An Introduction to Medical Record Keeping and Coding

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Who is this guy?

Dr. Charles Brownlow
- Practiced optometry in Weyauwega, Wisconsin
- Executive vice president of the WOA 1990-2008
- Currently associate director, WOA
- Currently working with AOA Third Party Center and AOA Clinical and Practice Advancement Group
- Long time volunteer in optometry, having served as president of his state association as well as the North Central States

Goals for this Course

- To provide an introduction to and/or a review of general principles related to medical records and choices of codes
- To introduce attendees to resources available through AOA for doctors and staff
- To provide direct assistance to doctors and staff for questions related to medical records and coding
- To enhance intra office and inter office communication/sharing of patient information
- To reduce doctor/staff frustration with medical records, coding, claims submission, etc.

Questions during the Presentation..

- Please type your question in the dialog space in the Chat box.
- You may be called on at the end of the presentation, or your questions will be answered following the presentation, or you will receive an email as time permits.
- After the live presentation, all questions will be directed and answered by Dr. Chuck Brownlow, askthecodingexperts@aoa.org
Keys to Good Health Care and Medical Records

Doctors and staff must...

- Carefully interview each patient to learn why they’ve come in
- Provide the care each patient needs; no more no less
- Accurately record all elements of the history, examination, diagnoses, management options
- Choose codes to represent what is done, based on the content of the record
- Submit a bill to the patient and/or to the patient’s insurance company for payment

Medical Records Have Multiple Roles

- To ensure that the patient’s needs are carefully assessed and all related diagnoses and options for care are recorded
- To provide effective communication among doctors and staff in the office
  - Staff needs clear instructions regarding what needs to be done for the patient at this visit and subsequent visits
  - The doctor/staff will refer back to the chart at the next visit
  - Other doctors in the clinic may see the patient the next time
- To provide necessary information for communication with the patient’s other care givers, as necessary
  - e.g. The patient’s family, general physician, other specialists involved with their care
- To provide the basis for communication with the patient’s insurers regarding the care provided to the patient

Importance of Good Records

- The need for records preceded insurance
  - Health care providers kept records of patient visits long before insurance entered the scene
  - Internal use of records is far more critical to patient care than external use
- Good, legible records are possible in any currently used format
  - Pen and paper
  - Recorded and transcribed/typed
  - Electronic health care records
- Bad, illegible records are also possible and common in all formats
The Future of Medical Records

• Expeditious/accurate sharing of patient information will eventually require all providers to be computerized
  – Electronic health care records
  – Electronic submission of claims
  – Electronic recording and transmission of pharmaceutical and other prescriptions
  – Electronic communication with payers regarding compliance with required protocols
  – Rewards for EHR use will be followed by penalties for not using EHR

• Current goal for 100% EHR use by providers, 2015*
  *subject to change, of course

Role of Doctor and Staff in Records

• Doctor is responsible for every record, even if some material is recorded by staff
  – Signature and legible identity of the doctor at the end of each chart signifies the doctor has reviewed all the content and is accepting responsibility for the content

• Staff is responsible for recording based on doctor’s instructions
  – Doctor may require staff to initial all entries they make to aid in any review of the content later; internally or externally

Contents of Records Are Subject to Several Sets of Rules:

• Standard use, established by providers
  – SOAP format (Subjective, Objective, Assessment and Plan)
  – Aligns information in the order that it is gathered
  – History, Examination, Medical Decision Making

• Standard of care, established by the courts
  – EG, if it is not recorded, it was not done!

• Payers’ requirements, by contract
  – Signature requirements, interpretations and reports, doctors’ orders for any special testing
National Guidelines for Records

- Codes for all procedures and all diagnoses are chosen based on three national documents:
  - International Classification of Diseases, 9th Edition
  - The Documentation Guidelines for the Evaluation and Management Services, 1997

- Health Insurance Portability and Accountability Act (HIPAA) requires all payers and insurers to use and respect those three documents in preparing and considering claims for health care services

Current Procedural Terminology, CPT

- CPT Includes...
  - Five digit code for every health care procedure in common use in the US, and
  - Definition for each of those procedures
- Doctors/staff choose codes by comparing the content of the patient’s record to the CPT definition
  - Note: Copyright prohibits the use of any CPT code unless the medical record shows the service matches the CPT definition

Procedure Coding Example (CPT)

- 92014, comprehensive ophthalmological service, established patient; the most commonly used code in eye care
  - CPT definition is written subjectively, pretty general, but includes seven things that must be included in the visit and the record if the code appears on the claim...
    - History, general medical observation, external examination, ophthalmoscopic examination (with or without dilation), gross visual fields, basic sensorimotor examination, and initiation of diagnostic and treatment program
- 92014 can be used only if all of those elements were completed during the visit and included in the record
International Classification of Diseases, Ninth Edition, ICD-9

- ICD-9 provides numeric and alpha numeric codes for all diagnoses, conditions, situations, known to human beings (well, most)
  - Open Angle Glaucoma
- Important to choose the code that most closely matches the patient’s situation at this specific visit
- Important to code as specifically as possible

Note:  ICD-9 will be replaced by ICD-10, October, 2013. AOA will provide lots of advance information in 2012 and 2013

Diagnosis Coding Example

- Patient is diagnosed with primary open angle glaucoma,
  - ICD code, 365.11
  - 365 is the general classification of ‘glaucoma’
  - 365.1 indicates ‘open angle glaucoma’
  - 365.11 indicates ‘primary open angle glaucoma’
  - Coding anything other than the full five digits in this case would be improper

More ICD-9 Considerations

- Nearly all diagnoses must be coded to two places past the decimal point
  - Rare exceptions (e.g. 351.0, Bell’s Palsy)
    - In these cases, it is incorrect to add an extra ‘0’
  - Always attempt to find specific code, two digits past decimal point
  - Avoid codes ending in .9 (unspecified) if possible
- Some codes are alpha numeric
  - V codes and E codes—Supplemental to disease or injury classification, include other circumstances
    - e.g. Long-term use of high risk medications, V58.69
    - e.g. Accident caused by caustic/corrosive substance, E924.1
Good Reference Materials Are Critical to Accurate Choices of Codes

- Eye doctors deal with thousands of ICD codes in their practices
  - Must choose the code that most closely matches the patient’s diagnosis today
  - Office’s route slip or superbill cannot be large enough to hold all diagnosis codes
  - Need online and/or paper reference materials in order to choose accurately

AOA Resources Related to Coding

- Codes for Optometry—Two volumes $125
  - AOA Order Department, 1-800-262-2210
    - AMA Current Procedural Terminology, and
    - AOA Codes for Optometry
      - ICD-9 abridged for the eye
      - Documentation Guidelines
      - Correct Coding Initiatives from Medicare
      - HealthCare Common Procedure Coding System (HCPCS) for Coding Materials in Medicare
      - Companion readable CD, $25

Web Based Resources

- AOAReimbursementPlus.com
  - Subscription based resource, including coding information for procedures and diagnoses, accepted combinations of codes, compliance guidelines and reimbursement information specific to the insurers with which your office is contracted
  - Popular program offered to AOA members at significant discount
AOACodingToday.com

• Online Coding and Reimbursement Tool
  – Includes info from key national references
    • Medicare - Coverage determinations, RVUs, Correct Coding Initiatives
    • CPT - Current Procedural Terminology
    • ICD9 - International Classification of Diseases
  • Special information about codes common to eye care
    (audit cautions, etc.)
  • Improves Accuracy and Efficiency of Your Medical Billing,
    Making It Easier to Submit “Clean Claims”

AOACodingToday.com

$349

New AOA Member Benefit

No Cost to AOA Members (June 2010)

New and Renewing AOA members

AOA Resources

AOA Website Sections Provide Information Regarding
Private Insurers and Governmental Health Programs
  – Third Party Center http://www.aoa.org/TPC
  – Clinical & Practice Advancement Group
    http://www.aoa.org/CPAG
    • Clinical Practice Guidelines
    • Frequently Asked Questions
    • Webinars and other online education for doctors and staff
    • Articles in AOA NEWS and the Journal of the AOA
    AskTheCodingExperts@aoa.org
  – Email your questions direct to an expert
  – Paraoptometric Membership ps@aoa.org
No Office is an Island

- Many resources available, but it’s up to you to seek the answers
- Don’t be shy about emailing your questions to AskTheCodingExperts@aoa.org. This is a free service to AOA Members and their staff.
- Watch for additional webinars and other AOA educational programs on medical records and coding coming this summer!

Thank You Questions?

AskTheCodingExperts@aoa.org

Additional Resources:  Order Department 800-365-2219 or 800-262-2210
www.aoa.org/TPC orders@aoa.org
www.aoa.org/CPAP orders@aoa.org
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ps@aoa.org