FORESIGHT

Optometric Documentation & Coding Consultants

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June 2017

How to Become a Documentation Expert

I attended a meeting in Fort Worth, Texas a couple weeks ago. During a conversation with some colleagues, I was asked, “How did you become a coding expert?” My first thought was, “Expert?! That sounds a little braggadocious, but I suppose I am.” And then my response was the same one that Dr. Charles Brownlow told me when I asked him the very same question several years ago, “I read the book.” That really means I read the one document and keep handy the two books that contain nearly all the answers. If you continue reading and follow the advice below, you too could achieve every little kid’s dream and be a Medical Record Documentation Expert!

I may sound crazy, but I’m about to tell you where I get all the answers that people pay me to provide. That’s right, state associations have me on a monthly retainer, an EHR company hired me as a consultant, and several optometrists send me checks directly, and all I do is look up the answers in these three references. Why would I tell you how I pull the rabbit out of the hat? Because the real purpose of what I do is to empower and teach fellow optometrists the rules they are required to follow, to keep them out of trouble, and to allow them to care for their patients.

Step 1: Read the 1997 Documentation Guidelines. This document contains the details of what needs to be included in your medical record. It tells you what a Reason for Visit is, how to grade a history, what elements of the physical exam are graded, and how to grade the Medical Decision Making. This is all the information you need to grade the 99000 E&M office visit codes. It is a 51-page document, but you only need 18 pages of it (pp. 1-12, 25, 26, and 46-51). You could read it over lunch…seriously.

Step 2: Order a current set of the AMA CPT reference and a current ICD-10 book. Every year there are small changes, so you always want to be working out of the current version. Each book is less an $100, and if you can avoid just one rejection and resubmission because of a poor code choice, it was worth the money. These books are also important because they not only include the proper procedural codes and diagnosis codes, but they contain the information you need to use them. For example, if you look up 92014, it tells you this is a “Comprehensive Ophthalmological Service – established patient,” but if you look at the beginning of this section, it gives the definition of these services and what they require. If you look up a diagnosis in ICD-10, it tells you things like, “Requires a 7th digit,” “These codes ‘*Exclude* XXXXXX’,” and “Use additional external cause…”

Step 3: Another very useful tool is the physician fee schedule search on the CMS site, http://go.cms.gov/1j3QI9Q. From here, you can find Medicare reimbursement rates for all the regions or the national average, global periods, relative value units…all great stuff!

With these three steps, and occasionally googling a Local Coverage Determination (LCD) to see which diagnosis codes match with a CPT code, you can answer almost all your documentation and coding questions. Of course, there are things like when to combine certain modifiers, or, how to code unrelated services during a global period that can be a little tricky, but all the answers are there.

As audits from Medicare and other third-party payers continue to become more common, it is crucial that all physicians become very comfortable with the national rules. If an auditor asks why you billed a comprehensive ophthalmological service for a patient, you need to be able to point to the definition within CPT and say, “This is why. I took care of the needs of the patient and followed the standards of care set forth by my profession and state laws. Once the care was provided, the chart was graded based on the documentation. As you can quite clearly see, it very nicely matches the definition of that code within the only reference book available. Any questions?” And then you drop the mic.

The alternative to understanding these rules and knowing where to look them up puts you in a very vulnerable position. Answers like, “I used that code because I always billing a 99213 for IOP checks,” or, “It had been a year so I billed a comprehensive,” or, “Look at that diagnosis! How could it not earn at least a 99214?” will ultimately not end in your favor. The best defense is always a good offense. Know the rules before you must defend why you didn’t follow them.