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# The Insider News

December 2010

Volume 3, Number 1

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## Stocking Stuffers: Quick Coding Tips

Happy Holidays from GR Medical Management! This edition of The Insider News marks the beginning of its third year in production. To celebrate our success, in this edition we're providing you with "stocking stuffers": simple coding tips to support your day-to-day E/M documentation and coding.

- A chief complaint is a required element for all levels of service in all settings, including subsequent inpatient encounters.
- Medicare guidelines require the HPI component of each encounter be written by the provider: information documented by staff members can't count toward HPI.
- There are eight elements of HPI: location, duration, severity, quality, timing, context, modifying factors, and associated signs and symptoms. When determining the HPI level, elements are counted once per type. For example, documenting four "locations" only supports one HPI element.
- A complete system review is a minimum of ten systems. Per guidelines, when this has been achieved, the provider can either document each system individually, or document the positives and pertinent negatives and then indicate "all other systems negative".
- If a complete system review has not been accomplished, all systems must be individually documented.
- If stating that a complete system review has been accomplished, don't use the word "point" interchangeably with "system". A ten "point" system review refers to elements within a system (i.e., "nausea" and "vomiting" would be two points within the GI system). A ten "system" review of systems means that ten systems have been reviewed, which is the requirement for a comprehensive system review.
- Beware of the phrase "Family history: noncontributory". Auditors state that it is not clear whether the provider reviewed the family history and found it to be noncontributory, or decided in advance that it would not be relevant to the presenting problem and so did not obtain it. If the family history has been obtained, the better phrase is "Family history obtained and is noncontributory".
- ROS and PFSH from a previous encounter can be referenced in the current encounter, but only if it is referenced by the date and location of the information in the chart. For example, stating "social history unchanged" is not acceptable. Stating "system review from my note of 12/2/10 is unchanged" is acceptable.
- Exam from a previous encounter (i.e., "exam unchanged") is not acceptable and would not count toward development of the code.
- For new patient coding, all three key components must meet or exceed the documentation requirement for the level. For example, using 1995 guidelines, a minimum comprehensive exam is 8 systems. If less are documented, the code will be lower.

- In medical decision making, credit is given when history is obtained from someone other than the patient. However, the guidelines do require documentation of the information provided. For example, to state "history obtained from family" without elaborating what information is being provided is not sufficient.
- Medical decision making is based on the volume of problems and the status of those problems. When seeing a patient in follow-up for a chronic condition, always document the status of the problem (i.e., improved, at goal, not at goal, deteriorated, etc.)
- For 2011, Medicare continues to follow its 2010 guideline: consultation codes are not accepted. This means that consultation codes cannot be billed to any federal insurance program, including Medicaid, and any Medicare HMO. Consultations also cannot be billed to carriers known to be following Medicare guidelines.
- In the office, new patient encounters (and consultations, for those carrier that accept the codes), cannot be billed as a shared/split service or an "incident to" service. If a mid-level provider participates with the physician in a new patient or consultation service, the service must be billed under the mid-level's name and PIN number.
- Relevant documentation is counted toward the code. For example, if a patient is seen for a splinter in the finger, and no other purpose, a comprehensive level system review or exam would not be relevant to the presenting problem.

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### **New for 2011: Change in Nerve Block Coding**

Codes in this section of CPT continue to undergo changes. This is a summary of 2011 changes:

- Codes 64479, 64480, 64483, and 64484 are revised to include fluoroscopic and CT guidance with transforaminal epidural services
- New reporting cross-reference instructions have been added for reporting these codes as well. Be sure to review new instruction in CPT prior to reporting these codes in 2011.
- In support of the new guidelines, instructions have been added to the fluoroscopic guidance codes 77001-77003 stating that they should not be added to an injection code when fluoroscopic guidance is included in the descriptor for that code.

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### **Worker's Compensation Corner: New Reporting Regs in California**

There will be new regulations updating the Workers' Compensation Information System (WCIS) reporting requirements. As part of a 12 point plan to more closely and effectively monitor medical costs, the new rules will mandate electronic reporting of claims information to the Division of Worker's Compensation.

Additionally, the regulations, mandated by the California Division of Worker's Compensation, and which take effect on November 15, 2011, will actually increase the time for filing the first report of injury from five business days to ten. Additionally, the regs will update the two WCIS implementation guides (the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records), as well as relax certain data edits to allow easier transmission of claims data with fewer rejections. Acting administrative Director Carrie Nevans said that more accurate electronic reporting will allow DWC to identify key cost indicators in the system, and will help keep medical costs from rising the way they did in 2007 and 2008.

The new rules, which are authorized by California Labor Code Section 138.6, may be found in the California Code of Regulations, title 8, sections 9701 and 9702.

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