CMS Medicine Dish
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Dorothy Dupree:
Anpetu was'te and welcome to the February 2008 Medicine Dish broadcast. I'm Dorothy Dupree, your host, and I want to thank you for joining us today.

The topic of today's show is an important one, coding and billing for Indian healthcare providers, and starting with today's show, we will be introducing a new segment, called Nation Builders. We will talk more about this in a few minutes. Also, we will not be taking live questions today, but instead, we'll be asking our guests to respond to questions we have received throughout the past year or two. For those of you who have new questions regarding coding and billing, you can relay your questions to us by faxing them to 410-786-0123. We will post your question and answer on our Web site. That number and Web site are on the screen. Once you are on the American Indian Alaska Native Center Web page, follow the link to Medicine Dish, where your questions and responses will be posted under Today's Topic.

Coding itself is a specialized topic, and is a vital part of any facility's successful operation. It gets to the heart of the bigger picture of what actions IHS, tribal and urban healthcare facilities must take in order to receive correct and timely payments from Medicare and Medicaid. Our show today will provide an overview of how coding works, and how it fits, not only into the third-party revenue process, but also how IHS manages its overall responsibility for American Indian and Alaska Native healthcare. All this and more, in this installment of "Medicine Dish."

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Again, I'd like to welcome you to our February 2008 Medicine Dish broadcast. As I mentioned earlier, the topic today is Coding and Billing for Indian Healthcare Providers, but before we move to today's presentation, I want to introduce our segment called "Nation Builders," and take a few minutes to talk about our first interview.

The Nation Builders segment will feature tribal leaders and other principals who are involved in securing access to high quality healthcare for our Indian people. We will highlight a new Nation Builder each month, who will share his or her view about what we as people can do to protect and expand American Indian and Alaska Native rights and access to quality healthcare. We will have guests who have the perspectives and experience of tribal government leaders and professional and administrative positions. We will explore their thoughts and visions about what each of us can do in our roles to improve the health status of Indian people.

Our first segment today of Nation Builders is a very special one because it was about the vision of a very special person, Carol Ann Heart. Many of you knew personally Carol Ann, who left us much too soon. Carol Ann devoted her professional life to the cause of improving education and healthcare for Indian people throughout the country. Most of

the work that we here at CMS engaged with Carol Ann on related to health. CMS staff that got to know Carol Ann, were immediately swept up in her passion. On a couple of occasions, we were able to interview Carol Ann on camera to capture what her vision was, regarding healthcare for Indian people. We are privileged today to be able to share some of her thoughts with you. She speaks about what we all can do to improve the health care of our people and strengthen our nations.

Before going on to our video, I want to add a personal note that I was privileged to be one of Carol Ann's friends. Whenever we could, we would get together for long discussions about family, about healthcare and about the future of our people. Our many conversations helped to keep me grounded in making sure that the work that I do here had a positive impact back home. Her commitment to the way in which she approached life was not about just living and doing; it was filled with passion on all fronts. Yet, through even the most difficult times, she maintained that wonderful sense of humor that could make us all laugh and look at things differently. Your passion and your sense of humor was a gift to us all, Carol Ann. You will be sorely missed. I will miss you.

[music]

Carol Ann Heart:
I think that CMS, in order to do a better job of serving the tribes and tribal people, number one, I think they need to learn more about the tribes in their area, and I know this from experience that the State of South Dakota has a very difficult time working with tribes, and a lot of tribes almost feel like that's a broken relationship and that they almost refuse to work with the states because the states, on the other hand, also have refused to work with tribes, and so that broken relationship, I think, needs to be repaired. So in order to repair it, I think maybe CMS first of all needs to work with the states that have large populations of Indians, and maybe direct those state governments to learn more about the tribes in their state. Also, I think the tribes need to take a more action-oriented stance in attempting to also educate themselves, so that they understand what their role is, that they need to know more about CMS, to advocate on behalf of their people so that they can answer these questions and understand how to get the people enrolled, so that it is a good supplement to the Indian Health Service.

Indian Health Service really is not fully funded. I mean, if you just look at the operation of a clinic or a hospital in Aberdeen area, they say that we're only funded at 40 percent. That means you're only meeting 40 percent of the health needs of people in Aberdeen area. So then you have to switch to the Priority One system, which really isn't a way to administer healthcare. So only the Priority One needs, such as loss of life or limb, are being met. My cousin, and this is a concrete example, my cousin had a very bad pain in her stomach. You know, she didn't really quite know what it was. She went to the doctor and they gave her two aspirins and sent her home, which is like typical. We don't want to tell that story but it was exactly true, and so she went home, but it continued to hurt. She went back to emergency, again. I think they gave her a shot, sent her back home, and it turns out that she had a ruptured appendix. When it was that bad and she was, you know, in such bad pain and the appendix was ruptured, then they had to fly her to Sioux Falls,

South Dakota, where they kept her in emergency care there and long-term care, I'd say for almost two weeks after that. It took her a long time to recover.

Now if that was caught right at the beginning, and people had the education about that, and IHS just could respond to more than just Priority One, you know, we would, we would get all of our healthcare needs met in a better way. But right now, with such a limited budget, they only can administer to Priority One, and that's because IHS is under-funded, and I think that is one of the myths is that HIS and BIA are the only two Federal agencies that administer to Indians, which is not true. That the Federal government is responsible and that means all of the agencies of the Federal government have a responsibility.

So I think it's very appropriate that CMS is reaching out and helping to assist in supplementing the healthcare of IHS. But if you look at the local people that live out in Two Strike Community or Red Scaffold or, you know, they're not aware of that. And so I think the effort has to be made to educate those people to understand that there is an alternate and supplementary healthcare methodology available to them, which is CMS, and I would tell them that, if you enroll in CMS, this is going to supplement the healthcare that you presently, you know, receive from the Indian Health Service. It would also give you a little bit more money, you know, to spend on yourself so that you don't have to spend this money, you know, driving to Rapid City or, you know, buying, you know, your prescriptions or whatever that might be, and that it would prolong the life of your relatives that need to go to dialysis, you know, that sort of thing. So I would specifically tell them how it impacts them and their family and their relatives.

I think people in the Federal government, which are the Congressmen, and President Bush -- I'll say his name because he's the President -- they have no clue about Indians and they haven't been out here, they haven't seen how we live. Maybe they -- right now the big thing is casinos so now they have this red stereotype that all Indians have casinos and they make a lot of money and all the Indians are rich, right? So when they -- You know, I meet people all the time that go, “Does the tribe have a casino out at Pine Ridge?” I said, “Yeah, but it's not like Foxwood's Casino. They don’t make a lot of money and their casino is not going to support the whole tribe. You know, it's barely an economic venture in and of itself.”

So I think a lot of it is based on stereotypes, education, the lack of education that people have for Indian people, and a lack of understanding. And they don't want to go back to that time and they don't want to reimburse us. They don’t want to give the land back. They don’t want to deal with that, you know, because we did sign that treaty and we said, in exchange, they're going to give us free education, we're going to get healthcare. And we're not getting it, and they don't understand that. They don't want to live up to the treaty, either. So I think it's really a big education process and it's a constant one because when we get a new Congress, just like you guys get a new council every two years, the same way with Congress: you have to educate them all over and maybe somebody gets particularly smart in water rights or maybe somebody gets particularly smart in CMS, then they’re off the council and then you’ve got to start all over again, you know.

Well that's the same way with Congress, too, and I think it's a constant educational process to teach these people about trust responsibility, about the treaties, and about the relationship that they have with indigenous people in this country. So it's very complex.

Dorothy Dupree:
Carol Ann's words are thought provoking and inspiring. It is our hope that through this series of Nation Builders, our viewers will absorb the words and visions expressed, making them a part of what you do and working for the betterment of healthcare for our people. And now as we start today's show, let's begin to put Carol Anne's words and thoughts into actions as we do our jobs each day.

Now before we turn to the topic of coding itself, it is important for us to briefly review how IHS works with CMS programs. The Indian Healthcare Improvement Act, passed in 1976, authorized Medicare and Medicaid reimbursements for services provided through facilities of the Indian Health Service, including tribal health programs operating under Indian self-determination authorities. The original amendment to Medicare allowed payment for services provided in a hospital or skilled nursing facility. The Benefits, Improvement and Protection Act, otherwise known as BIPA 432, passed in 2000, authorized payments for services of physician and non-physician practitioners furnished in Indian Health Service hospitals and freestanding clinics that are owned and/or operated by IHS. Payment was limited to services under the physician fee schedule.

The Medicare Modernization Act, otherwise known as MMA 630, passed in 2003, authorized for a five-year period, beginning on January 1, 2005, payment for all items and services under Part B, including DME, durable medical equipment. A couple of points that I feel also need to be highlighted are as follows: section 1905 B of Medicaid authorizes the Federal Medical Assistance percentage, otherwise known as FMAP, to be 100 percent with respect to amounts expended as medical assistance for services which are received through a facility of the Indian Health Service. In other words, states are reimbursed 100% of payments made for Medicaid services provided through a facility of IHS.

Another point is the 1996 Memorandum of Agreement, which was signed between IHS and CMS, confirms that CMS will reimburse states 100 percent FMAP for Medicaid payments for services provided by facilities operated by tribes, tribal organizations, under tribal self-determination authorities.

A final note. IHS is the payer of last resort. This means that Medicare and Medicaid, which are normally the payer of last resort, will now pay before IHS pays. With this background provided, I'd like to move on to review payment history. You can see from the series of three charts, that we will display on the screen, how revenue generated from Medicare and Medicaid has grown over recent years. It's important to note that coding is vitally important to ensuring Indian health providers get paid for the correct level of services that they provide.

The first chart reflects Medicaid payments for a period of five years, from 2001 through 2005. These figures are a compilation of all state Medicaid payments for services to American Indians and Alaska Natives. The total dollar amount is greater than what the Indian Health Service would show in their records, as these charts reflect payments made for care to all Indians in Medicaid, not just those reflected in the IHS RPMS reporting system.

The second chart shows Medicare payments for 2002 through 2006 for both Part A and Part B. Calendar year 2002 was incomplete as CMS began receiving payment information from our contractor only that year. Since then, we've received payment figures for both programs. Also important to note is that this chart reflects only payments made by our Medicare contractor, Trailblazer. Not all Indian health programs utilize Trailblazer, so the actual Medicare payments to tribes, if they would be included, would exceed these amounts.

The third chart is a comparison of Medicare and Medicaid payments. It's clear that Medicaid is the program that benefits Indian health to a much greater degree.

Now let's get to the specifics of coding. Our guest today is Deanna Stops. Deanna works in the Billings area office and is presently the only certified coding instructor in the Indian Health Service. She brings a wealth of knowledge about coding and the operations of the IHS to today's Medicine Dish show.

However, before turning to Deanna, we will view a taped segment of Sheila Hammonds, who is a certified coder and has conducted training under contract with CMS to instruct students at tribal colleges and universities on coding, and to prepare them to take the coding certification exam. Sheila will provide us with an overview of coding, including a discussion of principal diagnosis, additional diagnosis, sequencing of ICD-9 codes, signs and symptoms, screening versus diagnostic, and VNE codes, and she will further comment on the future of coding.

Sheila Hammonds:
The coding and billing profession has a huge shortage of qualified coders and billers. Therefore, many tribal providers have had to learn on the job, and because of that, and because of all the billing and the coding reimbursement regulations, it is extremely important that the coders and billers, when they bill Medicare and Medicaid, that they bill properly. That ensures quality. That ensures proper reimbursement.

The basic coding steps: first select the term. That may be challenging; you may have to actually use a similar term for the condition or the disease. Sequencing is the next step, and sequencing is actually based on the principal diagnosis, and this may vary based on the condition that the patient presents with. The code selected should give an accurate reflection of the patient, as well as be documented in the records. So each code that’s selected, each term that’s selected should be documented by the provider. That gives you the complete picture or the complete formula for the documentation, plus the diagnosis will equal the ICD-9 code.

One of the most commonly asked questions is, “How do I use an ICD-9 coding book?” So we're going to discuss that. The coding books are actually divided into one to two volumes. Some coding books will have a third volume. The third volume is typically used for ICD-9 procedures; in most of the physician outpatient offices, the volume three is not used. So we will only discuss volumes one and two.

Once you've selected your main term, you're going to go to what is called the alphabetic index to verify and look at this condition or the disease. This is where you may actually have to utilize a synonym or another similar term because, for instance, if you go to pain or if you go to bleeding, you may actually not find what you need under the word, “bleeding.” Therefore, the coding book may prompt you to go to the word, “hemorrhage.” That is an example of when you have to actually think about a similar medical term that can describe the condition or disease that you're trying to locate in the alphabetic index.

Secondly, once you've identified this main term in the alphabetic index, you’re actually going to go to your tabular index, where you're going to verify the numerical code that is actually given to you from the alphabetic index.

The next step are some basic coding rules and you should always refer to the official coding guidelines that are typically published once to twice per year.

The first rule and guideline that we're going to discuss is the principal diagnosis. And you will remember when we talked about what some of the basic coding steps are, that one of the very first steps is determining the principal diagnosis. There's a uniform definition for the principal diagnosis. This definition is utilized in every setting -- in the inpatient setting, in the physician clinic outpatient setting, in ancillary services, out-patient ambulatory surgical centers, this is the uniform official definition for a principal diagnosis. Every patient should have a principal diagnosis that is going to be based on the official documentation. The definition is that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. And you can actually substitute the word “admission” for “encounter” if you are in the outpatient clinic setting, as well as “surgical procedure” if you're in a standalone, outpatient ambulatory surgical center.

I do want to talk about after study. After study can be further defined as the examination that the physician will perform on the patient. After study can mean laboratory work that may be done on the patient, as well as other ancillary services that may be performed, i.e. radiology, maybe a chest x-ray. All of that information is gathered by the physician or the provider where, once that information is analyzed, a principal diagnosis is determined. Also, the directions in the coding book may direct you to additional information to assist with selecting this principal diagnosis. Please remember that all the conditions must be clearly documented and supported in the record. It is not the coder’s or biller's job to diagnose patients. All of that information should be documented by the physician and the provider, and then this definition is applied based on what the

physician and provider has documented.

The principal diagnosis is important for a number of reasons. One of the main reasons for this definition and the principal diagnosis is that the principal diagnosis helps to support medical necessity, and as well as show quality care as well as cost analysis, and also, it's all based on accurate documentation. The principal diagnosis may not be the same as the chief complaint, and another area of confusion for coders and billers is the fact that the principal diagnosis may not be the first listed code that the physician or the provider will list on the patient charge ticket or in the patient's record. So this is where you need to verify sometimes with the physician, based on that official diagnosis or definition.

I'm going to go back to that definition. Just because a provider lists a particular condition first does not mean that it is going to meet that definition that's listed here as being the principal diagnosis. This is a time when either you, the coder or the biller, will need to verify and communicate with your provider. So please do not take the first listed code to always mean the principal diagnosis. This is where you will communicate with the provider and that provider will then go through and put number one or put an asterisk, or somehow tell you which diagnosis should be listed as principal. Also coder and billers, please remember after study could mean ancillary tasks: it may mean consultations, it may mean the examination, it may mean different medications. All of that with the physician’s documentation will determine the principal diagnosis.

Also, the principal diagnosis may not be the admitting diagnosis for inpatient coders and billers. The admitting diagnosis is the reason that the patient presents, and the admitting diagnosis is a term that is used for inpatients, but in the outpatient setting, the, a term that is similar to admitting diagnosis is the chief complaint, and we know that the chief complaint or the admitting diagnosis is what the patient presents with. It's something that is described in the patient's own words and a principal diagnosis is not, or a definitive diagnosis, is not determined until after study, and the study is completed by the physician and the provider.

Another area for basic coding guidelines is additional diagnoses. And additional diagnoses or other chronic diagnoses can be defined as, “all conditions that coexist at the time of admission or the outpatient encounter, or any condition that develops subsequently that may affect the treatment received and/or provided, and it may also require additional monitoring as well as affect the length of stay.” If these additional diagnoses have no bearing on the current clinic visit or the current admission, or if they are not documented, they should not be coded.

Resolved conditions may not be coded and this is an area where you may need to communicate more with the provider. Because some providers will document a resolved condition, but they may still be treating that condition just for that one visit. An example may be someone who has a sinus infection or maybe they have an ear infection and the physician will say this condition is resolving but I'm not going to increase your antibiotic. Once you’re completed with the one course of antibiotic, I am believing that this

condition will be resolved. But there are times when the condition is resolved and no longer exists. During these times, this is when the coder or biller can actually assign a V code, which will list a personal history of that resolved condition, and I want to refer you to the official coding guidelines regarding this.

Also, abnormal findings. These are additional conditions that can be selected. Abnormal findings should be coded. For instance, if a test is ordered, a laboratory or radiology test is ordered, and an abnormal finding is found during the performance of this test, and it is documented but the physician may not address this abnormal finding during this visit, or the patient may need to be referred out to a specialist or a consultant. These types of abnormal findings and conditions should be listed and coded. Abnormal findings may be found in the alphabetic index under findings abnormal, and there in that section, you're going to find numerous abnormal findings from just about every laboratory, as well as radiology tests that is performed on the patient.

Now once we have selected the principal diagnosis based on the documentation, secondly we have talked about all of the coexisting additional diagnoses or abnormal findings. Now we get into the sequencing of all of these codes, and the sequencing should be based on the outpatient medical case or encounter. You are always going to list the principal diagnosis first. That is going to always be the first sequence code. Other conditions that coexist are listed subsequently. For instance, all of the additional diagnoses, all of the chronic conditions, any abnormal findings, they will all be listed second, third, fourth and fifth.

All of these additional conditions should be documented. They should be treated. Also, it includes any condition or conditions that may affect treatment, that may affect the length of stay, that may require nursing intervention or monitoring.

Codes for signs and symptoms should be coded as a principal diagnosis only when there is not a definitive diagnosis confirmed by the physician. Signs and symptoms that are part of the disease process should not be coded as an additional code when the definitive condition has been documented. For example, influenza with vomiting and fever. In this example, you would only assign a code for the influenza. The vomiting and fever are actually symptoms of the influenza.

Signs and symptoms that are not usually a part of the disease process can be coded additionally. For example, in the same situation where you have a patient with influenza, vomiting, and fever, if the physician determines that this fever is not the norm for someone presenting with influenza, and they are going to perform additional workup on the fever, then yes, the coder and biller can assign an additional code for the symptom of fever.

Screening versus diagnostic tests. A screening can be defined as a patient who presents with no abnormality or symptom. The patient has no precursors, and if a screening test determines that the patient actually has the condition, then that condition can be listed as an additional diagnosis. A diagnostic test can be defined as a patient who presents with

an abnormality or a symptom. Typically, the symptom or abnormality should be coded. If the result from the tests are available at the top of coding, then the definitive diagnosis should be assigned.

I'm going to further explain the difference between the screening and diagnostic test. Again, the screening is when the patient has no abnormality, no symptom, and no precursors. Also, for screening exams, the family history V codes may be assigned if they are documented. An example of codes that are available for screening exams include screening colonoscopy code, as well as codes for screening mammograms. For diagnostic tests, an abnormality or symptom should be documented to support the medical necessity of performing the diagnostic test. If during this time a definitive disease is documented, then the code for the definitive disease should be assigned.

Abnormal findings. Abnormal findings for conditions or symptoms are appropriate, again, when there's no definitive diagnosis that has been determined by the provider. The abnormal findings may be after an ancillary test is performed. It may be, actually, only an abnormal finding that is documented as a result from this test. Again, the way you find abnormal findings is to go to the alphabetic index under "findings, abnormal." The abnormal finding may also support medical necessity for the performance of any additional diagnostic tests that may be performed on the patient.

V codes. Let's talk about V codes. V codes are one of the more difficult codes to actually find and locate in the coding book. There is not a specific V-code section in the alphabetic index. I've listed some terms that you can actually go to in the alphabetic index that will direct you to V codes. Some of these terms are the word “admission,” “examination,” “history,” “observation,” “aftercare,” “problem,” and “status.”

V codes are considered supplementary codes. They can be sequenced as a principal diagnosis. The official coding guidelines give specific times and examples of when a V code may be sequenced as a principal diagnosis. I would refer you to the official guidelines, but I am going to discuss some of those examples here. For instance, if a patient is receiving aftercare, a V code may be assigned. If the patient is receiving chemotherapy or radiation therapy, as well as dialysis, if that is the main reason for that patient encounter, then a V code would be appropriate to be assigned as a principal diagnosis. Also, for admission for observation and evaluation, as well as some screening exams, as we have already discussed. These are times when a V code could be appropriate as the first-listed or the principal diagnosis.

E codes. E codes are considered external causes for injuries, as well as poisonings, accidents. E codes actually provide data for research and injury prevention at the state, local and national levels. And an E code actually describes how the injury or poisoning occurred or the adverse event occurred.

The E code also describes how it occurred, where it occurred. And E codes can never be listed as a first listed code. They should be sequenced after the principal or first-listed diagnosis code. And the E codes actually provides additional information for all of the

800 and 900 Series codes. It answers the how, why and where.

Let's talk about the difference between follow-up versus aftercare. The official definition for follow-up is when a patient is being seen for continued monitoring of a completed treatment or disease. The patient has been fully treated and the condition no longer exists. This is a time when the coder or biller may actually assign a V code for that visit. Aftercare can be defined when the patient has a condition or disease that is in the healing phase, and the condition may be present or a sequela, or a late effect of the original condition may be present.

In summary, I have discussed some of the basic coding rules that will help any coder, any biller, at any level. Remember the definition for the principal diagnosis. Remember the difference between follow-up versus aftercare, as well as the differences between a screening versus a diagnostic test.

In addition, when talks about the future of coding, there are some things you should know as a coder. Some of these things, you could consider this to be your toolbox. One of the things is to make sure that you stay up-to-date on medical terminology. We've discussed some terminology as it pertains to coding for surgery and procedural reports, but make sure you stay abreast of medical terminology. Have a knowledge of anatomy. Have a knowledge of pharmacology.

Coders and billers should also have computer skills, as well as analytical skills. And most importantly, have a desire to stay abreast of the changes in the coding and billing profession. Remember, continuous training is the key. I would refer you to CMS's Web site for additional training opportunities.

Dorothy Dupree:
Welcome back. As mentioned earlier, Sheila has provided coding training through CMS arrangements with our Tribal College and Universities Initiative. However, many IHS coders may realize that they must tailor their learning to fit the IHS environment, as responsibilities at the local level may differ from those of the private sector. We will now turn to Deanna for a discussion about IHS and coding.

Deanna, what are the essentials of coding?

Deanna Stops:
Thank you, Dorothy. The essentials to Certified Medical Coding is the Indian Health Service process and the compliance plan. Certified coding promotes integrity and professionalism to the billing and coding staff. Every diagnosis, procedure, and supply is coded according to the ICD-9, CPT, and HCPCS guidelines. Codes are written or verified directly on the patient encounter form or in the Electronic Health Record. It communicates and educates the provider by enhancing documentation in data integrity.

Dorothy Dupree:
When I look at coding and I see the thick books that coders have to refer to to get the

codes for anything that is done to that patient, how does Indian Health Service or maybe, more specifically, the billings area, since that's the area that you're from, how does the billings area support training for the coders? Because that's a lot of information to absorb. And I would think that there has to be some ongoing training type of program that must be instituted.

Deanna Stops:
Well, it's very important for the coder to be able to communicate with the doctor, have a little bit of experience in physical anatomy, medical terminology, and in other health-related areas, so that they could better understand what the provider is documenting in the record. And then take that abstraction from his documentation and go to your coding books and look up these codes and apply them to those particular codes.

Dorothy Dupree:
But in order to become familiar, you mentioned terminology, for example, to be familiar enough with the terminology. Is there training that is provided for the coders so they become familiar with medical terminology? Is that part of the educational process or is that on-the-job training?

Deanna Stops:
Dorothy, most of the time coders and billers receive that training on the job. They start to get interested in medical coding or they're asked to make copies for billers and coders or providers, and then they start picking up on the documentation. And then when they're wanting to learn more, what they do is they go to the local colleges and they maybe get official medical terminology. They maybe take physiology or any of the healthcare-related types of classes. Once they get that, they feel comfortable going in there and looking through the medical documentation, providing that information back, and even talk to providers, ancillary providers, and ask them, "When you do this, what does this mean?" And then they go to the books, look them up in the index. That's how I learned. That's how I was exposed to medical coding, is that I went in there and just learned on the job and then started receiving your training at the local colleges.

Dorothy Dupree:
The other thing that I'm curious about are your providers. What type of education or activity or engagement do the providers have with the billing effort and the coding effort?

Deanna Stops:
Providers actually play the biggest role with coders and billers. When we say "providers," for Indian Health Services, we mean physicians, we mean contracted physicians, nurses, all the ancillary staff, and mid-levels as well. Because their documentation is necessary for us to be able to provide a code for all the services that they're rendering to patients. Documentation has to meet legal Indian health care and billing requirements. Documentation is completed in a timely manner so that everything comes together.

Appropriate documentation includes ENM, Evaluation and Management Coding Requirements, of history, exam, and medical decision-making. Also documented are the are the supplies, the labs, and the x-rays that were ordered and the meds prescribed by those physicians. Documents are also documented in various types of forms: PCC plus, PCC form, and the Electronic Health Record. The providers must follow the PIN, UPIN, or the NPI requirements, the National Providers Identifiers requirements. The key point is that providers must document, and they must document everything they're doing for a patient.

Dorothy Dupree:
And whose responsibility is it, then, to ensure that the type of documentation that they're putting into the medical record is good documentation, so that when the coders extract that information and assign a code, that they're assigning the right code for the type of service that's provided? Is there a function or how is that qualify, I guess, quality assurance provided.

Deanna Stops:
With that, the coders must communicate with the providers and interact with them when they see documentation that is not clear or can mean more than one specific diagnosis. So, they cannot code for the physician, but they review his documentation, talk to him, and make clarifications for the notes that he has on the record. And then, once they have that understanding, they go to the book and they apply abstract, that information, to the codes and then apply them. So the physician and the coder, or biller, must interact and communicate when they're not understanding something or something isn't clarified.

Dorothy Dupree:
Okay, thank you. Another area is regarding chart reviews. Can you tell me a little bit about that?

Deanna Stops:
The responsibility of the chart reviewer is to ensure that all of the documentation that is required is present: that it's documented on the encounter form or the Electronic Health Record and it is complete, according to the preset guidelines. Such as, accurate clinic codes, visit types, vitals are listed, correct providers are documented, chief complaint and purpose of visit or diagnosis; they're present. It also communicates and educates the provider in enhancing the documentation and then, data integrity. Incomplete and inaccurate encounter forms, the Electronic Health Record notes, are returned to providers prior to going on to the next step of coding. That's important. Otherwise, we have deficient health summaries, deficient medical -- current medical listings.

Dorothy Dupree:
I guess it's always interesting to me, if a coder is looking at the medical chart, and they can always go back to the provider, you said, to ask questions. But how do they gauge whether that information is something they need clarification on? I mean, to me, I would be sitting there reviewing and just trying my best to assign a code, I would imagine, not knowing the codes myself. But at -- what guidance do the billers have, that at this point

is when you go talk to the provider? Or is there? Is it just a judgment call?

Deanna Stops:
Well, you would review the complete record for that visit. You would look at the physician's tests that he ordered, the medications he ordered. You would look at his diagnosis code, his purpose of visit that he's listing. And then when you're reviewing the record, you bring that all together, and you say, okay, if he ordered this lab, it is not relevant to this diagnosis code. So then you would go back and you would ask him, you know, you ordered this test, is it relevant to this code? Or were you thinking of another code? And then, or another illness that the patient may have. The coder does go and look at the whole health record. You go and look at the health summaries, the past visits, and you go and see if he's already previously diagnosed the patient. And then, you can bring that forth.

But when it's not clear, you must go back to the physician and ask him if this is what he meant. So you have to communicate that back and forth. And a lot of times it is the coder's call, or the biller's call, when to query. According to the Coders' Ethics, when you look at documentation, it is your responsibility to query the provider in order to provide all of the necessary codes to that visit.

Dorothy Dupree:
Okay. Thank you. The other question I have, you talk about medical records. You've mentioned PCCs. And then we have the billing office. How is all of that integrated?

Deanna Stops:
Well, the link is always to documentation. The documentation is linked to medical records, who keeps the records on file in a safekeeping, organized manner. Legality and continuity of care is coming from that medical record chart. PCC and the Electronic Health Record, that's where our statistics come from for Indian Health Service, for tribes and the urbans. And then, of course, the billing requirements in the business office. All of that documentation has to support all of our reports all of our diagnosises [sic] and our billing.

Dorothy Dupree:
Let's talk about billing.

Deanna Stops:
Billing is the area where -- it's the checkpoint, and it validates the accuracy of the coding. You have to know and apply all the billing requirements, the rules to each individual claim, before it's approved. Sequencing and linking is appropriate for the diagnosis and procedures to ensure the correct payment and the maximum payment. Billing also approves and submits claim bills to third-party payers, so we don't have to pay any money back. When they go through, they're not requesting additional information. They look at the codes, everything's in sync, and it tells the story of that patient visit. So they're paid and the money is then part of the third-party resource.

And it also serves as the final checkpoint. We only -- That we're only billing for documented services and that we're only billing for services that can be supported by that documentation. So it's the final checkpoint, and it also keeps our agency from being put at risk.

Dorothy Dupree:
With regard to billing, I recall a conversation, or several conversations in the past, that I've had with people from TrailBlazer. And I'm sure you've been in many conversations with people from TrailBlazer, since that's what you do. They have often said that coding training is so vital, they cannot do coding training. They do billing training. So from a layman, that I am, in understanding billing and coding, explain the difference.

Deanna Stops:
When we use the word "coding" in Indian Health Service, and that is my true reflection there, because that's where I've worked, we look at the provider documentation. The provider goes through, selects the appropriate ICD-9 or disease code, and he puts it down and he orders his test and then goes through the whole history, exam, and medical decision-making for that visit. Well, then he will document all of that. Data entry or data capturing will go in and look at his, either documentation or in the Electronic Health Record, what he has documented. And then they ensure that those codes are correct. So then, that's coding. The billing requirements include the coding and include the provider. However, we don't bill for every patient that we -- the provider sees.

So, for Medicare or for Medicaid or any third-party resources, and we'll use TrailBlazers. We look at how TrailBlazers, what they cover, and the requirements that they expect claims to come through on, and what is required as far as a referring provider, an MPI number, a service that's professional service versus a facility charge. And so they train us on the billing process because they know that that's what we see when we really monitor and audit the codes because we're look that more in depth, because we're providing another process to that coding segment. So, we carry it over, and then, again, the billing area ensures those codes are correct. So they validate everything.

So Medicare, again, has a specific way of billing. So, in order to do that, we have to be trained on their process. Because if it isn't done in their process, with their guidelines, then we don't receive money on Medicare claims. They will reject the claim and then we have to rework them.

Dorothy Dupree:
Okay. So your coding staff and the billing staff are two different functions? Or do you have them performed by the same staff?

Deanna Stops:
That is a question that is in the process -- in some areas in Indian Health Service -- as being separate duties. Where they have the Electronic Health Record, they have a coding cue, where a coder, the data entry person, would go in and they would review all of that documentation. And what they would do, is then ensure those codes are correct. And

they would list everything, you know, all of the procedure codes, not just the ICD-9, but the CPT and the HCPC codes. And once they do that, that visit is complete. Then when it crosses over to third party, if there's an alternate resource there, then the biller has to have knowledge of coding, has to have to same knowledge as the data entry people, but there's two separate components. Because they capture that data from statistics and the overall cost of that visit. And in third-party billing, we only look at alternate resources that those apply to. So, you see where I mean that the coding and the billing is separate, but yet they're together, because they cross over.

Dorothy Dupree:
Okay. Great. Thanks. You mentioned the billing. And what comes to my mind is electronic billing.

Deanna Stops:
Okay.

Dorothy Dupree:
And I know IHS has implemented electronic billing package. And I don't recall how long ago that was, but a question that comes to my mind, with regard to electronic billing, is whether or not that's applied for -- I know it's applied for Medicare, because we've dealt with a Medicare electronic billing issue before. Does it also apply to Medicaid? And so if it does apply to Medicaid, if it does, is it acceptable by all states in the form that it's transmitted from IHS?

Deanna Stops:
Yes, it is. Especially when HIPAA came into play, big time. We had to modify all the reason codes and we had to make them all HIPAA-compliant because Medicaid receives all of the claims electronically. And then -- But when you resubmit for an error or duplicate or additional information, then those can go out on paper. But initially, all the claims go out electronically and then payment is received electronically.

Dorothy Dupree:
Okay. Thank you. I have another question with regard to Electronic Health Records. You mentioned the Electronic Health Records. I know that Electronic Health Records is a big push from the department level by the Secretary. It's highly encouraged, that that's where we're going as a nation is to Electronic Health Records when it comes to healthcare. I'm also aware that IHS already has Electronic Health Records.

Deanna Stops:
Yes.

Dorothy Dupree:
And could you give me a little bit of background on that? I mean, do you know how long they've had Electronic Health Records? And how is it working?

Deanna Stops:

Well, you know, I can give you some background on that. I don't have official timelines. But I do recall back in, probably, oh, maybe five years ago, they were looking at the VA system. And they initially utilized their program and modified it to the RPMS software. And then they started incorporating Electronic Health Record. And I think Wind River was -- Wyoming was the first facility to use the Electronic Health Record, and then it just branched out. And they were beta testing, and then it branched out and then other areas were using it. And I think all of our six reservations are using it in Montana. Some of them are 100 percent providers; most of them are, there are a few that aren't, and they're still working at getting providers on.

But the big thing with that, is that you have to get your providers to utilize the Electronic Health Record, and it's computerized, so they have to get used to putting those notes in there. And sometimes it is -- You've got some providers that have been there a long time and that are not really used to that electronic or that IT kind of process. And then you have newer providers, where they think it's great and they're buying into it and they're just ready to learn it. So there's a learning curve there and we're still going through that. But it is very helpful. And I really enjoy it. It takes less search for the chart, the actual medical record, when the patient has come in for multiple visits that day.

Dorothy Dupree:
I would think so.

Deanna Stops:
They could also -- You can just pull that record up right there and it's there. It's very convenient for the physician and for the coders.

Dorothy Dupree:
Yeah. I know that in the discussion that I've been involved in with regard to the Electronic Health Record, there's often reference to the VA. And you just referenced the VA yourself. It would be wonderful. I mean, know that the health record -- and Indian Health Services, as well, it would be wonderful to get that information transmitted, too. And maybe that's something that we can begin doing here at CMS, is to highlight that IHS is fully vested in Electronic Health Record. I think it would be really a good thing. Because I think that's a real positive because that's the way the rest of the country is going and, hey look, IHS is already there, and I think that's wonderful.

Deanna Stops:
It is great to feel like you're staying up with the private industry. It really is good to feel that way for our Indian Health Services.

Dorothy Dupree:
I have one last question, and this is for the benefit of those in the viewing audience who may be interested in going into the field of coding. I mean, clearly, we need certified coders in Indian Health and in Indian country in general. Sheila, in her presentation, went over some of the training that coders need. But if you could tell me, from your perspective, what would a coding individual, or person who's interested in coding, need

to do -- what steps do they need to accomplish, in order to become a certified coder.

Deanna Stops:
Well, first of all, I think that, if they're working already for Indian Health Service, tribes or urbans, I think they need to let their supervisor know, so they can get in there and get some on-the-job training, where they would go in there and work with providers and look in that PCC encounter forms or just get familiar with it, because really, they really need to be strong in medical terminology. They need to have physiology and anatomy. They have to be able to look at or be knowledgeable in pharmacology, because all of those tie in together because you're going to see every one of those in an office setting and definitely in an inpatient setting.

So, and if they're not in the Indian Health Service or currently working in a business office department, I think they should try to go to the website and look at actually attending a certified coding curriculum course. And it actually runs, oh, they vary, 9 weeks to 16 weeks. Or Indian Health Service has been known to put on 3-4 week crash course where you go to a conference room in a classroom-type setting and attend it for 3 weeks straight. Then you review the last week and you sit for the national exam. But that's a lot of really, really in-depth and intense type of training. And again, it just depends on the individual and how much study they put into it and how much work they put into it.

Dorothy Dupree:
Well, thank you, Deanna. I want to thank Deanna for all the useful information that she's been able to provide us today. We're at the end of our Medicine Dish hour, and I want to thank you, our audience, for watching our broadcast on coding and billing for Indian Health Providers. I hope you find this information useful, as well. Before we close today's show, I want to tell you about a special program that we'll be broadcasting on March 19 from 1 to 3 p.m., Eastern Time, on care-giving. You can find a copy of the announcement on our CMS Web site.

The program is designed to provide information to health care-givers in rural settings. We all know how important family and community are to American Indians and Alaska Natives. So this show will be important to help us understand what resources are available and how we can provide the best care for our elders.

I also want to take this opportunity to remind you that our Medicine Dish broadcast will be on March 12, and that it will be a special presentation by IHS on the resources available to you through the Offices of Resources, Access, and Partnership, otherwise known as ORAP.

I also want to remind you that you can access previous broadcasts of our Medicine Dish programs at the NIH Web site. Instructions are on the screen. Thank you and I hope you enjoyed and benefited from today's Medicine Dish hour. I'm Dorothy Dupree, your host, wishing you a very productive day.

[Music]

[End of Transcript]