive heart disease, or hypertension with chronic kidney disease without the provider telling me that. So I recommend that they look in the beginning of the ICD-10 book. If they do

not have that available, if they Google 2018 Official Coding Guidelines, they can google that for free, it will pull up for free, and then they can look at that as well.

Shellie Sulzberger:

So those are key things that they should be reading every singly year and highlighting so they know which codes have a relationship that they can automatically use the most specific diagnosis. Again, you can also set up rules in your EMR, so if you see an E11.9, and chronic kidney disease, that we can have that drop into a bucket or changed to the most specific diagnosis.

Shellie Sulzberger:

Next question: Is it acceptable for the provider to indicate the Review of Systems are noted in the HPI? Or under the Review of Systems, can they document as outlined in the HPI?

Shellie Sulzberger:

Yes. That is acceptable. Providers can put the Review of Systems anywhere in their note, and long as they're there. One of the key things I would caution you on is, when providers say, under the Review of Systems, "As outlined in the HPI," make sure it's outlined in the HPI. Many times what happens is, providers create that in their template to say, "As outlined in the HPI," and when you read the documentation of the HPI, many times, I find during my audits, there is not Review of Systems. So, when we're saying that, then that starts to beg the question to a payer, "Gosh, is this a pre-built template? And I'm not checking my work?" Or, "Am I thinking I put a Review of Systems, but I'm not sure as a provider what coding Review of Systems actually is?" So again, caution your providers. And these are things to watch. If it says outlined in the HPI, make sure that it's outlined in the HPI.

Shellie Sulzberger:

Next question: We as clinical staff review our asthma patient charts that have unspecified diagnoses. We review the medication the patient is taking and document a more specific diagnosis based upon the medication they are taking. Is that okay?

Shellie Sulzberger:

The physician or provider, nurse practitioner, PA, et cetera, should document the most specific diagnosis. I don't think it would be acceptable for clinical staff to go through and look at medication and things like that to determine the most specific diagnosis. This really should come from our providers. Our providers are the ones who can diagnose patients.

Shellie Sulzberger:

The next question is: When reviewing the patient's chart, and the chief complaint and HPI only have "here for followup on diabetes," is this acceptable, or do we need more documentation?

Shellie Sulzberger:

"Here for followup on diabetes," would be the reason for visit or chief complaint. So, pertinent HPI might be something along the lines of, "Patient's here for diabetes today. They check their blood sugar at night ... " So I would have when it's checked ... Or, "Their blood sugars run between 80 and 120," so I have a severity ... Or, "After eating a donut, their blood sugar seems to spike and they get a little shaky." So, just "here for follow up," doesn't give us any HPI. So History of Present Illness, we're looking for

those key elements like location, duration, timing, severity, context, modifying factors, associated signs and symptoms, quality. So we're looking for those key things.

Shellie Sulzberger:

If a patient is coming in for a preventative visit, and the physician focuses on managing chronic conditions, would this be billed as a preventative or an office visit?

Shellie Sulzberger:

So this question's really not black and white, and this is a thing I've been working with providers on a lot lately, as well as training medical assistants when I'm doing operation reviews. We really need to know why is your patient here today. That really is driving the visit. What made me come in today? And when you're thinking about patients that come in and say, "I'm here for a checkup or a physical," what does that actually mean? Because to a 90-year-old, a physical and a checkup is making sure that all my conditions are good, my medications are right, versus a 25-year-old coming in for a checkup or a physical. "I'm not really on any medications. I'm just coming for that yearly thing to make sure I'm all good," is what the 25-year-old would say. So, this really starts from that very first phone call. So, working with our scheduling staff so when patients call to make an appointment ... "I'm here to see Dr. Jones. I need an appointment ..." Well, first of all, why are you coming in? When they say, "I'm coming in for a checkup or a physical," we need some key things for our scheduling staff to ask those patients. Mrs. Smith, are you coming in because you want to head to toe wellness visit, or are you coming to go over your chronic medical conditions and medications? So really start prompting the questions for that scheduling staff to ask.

Shellie Sulzberger:

When our medical assistants room the patients, it's revisiting that same question. "Mrs. Smith, it looks like you're here for a wellness visit today, a physical. Now, it looks like you have diabetes and hypertension, but haven't been seen for that for the last six months. While you're here, do you want to go ahead and have Dr. Jones take care of that? Or would you like me to get you scheduled to come back in a week or two?" So again, just trying to figure out why the patient's here and then we need to make sure our providers know that so that we know exactly what their game plan is with that patient. Because payers give preventative services, usually at not copay to the patient. So if a patient's goal is a preventative visit, and they end up coming in and we do something other than that, they get a copay. You may be getting calls. However, sometimes patients come in for that preventative, but also want to address everything. So they need to be aware that they may end up with a copay as well, which is okay. We just need to inform them, because otherwise, if they have to come back, they would have that copay anyway. So it's really for the convenience of the patient that we're trying to get everything done today in one visit.

Shellie Sulzberger:

If the provider documents in the HPI, "Follow up on diabetes," would I count this as a brief or extending HPI?

Shellie Sulzberger:

Again, you wouldn't have any HPI, because that's the reason that they walked in the door. So, we have to really spend time with our providers and shadow them and figure out what they do. When that patient says, "I'm here for diabetes," what is that provider asking that patient? "Are you taking your

medications? Are you checking your blood sugar? Do you have any numbness and tingling in your feet?" Those are things that start driving my HPI. So it's really taking our coders into a new role and spending time trying to help providers more in a, kind of what I would call, an investigative, more of a resource, shadowing them, helping them understand what drives the coding. So sometimes providers, I say, kind of are like horses. They have two sides of the brain. They do a lot of work, and then they drop part of it in the trash and part of it in the important side of their brain. Well, sometimes that trash is what helps drive my HPI, so it's working with those providers so they know what's important from a coding and billing perspective, and then what do they need for them clinically?

Shellie Sulzberger:

Next question is: Can you explain how documentation affects the revenue cycle?

Shellie Sulzberger:

Absolutely. Clinical documentation does affect the revenue cycle. If the note's not properly documented, it kind of creates what I call a domino effect. If our providers don't have clear, concise, credible documentation, and we bill for a service, it could be considered as incorrect coding, either over-billed, under-billed, incorrect codes. So like I said earlier, knowing if the patient's coming in for a preventative service, or a sick visit can lead to incorrect coding. So documentation plays a part in that. Why is your patient here today? Also, documentation affects the billing and financial management of the practice. So, obviously if we don't have a good revenue cycle, we can't keep employees. We can't keep the doors open. And also could affect quality of care. So, when we don't have good documentation, it doesn't really explain what happened with that patient during that encounter. We also could have dissatisfied patients, because when our documentation is not up to snuff, we could get denials for medical necessity, which would in turn be turned over to the patient for patient responsibility. And then our patient is upset because we didn't do a good job documenting. So, the documentation and the revenue cycle go hand in hand.

Shellie Sulzberger:

One of the things that our billing office has to change a little bit, I think, as we move to this new value-based healthcare world is really keeping our providers posted on things that we're getting denials and rejections on. High level, but if it's related to diagnoses or documentation, then the providers need to know, otherwise they're not going to change their habits. So, just reminding them, "You've got to keep submitting unspecified diagnosis. Every time we look in your note, we can't find a more specific diagnosis, so we're not getting paid for that service." So again, it all goes back to education. It kind of is this full circle.

Shellie Sulzberger:

The next question is: What is HCC?

Shellie Sulzberger:

HCC really is just a model that Medicare started back in 2004 to adjust the capitation of payments to private health plans. So it's taking those most significant diagnoses, which are going to drive the risk of the patient. So they measure the disease, and they assign what they call like a RAF score to that diagnosis. So, there's several diagnosis codes that represent what they call costly chronic diseases. So they're looking at patients with diabetes, chronic kidney disease, congestive heart failure, rheumatoid arthritis, vascular disease, and saying these patients are more risky, cost us more money. So, payers are

wanting to see how sick are our patients. So it's really important that we internally educate our providers on not just putting diabetes or chronic kidney disease. We want to know that the patient's uncontrolled diabetic, with neuropathy, and then we want to know that they're a chronic kidney disease, stage four. So again, do they have systolic or diastolic congestive heart failure? Those are things that payers are starting to ask providers, "Give us more documentation of the specificity of how sick your patient is. Don't just throw diabetes on a claim form."

Shellie Sulzberger:

Next question is: How do we start a CDI program? Clinical Documentation Improvement.

Shellie Sulzberger:

So, number one, you have to develop a plan. Do you see patients in-patient and out-patient? If you do, where are you going to start? Do you want to start on the in-patient side? Do you want to start on the out-patient side? And then you have to start identifying the resources. What personnel is going to be the one to kind of head up the CDI program, and who will they have under them? What systems do you have available? Can you use technology? You have to set goals. So when you're setting your goals, you really need to think about getting buy-in from your providers. So find a provider that buys into quality, that buys into the program, and really start working with that provider for them to buy in to what diagnoses that can go under our goals. So if your providers say, "Gosh, the main things we want to manage are our diabetic patients and our hypertensive patients." Start with those two, and really spend time educating your providers on what you need. Audit your charts, see where your deficiencies are, and use those charts as examples. So, find some that are documented really well, and some not so well. Then work with technology to see, can you built prompts in your electronic medical records to get those key things you need.

Shellie Sulzberger:

So when I click on diabetes, can my technology say, "Whoops, wait a minute. Is it type I or type II? Is it controlled, or is it uncontrolled? Do they have any of these?" Click the ones they have. Neuropathy, retinopathy, et cetera. So, use technology to help drive those check boxes to prompt providers, because in a provider's mind, when they're seeing the patient, and they're documenting in their history that there's a patient that's here with uncontrolled diabetes, they've got neuropathy, et cetera, that may all be in their history. Providers don't like to re-document that same information in their assessment plan. However, we need it in the assessment plan to get on the actual claim form. So if we can use technology to help answer some of those questions quickly, then that is going to help get you your CDI program. So then, after you do this, you have to start measuring the performance. How'd they do, and then kind of re-audit. It's an ongoing process.

Shellie Sulzberger:

So again, conduct your review. Identify areas that need improvement. So, do accuracy rates. Look for errors based upon coding. Use the time, really, to talk about documentation, correct CPT, correct ICD-10 codes. And then of course, determine direction based upon the outcome. But the key is, it should be an ongoing program. It should never stop, so you should always be auditing, monitoring, reevaluating, and educating.

Shellie Sulzberger:

So before I go to this risk adjustment model, I know April had indicated that there are some questions in the queue, so I definitely want to get to those. So, April, if you want to go ahead with the first question?

April Lewis:

Thank you, Shellie. This is from ... The name that's listed is William May, so in the event that I saw something off, I'll unmute you so you can chime in. But her question reads ... And it's going back to what you mentioned ... So why are scribes allowed to document if MAs are not allowed to document? And that's one part of it.

Shellie Sulzberger:

Can you read that again, one more time?

April Lewis:

She asked: Why are scribes allowed to document if MAs are not allowed to document?

Shellie Sulzberger:

Okay. I'm not sure I understand the question, but I'll try to answer how I think, and if I don't get this right, feel free to jump in and re-ask the question. So, scribes can be a medical assistant, it could be a transcriptionist, it could be a hired staff member. Scribes are literally sitting in the room so when Dr. Jones says, "Mrs. Smith, how are you feeling today?" And Mrs. Smith says, "Well, I feel pretty good, but I've been really tired," that scribe is going to put down, "Mrs. Smith indicates she feels pretty good but been pretty tired." When Dr. Jones says, "Are you tired every day?" And she said, "Yes ..." "Tired every day." So they are typing word for word. MAs can also scribe, as long as they're scribing what the provider says there in the room. MAs can't go in and say, without the provider, "Mrs. Smith, why are you here today?" And she says, "I'm here for low back pain. That's my chief complaint." The MA can ask, "How long has the pain been there?" "Two weeks." "Does it hurt all the time? Does it come and go?" They can ask all those questions. They can document all that.

Shellie Sulzberger:

But your provider cannot use that for the HPI. They can use it as a guide. The provider can walk in and say, "Mrs. Smith, it looks like you've had back pain for the last two weeks. It's worse in the morning." He can re-ask and re-document, but he has to re-document that information if he was not the one to originally ask those questions. Does that answer the question? Can you ask them?

April Lewis:

She said that that does make sense, and it does answer your question. And so, our next question ... And I just gave her a warning. I may have to unmute her for this one. What about time-based? For example, asthma exacerbation where I have to give back to back A-L-B ... Maybe Albuterol-

Shellie Sulzberger:

...Abluterol?

April Lewis:

Yeah, okay ... Treatment, and reassessment, and then get sent home. What about infant weight check in? Does that make sense, Shellie? William, I'm going to unmute you. Does that-

Shellie Sulzberger:

Yeah, unmute, because I don't know what you mean by the Albuterol treatments with the weigh-ins.

April Lewis:

Okay.

William:

No, sorry. Those are two separate things.

Shellie Sulzberger:

Okay.

William:

I didn't know ... The first one is basically ... I know you mentioned something about the 99213 versus the 214 code. So, a lot of times we'll have to give multiple treatments, and then we spend a lot of time re-assessing them, and then obviously now we're spending not 15 minutes, but now it's like half and hour or 45 minutes by the time we're all done. Would that be a 99214, then?

Shellie Sulzberger:

Yes. So, that's a great question. Let's take time out of the equation for a minute. I'll talk about time. Are you a provider?

William:

I'm sorry, a pediatrician.

Shellie Sulzberger:

Pediatrician, perfect. I would ask you, what's the risk of that patient between today's visit and the next one for that patient that you're doing Albuterol treatments on from a...standpoint? Pretty risky?

William:

Well yeah, because usually if they come in wheezing and they're retracting, yes. That's always that risk that they can go under respiratory ... They're already in respiratory distress, technically.

Shellie Sulzberger:

Right. So, they're already at ... Whether it took you 30 minutes or 15, that patient is at moderate risk. So, those are going to be a 99214 as long as you have your history or exam documented, plus you'll bill for you nebulizer treatment and Albuterol. A 99213 would be that asthmatic patient that comes in, they're doing well, they've used their rescue inhaler once in the last month, but over all, they're doing well. They're really there just for their checkup, get a refill. Those are your 99213s. Once you start saying, "You're sick enough that I have to do a neb treatment," that pretty much elevated you to a level four.

William:

But do I have to document ... So, like the risk, saying that their risk for respiratory failure, or can I just document the-

Shellie Sulzberger:

No.

William:

The time that I spent? Or is it just assumed?

Shellie Sulzberger:

Nope. You can just document asthma exacerbation. Patient given two nebulizer treatments in the office with Albuterol, whatever you gave them. Your medical decision-making ... We should be able to tell from what you documented and what you did. So you don't have to list your differential diagnosis. So if the patient comes in wheezing, you've got the exam to support that, and you move to your assessment asthma exacerbation and kind of your work up plan. You're doing the neb treatments in the office, have you told the patient X, Y, and Z. That should easily support that.

William:

Okay. Yeah, I've been putting time in the past.

Shellie Sulzberger:

Okay.

William:

So I can leave those out.

Shellie Sulzberger:

So, time filling ... A bill passed upon time, it has to be face-to-face, and it has to be greater than half-counseling or coordinating care. So, let's say your ADH patient comes in, and they've had some behavior issues at school. I might see a note that says, "I spent 25 minutes. The majority of the visit was counseling the patient on the importance of taking their medication, finding strategies to reduce their anger outbursts during school, trying to take 10 minutes every morning to journal ..." Whatever you're telling them. So that's more of a counseling code. It's time, or complexity. So, if you have a patient that is moderately complex going for a level four to drive that, time is really irrelevant unless the majority of the visit's counseling or coordinating care.

William:

Okay.

Shellie Sulzberger:

Does that make sense?

William:

That makes sense, yeah.

Shellie Sulzberger:

Okay. And your other question on the weight?

William:

Yeah. A lot of times like newborns, we have them come back the next week and just do a nurse check for a weight visit. And I really haven't been documenting ... Especially if they come in, they're gaining appropriately and they get sent home. Now, they're a Medicaid patient, so do I still need to document anything at that stage, the nurse visit?

Shellie Sulzberger:

What are you billing? Are you just billing a nurse visit?

William:

Yeah. 99211 code.

Shellie Sulzberger:

Yeah, you don't need to document anything.

William:

Okay. Okay.

Shellie Sulzberger:

Yep.

William:

Okay. Just wanted to make sure.

Shellie Sulzberger:

All right. Perfect.

April Lewis:

All right, Shellie. Thank you, William.

April Lewis:

Yes. The second one: Our practice has standing orders for the nursing staff for 30 patients to have tests before they see the provider. With this, the nurse has to input a diagnosis into the EMR to put in the test and results. They are putting in symptoms as a diagnosis. Is this legal? Examples: dysuria for UA, then the provider diagnoses the patient with UTI.

Shellie Sulzberger:

So, yeah. That is acceptable. Nursing staff can take signs and symptoms. Coders can pull out signs and symptoms from the note. We just can't diagnose. So, if that patient comes in with dysuria, low back pain, we can use all those signs and symptoms. When your nurse dips that urine and looks and ... The nurse is smart enough. The nurse knows that patient has a UTI, but the nurse can't give that patient the diagnosis of the UTI. We can use the signs and symptoms until the provider has diagnosed the patient with a UTI. So that is acceptable and legal and appropriate.

April Lewis:

Perfect. And the other one, I'll put in your chat box, because I think it'll be easier for you to read it, especially since it's an example.

Shellie Sulzberger:

How do I find the chat box? Oh, here maybe?

April Lewis:

Yeah. If you click on chat in the right corner.

Shellie Sulzberger:

Okay. Is it the last one that says: My question is-

April Lewis:

Yeah.

Shellie Sulzberger:

If this is correct documentation. Okay. My question is, if this is correct documentation in a master IM for family, social, and medical history. It says, reviewed no changes. Last detail document date, 8/8/13. It does not state what was reviewed.

Shellie Sulzberger:

I don't know what the master IM is. So I don't know what that means, but it might be an EMR terminology. Provider can reference information. So, if my family history was documented in January, and they reviewed it and there's no changes ... They can indicate they reviewed it ... I would be a little concerned if it's 2018 and they're referencing something from 2013. I think that I would recommend ... And there's nothing in writing, but I would recommend that our past family social history is reviewed and updated annually, because five years is a long time. Things can change.

Shellie Sulzberger:

The other thing I think it's really important is making sure the medical assistants that are rooming the patients ... If they're responsible for updating a family social history and past medical history, that they're truly asking the patient those questions. As a patient myself, I can tell you I was just at the doctor, and the medical assistant so nicely said to me, "Has anything changed on your history?" Well, I've never even been to this dermatologist before. I've been to the primary care. They share the same record, but I don't even know what she has in there. But I just said, "No, nothing's changed." So I think it's really important that whoever's taking the information, especially if I haven't been seen for a while, to say, "Shellie, do you still take whatever medication?" And ask specific questions. "It looks like you're a non-smoker? Have you started smoking since we've seen you last?" Really ask some pinpointed questions.

Shellie Sulzberger:

So I think my personal opinion is five years is too long. I think it should be updated annually. But they can update it. They just have to indicate where they got that information.

April Lewis:

Okay. And Rebecca, let me know if that did or did not answer your question. And Shellie, we'll do one more before you go back in the presentation. Somebody wanted clarification on the standing orders. If a patient comes in with a sore throat, et cetera, and a nurse does a strep test or a flu swab before the provider even sees the patient, is this okay?

Shellie Sulzberger:

If the clinical and health center have what we call ... I don't call them standing orders. I call them protocols. So if the protocol is, if a patient comes in with these symptoms, then we'll go ahead and do a flu swab ... If that protocol is in place, if the patient meets those symptoms, then that would be appropriate. You see that a lot, especially in the emergency room. So if a patient comes in with low back pain, difficulty going to the bathroom, we'll get a urine dip. We use the signs and symptoms to drive what we're doing, then when the provider sees me, if I have a more definitive diagnosis, we code what we know at the time of coding. So if they do that rapid flu, and I end up with influenza, then we would use influenza as my final diagnosis, not the signs and symptoms.

April Lewis:

Perfect. Thank you. All right. We will take ... I got a couple more that came through. We'll add those to the end time. We have four minutes left, so I'll let you finish up, Shellie, and then for the ones that remain, we can email them out as best we can.

Shellie Sulzberger:

And I can stay on. This shouldn't take very long to finish up.

April Lewis:

Okay, great.

Shellie Sulzberger:

So we know healthcare is rapidly changing, so we're looking at risk adjustment. It's going to be the future model for all healthcare, not just the free-standing providers right now. It's going to affect more than just Medicare patients. And we know that documentation and coding is driving reimbursement, quality. Medicare is starting to say, "Patient over paper," so they want more patient engagement. So we know that this is the model that the world's going to. So we just need to be ready. I'll open it up to questions now, and I'm happy to stay. 2:55, I guess for you guys, so I can stay on past 2:00 if we need to, just to ... I want to make sure we get everybody's questions answered.

April Lewis:

Okay, great. And the other question that came in: If a patient has multiple chronic conditions such as diabetes, hypertension, and COPD and comes in for an acute issue, do all of the chronic conditions need to be addressed in the assessment at the time of the visit, or does the chronic conditions just related to the acute visit process?

Shellie Sulzberger:

That's a great question. So, if the patient is coming in for a cough, and they have multiple chronic conditions, and those conditions are not really addressed or impacting the care today ... Maybe the only

thing being impacted might be that patient's COPD, then we would not list all those chronic medical conditions. We would list the ones that are pertinent to the visit. Now, if I come in for my cough today, and the medical assistant looked, and the doctor looked, and I haven't been seen for three or four months and I'm due to be seen for my chronic conditions as well, and the provider does address those during the encounter ... "Patient's here for a cough. Also is due for updates on diabetes and hypertension ..." You can go ahead and include all of that. But I would expect history and exam to correlate, followed by the medical decision-making. So, our diagnoses are what we talk about today, what we assess today, what we're treating today, or that affected the decision-making.

April Lewis:

The next question is: If we can diagnose a symptom, why can we not use RSV as a primary diagnosis?

Shellie Sulzberger:

RSB or RSC?

April Lewis:

It says RSV, like Romeo, Sierra, Victor. Melissa, point of clarification ... RSV?

Shellie Sulzberger:

V like Victor, I think.

April Lewis:

Yeah, V like Victor.

Shellie Sulzberger:

Yeah. So, that respiratory syncytial virus ... Medical assistants and coding staff, we can use signs and symptoms, but for us to be diagnosed with that medical condition of RSV, have to come from the provider. So, even though the clinical staff may be able to look and come up with what they consider the appropriate diagnosis, we are not allowed to use diagnosis. A patient's not going to come in and say, "Here's my diagnosis based upon my symptoms," and medical staff can't do that as well. Only providers can diagnose patients. That really doesn't have anything to do with coding.

April Lewis:

She said: Right, but we cannot use it as a primary diagnoses?

Shellie Sulzberger:

Who can't ... Her provider can't use it as a primary diagnosis? I don't know what you mean by that.

April Lewis:

Okay. Melissa, we need clarification. Let me see if I can get to her. Let me see. I'm waiting on her to chime in.

Shellie Sulzberger:

No problem.

April Lewis:

Hello, Melissa?

Shellie Sulzberger:

While you're waiting...

Melissa:

Hello, it's Melissa.

April Lewis:

Hey, Melissa. We can hear you okay.

Melissa:

Okay, hang on just a minute. Go ahead.

Melissa:

So, we've been told, as providers, when I put in RSV, they cannot bill that as a primary diagnosis. I have to also put cough and put that as the primary diagnosis.

Shellie Sulzberger:

I've not heard that. This is allowed to be a primary diagnosis. It does tell you to code first if a patient does have like influenza or anything, but I'm not sure if that's a-

Shellie Sulzberger:

Do what?

Melissa:

RSV is similar. So, RSV is something that affects little babies a little bit more, but it's the same type of idea. It's a respiratory illness, a very significant one. But we've been told multiple times, that cannot be used as a primary diagnosis, which I think is ridiculous, but that's what we've been told.

Shellie Sulzberger:

Do you know what code they're using, by chance?

Melissa:

Whatever comes up for RSV?

Melissa:

I don't know, but Shellie, there's a guideline that we found in the ICD-10 book that says it can't be a primary diagnosis.

Shellie Sulzberger:

Can you ... I'm going to go to the next slide. My email's right here at the bottom in the contact me. Can you email me the code so I can look it up?

Melissa:

Yes. Yes, I can email it to you.

Shellie Sulzberger:

Because that will help me, because I just pulled up one, and the one I see doesn't say that it's not a primary, but if you're using a different one I can just look at it to make sure I'm looking at the same one, because there's two or three different RSV codes that I see.

Melissa:

Okay.

Melissa:

Thank you.

Melissa:

Go ahead.

Melissa:

While we're still on that, can we readdress the weight check visit? So, a nurse weight check visit ... Can we bill a nurse visit for that? They always have to come to me, because I'm the provider. They come to me with the last weight, the weight now, I tell them what to do. Whether to schedule them back in two weeks, whether I need to go in and see them right now. Should we be billing those as 99211s?

Shellie Sulzberger:

That would depend on the Medicaid contractor. So, typically in an FQHC, nurse visits are for anybody that follows the FQHC guidelines, payers. Usually, a nurse visit is just part of doing business. However, there are some Medicaid contractors that allow that even under FQHC. So that would be the first thing is to have your billing office check with your top five payers to see if they allow that. And they have to make sure they specify when they contact them, can we do this in an FQHC? Because we can do it in a free-standing clinic all day long for any payer, but in an FQHC, it's a little bit different.

Melissa:

Okay.

Melissa:

Thank you, Shellie.

Shellie Sulzberger:

You're welcome.

April Lewis:

All right. Thank you all. And to anyone ... Because we are a few minutes over ... If you need to jump off, I understand and thank you so much for joining. You did just get the automatic response from web-X, so please be on the lookout for an email from me with today's slides. The full recording will be available on your MyNACHC portal within, the absolutely most, two weeks, but as soon as it gets up, I'll send out an email and let you know that you can download the recording. So again, if you have to hop off, we understand and thank you so much for joining. Another question just came through, Shellie, that reads: If a patient comes in for a cough and the patient is due for routine lab, the provider doesn't really address the chronic conditions. Can it be added to the assessment, or do they order the lab with the specific diagnosis and then remove it from the assessment?

Shellie Sulzberger:

Yeah, so it should be just with the order for the lab. It shouldn't be on the claim form if they were not addressed during that visit. But you can put those diagnoses on with the orders for your lab work.

April Lewis:

Okay. All right. Well, I did not see any other questions come in. Shellie, you will get an email from Ms. Jackie Royston with a specific question. And anyone else, please do ... Shellie's email address is on the screen now, and it'll also be in the slides that'll be coming to you within the next few minutes. Shellie, did you have anything else for the good of the group?

Shellie Sulzberger:

No, thank you so much for having me.

April Lewis:

Of course. Thank you for always being available to help with our network so they can go from good to great. You know, my two favorite words. And to you all who are on the call, please have a great, safe weekend, and reach out if there's anything that we can do from this side. Thanks so much.

Shellie Sulzberger:

Thank you.