



# The Coding News

AFMSA/SGOZ  
Population Health Support  
Division

Fall/Winter, 2003

## HOT ITEMS!

### Ready to Roll with Industry Based Workload Alignment

The Industry Based Workload Alignment (IBWA) project got underway for bedded facilities. The phased approach began 15 Nov 03 with the goal of full implementation by 31 Dec 03. Tracking of implementation is available on the BDQAS web site. Current information indicates 17 sites out of 22 have at least one service implemented.

In order to capture inpatient professional services, the patient's inpatient medical record has to be annotated. Complexity of care and time spent with patients are important factors in assigning the appropriate codes. Providers must ensure the history, examination, and medical decision making factors are present along with the time spent with the patient. Initial hospital care services will be documented and coded for admission and discharges on the same date.

Subsequent hospital care will be coded when the attending physician or other physician providing concurrent care documents a visit with the patient. These may be daily rounds or possibly once every three days. As part of the note, an interval history is needed on the patient – meaning any new history information that has been obtained since the last provider/patient encounter. Again, time spent with the patient and the coordination of care must be documented.

Discharge services are reported on patients when the discharge date is different from the admission date. Time spent doing these activities should be documented in the record. This includes the patient's condition upon final examination, instructions to patient/family members, and preparing the discharge records (discharge summary for the hospital record).

Remember, implementation of IBWA is the precursor for inpatient itemized billing which is looming in the not too distant future. ☺

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### The Population Health Support Division (AFMSA/SGOZ)

#### Our Mission

*We support DoD health professionals in optimizing the health and wellness of their populations through appropriate, effective, and efficient healthcare practices and service delivery.*

#### Our Vision

*Become the most trusted name in population health services support.*



## Healthcare Insurance Portability and Accountability Act (HIPAA) Compliance of 837 Claims Processing

A new software interface is forecast for deployment to all medical treatment facilities (MTF) in Spring 2004. The HIPAA 837 Claims Processing software interface to the Composite Healthcare System/Ambulatory Data Module (CHCS/ADM) will make MTFs HIPAA compliant for electronic billing of claims and ensure that all the required data for the x12 837 Professional and Institutional transactions flow to the Third Party Outpatient Collection System (TPOCS). This new software is one part of the Outpatient Itemized Billing (OIB) project implemented in Oct 02 that revised TPOCS to automatically capture standard data files, patient-level data regarding a patient's insurance data, and current demographic data to include enrollment and eligibility status through the Defense Eligibility and Enrollment Reporting System (DEERS). The HIPAA 837 Claims Processing software CHCS/ADM interface is forecasted for deployment around the mid fiscal year to all MTFs. This new software will enable MTFs to be HIPAA compliant for electronic billing of claims and ensure that all the required data for the x12 837 Professional and Institutional transactions will flow to TPOCS. ADM has been modified allowing new data fields to capture additional information required by HIPAA. Some of the most prominent changes that will impact the coding process are:

### • Injury Related – Accident Log Information

During encounter processing for an injury, the date of the accident needs to be entered in the ADM. The window where the information is entered has been renamed "Injury Related" from "Work Related" and requires user response to a "Yes/No" prompt. If the prompt is answered "Yes," the data must be entered by the user in the new window that appears. This window will ask the user to enter the cause of injury, date of the incident, and geographic location where the injury occurred. If the user completing the encounter does not answer "Yes," the system defaults to "No." If the coder assigns an ICD-9-CM code beginning with "E", then the "Injury Related" field automatically changes to "Yes" and the user will be required to complete the window requesting the injury related information.

ADM Patient Encounter

SERPENT, SYBIL 30/987-65-4321 AGE: 43Y

Appt Date/Time: 01 Aug 2003@1135 Type: ROUT: Status: WALK-IN  
Clinic: CLARK CENTER MEPRS: BGAA

In/Outpatient: Outpatient APV: No **Injury Related: YES**  
Appt Provider: ABREAU, TYLER Pregnancy Related: No

Appt HCP Role: 1 ATTENDING  
Additional Providers: No  
Disposition: RELEASED W/O LIMITATIONS

ICD-9 Dx Description

813.83

Chief Complaint

Help = HELP Exit = F10 File/Exit = DO **INSERT OFF**

**YES**  
in the **Injury Related** Field  
Results in additional  
actions/information  
being requested  
from the User.

Entering a Valid Injury ICD-9 Code  
Will automatically populate the  
**Injury Related** Field with a YES  
and additional actions/information  
will be requested from the User.

### • Pregnancy Data

Information on pregnancy status needs to be entered in the ADM. The date of Last Menstrual Period and Estimated Date of Delivery must be entered into system when CPT codes within the ranges of 59000-59426, 59510-29622 or 59898-59899, or ICD-9-CM codes of 631, 633, or within the ranges of 640-665, 668-671, 673-674 or a code V22.2-V23 is used. When any of these codes are used, a default data input window for these dates will appear. This information is stored with the encounter information and displays the pregnancy status of the patient at the time of the encounter. This data is also passed to TPOCS.

ADM Patient Encounter

SERPENT, SYBIL 30/987-65-4321 AGE: 43Y

Appt Date/Time: 01 Aug 2003@1135 Type: ROUT: Status: WALK-IN  
Clinic: CLARK CENTER MEPRS: BGAA

In/Outpatient: Outpatient APV: No **Injury Related: No**  
**Pregnancy Related: No**

Appt Provider: ABREAU, TYLER  
Appt HCP Role: 1 ATTENDING  
Additional Providers: No  
Disposition: RELEASED W/O LIMITATIONS

ICD-9 Dx Description

Chief Complaint

Help = HELP Exit = F10 File/Exit = DO **INSERT OFF**

User is unable to access the  
**PREGNACY RELATED** field  
at this prompt to  
respond with a YES.

Entering a  
**Pregnancy Related**  
**ICD-9 or CPT Code**  
will populate the  
**Pregnancy Related** field with YES  
and additional actions/information  
will be requested from the User.

Continued



## HIPAA Related Coding Changes *(Continued from previous page)*

### • Additional Provider Data

The process for adding secondary and tertiary providers has been modified in the ADM software update. "Additional Providers" are now added by responding to a "Yes/No" prompt. If "Additional Providers" need to be entered, the user selects "Yes" (or types "Y") and a new window appears requesting information for "Secondary Provider #1/Role" and "Secondary Provider #2/Role." Ambulatory Procedure Visit (APV) encounters allow the user to designate Health Care Provider (HCP) 1, 2, or 3, (in their appropriate role) with each CPT code entered. At least one HCP must be associated with each CPT code.

ADM Patient Encounter  
SERPENT, SYBIL 30/987-65-4321 AGE: 43Y

Appt Date/Time: 01 Aug 2003@1135 Type: APV Status: MED  
Clinic: APU CLARK CENTER In/Outpatient: Outpatient Injury Re: Pregnancy B

Appt Provider: ABREAU, TYLER  
**Appt HCP Role: 1 ATTENDING**

Additional Providers: No  
Disposition: RELEASED W/O

*The Appt HCP Role defaults to "ATTENDING" Appt HCP Role-can be changed to a Role identified on the PICKLIST for that field*

**PICKLIST Options for Appt HCP Role:**

- 1-ATTENDING
- 2-ASSISTING
- 3-SUPERVISING
- 4-NURSE
- 5-PARA-PROFESSIONAL
- 6-OPERATING PROVIDER #1**

*Note: Role #6-'OPERATING PROVIDER #1' will only appear if APV field is YES*

Help = HELP Exit = F10 File/Exit = DO INSERT OFF

### • Physical/Occupational and Podiatry Data

Encounters associated with Physical Therapy, Occupational Therapy or Podiatry, using CPT codes 97001-97799, G0246, G0247 or G0256, requires ADM to capture Consulting/Referring provider information with the appointment date (if available) and include the provider on the ADM TPOCS extract. After data input, ADM automatically scans all appointment encounters completed for the previous six months and, if available, captures the Date Last Seen with the previous encounter information. This data is included on the ADM TPOCS extract. ☺

## Preparing for AdvanceMed Coding Audits

In January, 2004, the AdvanceMed Corporation began a DoD-wide audit of inpatient and outpatient medical coding encounter data. The primary goal of this audit is to examine the accuracy and precision of DoD's medical record coding. A second goal of the audit is to conduct a focused study evaluating the impact of providing feedback to providers on coding accuracy.

This forthcoming audit is the third stage of the contract between AdvanceMed and Health Affairs/TRICARE Management Activity (TMA). The first of the two audits evaluated coding accuracy in Regions 11 and 1. The second coding audit was to provide a complete picture of DoD's data coding across all regions on inpatient, outpatient and ambulatory procedure visits (APVs) encounters occurring between January and March 2003. The results of both audits were dismal. A major contributing factor was record unavailability or missing encounter documentation.

This audit continues DoD-wide using largely identical methods for data collection and reporting. In this case, the audit period will cover a longer time frame and incorporate enhancements to the audit process. Inpatient and outpatient data for encounters occurring between September 1, 2003 and June 30, 2004 will be examined. Important facts to remember for the audit:

- MTFs will not be required to provide more than one type of record (i.e., inpatient, outpatient, or ambulatory procedure) in any given reporting period.
- AdvanceMed Corporation will provide MTFs with a list of records in advance of the audit. MTFs will have 21 calendar days to comply with the request for 30 records. Records must be photocopied and sent to AdvanceMed in accordance with their instructions. **Records or documentation for encounters not received will be reported as missing and have a negative impact on the audit outcome.** ☺



### Status Report on 3M External Audit Results

The 3M Health Information Systems external coding audit has examined all of the 43 MTFs in the Peer Group 3, 4, and 5-levels. Subsequent to the audits, MTFs receive clinic-specific coding training for providers, coders and coding auditors.



Initial results indicate coding accuracy for the AFMS is running between 40% to 60%. This reflects better results than previously reported by the TRICARE Management Activity (TMA) audit contractor, AdvanceMed. Lt Gen Taylor (USAF/SG) addressed these improvements in his 25 Nov 03, memo to Dr. Winkenwerder (ASD/HA). General Taylor opens this memo with the following statement, "Accurate coding and record availability is of paramount importance. The AF Population Health Support Division (PHSD) has been responsible for overseeing all coding and audit improvement activities across the AFMS..." One concern that has been consistent throughout the external coding audits has been a trend that documentation of the coded encounter has not been filed or was missing from the outpatient record. Missing documentation averaged 14% in the audited encounters and in one case was as high as 36%! Certainly, some of the errors may be beyond the control of the MTF, but overall, it does not reflect well on the AFMS and is contrary to Joint Commission on Accreditation of Health Organizations (JCAHO) and Health Services Inspection (HSI) standards. Once the 3M audits are completed, a final overall briefing of results will be presented to AF/SG early in 2004. ☺



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## INITIATIVES

### Take Advantage of Coding Training Courses via LearnLinc®

A series of new web based **LearnLinc® advanced coding modules** are being created in collaboration with the 3M training staff that will be available on the <https://starview.brooks.af.mil/learnlinc> web site. A total of 52 courses will be posted to the web within the next several months. New courses will be added to the first 26 modules covering basic E&M and CPT and inpatient coding conventions, including a module on IBWA for capturing the inpatient professional services. The information in these new modules are directed to providers, coders and coding auditors. This is an excellent source of training without cost to facility or student and is always available. The courses target areas with the greatest potential for improvements as determined from results of the 3M coding accuracy audits.

Here are some of the topics you will be seeing in the very near future:

- ◆ Life Services Encounters
- ◆ Advanced Ophthalmology/Optomety Training
- ◆ Physical and Occupational Therapy
- ◆ Use of CPT 99499 (Place Holder and Other)
- ◆ Documenting for Time Based CPT Codes
- ◆ Documentation Requirements for a Teaching Facility
- ◆ Capturing Inpatient Professional Services

A pre and post test is available to attain a certificate of course completion which may be used for continuing education through the American Health Information Management Association or the American Academy of Professional Coders. To take the tests, go to [https://phsd.afms.mil/phsd/coding\\_training/login.htm](https://phsd.afms.mil/phsd/coding_training/login.htm). 



### Coming Soon! Correct Coding Editor (CCE) Interface for ADM

What is a Coding Compliance Editor (CCE)? CCE is the back-end coding application where coded records are examined by an automated audit and edit process. CCE is a suite of commercial-off the shelf (COTS) products from 3M Health Information Systems. The software products will assist the Air Force Medical Service (AFMS) and the Military Health System (MHS) with solutions for coding, compliance, and data management. Implementation of this product will bring the AFMS and MHS closer to a commercial coding and billing environment. The coding software provides clinical decision logic and integrated references to enable consistent, accurate and complete ICD-9-CM and CPT coding. It will also contain editing and grouping software for reimbursement, and a compliance system based on clinical guidelines, the National Correct Coding Initiative (NCCI), and Outpatient Code Edits (OCE). The system also will provide a data collection and analysis system of patient information and coded data for operational management and performance improvement.

To achieve optimal use of the CCE, each MTF must ensure processes are in place to capture the needed clinical documentation and related diagnoses and procedures. The first release of the CCE, Version 1.1 will consist of the core 3M Coding, Editing, Grouping, and Health Data Management (HDM) products. These products will integrate CHCS ADM, Laboratory, and Radiology Modules.

*"Implementation of this product will bring the AFMS and MHS closer to a commercial coding and billing environment."*

*Continued on next page*



## Correct Coding Editor (CCE) Interface (Continued)

The 3M suite of products includes:

- ◇ 3M Codefinder
- ◇ 3M HCPCS/CPTfinder
- ◇ 3M Reimbursement Calculation
- ◇ 3M Physician Coding and Reimbursement
- ◇ 3M APG Grouper
- ◇ 3M APCfinder
- ◇ 3M Coding Reference Software
- ◇ 3M HRM Plus
- ◇ 3M Audit Expert Outpatient



As part of the software, work lists will be provided to the coding auditor to identify records requiring correction. Testing will begin soon and the new software will be deployed to those MTFs already using P-GUI. Although CCE is a superb automated auditing tool, it does not replace the need for certified coding auditors. 🌀

## BDQAS Updated to Reflect New Timelines for ADM Completion

The Biometrics Data Quality Assurance System (BDQAS) website will unveil a new method of looking at ADM "Completion" data on 8 December 2003. This enhancement displays the newly redefined and much anticipated "Timeliness" view of Standard Ambulatory Data Record (SADR) encounters within ADM and the revised "Completeness" metric. The revised metrics, graphically displayed on the website, are the first step in a comprehensive plan designed to improve coding throughout the AFMS.

The old metric, 30 Day Completeness, was calculated from data collected from Day 15 through Day 30 following the day of the encounter or visit. The metric also did not exclude Ambulatory Procedure Visits (APVs) or Observation unit Visits (OBSVs).

These changes in the website reflect the direction given by Dr. Winkenwerder, ASD (HA), in his 20 Aug 03 memorandum that established coding timeliness and accuracy standards for the military healthcare system (MHS). These standards make a distinction between clinic visits and APV/OBSV visits. The first requirement is all clinic visits, excluding APVs and OBSVs, must be coded and completed within 3 business days from the date of the visit. The second requirement is APV/OBSV encounters must be coded and completed within 15 days from the date of the visit. Due to the difference in meeting the "timeliness" criteria between clinic visits and APV/OBSV visits, the divided metrics display two ways:

- ADM Timeliness Metric – displays both "Timeliness" and "Completeness" percentages for the rolling 30-day period prior to the present day. The "Timeliness" metric measures all clinic encounters coded and completed from day 3 through day 7 from the date of encounter/visit. The "Completeness" metric measures day 8 through day 30 from the date of encounter/visit. This metric does not include APV's and/or OBSV encounters. Clinics with "0" for both SADR and Daily Outpatient Workload Report (DOWR) on the weekends will display "N/A" in the percentage column to reflect no clinic on weekends.

*Continued*

*It is . . . "time to move beyond simply measuring coding completeness and begin to focus on timeliness and accuracy."*

Lt Gen Taylor,  
USAF/SG



## BDQAS Updated (Continued)

- APV/OBSV Timeliness Metric – displays both “Timeliness” and “Completeness” percentages for the rolling 30-day period prior to the present day. Timeliness measures all APV/OBSV encounters coded and completed on day 15 from the date of encounter where Completeness measures day 16 through day 30. Clinics with “0” for both SADR and DOWR on the weekends will display “N/A” in the percentage column to reflect no clinic on weekends.

Lt Gen Taylor, AF/SG, stated at the 25 Nov 03, “Hollywood Squares” Performance Improvement Board, that it was “time to move beyond simply measuring coding completeness and begin to focus on timeliness and accuracy.” Based on this statement, expect to see similar metrics displayed on P2R2 as they are developed and refined during 2004. Feedback on the BDQAS displays will also help to refine the modified metric and advance General Taylor’s plan. Questions concerning these updates may be directed to Lt Col Joseph Haggerty at DSN 240-4774 or email joseph.haggerty@brooks.af.mil. ☎

## Tips for General Medical Education (GME) Resident Outpatient Coding

Facilities with GME programs need to follow the documentation guidelines set by the Center for Medicare and Medicaid Services (CMS).

- Be sure the correct provider specialty code of “RESIDENT” has been assigned.
- If the supervising/teaching physician is present for “critical elements” of the encounter, add the supervising/teaching physician as an additional provider “supervising.” This should be a “count” encounter. Coding should be based on what was done (and documented) during the time the supervising/teaching physician was present. This work can be billed if there is other health insurance.
- CMS revised its documentation requirements to clearly state that teaching physicians do not need to repeat documentation already provided by a resident for Evaluation & Management (E&M) services. The revised regulations provide common scenarios instructing teaching physicians how to properly code when residents are involved in providing E&M services. The regulations also give examples of acceptable and unacceptable medical record notations.
- Here are some examples of minimally acceptable medical record notations under the new regulation:
  - Admitting note: “I performed a history and physical examination of the patient and discussed management with the resident. I reviewed the resident’s note and agree with the documented findings and plan of care.”
  - Follow-up visit: “Hospital day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident’s note.
  - Hospital day #5. I saw and examined the patient. I agree with the resident’s note except the heart murmur is louder, so I will obtain an echo to evaluate.
- If the resident furnishes services without the presence of a supervising/teaching physician, the occasion of service may be collected with the E&M based on the documentation. The encounter MUST be coded as a “non-count” encounter. This can be done during end-of-day processing. This data will be available on your server and will have to be pulled using an ad hoc report. This work should NOT be billed. For instance, if a teaching surgeon is present during a surgery done by a resident (does not have to be physically in the room for the opening and closing unless it is a “critical” part of the procedure, but must be immediately available, i.e., the teaching surgeon cannot be involved in the critical part of another procedure), and then the residents do most of the follow-up, you can still bill the total global procedure. You would still need to document the encounters and code them as non-count. ☎



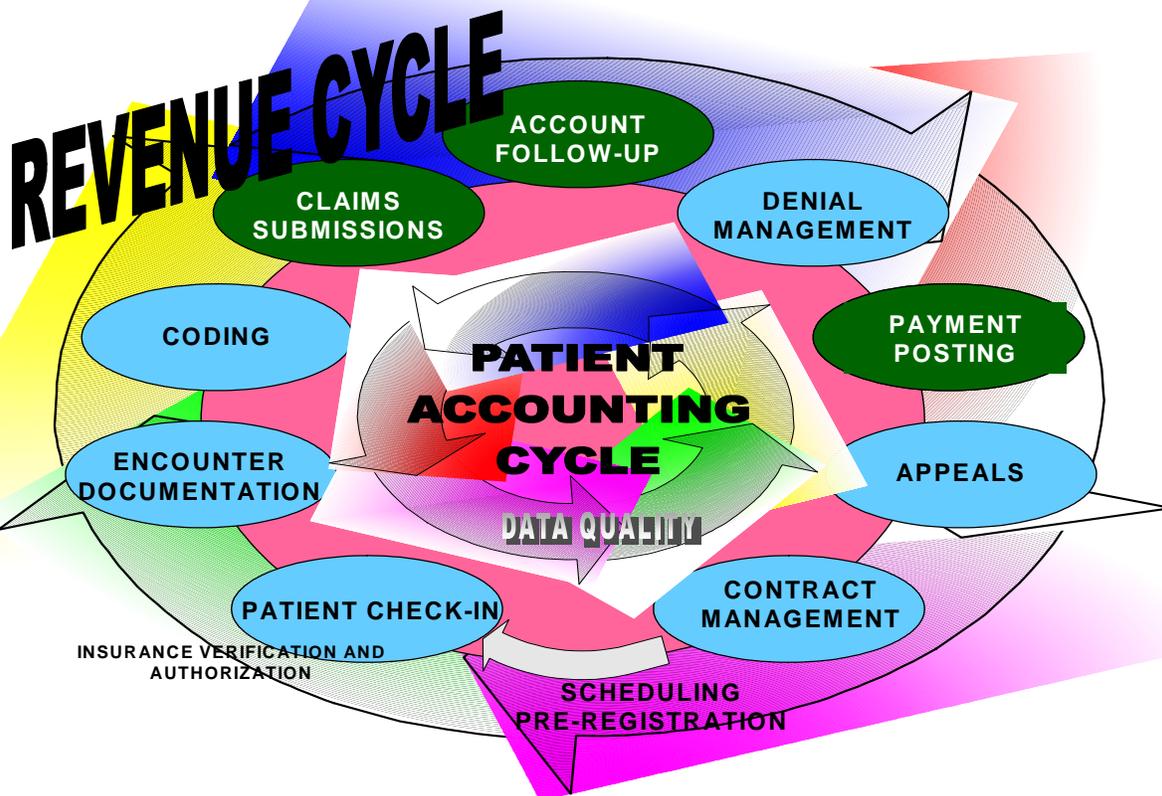
## COMPLETING THE REVENUE CYCLE

### Improving the AFMS Revenue Cycle

HQ AFMSA/SGSR and SGOZ have prepared to present a Revenue Cycle Improvement Plan and contract proposal directly impacting MTF clinical and resource business activities throughout the AFMS corporate structure. The purpose of the proposal is to optimize management and accountability of medical records, improve records documentation, increase accuracy of coding, and finally, improve collections. In order to appreciate the impact of the revenue cycle activities, a discussion of front and back-end efforts is presented independently. On 25 Apr the AF SG was briefed on a proposed back-end contract solution for improving collections. Although the AF SG agreed with the concept, he did not concur and requested the proposal include a front-end coding solution.

### Revenue Cycle:

The illustration displays the activities in a clockwise flow as they occur in the revenue cycle. Also illustrated is the effect of revenue cycle activities on data quality as a whole and between the activities themselves. Data quality is the central activity for ensuring information/data is optimally sound within the activities. Data quality also provides the checks and balances between clinical and resource business processes. Front-end, or clinical business activities, start with scheduling and pre-registration and end with coding. Back-end, or Uniformed Business Office (UBO) activities start with claims submissions and end with contract management. Note the green or darker shaded circles are activities requiring cross or lateral communication to ensure no informational gaps exist. The blue or lighter shaded circles represent functions requiring little or no communication with the front-end.





## Front-end Discussion

### *Current coding audits:*

Coding audits are currently being conducted by the Air Force and the Tricare Management Authority (TMA). Results from the two auditors, the AF is using 3M and TMA is using Advanced Med, show indications of less than desirable outcomes. On average, medical records are available less than 70% of the time requested, insufficient records documentation is severely evident, and coding is far below accuracy standards. E&M coding is less than 60% accurate and CPT coding less than 40% accurate. Some E&Ms and all CPTs generate billing revenue. Results are improving daily as various initiatives are being implemented.

In addition to the audits mentioned above, BearingPoint also conducted site visits for 57 AF MTFs during 2001 and observed all clinical and resource business practices affecting healthcare revenue cycle operations.

BearingPoint prefaced their recommendations for improving coding practices stating, "Sound, timely, and accurate coding provides the data necessary for healthcare organizations to make sound business decisions. Accurate coding provides information for TPCpayers to determine medical necessity, and amount of reimbursement, determine staff productivity and accurately manage quality healthcare delivery. Proper coding will allow decision support systems to determine current cost of offering a product line or service; making budgeting and resource decisions and negotiate payment contracts." The following recommendations represent BearingPoint, TMA, PHSD, and UBO's suggestions and actions for improving coding practices.

- The Military Health System (MHS) requires the implementation of software systems to provide ease and access to coding nomenclature, such as, ICD-9, HCPCS application for Levels I, II, and III procedural codes for ambulatory and physician services. One system in development for some time is CHCSII, scheduled to begin deployment in Apr 04 over a 30-month period. Subsequent to the BearingPoint study, MHS plans were developed to implement two additional software applications, Provider Graphical User Interface (PGUI) and Coding and Compliance Editor (CCE). Because of the accelerated CHCSII deployment, PGUI will only go out to about one-third of the AFMS.
- It is critical the AFMS, or more specifically, the MTFs implement performance standards. TMA, through the Unified Biostatistical Utility (UBU) Working Group and PHSD, published coding guidelines with standards/metrics to the field. The DODD and DODI for encounter documentation and coding will further outline specific performance standards.
- MAJCOM and MTF consensus requires a need to hire certified coder auditors and trainers using civilian standard performance expectations to ensure accurate and timely coding. MAJCOMs used optimization dollars to fund auditors in FY03. The plan in FY04 is to sustain the auditors. Some MTFs took the initiative and assumed the risk to hire additional certified coders and trainers. These proactive steps have considerably improved their data quality metrics.



*"On average, medical records are available less than 70% of the time requested, insufficient records documentation is severely evident, and coding is far below accuracy standards. E&M coding is less than 60% accurate and CPT coding less than 40% accurate."*



## Front-end Discussion (Continued)

### *Medical Records and Coding Improvement*

Dr. Winkenwerder, Assistant Secretary of Defense for Health Affairs, recently signed a memo summarizing a forthcoming Department of Defense Directive (DODD) for encounter documentation and coding. Two of the DODD mandates will require encounters to be closed in three business days (APVs 15 days) and coded with 100% accuracy. The front-end solution for the AFMS comes in three forms, (1) experienced professional coders, auditors, and trainers, (2) automated systems applications, and (3) program changes/initiatives.



*“Two of the DODD mandates will require encounters to be closed in three business days (APVs 15 days) and coded with 100% accuracy.”*

- It is imperative to provide ongoing coding training. SGOZ has developed several training elements: documentation and coding guidelines, VTCs, on-site, and web based applications.
- The Populations Health Support Division (PHSD) has various program initiatives in place to assist MTFs to meet the recently established DoD requirements for encounter documentation and coding. Current programs include:
  - An AFMS funded external documentation and coding audit at Peer 3-5 facilities, which provides subsequent “on-site” training for providers and support staff.
  - A policy letter dated May 03 outlining coding audit methodologies to measure accuracy.
  - Coding references and material funded last three fiscal years for each MTF. Once CCE is in place, all references will be web-based and available to the MTFs at no cost.
  - Onsite training and web based training courses via LearnLinc®.
  - Accuracy metrics posted on P2R2 as of Nov 03.
  - Revised timeliness/completeness metric on BDQAS and P2R2.
- Proposed future initiatives:
  - Continue AFMS external coding audit and training program (ECD: Feb 04).
  - Establish guidance and produce a template compliance plan for MA-JCOM implementation. Emphasis will be on increased utilization of MTF auditors/trainers. Primary objectives will be:
    - 100% of all outpatient encounters, other than ambulatory procedure visits (APVs), should be coded within three (3) business days of encounter.
    - 100% of APVs should be coded within 15 days of encounter
    - 100% of inpatient records should be coded within 30 days after discharge.
    - 100% medical record coding accuracy
    - The most critical recommendation BearingPoint asserted was to implement change management.



## Back-end Discussion

### *BearingPoint Findings Affecting MTF Billings and Collections*

- Scheduling personnel do not routinely ask for Other Health Insurance (OHI) information.
- MTF Staff appointing patients do not validate OHI.
- MTFs do not perform routine pre-registration for high dollar outpatient services.
- Most MTFs did not obtain pre-certifications for high dollar ancillary services.
- MTFs generally did not market Third Party Collections (TPC) to staff and beneficiaries.
- Claims generation is hampered by deficiencies in automated systems.
- Military information systems were not par with civilian industry standards.
- Electronic billing minimally used. Today, only five MTFs bill electronically.
- Staffing for TPC was insufficient for the volume of encounters with associated OHI and subsequent billing.
- Most existing staffs are minimally qualified.
- Accounts follow-up are hampered by deficiencies in automated systems.
- Denials and appeals management programs were weak. MTFs did not have the staffing or the expertise to effectively manage the programs.
- It was clearly evident, MTFs lacked customer service support for all billing programs to include TPC, Medical Service Account (MSA) and Medical Affirmative Claims (MAC), formerly known as Third Party Liability.
- There were many other findings. However, the above are highlights of the major findings.



## **Back-end Discussion (Continued)**

### ***Proposed Recommendations for Activities Affecting Billings and Collections (NOT YET APPROVED)***



The UBO is currently updating AFI 41-120, Medical Resource Management Operations, to include additional items and comments for complying with DoD policy and guidance. In addition, the AFI will be updated to include audit processes to support data quality initiatives.

The business case strongly suggests and encourages one centralized billing and collection office. A second part of the recommendation is to separately contract an oversight function with the UBO maintaining government oversight. This alleviates any possibility for conflict of interest for prospective vendors. If centralization does occur for billing and collections several things need to happen:

- Realign government service civilian employees to other revenue cycle activities for management and oversight of various activities.
- Develop procedures to ensure every new and updated Third Party Information Collection Sheet (DD Form 2569), is verified prior to entering CHCS and TPOCS. The DD Form 2569 collects OHI information.
- OHI coverage should be verified for all inpatient and ambulatory procedures to include high cost ancillary services.
- The AFMS should consider adoption of a uniform card system to document the presence or absence of OHI.

### ***Revenue Cycle Proposal***

This proposal consolidates both front and back-end solutions under one plan. MAJCOMs shall centrally manage the front-end for their MTFs under separate contracts and SGSR shall centrally manage the back-end piece for the entire AFMS.

There are several reasons why this proposal is necessary for the AFMS. Four are listed below:

- Reason #1: As illustrated in the beginning of this document, data quality is the central activity or process for the revenue cycle ensuring information or data is optimally sound. Implementing the above front-end proposal(s), data quality compliance will get better with improved ADM filing times, increased records availability, inability to enter invalid diagnosis, ability to associate orders to



## Back-end Discussion (Continued)

### Revenue Cycle Proposal (Continued)

diagnoses, and improve reconciliation procedures for financial, workload, and manpower.

- Reason #2: The DoD Medicare-Eligible Retiree Health Care Fund (Accrual Fund). The Accrual Fund recognizes DoD's accrued and future liability for cost of retirees/survivor health care for uniformed service members and their family members. The mechanics of the program involve removal of dollars from the AFMS budget each FY which must be prospectively earned back through established levels of effort (LOE). Accurate coding heavily impacts data sources for determining future LOE levels. Data sources are the Standard Ambulatory Data Record (SADR) and Standard Inpatient Data Record (SIDR). These sources supply the Ambulatory Procedure Groups (APGs) and Relative Weighted Procedures (RWPs) data figures, which are applied against MEPRS costs. To improve/sustain performance, MTFs must capture, correctly code, and transmit 100% of patient encounters. Failure to meet expected LOE will result in less O&M dollars available for overhead and expenses.
- Reason #3: Population health initiatives.
  - Need to have a clear understanding of our health care needs. HEDIS<sup>®</sup> metrics are centrally pulled and without accurate coding this process does not give the AF/SG a clear picture of the health care provided.
  - Numerous health care studies are being performed using the data in the Military Healthcare System (MHS) data mart. Without accurate coding the findings are suspect.
- Reason #4: Reimbursement opportunity/loss.
  - As of 1 Oct 02, the MHS changed from a flat rate billing to an itemized outpatient billing methodology. Optimizing collection efforts rely on accurate records of documentation and coding, specifically CPTs.
  - Programs affected by itemized billing are Third Party Collections (TPC); Medical Service Account (MSA) for interagency billing, all categories of pay patients, and Medical Affirmative Claims (MAC).



*"To improve/sustain performance, MTFs must capture, correctly code, and transmit 100% of patient encounters."*



## Back-end Discussion (Continued)

### Reimbursement (TPC only) Potential

The MHS is experiencing many of the same symptoms the VA did during its first year of implementation. However, the VA did not experience the level of systems or administrative compliance problems the MHS suffered to date. The MHS is working resolutions beyond FY04, which will provide fixes to medical systems applications and administrative compliance programs affecting all three reimbursement programs.

There are three major reasons the AFMS finished FY03 24% or \$10.2 million below FY02 collections (\$42.3 million).



*"The largest contributor to the \$10.2 million loss is the absence of facility charges for emergency room (ER), ambulatory procedure visits (APV), and observations visits."*

- The AFMS is behind in adequately identifying and verifying OHI. Although some MTFs continue to state the number of patients with OHI is decreasing, it is UBO's position that overall management of OHI is lacking and not given the necessary level of attention. Identification and verification of OHI is more critical today than ever before with health care benefits expanding under Tri-care For Life, Tricare Plus, and TNEX making the MHS the more popular choice of coverage for health care services. Efforts must be to maximize the recovery of costs for health care rendered to patients with OHI. This can be accomplished by ramping up OHI identification and verification processes consistent with Bearing-Point's recommendations.
- Lack of available medical records for documentation and coding. This particular issue was discussed in the front-end section of this document but it is important to stress again if the AFMS is to bill OHI, the medical record must be available, must be documented at the appropriate level of health care delivered, and accurately coded.
- The largest contributor to the \$10.1 million loss is the absence of facility charges for emergency room (ER), ambulatory procedure visits (APV), and observations visits. UBO's assumption is by not including these fees in the rate tables for FY03, the AFMS lost a minimum of \$11.5 million. Had the rates included the appropriate level of facility charges, collections would have finished at \$43.6 million, \$1.3 million higher than in FY02. While facility fees for ER and observations were introduced in May 2003, facility fees for APVs should be implemented midway FY04. The assumption is we could have billed the \$11.5 million in FY03 for ER, observation and APV facility charges.



## Back-end Discussion (Continued)

### Reimbursement (TPC only) Potential (Continued)

- One of the major findings with the audits was poor denials and appeals management, specifically the impact to write-offs. The billing and collections contract at Lackland AFB was directly attributed a 50% decrease in write-offs over a period of three years. Write-offs can occur before and during claims denial and appeals management. It was determined due to staff shortages, availability of time, and level of expertise, MTFs simply wrote the claims off to reduce their Accounts Receivables below the mandate.

The goal of UBO and PHSD is to improve operations across the revenue cycle, specifically the front-end processes for medical record documentation and coding. If we fix the problems on the front-end, the back-end will take care of itself. TPOCS only bills for the data it receives from CHCS. If CHCS files and tables are managed correctly, medical records are made available for documentation and “accurate” coding, then all the variables required to complete the TPOCS extract file out of CHCS are there and data will be pushed to TPOCS for billing. However, this is not possible without the support and correct management oversight of the processes. We need your continued help to make the improvements work. The quality of data is improving everyday and improvements are to the credit of those who dare to make a difference. ☺



## Provider Graphical User Interface . . . Provider—GUI . . . PGUI What is it?

Whether we like it or not, the best indicator of poor documentation and coding is FY03 collections. There was a 25% decrease AFMS wide. Coding of medical records has been required for several years but with little success and accuracy. For most, it was not a priority—until now! Although there are many reasons for complete medical record documentation and coding, sadly it didn't really hit home until outpatient itemized billing (OIB) was implemented in the beginning of FY 2003 (October 2002). OIB is the mandate for the MHS to bill for reasonable charges, which requires accurate E&M/CPT coding. Prior to October 2002, collections were based on an all-inclusive rate regardless of coding; you were only required to have documentation of a visit. We continue to bill inpatient care using an all-inclusive rate. For OIB, E&M/CPT coding drives reimbursements for Third Party Collections, the Medical Service Account, and the Medical Affirmative Claims (Third Party Liability). To support OIB, the Ambulatory Data Module (ADM) in CHCS had to be modified to push the right collection of data to the TPOCS. ADM 3.0 was born a very ugly baby. As quickly as OIB rolled out, all three Services (for one reason or another) objected to ADM 3.0. Objections were related to poor configuration, cumbersome administration, unfriendly user software, and poor training. Representatives from all three Services evaluated a half dozen commercially off the shelf (COTS) products and P-GUI was the unanimous choice as an alternative to ADM 3.0.

*Continued next page*



## Provider Graphical User Interface . . . Provider—GUI . . . PGUI What is it? (Continued)



CHCS II is configured to provide the computerized patient record (CPR). To support the CPR, configuration of CHCS II includes a process for MTFs, more so the provider, to complete Subjective, Objective, Assessment, Plan, and Disposition (SOAP/D) sections of the note—the record. Coding of the encounter will simultaneously occur when completing the SOAP/D in CHCS II. P-GUI works much the same way as CHCS II. As a matter of fact, it's the same software product developed by 3M. More specifically, P-GUI is Windows-based and uses a graphical user interface (GUI) to communicate directly with CHCS and ADM. It provides a user-friendly method of using most CHCS functions and all ADM functions in addition to providing more advanced coding capabilities. The present configuration allows for order entry (labs, rads, meds, consults), results retrieval, health history review, appointment creation, automatic documentation of the assessment, plan and disposition (A/P/D), and entry of all coding data. Further, the legible printed documentation of the A/P/D presently includes the option to fully document an encounter electronically. The majority of the data entered for documentation of the A/P/D is directly linked to the ADM coding modules. Thus, when the provider enters their note for the medical record ***it is coding*** the encounter. The only true coding decision a provider needs to make occurs is if they choose to use modifiers. If a modifier is used, the user must pick the E&M code. This design provides for the potential to improve coding quality, consistency and speed, and to improve third party collections. It also creates an association of all orders to diagnoses and procedures codes, a major improvement over ADM, and allows for billing of previously difficult to bill workload. P-GUI was not designed to replace the coder but to enhance the coding process.

Sheppard AFB was the AF alpha test site for P-GUI with impressive results. Initial feedback indicated clinicians enjoyed the Windows-based format and appreciated the ability to document the encounter, code, and enter orders all at once. Early sampling indicates encounters for nine of eleven providers were closed within the same day, 100% closed within the second day and audits showed coding accuracy at 92%. So you ask, why don't we have it already?

*Continued next page*



## **Provider Graphical User Interface . . . Provider—GUI . . . PGUI What is it? (Continued)**

P-GUI was originally to deploy worldwide in FY03. Unfortunately, half-way through the FY, TMA centrally pulled all funding for end user devices (EUDs). EUDs are the desktop computers configured to support P-GUI and CHCS II. These were to go on the desks of each provider and in each exam room. TMA's decision threatened P-GUI and for all intents and purposes, shelved the program. For this reason, and many others to include the need for enhanced automation of documentation and coding, each of the Services CIOs agreed with concurrence from all three Surgeons General to accelerate deployment of CHCS II over approximately 30 months beginning April 2004. About 30 days prior to the end of FY 2003, most of the EUD funding was restored. In addition, AFMSA/SGSR obtained \$2.5 million in procurement for P-GUI training and gained critical support from the AF CHCS II Office to ensure the future success of P-GUI. Because CHCS II is scheduled to roll out in April 2004, prime candidates for P-GUI are MTFs on the back end of the CHCS II deployment and training schedule. The AF CHCS II Office used a nine to ten month window for identifying feasible P-GUI sites. MTFs with nine to ten months prior to receiving CHCS II are candidates. MTFs in the window but not considered as good candidates had limiting constraints, such as infrastructure limitations, EUD requirements, commander support, and IT support. Twenty-three MTFs have been scheduled to receive P-GUI. MTFs currently on the list to receive P-GUI no later than March 2004 are Cannon, Columbus, Davis-Monthan, Edwards, Eglin, Ellsworth, FE Warren, Grand Forks, Hill, Holloman, Hurlburt, Los Angeles, MacDill, Maxwell, Minot, Moody, Mt Home, Nellis, Offutt, Robins, Shaw, Tyndall, and Vandenberg. If CHCS II deployment slips or if one of the established P-GUI sites falls off the list for reasons mentioned, other MTFs may have the opportunity to receive P-GUI at their site. The contingency plan outlines a plan for a total of 48 MTFs, funding available.



Questions concerning this project can be directed to Major John Graves or MSgt DeLisa Prater, DSN: 297-4856 and 754-4366, respectively. For specific information on P-GUI deployment, contact the AF CHCS II Office, specifically Major Francis Holland or Major Kurtis Dean, commercial: 703-681-6068 and 703-681-3118, respectively. ☎



## GENERAL INFORMATION

### Radiology Clinic—How Accurate is Your Coding?

Proper coding, along with maximum reimbursement, is our number one priority. With that said, have you put this priority into practice with your Radiology Clinic? When was the last time you cleaned up your radiology codes? Did you know there is a possibility you could be coding and billing erroneous information? Here are a few helpful steps that will maximize your coding compliance.

First, meet with your information systems people to see if you have access to the Procedure File Edit (PFE) menu. Remember the Radiology Clinic runs in the Composite Healthcare Computer System (CHCS), not ADM. Second, take a look at each procedure code along with the descriptors. Does the description match the code? Is the code outdated? If you do not see any errors, then you are in great shape! Otherwise, make a list of all errors and questionable codes found. Next, sit down with the Radiology team and explain the changes that need to be made and work with them in implementing the changes. The next step is to meet with Third Party Collections (TPC) staff to ensure the process flows through to TPOCS. You will be amazed of all the procedures that they are unable to bill due to incorrect data in CHCS. Once you have gathered all of your information and have access, go into CHCS and start cleaning up the Radiology Clinic. You can use any description that works best for the clinic. The Radiology Clinic is controlled individually at each MTF, which will help keep all parties involved in staying accurate. When cleaning up, start by inactivating incorrect codes. You cannot delete codes, however, by inactivating them, you will be shielding the incorrect information from the providers and technicians who are responsible for the ordering of the procedures. By inactivating the incorrect codes, this will prevent the wrong procedure from being selected. When entering new procedure codes in the radiology module, CHCS does have an internal audit that will attach the proper fee to the procedure code in the Radiology Clinic. CHCS will also attach the correct modifiers to the procedure codes. Remember though, that this is an internal audit, and CHCS does not recognize individual modifiers and you will more than likely use the same procedure code more than once, but with a different description. Here is an example with the Mammogram procedure codes:

CODE	CHCS DESCRIPTION	CPT DESCRIPTION FOR BILLING
76090	Mammogram, Left breast (spot compression)	Mammogram, unilateral, Lt breast
76090	Mammogram, Right breast (spot compression)	Mammogram, unilateral, Rt breast
76091	Mammogram, bilateral (spot compression)	Mammogram, bilateral
76091	Mammogram, read only	Mammogram, bilateral, -26
76091	Mammogram, bilateral, diagnostic	Mammogram, bilateral

Create a spreadsheet and send this out to all of the providers, technicians, radiology staff and TPC to show each procedure description with its definition. This way, the people ordering the procedure, performing the procedure, coding the procedure and billing the procedure all have the same understanding about the procedure. Once you have taken the above-mentioned steps, hold a briefing with all involved parties to clarify any information that still may be questionable.

This may take some time on your part, but the pay off is immense. Not only will you be coding correctly, the Radiology Clinic will be receiving the credit for performing the procedure as well as TPC being able to bill and collect the correct procedures. Remember you cannot do this alone, so teamwork is a must! Good luck and happy coding! (Article submitted by Christy Huggins, Coding Auditor at Robins AFB, GA) 🌀



## Coding for Flight Medicine Ground Testing

This article answers some questions about the proper coding for medication ground testing performed by Flight Medicine providers. First we need to understand what typically is being done during these encounters and their purpose. The philosophy behind ground testing is to provide assurance that aviators can safely take certain medications under certain conditions (e.g., combat, very long flights, exposure to BW/CW, deployment to malarial areas, etc.) without going unexpectedly "DNIF" (Duties Not to Include Flying or "grounded") and thus adversely impacting the mission. The most common medications would be stimulants (d-amphetamine or "go-pills"); sleeping medications (Restoril and Ambien or "no-go pills"); anti-nerve agents (pyridostigmine); or antibiotics (Cipro against anthrax or doxycycline against malaria).

Most commonly, an aviator will present to the flight medicine clinic and request ground testing for a specific medication. (There may be a ground testing program in effect at the MTF, or aviators may opt to present early in anticipation of an upcoming deployment.) He will be DNIF'd, given instructions, and prescribed a small sample of the medication. After a brief observation period, the aviator will come in and discuss the side effects with the flight surgeon. If the ground test is successful, then the aviator is returned to flying status and an entry is made in the chart. If he needs the medication in the future, he can take it and remain on flying status. Ground testing may appear cumbersome, but there are significant advantages from the flying mission and war fighting perspectives.



In most cases, a physical examination is not clinically required at the initial visit. But, there must be communication to the aviator about the intent and possible side effects of the medication. This is usually accomplished in a face-to-face setting. A follow up encounter will determine if there were any untoward side effects. There may be a face-to-face encounter; or, some providers may follow-up via telephone. But, there must be clear communication from the aviator whether side effects occurred. Most of the time, aviators will come in to the MTF for the follow up, since they must sign an AF Form 1042 (Medical Recommendation for Flying or Special Operational Duty) anyway to return to flying status.

The ICD-9-CM code V70.5\_\_1, Aviation Examination for the initial encounter is the appropriate code. If, on the face-to-face follow-up encounter, any adverse effects occur due to the administration of the drugs, the most severe would be coded as the primary and any others as secondary diagnoses. E-codes to identify the drug causing the adverse effect would be used also. If no adverse effects occur, use code V68.0, Issue of Medical Certificate. The Evaluation & Management code for the initial visit is 99401, preventive medicine counseling. Follow-up visits to assess without any effects from drugs, use 99455 or 99456 to return flyers to duty. The exact protocol or clinic operating instructions for ground testing may vary considerably from MTF to MTF within the AFMS. ☉

*"Ground testing may appear cumbersome, but there are significant advantages from the flying mission and war fighting perspectives."*

## More Coding Changes That Warrant Attention

"One of the new ICD-9-CM code changes that warrants close attention to avoid mistakes is a notation that instructs coders to code acute bronchitis separate from the chronic condition," says Kathy Johnson, Manager of **CARE's** Coding and Consulting Services. Other important ICD-9-CM changes include:

- New codes for concussion, encephalopathy, septic shock and spinal fusions.
- New V codes for current long term use of antiplatelet/antithrombotic medications, nonsteroidal anti-inflammatories and steroids and steroids.
- Changes to the sections for laparoscopic surgical procedures (inpatient) and diseases of the respiratory system.





## Supplemental Care and the Standard Inpatient Data Record (SIDR)



Supplemental Care describes the care given to **active duty** patients originally admitted to a Medical Treatment Facility (MTF) and "moved to" a civilian hospital for continuous hospitalization. In the case of the active duty patient requiring special tests with equipment or resources unavailable at the MTF, the patient may undergo treatment at a non-federal treatment facility, where the patient either returns to duty after the stay in the non-federal facility or returns to the MTF to continue the inpatient stay.

To accomplish the transaction, the active duty patient is placed in "Absent Status" with the type of absence being **Supplemental Care** through the following menu path:

- o PAD (Pad System Menu)
- o PAM (Patient Affairs/Administrative Menu)
- o AST (Absent Status)

Non-active duty patients should not be placed on Absent Status on Supplemental Care if being sent to a non-federal facility and should be discharged from the MTF. CHCS does not generate bed days at your MTF; the days are calculated as Supplemental Care days.

The patient on Supplemental Care is returned from absence status of Supplemental Care, returned to a status of "BO" or Bed Occupied, then either continue hospitalization at the MTF or be discharged to duty. DO NOT discharge the patient and create a new record for every instance an active duty patient is admitted as a direct admit to the MTF and moved to a non-federal facility. Note for the Coders: When the record is completed, verify the bed days distribution by running a copy of the Coded Episode Summary (Clerk Action Screen, Selection "S"). ⚙



## SIDR: New Fields and Changes in Record Format

Did you know there were changes to SIDR format introduced this past summer? The SIDR consists of 6 segments with 222 characters per segment. Some fields were redefined and others were added where filler (blank) fields existed. Here are the changes to the record:

### Segment 1, (Positions 75-76)

Delete: Alternate Care Value (ACV)

Add: *DEERS Dependent Suffix (DDS)*

Note: The DDS is a 2-character code that is analogous, but not exactly identical to, the CHCS Family Member Prefix (FMP) code. It shows the relationship between the sponsor and the person receiving care at the MTF. For example, DDS 20 = Self, 30-39 = Spouse, etc.

### Segment 1, (Positions 217-219)

Add: *Health Care Delivery Program (HCDP)*

Note: This is a 3-digit alphanumeric code indicating the health care coverage to which the patient is entitled. The HCDP code superceded the ACV code.

### Segment 1, (Position 221)

Redefine: *Format Indicator (Hard Coded to "H")*

Note: This format indicator was coded to "P" when changes were made to the SIDR a few years ago. At that time new fields such as NED PCM ID and NED PCM Type Code were added in support of NED. The new SIDR format indicator will change to "H" to denote that changes were made to the record. This will also be hard coded by CHCS.

### Segment 3, (Position 200)

Add: *Medicare Eligibility, Part A*

Note: This is a 1-character code of "A" to designate Medicare Part A Eligibility.

### Segment 3, (Position 201)

Add: *Medicare Eligibility, Part B*

Note: This is a 1-character code of "B" to designate Medicare Part B Eligibility.

### Segment 5, (Positions 196-205)

Add: *Patient Identifier*

Note: This is a 10-character alphanumeric code. It is a unique patient identifier auto generated by CHCS.

### Segment 5, (Positions 206-213)

Relocate: *Diagnosis #9*

Note: Patient identifier field displaced both Diagnosis #9 and 10. Diagnosis #9 has been moved from positions 204-211 to 206-213.

### Segment 5, (Positions 214-221)

Relocate: *Diagnosis #10*

Note: Patient identifier field displaced both Diagnosis #9 and 10. Diagnosis #10 has been moved from positions 212-219 to 214-221.





### **New Code for Pre-Diabetics – FY04**

Great news! With release of the updates for FY 04, ICD-9-CM, a new code, has been added to identify pre-diabetic patients. Use of **790.29**, *other abnormal glucose, pre-diabetic patients*, will improve the accuracy of the HEDIS® metrics and identify true diabetic patients. Providers and clinical staff should ensure the new code is included on their ADM pick lists or super bills. ☺



### **Using Primary and Secondary Diagnosis (Inpatient vs. Outpatient)**

If your MTF purchased new code books for their coding staff, chances are one edition was ordered for both inpatient and outpatient coding. The Ingenix ICD-9-CM Professional Edition for Physician Volume 1 & 2 is for outpatient only, whereas the Ingenix ICD-9-CM Expert for Hospitals, Volumes 1,2 and 3 should be used for inpatient services. The primary difference between the two books is evident when selecting primary or secondary “V” codes, Factors Influencing Health Status and Contact with Health Services for outpatient services. Many outpatient codes can be used as primary, but only secondary for inpatient or vice versa. ☺

## **LESSONS LEARNED FROM THE FIELD**

Since the advent of ADM 3.0 and other system nuances to the way we do business, all we can say is thank you all for your diligence and efforts with keeping the AFMS rolling ahead this past year. We are not all to the level that we would like, however, with continued efforts to stay current and learning from our peers and best practices we will get there.

Recently, during some site visits, we encountered situations where MTFs have not been meeting metric and workload goals. Upon reviewing their processes, our assessment concluded that many problems were attributed to parameter settings and provider code inconsistencies within CHCS. The AFMS Data Quality office has identified the following issues, which we recommend each site to review and adjust as necessary.

### ***Provider Specialty Codes***

If Provider Specialty Codes are not being assigned to all providers within the system, provider information will not link to the HIPAA table and you will lose credit for the workload.



Incorrect Provider Specialty Codes assigned to providers will also not link to the HIPAA table and you will lose credit for the workload. Further, you will not get credit for the RVU associated with the visit and provider productivity is understated – more credit lost. With regard to P2R2 metrics, if the provider specialty codes don't link to the HEDIS® metrics, again you will LOSE CREDIT for the WORK being accomplished and will lose contributions to the Medicare Accrual fund.

If coding indicates that the provider is more than a technician, but the provider specialty code indicates it is a technician, then the encounter will not be counted as part of the metrics and will not be credited to the MTF for workload. You will lose reimbursable dollars and you cannot send billable records to TPOCS (Third Party Collections) or MSA (Pay Patients, NOAA, Public Health, Coast Guard, Foreign Military Members, DoDD Teachers.)

Nurses and technicians using E&M codes other than 99211 or 99499 is a major red flag coding discrepancy for an outside auditor. If a Fiscal Intermediary on behalf of an insurance company conducted an audit we would be charged with fraud!

Physical & Occupational Therapy, and Optometry codes often have the E&M piece embedded in the CPT code, therefore the E&M for these records should be coded as 99499. However, in some cases folks have been adding an additional E&M code to the file -- this is "up coding" and constitutes fraud.



### ***Ancillary Coding***

Coding Radiology procedures in the clinic -- Foul --- Double Workload counting; you can only code what happened in the clinic.

Although these topics will not be the "fix all", they will ensure your settings are correct and will ensure you receive the credit for the wonderful work you all are doing.

Until the next newsletter comes out, we wish a Happy New Year and look forward to working with you all again in 2004! ☺



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**Correction to Coding News, Summer 2003,** page 13, Frequently Asked Questions, 4<sup>th</sup> question/answer contained a code error. The correct code assignment for Tobacco Use should have read 305.1 in both the question and answer.

## FREQUENTLY ASKED QUESTIONS

**Q.** Should modifier -32, Mandated Services, be used to identify DoD specific encounter information such as mandated deployment examinations or PHAs?

**A.** Modifier -32, Mandated Services, should be used to report mandated consultations and/or related services. It is used when the physician is aware of third-party involvement regarding mandated services. Because insurance carriers do not cover DoD mandated encounters, it is not necessary to use this modifier.

**Q.** When probing of the nasolacrimal duct is performed and a tube or stent is inserted, is it correct to report both 68811, Probing of Nasolacrimal, with or without irrigation; with insertion of tube or stent?

**A.** Report only code 66815 when probing of a lacrimal duct, with insertion of a tube or stent is performed, since probing is included in the code description.

**Q.** Is it appropriate for a Physician Assistant (PA) to request a consultation from another provider?

**A.** The consultation guidelines indicate that the consultation can be requested by another physician or other appropriate source. From a CPT coding perspective, CPT guidelines do not set restrictions regarding individuals who may be considered an "appropriate source" when reporting the consultation evaluation and management services codes 99241-99275. Some common examples include a physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech therapist, psychologist, social worker, lawyer or insurance company. Therefore, it would be appropriate for a PA to request a consultation from a physician.

**Q.** Should a superficial laceration without sutures be coded to an open wound or a superficial injury?

**A.** Unspecified lacerations are coded as open wounds, categories 870-897. If the provider described the wound as an abrasion, it would be coded to superficial injury, category 910-919.

**Q.** Provider performed two trigger point injections in two different muscles. Would it be appropriate to report code 20552 twice for the two injections.

**A.** Code 20552-20553 are reported one time per session, regardless of the number of injections or muscles injected. Therefore, it would not be appropriate to report code 20552, *Injection(s); single or multiple trigger point(s), one or two muscles(s) twice for the two injection administered.*