



Revenue Operations Manual



Part 3

Coding

Version 2

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Business Office

Part 3. Coding

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1. Overview of Coding

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1.1 **About the Revenue Operations Manual**

The Indian Health Service (IHS) Revenue Operations Manual (ROM) provides a system-wide reference resource for all Indian Health Service (Federal), Tribal, and Urban (I/T/U) facilities across the United States. The manual will provide guidance for any questions related to business operation procedures and processes.

This manual is an important reference document for the entire Revenue Operations staff, enabling them to perform in a consistent, standardized manner.

Each part and chapter of the manual is designed to address a specific area, department, or function. A part may also contain one or more appendices of topic-related reference materials.

Because the focus of this document is for the business office, there will be links throughout the manual to other business functions (Purchased Referred Care, Accounts Receivable, etc.) to provide detail on the function's processes.

Updates to the manual based on new information from the business office or insurer need to be reviewed by the Revenue Operations team prior to being placed into the ROM. After approval of content and wording, the information should be added to the correct part or chapter and should be dated.

Information that is no longer relevant should be deleted or highlighted with a date when the information will no longer be valid. This update process is important for insuring that the manual does not become outdated.

1.1.1 **ROM Objectives**

- Provide standardized guidelines for the Business Office related functions of IHS facilities.
- Capture accurate coding for all procedures and services to maximize reimbursement for each facility.
- Provide on-line, via the IHS Intranet, reference material subdivided by department and function that is accessible to all facilities.
- Share innovative concepts and creative approaches to Business Office functions across all the Area offices and facilities.
- Promote a more collaborative internal working environment throughout all IHS.
- Foster and promote continuous quality improvement standards, which when implemented and monitored on a day-to-day basis, will ensure the highest standard of quality service at each Business Office operation.

The manual is divided into the following five (5) parts:

Part	Title/Contents
1	Administrative Roles and Responsibilities <ul style="list-style-type: none"> • Overview of Revenue Operations • IHS Laws, Regulations, and Policies • Business Office Management • Business Office Staff • Business Office Quality Process Improvement • Compliance
2	Patient Registration <ul style="list-style-type: none"> • Overview of Patient Registration • Patient Eligibility, Rights, and Grievances • Direct Care and Purchased/Referred Care (PRC) • Registration, Discharge, and Transfer • Third Party Coverage • Scheduling Appointments • Benefit Coordination
3	Coding <ul style="list-style-type: none"> • Overview of Coding • Health Record Documentation • Coding Best Practices • Data Capture Entry
4	Billing <ul style="list-style-type: none"> • Overview of Billing • Paper Versus Electronic Claims Processing • Billing Medicare • Billing Medicaid • Billing Private Insurance • Third Party Liability Billing • Billing Private Dental Insurance • Billing Pharmacy • Secondary Billing Process • Billing Veterans Administration (VA) • Billing for Commissioned Officers and Their Dependents (BMP)

Part	Title/Contents
5	Accounts Management <ul style="list-style-type: none"> • Overview of Accounts Management • Receipt Methodologies and Processes • Batching (Recording Revenue) • Remittance Advices and Explanation of Benefits • Posting (Processing Payments and Adjustments) • Managing Patient Accounts • Denial Management • Debt Management • Overview of Reconciliation – File, Accounts Receivable, and Cash Management • Account Management Reports

This manual also contains an **Acronym** dictionary and a **Glossary**.

1.1.2 Facility Expectations

Each facility will be able to obtain from the IHS Revenue Operations Manual the following:

- How to use and implement the various guidelines;
- What information needs to be consistently captured at the time of registration;
- What documentation is needed from the facility staff for the health record;
- Verification and application of the correct code. How to accurately complete billing claim forms;
- How to create a bill for various insurers;
- How to establish electronic billing and auto-posting interchanges with insurers;
- How to understand Explanation of Benefits (EOB) and Remittance Advices;
- How to follow-up on outstanding accounts in a consistent, organized manner; and,
- Understand the requirements, frequency, and importance of external compliance audits.

1.1.3 Accessing the Revenue Operations Manual

The *Revenue Operations Manual* is available for viewing, and printing at this website:

<https://www.ihs.gov/BusinessOffice/rom/>

Having the manual available from a website allows more timely updates.

1.2 Coding Profession

Coding, as defined by the **American Health Information Management Association (AHIMA)**, is the transformation of verbal descriptions of diseases, injuries, and procedures into numeric or alphanumeric designations.

Coding includes clinical documentation review and abstracting information into the most appropriate code(s) to accurately reflect the medical services provided.

Originally, medical coding was performed to classify mortality (cause of death) data on death certificates; however, coding is also used to classify morbidity (disease or condition) and procedural data. The coding of health-related information permits access to data for use in clinical care, research, and education.

Since the implementation of the Federal government's payment system (Diagnosis Related Group) in 1983, greater emphasis has been placed on medical coding. Currently, reimbursement of hospital and provider claims is based on the codes assigned to describe the diagnoses, services, and procedures provided.

During the 1990s, the Federal government identified the problem of healthcare fraud and abuse. Medical coding became crucial as healthcare providers sought further compliance with official coding guidelines and reimbursement requirements.

Codes are also included on data sets used to evaluate healthcare processes and outcomes. Additionally, coded data is used for quality management activities, reporting, case-mix management, planning, marketing, and other administrative and research activities.

1.3 Customer Service

Customer Service is an important function for providers, coders, and billers both externally and internally. Providers, coders, and billers interact often with insurance companies, auditors, patients, third party billing agents, and other individuals. The external party may need additional information, to process their claims, verify documentation. The provider, coder, or biller needs clarification of regulations, processes, procedures, or requirements for justifying an appeal.

Regardless of the reason, external customers are dependent on the internal business operations of the facility and vice versa. Therefore, coders, providers, and billers need to:

- State specifically their requests in a professional manner.
- Provide timely responses to external requests.

- Document responses and maintain a copy.
- Build working relationships, which will benefit future inquiries.

With regard to the inter-departmental customer service, all departments must work as a team to provide accurate documentation and billing to the insurer. Without a team approach, the written documentation could not be transferred to applicable coding and billed correctly to the insurer. The team needs to build a strong and, collaborative working relationships where everyone relies on each other to perform their function.

1.4 Clinical Documentation Improvement (CDI) and Coding

The need for clinical documentation improvement became more visible with the implementation of the International Classification of Disease (ICD)-10, Meaningful Use (MU) and Quality Payment Programs (QPP). These pay-for-performance/value-based payment models reward healthcare providers with incentive payments for the quality rather than the quantity of care to patients. Identifying and understanding the types of payment models is important for coding and CDI professionals to ensure visits reflect the requirements of the QPP.

A CDI program focuses on improving patient outcomes by monitoring and improving documentation, data quality and accurate reimbursement. This includes auditing and training of coders, providers and other professional staff on clinical documentation and coding guidelines.

As members of the health care team, coding professionals should assist and educate providers. They serve as CDI advocates for proper documentation practices to accurately reflect the acuity, severity and occurrence of events including:

- further specificity,
- re-sequencing, or
- inclusions of diagnoses or procedures

The provider must be queried when questionable, ambiguous or conflicting documentation is present. The goal of clarifying documentation is to capture codes that reflect the highest degree of specificity.

Accurate coding supports quality of statistical data, evaluation of services, data used for performance review programs and appropriate reimbursement.

For more information:

American Medical Association Coding Guidelines, available at:
<https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology>

Current Dental Terminology (CDT) available at:

<http://www.ada.org/en/publications/cdt>

Diagnostic and Statistical Manual of Mental Disorders (DSM) available at:

<http://dsm.psychiatryonline.org/>

HCPCS available at:

<https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.html>

ICD Official Guidelines for Coding and Reporting, available at:

<https://www.cdc.gov/nchs/icd/index.htm>

<https://www.cms.gov/Medicare/Coding/ICD10/index.html>

1.5 National Correct Coding Initiative (NCCI)

The **Centers for Medicare and Medicaid Services (CMS)** developed the **National Correct Coding Initiative (NCCI)** to:

- promote national correct coding methodologies
- control improper coding that leads to inappropriate payment in Part B claims

The coding policies are based on coding conventions defined in the American Medical Association's **Current Procedural Terminology (CPT)** manual, national, and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice and review of correct coding practice.

The NCCI includes the following:

- **Procedure-to-Procedure (PTP)** edits is to prevent improper payment when incorrect code combinations are reported.
- **Mutually Exclusive Edits** prevent improper payments when services are reported with incorrect units of service. The edits include where two procedures could not be performed at the same patient encounter because they were mutually exclusive based on anatomic, temporal, or gender considerations.
- **Medically Unlikely Edits (MUE)** to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE.
- **Add-on Code Edits** is a HCPCS/CPT code that describes a service that, with one exception (see CR7501 for details), is always performed in conjunction with another primary service. An add-on code with one exception is eligible

for payment only if it is reported with an appropriate primary procedure performed by the same practitioner. An add-on code with one exception is never eligible for payment if it is the only procedure reported by a practitioner.

The NCCI edits are updated quarterly and are available at this website:

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

1.6 Ethics for a Medical Coder

Integrity, ethics and professionalism are essential to the Health Information Management (HIM) profession. The following links provide further guidance:

- 1) IHS Ethics Policy:
http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c23#3-23.2
- 2) American Health Information Management Association's (AHIMA) Code of Ethics: <http://library.ahima.org/doc?oid=105098#.WTAlzofrupo>
- 3) American Academy of Professional Coders (AAPC) Code of Ethics:
<https://www.aapc.com/aboutus/code-of-ethics.aspx>

1.7 Standards of Ethical Coding

A goal for all coders is to code accurate clinical and statistical data. The following standards of ethical coding, developed by AHIMA Coding Policy and Strategy Committee should be used as a reference guide:

- 1) Apply accurate, complete, and consistent coding practices that yield quality data.
- 2) Gather and report all data required for internal and external reporting, in accordance with applicable requirements and data set definitions.
- 3) Assign and report, in any format, only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, and requirements.
- 4) Query and/or consult as needed with the provider for clarification and additional documentation prior to final code assignment in accordance with acceptable healthcare industry practices.
- 5) Refuse to participate in, support, or change reported data and/or narrative titles, billing data, clinical documentation practices, or any coding related activities intended to skew or misrepresent data and their meaning that do not comply with requirements.

- 6) Facilitate, advocate, and collaborate with healthcare professionals in the pursuit of accurate, complete and reliable coded data and in situations that support ethical coding practices.
- 7) Advance coding knowledge and practice through continuing education, including but not limited to meeting continuing education requirements.
- 8) Maintain the confidentiality of protected health information in accordance with the Code of Ethics.
- 9) Refuse to participate in the development of coding and coding related technology that is not designed in accordance with requirements.
- 10) Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal coding practices, and fosters trust in professional activities.
- 11) Refuse to participate in and/or conceal unethical coding, data abstraction, query practices, or any inappropriate activities related to coding and address any perceived unethical coding related practices.
- 12) Coding professionals in all health care settings should adhere to the ICD coding conventions, official coding guidelines and rules established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets. Coding professionals must utilize the appropriate classification system for code selection based on facility type. Sequencing of diagnoses and procedures must conform to applicable code set requirements.
- 13) Coding professionals should use their skills, knowledge of currently mandated coding and classification systems, and official resources to select the appropriate diagnostic and procedural codes.
- 14) Coding professional should only assign codes that are clearly and consistently supported by provider documentation in the health record. Codes must be assigned to the highest level of specificity that reflects services provided.
- 15) Any reassignment and/or re-sequencing of codes for reimbursement purposes should be reviewed and approved by the coding supervisor or designee. When individual payer policies conflict with official coding rules and guidelines, obtain these policies in writing whenever possible. Reasonable efforts should be made to educate the payee on proper coding practices in order to influence a change in the payer's policy.
- 16) Coding professionals should participate in the development of a coding compliance plan to ensure that policy does not conflict with official coding rules and guidelines.

- 17) Coding professionals should maintain and continually enhance their coding skills, as they have a professional responsibility to stay abreast of changes in codes, coding guidelines, and regulations.
- 18) Coding professionals are encouraged to be credentialed (or overseen by a credentialed coder) through a nationally recognized organization.
- 19) Continuing education should be ongoing to maintain coder competency and credentials.

1.8 **International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)**

The **International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)**, Volumes 1, 2, and 3, is a coding system used to translate medical terminology for diseases and procedures into numeric codes. Maintenance and updates to ICD-9 is carried out collaboratively by the:

- American Hospital Association (AHA)
- National Center for Health Statistics (NCHS)
- Centers for Medicare and Medicaid Services (CMS)
- American Health Information Management Association (AHIMA)

Originally ICD-9-CM was used as a means to track the morbidity and mortality of diseases to determine disease trends. These codes may still be used for Workers Compensation. IHS adopted ICD-10 on October 1, 2015, as the primary coding set.

1.9 **International Classification of Diseases Tenth Edition, Clinical Modification (ICD-10-CM) and Procedure Coding System (PCS)**

The **International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) and Procedure Coding System (PCS)** is a replacement of ICD-9. ICD-10 is designed for all health care settings. A greater level of detail is included. Essential attributes of ICD-10 CM/PCS:

- **Completeness** – a unique code for all substantially different diagnosis and procedures.
- **Expandability** – as new diagnosis or procedures are developed the new system is able to accommodate these unique codes.
- **Multi-axial** – each code character has the same meaning within the specific procedure section and across procedure sections.
- **Standardized Terminology** – the update will include definitions of the

terminology used.

- Addition of information relevant to ambulatory and managed care encounters.
- Expanded injury codes.
- The creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition.
- Incorporation of common fourth and fifth digit classifications.
- Laterality.
- Alphanumeric categories rather than numeric categories.
- Rearranged chapters.
- There are nearly 19 times as many procedure codes in ICD-10-PCS than in ICD-9-CM volume 3.
- There are nearly 5 times as many diagnosis codes in ICD-10-CM than in ICD-9-CM.

ICD-10-CM	ICD-10-PCS
<ul style="list-style-type: none"> • 3-7 characters • Character 1 is alpha • Character 2 is numeric • Character 3-7 can be alpha or numeric 	<ul style="list-style-type: none"> • 7 characters • Can be either alpha or numeric • Numbers 0-9; letters A-H, J-N, P-Z

1.10 Healthcare Common Procedural Coding System (HCPCS)

The The **Healthcare Common Procedural Coding System (HCPCS)** coding system is divided into two principal subsystems, referred to as level I and level II. The HCPCS coding system is preceded by a letter that standardizes the reporting of services, equipment, and supplies. HCPCS also:

- Ensures the validity of fee schedules because of the use of standard codes.
- Allows CMS to compare local, regional, and national utilization of services, procedures, and supplies.
- Makes it easier to coordinate the uniform application of CMS’s policies to all government health care organizations.

The Centers for Medicare & Medicaid Services announces the quarterly changes for HCPCS codes:

<https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html>

1.11 Level I - Current Procedural Terminology (CPT)

Level 1 – CPT, developed and updated by the American Medical Association, is a listing of descriptive terms and identifying codes for reporting medical services and procedures.

CPT was designed to uniformly represent and report medical services with a 5-digit code.

The medical necessity for a service reported with a CPT code is supported by the ICD-10 code that is coded from the supporting documentation in the health record.

Payers use claims management and editing software to review submitted CPT codes and compare them with ICD-10-CM codes reported as diagnoses and/or status codes specific to the patient’s care or condition on the date of service. Proper documentation of medical necessity can help to avoid denials and delays in claims processing.

1.12 Level II HCPCS Codes

HCPCS-Level II is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. These codes are published annually with quarterly updates.

Level II HCPCS codes are alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits. They are grouped according to type of service or supply within a section of HCPCS that begins with a specific letter.

Code Group	Type of Service or Supply
A	Transportation services including ambulance, Medical & Surgical Supplies
B	Enteral and parenteral therapy
C	Temporary Codes for use with Outpatient Prospective Payment System (PPS)

Code Group	Type of Service or Supply
D	Dental Codes - Current Dental Terminology (CDT)

E	Durable medical equipment (DME)
F	<i>Not Used</i>
G	Procedures/professional services (Temporary Codes)
H	Alcohol and Drug Abuse Treatment Services/Rehabilitation Services
I	<i>Not Used</i>
J	Drugs Administered Other Than Oral Method, Chemotherapy Drugs
K	Durable Medical Equipment for Medicare Administrative Contractors (DME MACs)
L	Orthotic and Prosthetic Procedures, devices
M	Medical Services
N	<i>Not Used</i>
O	<i>Not Used</i>
P	Pathology and Laboratory Services
Q	Miscellaneous Services (Temporary Codes)
R	Diagnostic Radiology Services
S	Commercial Payers (Temporary Codes)
T	Established for State Medical Agencies
V	Vision, Hearing and Speech-language Pathology Services

1.13 Evaluation and Management Codes

Evaluation and Management (E&M) codes were established by the American Medical Association and became effective with 1992 dates of services.

Evaluation and Management services include all “visit” codes, such as, office visits, hospital visits, nursing home visits, emergency department services, and consultations. To ensure correct reimbursement, it is important that the correct code be submitted.

The current Evaluation and Management documentation guidelines were developed in 1995 and 1997 to supplement the definitions of E&M codes contained in the American Medical Association's (AMA) Current Procedural Terminology (CPT) coding system – the system used for coding providers' services. The guidelines were developed with the active involvement of the AMA and specialty societies.

These guidelines were designed to assist providers and medical reviewers to determine:

- Which of five coding levels would be appropriate for an E&M service, and
- What documentation would be appropriate to document the level chosen?

Although the Indian Health Service recommends using the 1995 Documentation Guidelines, providers can choose to use either the 1995 guidelines or the 1997 guidelines. Thus, carriers may review and adjudicate claims using either the 1995 or 1997 guidelines. To review the guidelines, go to the following website:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>

The three key components when selecting the appropriate level of E&M services provided are history, examination, and medical decision making.

For the purposes of selecting the E&M code patients are identified as either new or established, depending on previous encounters with the provider.

New Patient: An individual who did not receive any professional services from the physician/ qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Established Patient: An individual who has received professional services from the physician/qualified health professional or another physician/qualified health professional of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

Note: No distinction is made between New and Established patients in the Emergency Department (ED). E&M services in the ED category may be reported for any new or established patient who presents for treatment in the ED.

Time is considered the key or controlling factor to qualify for a particular level of E&M services when there is clear documentation that counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter.

Time is the key or controlling factor to qualify for a particular level of prolonged services, care plan oversight services, standby services, critical care services, and hospital discharge services, the extent of counseling and/or coordination of care must be documented in the health record.

Time is NOT a descriptive component for the Emergency Department levels of E&M services because ED services are typically provided on a variable intensity

basis, often involving multiple encounters with several patients or an extended period of time.

E&M auditing tools may be used to assist in determining the appropriate level of E&M codes.

Prolonged Service Add-on Code

For monitoring and treatment services done in the clinic or inpatients, consider adding a prolonged service code. There are face-to-face codes, codes without direct patient contact, or prolong clinical staff service codes.

- When a provider spends prolonged time (more than 30 minutes beyond the time spent for the usual service) talking with family, reviewing complex health records, completing a comprehensive treatment plan, or coordinating plans with a home health agency or dietitian, bill the procedure code for a prolonged service without direct patient contact, in addition to the procedure code for the office visit.
- Provide a diagnosis code for each service, procedure, or supply billed.
- If the visit is for other than a disease or injury, such as follow-up for therapy, use one of the ICD-10 Z-codes (Z00-Z99).

1.14 Modifiers

Modifiers are two-digit indicators used to describe a service or procedure, which has been altered from the baseline description in the HCPCS level I and II. Modifiers provide additional information regarding a specific service or item and can ultimately affect reimbursement. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities.

- CPT Modifiers are always two characters, and may be numeric or alphanumeric. CPT modifiers are added to the end of a CPT code with a hyphen. In case of more than one modifier, the “functional” modifier is coded first, and the “informational” modifier is coded second.

The Provider’s documentation in the health record must reflect that the modifier being used appropriately describes altered services. Coders should apply CPT Modifiers and Billers should review CPT Modifiers for compliance to payment policy requirements. All disciplines are responsible to ensure CPT Modifiers are accurate in reflecting an altered service. The documentation must be made available to any insurer on request.

For the most current list of modifiers, refer to the current HCPCS level I and II code book. For the modifiers related to Medicare billable services, refer to Medicare Billing Guidelines provided by your fiscal intermediary.

1.15 Current Dental Terminology (CDT) Codes

Accurate recording and reporting dental treatment is supported by a set of codes that:

- Have a standard format;
- Appropriate level of specificity;
- Can be applied uniformly; and,
- Are used to report dental procedures provided under public and private dental insurance benefit plans.

In addition, the code set should contain the appropriate number of procedure codes that adequately encompass commonly accepted dental procedures.

These needs prompted development of the **Code on Dental Procedures and Nomenclature** (the “Code”). Individual dental procedure codes, as currently defined, are 5-character alphanumeric codes, beginning with the “D” and followed by four digits. Each code identifies a specific dental procedure.

	Category of Service	Code Series
I.	Diagnostic	D0100 – D0999
II.	Preventative	D1000 – D1999
III.	Restorative	D2000 – D2999
IV.	Endodontics	D3000 – D3999
V.	Periodontics	D4000 – D4999
VI.	Prosthodontics, removable	D5000 – D5899
VII.	Maxillofacial Prosthetics	D5900 – D5999
VIII.	Implant Services	D6000 – D6199
IX.	Prosthodontics, fixed	D6200 – D6999
X.	Oral & Maxillofacial Surgery	D7000 – D7999
XI.	Orthodontics	D8000 – D8999
XII.	Adjunctive General Services	D9000 – D9999

Components of a Dental Procedure Code Entry. Every procedure in the CDT Code must have the first two of the following three components:

- 1) **Procedure Code** – A five-character alphanumeric code beginning with the letter “D” that identifies a specific dental procedure. A Procedure Code cannot be changed or abbreviated.

- 2) **Nomenclature** – The written title of a Procedure Code. Nomenclature may be abbreviated when printed on claim forms or other documents that are subject to space limitation. Any such abbreviation does not constitute a change to the Nomenclature.
- 3) **Descriptor** – A written narrative that further defines the nature and intended use of a single Procedure Code, or group of such codes. A Descriptor, when present, follows the applicable Procedure Code and its Nomenclature Descriptors that apply to a series of Procedure Codes that precede the series of codes.

The CDT is periodically reviewed and revised by the ADA's Council on Dental Benefit Programs to reflect the dynamic changes in dental procedures. As of 2013, revisions to the CDT are published annually and it is critical that facilities purchase the new CDT book every year. The US Government has designated the CDT Code as the national terminology that must be used for reporting dental services on claims to third party payors. codes are now revised every year and the revisions are significant so it is critical that facilities purchase the new CDT every year. The US Government has designated the CDT Code as the national terminology that must be used for reporting dental services on claims to third party payors.

1.16 **Data Capture for Clinical Reporting/Audits**

The primary focus for Coding Specialist/ Patient Care Component (PCC) Data Capture Specialist is to assist with data capture (template design) and to audit visit data/codes to assure data reflects complete visit information for internal and external reporting. HIM and coders may need to be aware of the various types of clinical reporting due to their role in the management of coding changes, template design changes, and data analytics needed for clinical reporting, internal auditing, as well as external audit requests from CMS, Office of Inspector General (OIG), etc.

Government Performance and Results Act (GPRA)

The Government Performance and Results Act (GPRA) requires Federal agencies to report annually on how the agency measured against the performance targets set in the plan. GPRA measures may be either clinical or non-clinical. GPRA measures are reported using the Resource and Patient Management System (RPMS) via the Clinical Reporting System (CRS) application. The CRS system includes reports such as; National GPRA/GRAMA Reports, Selected Measures (Local) Reports, Other National Reports, Taxonomy Reports, and Meaningful Use Clinical Quality Measure Reports. <https://www.ihs.gov/crs/>

Meaningful Use – Clinical Quality Measures

Clinical quality measures, or CQMs, help track the quality of healthcare services provided by eligible providers (EP), eligible hospitals (EH), and Critical Access Hospitals (CAH). Based on a variety of data, CQMs measure many aspects of patient care such as health outcomes, clinical processes, patient safety, efficient use of healthcare resources, care coordination, patient engagements, population and public health, and clinical guidelines. Tracking and reporting these CQMs helps ensure that health care services are effective, efficient, and patient-centered.

<https://www.ihs.gov/meaningfuluse/cqmooverview/>

Quality Payment Program (QPP) – Medicare Access & Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA)

Prior the QPP – MACRA program payment increases for Medicare services were set by the Sustainable Growth Rate (SGR) law. The Centers for Medicare & Medicaid Services (CMS) is able to reward high value, high quality Medicare clinicians with payment increases - while at the same time reducing payments to those clinicians who aren't meeting performance standards.

<https://www.ihs.gov/qpp/>

2. Health Record Documentation

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2.1 About the Health Record

The health record is a legal document and should not be tampered with, falsified, or altered in any manner that would cause the loss of or suppression of data.

The **Health Record** documents chronologically the care of the patient. The health record documentation contains pertinent facts, findings, and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments, and outcomes. For more information, reference the IHM Part 3, Chapter 3 "HIM": <https://www.ihs.gov/IHM/pc/part-3/p3c3/#3-3.2B>

The health record facilitates:

- The ability of the provider and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor their health care over time
- Communication and continuity of care among providers and other health care professionals involved in the patient's care
- Accurate and timely claim review and payment
- Appropriate utilization review and quality of care evaluations
- Collection of data that may be useful for research and education

The health record needs to substantiate the codes billed to the insurer. For more information, reference Section 3.1 "Coding Best Practices."

2.2 Principles of Health Record Documentation

The following principles of health record documentation apply to all types of services in all settings:

- The health record should be complete and legible.
- Documentation in the health record shall be recorded at or near the time of care or treatment of the patient in order to ensure accuracy, credibility, and compliance with legal and regulatory oversight.
- A late entry is used to record the information in the health record with a notation giving the reason for the late entry. The entry of missing documentation or authentication is identified as "late entry" and must note the actual date the event occurred, not the date of documentation.
- An addendum to a health record be dated the date the information is added to the health record, not the date the service was provided.
- Facilities shall eliminate or minimize the use of the copy and paste function. Additionally, this electronic function should never be used to copy

information from one patient's health record to another.

- The confidentiality of the health record should be fully maintained and consistent with the requirements of medical ethics and federal and State laws (HIPAA/Privacy Act/42 CFR Part 2).
- The specific format required to document the components of the health record are described in the IHM Part 3, Chapter 3, 3-3.8 Health Record Documentation or at this link: <https://www.ihs.gov/IHM/pc/part-3/p3c3/>

Golden Rule of Coding – “If it is not documented, it has not been done”.

2.3 Electronic Health Record (EHR) Integrated Problem List and ICD Coding

The certified EHR requires Systemized Nomenclature of Medicine (SNOMED) terms to be used for encoding clinical data in the Integrated Problem List (IPL) when appropriate. The IHS EHR maps the SNOMED terms to ICD codes. When reviewing the visit consider the following:

- 1) The provider selects the SNOMED term in the EHR IPL, which are mapped to ICD 10 codes when appropriate. If there is one SNOMED term that could map to several ICD codes, the zzz.999 default will display.
- 2) ICD codes on the IPL may not be changed. Coders should work with providers if there is a more descriptive term that may be mapped to a more accurate code.
- 3) Map advice may be used to determine the most granular code by hovering over the ICD column within the IPL for a problem will expose the SNOMED CT® to ICD-10 map advice. For more information, reference the ROM section 3.2 for “Coding Queue.”
- 4) Conditional maps consider additional patient, qualifier, and encounter data from RPMS in map rules used to assign an ICD-10 code when set as V POV. These were developed based on NLM map algorithms and will leverage data in RPMS to derive ICD-10 for POV.

Note: only used for POVs.

- 5) Unconditional maps automatically assign an ICD code based on a SNOMED term and do not consider any other patient, qualifier (laterality), or visit entered data. The ICD-10 target code may/may not be 1:1 match. Also, not all SNOMED terms will have unconditional maps.

Note: SNOMED is used as the first step for the provider to identify the most specific diagnosis and if available will be mapped to an ICD-10. SNOMED codes are not the primary codes to be used for final reimbursement. ICD-10 is primarily for reimbursement to encode the entirety of the encounter for

billing. The coder is responsible to review and select the most appropriated ICD-10 code for final coding and billing.

3. **Coding Best Practices**

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3.1 Coding Best Practices

The AMA and CMS coding guidelines are to be used for applying diagnosis and procedure codes. In addition, facilities may have their own policies and procedures for applying codes.

Individual payers may have code requirements for reimbursement. In these instances, coordination between coding and billing staff is necessary to ensure the visit data matches the claim.

Provided below are best practices for ensuring that visits are coded in compliance with the applicable coding guidelines:

- Purchase yearly updates to coding books, encoders, DRG books, software or utilize the ICD map advice from SNOMED-CT. Consider purchasing AHA Coding Clinic and AMA CPT Assistant.
- Code all visits timely in a timely manner to ensure continuity of care regardless of reimbursement potential.
- Ensure a Clinical Documentation Improvement process is in place to improve patient outcomes, data quality and accurate reimbursement.
- The provider should be queried to clarify the documentation in the health record and achieve accurate code assignments. For example, when questionable, ambiguous, or conflicting documentation is present, for a specific condition in which the patient is receiving medication, therapeutic or diagnostic tests or treatment.
- The coder and the biller should never change billing information documented by a provider without querying the provider and the provider completing an addendum.
- Ensure there is a process in place with coding, billing and/or accounts receivable staff to address claims that are denied, when applicable.
- Monitor reports and notification logs on a regular basis for incomplete records and those that require a physician query.
- Conduct audits for coding accuracy.
- Ensure the EHR pick lists and RPMS coding tables that interface with the coding and billing packages are reviewed annually (at least) to include new and/or revised codes. The reviews should be a joint effort between the HIM, Business Office, Information Technology, and departments using the pick list or RPMS tables, i.e., laboratory, radiology, pharmacy, etc.
- Documents to consider for final coding may include:
 - discharge summary (*must be available*)
 - history and physical
 - emergency room record
 - provider progress notes

- PCC encounter form
- Integrated Problem List (IPL)
- provider orders
- provider consultations
- pathology reports
- operative reports
- provider notations of intraoperative occurrences

3.2 Coding Queue

All electronically created visits will be captured in the PCC Coding Queue, which is a summary list of visits pending review and completion by the coder. All visits, including telephone calls and chart reviews, must be completed whether or not the patient has third party coverage. All sites have the ability to set parameters for the coding queue. Coding Queue parameters are set by HIM to ensure visits are properly set up for review in the Coding queue. For more information, reference the IHS PCC Data Entry User Manual:

<https://www.ihs.gov/RPMS/PackageDocs/APCD/apcd020t.pdf>

The Coding Queue is used for the following:

- Provides a list of un-reviewed visits for the coding staff to manage
- Allows several options for sorting the list to distribute work load
- Provides various reports to track incomplete visits and/or un-reviewed visits, productivity, deficiencies, and workload

Below are some of the recommended reports for monitoring visits in Coding Queue:

- Use the EHRD and/or PEHR menu options to complete daily coding
- Use the following reports monthly, or more frequently depending on the size of the facility:
 - Tally of Reviewed/Completed Visits List by Operator (TRVL)
 - List Visits Marked as Incomplete (INCV)
 - Incomplete Charts by Provider with Deficiencies (ICPD)
 - List Unreviewed/Incomplete Visits (LIR)
 - Tally/List of Visits Not Reviewed in N Days (VNR) to monitor productivity (Daily, Monthly, Quarterly etc.)
- Maintaining the Coding Queue significantly reduces the TXER “aka” Error Report and eliminates potential backlog.

It is necessary for coders to be trained on the mnemonics needed to navigate and perform functions in the coding queue. *See section 4.3 Mnemonics.*

It should be noted that ICD-10-CM Map Advice is available in the coding queue to assist in code selection and determining the need for a more granular code. The ICD 10 coding guidelines should always be considered before the selection of any codes.

3.3 Coding Query

A query is necessary when the providers documentation is unclear or conflicting for completion of the coding process. There are various query methods to resolve documentation issues, such as, a query form, EHR notification, face-to-face, telephone call, etc. Provider queries must be clear and concise and not "lead" the provider to provide a particular response. A provider's response to a coding query to be used to support a code assignment must be documented by the provider in the health record.

For more information on examples of compliance plans, reference the IHS HIM webpage: <https://www.ihs.gov/HIM/codingresources>

3.4 Coding Audits

Internal or external coding quality audits must be completed on a regular basis to ensure compliance with the Third Party Control Policy, and other high-risk areas per Office of Inspector General (OIG) workplan and from the state Quality Improvement Organization (QIO) support. For more information, reference the Third Party Revenue Accounts Management and Internal Controls webpage: <https://www.ihs.gov/ihm/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/>

Audits should include review of the health record to determine accurate code assignment. Any discrepancies should be discussed further with the billing office or staff.

- Audits may include focus areas such as: Quality Payment Programs (MACRA, MU, etc.), previous audit findings, GPRA measures, denials, projects, etc.
- Findings from these coding audits should be used to re-educate coders and providers on documentation in the record.
- Audit findings that are potential issues of waste, fraud and abuse need to be reported to the organization's appropriate authority.

3.5 Coding Compliance

Targets of various OIG audits around fraud, waste, abuse include unbundling, over-coding and under-coding. Coding Compliance programs identify, address, and prevent, fraud, waste and abuse within an organization. For more information, reference the ROM Part 1, Chapter 6 “Compliance:”

<https://www.ihs.gov/businessoffice/rom/>.

It is recommended that facilities establish coding compliance plans and workgroups, or utilize other appropriate established committees, to:

- Monitor compliance and report noncompliance to the Compliance officer.
- Evaluate training and education needs of staff with regard to coding, reimbursement and documentation compliance issues and coordinate the training or make recommendations to leadership.
- Develop and oversee processes for regular auditing and monitoring of coding accuracy and coordinate or make recommendations for resolving problems.
- Monitor physician queries in the EHR or forms for compliance requirements and approve new queries or forms as needed.
- Evaluate procedures and processes as relates to coding and reimbursement compliance and develop and/or make recommendations for policies and procedures.
- Evaluate equipment, technology and information needs that relate to coding, documentation and reimbursement and make recommendations to leadership.
- Evaluate new legislation and regulatory requirements as they relate to coding, billing and documentation and make recommendations for revisions to policies and procedures if necessary.

4. Data Capture Entry

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4.1 Overview of Data Capture

A majority of RPMS Data Capture is typically done in the EHR by providers. The Coding Specialist/PCC Data Capture Specialist review these visits in the RPMS PCC/EHR Coding Queue and append health data as needed per the documentation.

The Coding Specialist/PCC Data Capture Specialist may capture data when the system is down, enter information from group PCC forms or for other facility specific purposes. The PCC Ambulatory Encounter Record is used to document these visits for entry into the PCC Data Entry Module.

In the event of a system downtime, please use the PCC paper forms and follow facility contingency plans.

Despite the method of data capture, the Coding Specialist/PCC Data Capture Specialist validates health encounter data to ensuring it is properly reflected in RPMS. This would include auditing of information such as:

- CPT Coding
- ICD Coding
- HCPCS Coding
- Vital Statistics, such as weight, height, blood pressure
- CDT Coding
- Health Factors
- Allergies
- Patient Education
- Other related coding information

This review and completion of visit function is the crucial link for conveying the information from the patient encounter to the RPMS for continuity of care, reimbursement and reporting. For more information, reference section 1.16 “Data Capture for Clinical Reporting/Audits.”

4.2 Additional Data Capture Considerations

- Develop a contingency plan for how data capture will be performed during system downtime. For more information on developing contingency plans, reference the IHM manual: <https://www.ihs.gov/ihm/pc/part-3/p3c3/#3-3.12H>
- Provide periodic training of the PCC Ambulatory Encounter Record to ensure providers are able to complete the form during downtime.
- Become familiar with the provider and clinic codes. A list of the IHS provider and clinic codes are available at this website: https://www.ihs.gov/scb/index.cfm?module=disp_tablesSCB&reset=1

- Completion of visits must be in accordance with the Indian Health Manual, Part 5, Chapter 1, “Third Party Revenue Accounts Management and Internal Controls” (5-1.3H), which is available at this website: <https://www.ihs.gov/ihm/pc/part-5/chapter-1-third-party-revenue-accounts-management-and-internal-controls/>

For more information on completing visits, reference section 3.2 “Coding Queue.”

4.3 Mnemonics

PCC Data Entry mnemonics are two- to four-character abbreviations of the types of data entered via the PCC Data Entry Module. When a mnemonic is entered, the system is alerted that a particular type of data is being captured.

Mnemonics allow the Coding Specialist/PCC Data Capture Specialist to capture or modify structured data such as:

- Existing items
- Historical event
- Elements from the note
- Group PCC encounters

The Data Entry Module has helpful tips to use mnemonics:

- A complete list of mnemonics may be viewed by typing two question marks (??) and pressing the ‘Return’ or ‘Enter’ key.
- If a mnemonic is typed in error, type a caret by pressing Shift+6 and then press ‘Enter.’ This usually allows the user to exit the erroneous mnemonic and choose the correct one. Some mnemonics do not permit using a caret to exit. In this case, type a value to return to the mnemonic prompt, and then type MOD (Modify) mnemonic to delete the data typed in error.
- For the PCC Data Entry Mnemonics Manual, access the following link: https://www.ihs.gov/JPMS/PackageDocs/BJPC/bjpc0200.16u_apcd_o.pdf