

## **Unlocking the Secrets of Coding – Jill Young, CPC, CEDC, CIMC**

The deletion of consultations has had a major financial effect on practices. This presentation will show areas that offices are providing services where billing dollars are not being captured and areas they may provide additional billable services. Proper use of the “new patient” code in the office and the “admit” code in the hospital is a must. What is required in the documentation?

Time is a multifaceted concept in coding with Counseling and Coordination of Care time, Prolonged Service Time and Critical Care Time. What to document and what is included in that time is important to know in today’s compliance driven environment.

There are several services in the past 3 years that have become payable in both screening and other procedures that are presented. (ie Smoking Cessation, Patient Education )

The incentives in PQRI and E-Prescribing become dis-incentives in the near future so participation today is important. This is especially true as these efforts are combined with Meaningful Use of Electronic Health Record systems. An overview of PQRI and the schedule of incentives will be presented

Coding specific is not only compliant coding but also documents a more difficult and complex patient requiring higher level Medical Decision Making. Some common diseases are consistently under coded. What they are and how easy it is to code with specificity is shown.

### **References:**

ICD-9-CM – Volumes 1&2 Expert for Physicians - 2011

CPT 2010 – Professional Edition

Medicare IOM Carrier’s Manual – Multiple chapters -

2010 National Physician Fee Schedule Relative Value File

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – July 2009