Master the Art of Dental Coding: Unlocking the Power of Accurate Documentation to Get Claims Paid

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Welcome to the Webinar!

What you will learn in this Webinar

In this webinar, we will delve into the essential principles and best practices of dental coding and clinical documentation. You will learn how to accurately code dental procedures and diagnoses, ensuring compliance with the latest coding guidelines and regulations. This session will also cover strategies for improving clinical documentation to support accurate coding, reduce claim denials, and optimize reimbursement. By mastering these skills, you will enhance the efficiency of your healthcare practice, mitigate financial risks, and contribute to better patient care through precise and thorough oral healthcare records.

THE KEY TAKEAWAYS FOR THE WEBINAR

- **What Is Dental Coding?**
- **Importance of Documentation for Dental Coding**
- **Proving Medical Necessity with Documentation**
- **How Coding Fits Into The Revenue Cycle**
- **Importance of Auditing Revenue Cycle Workflow**

The Background

WHAT IS DENTAL CODING?
WHAT IS THE IMPORTANCE OF CLINICAL DOCUMENTATION?

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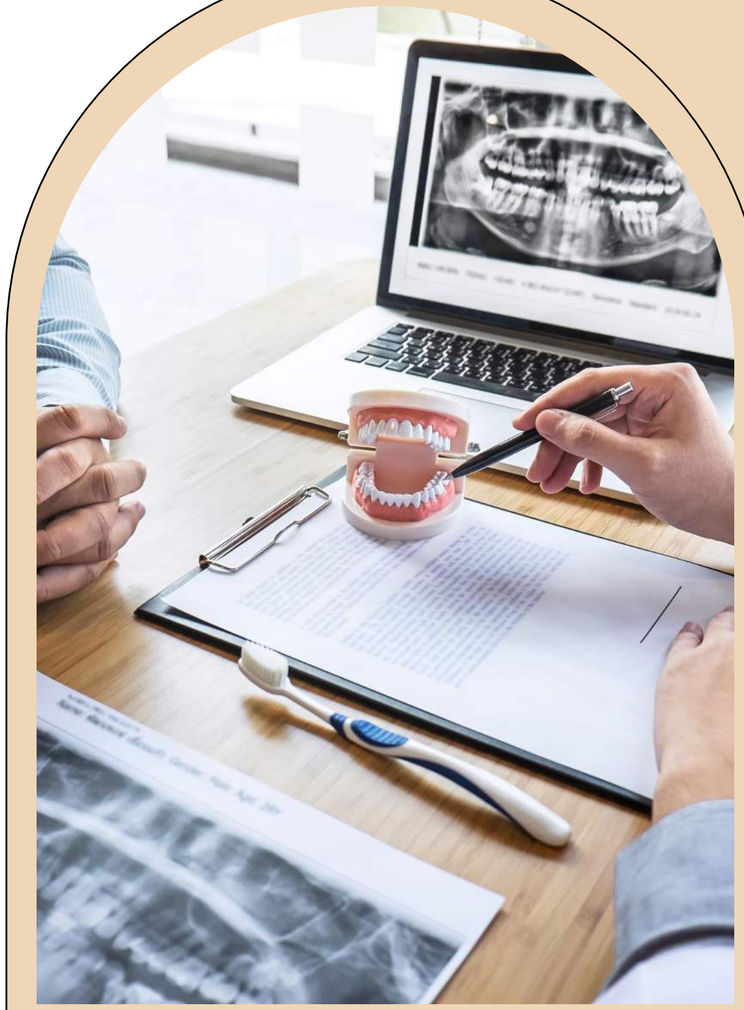


Dental coding is the transformation of oral healthcare diagnosis, procedures, and services into universal alphanumeric codes. The diagnoses and procedure codes are taken from dental record documentation. The American Dental Association (ADA) has developed a comprehensive set of guidelines for dental coding known as CDT (Current Dental Terminology). The CDT manual is updated annually.

Importance of Dental Coding

ACCURATE REIMBURSEMENT

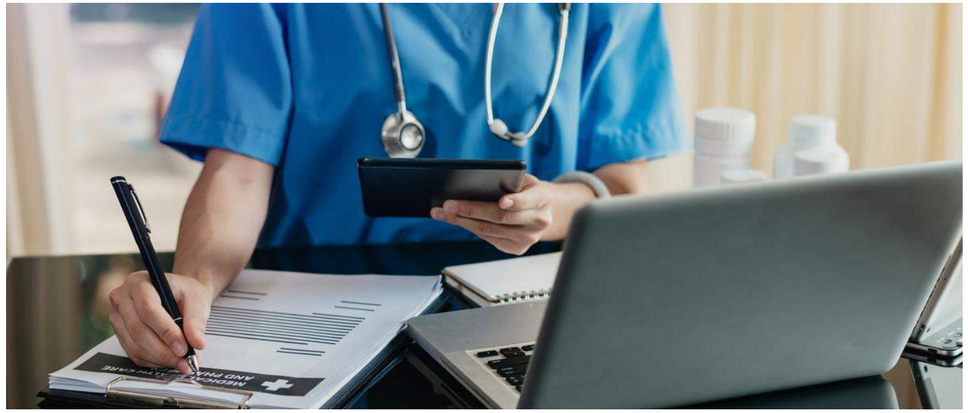
COMPLIANCE

COORDINATION OF CARE

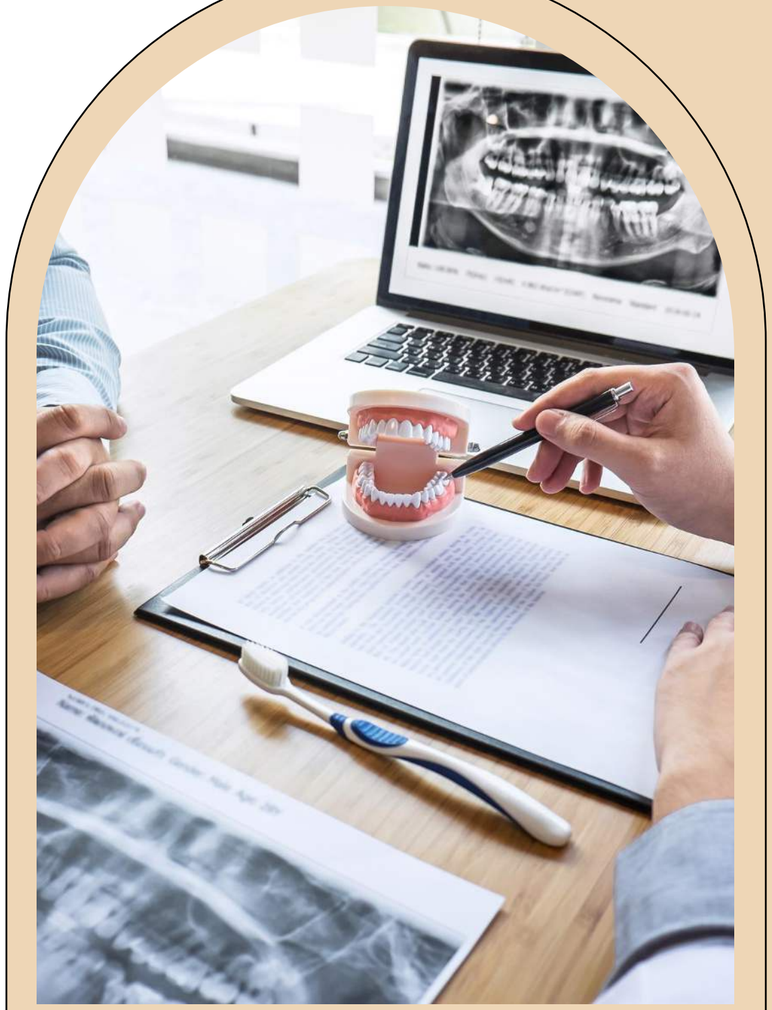
DATA COLLECTION

PATIENT CARE

QUALITY REPORTING

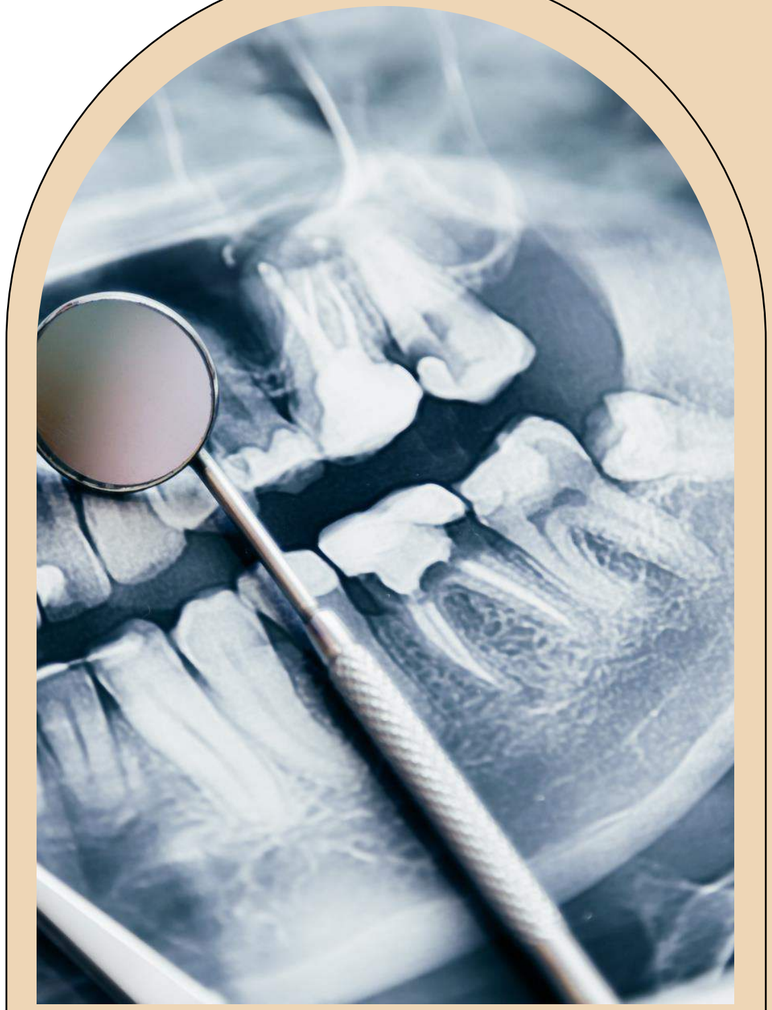


Dental coding is crucial in the healthcare industry as it ensures accurate reimbursement for services, maintains compliance with regulations, and streamlines the billing process. It enhances patient care by providing clear and consistent records and supports efficient resource allocation within healthcare facilities and dental practices. Additionally, accurate dental coding facilitates data collection for research, public health, and policy-making, while also aiding in quality reporting and performance measurement. By improving communication among healthcare providers, payers, and stakeholders, dental coding plays a vital role in the overall efficiency and effectiveness of healthcare delivery.



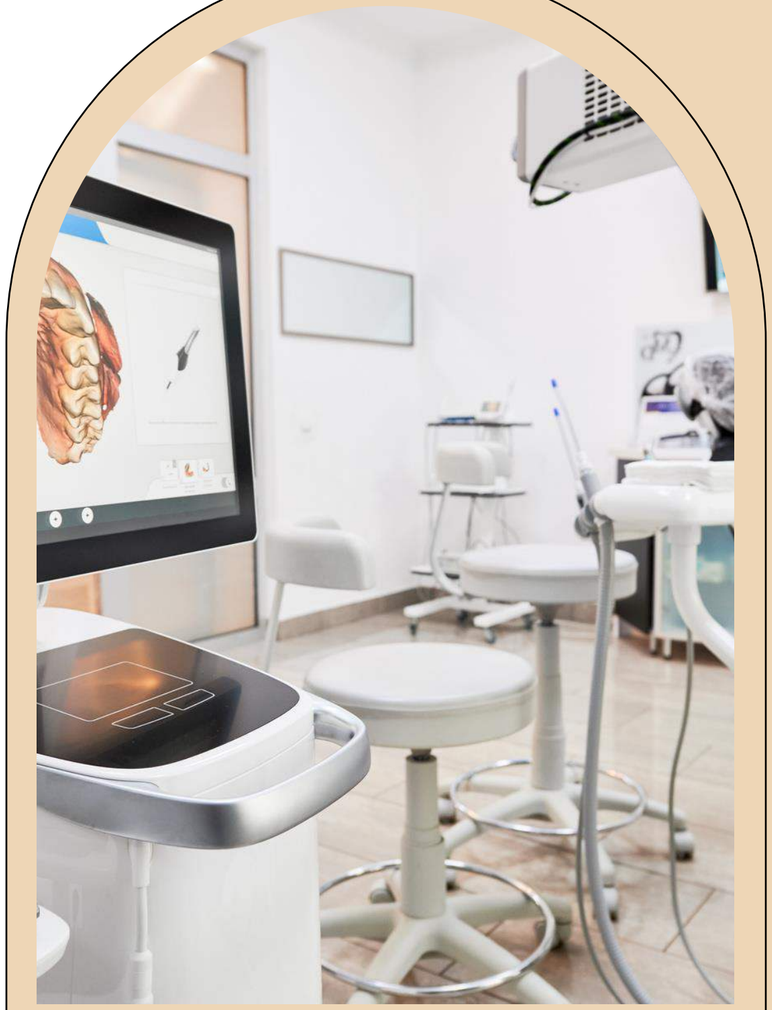
Dental billing and coding are important components of the healthcare revenue cycle. They involve two main processes: the translation of oral healthcare services into billable codes and the preparation and submission of claims to insurance companies for reimbursement. Coding is central to the revenue cycle, which spans from patient registration to receiving payment for services.

Dental Revenue Cycle



Steps to Dental Coding, Claims Submission and Follow Up:

1. Document thoroughly
2. Identify the procedure
3. Consult the CDT (or CPT) code set
4. Match the procedure to the code
5. Check for code updates
6. Consider specifics and modifiers (if applicable)
7. Verify with insurance provider any narrative or attachments required for claims submission
8. After submitting claim, review rejection report to ensure claim was accepted with payer
9. Follow up on claim until paid, responding to any notices from the payer
10. Consult colleagues or resources
11. Stay educated



How to Maximize Reimbursement:

1. Keep up to date with federal and your state's laws and rules
2. Read your insurance contract carefully
3. Detailed verification of benefits
4. Use correct codes
5. Submit adequate documentation and attachments with claim submission
6. Review rejection report
7. Scrutinize EOBs for errors
8. Appeal denials for medical necessary treatment (Use positive language)

Coding Guidelines and Resources

Dental Coding Resources

CDT MANUAL

ICD-10-CM MANUAL

HCPCS MANUAL

CPT MANUAL

SPECIALTY REFERENCE MANUALS

CODING COMPANIONS, ONLINE RESOURCES

Medical Coding Code Sets

CDT® (Current Dental Terminology)

CDT® codes are owned and maintained by the American Dental Association (ADA). The five-character codes start with the letter D and used to be the dental section of HCPCS Level II manual. Most dental and oral procedures are billed using CDT® codes.

ICD-10-CM (International Classification of Diseases, 10th Edition, Clinical Modification)

ICD-10-CM includes codes for anything that can make you sick, hurt you, or kill you. The 69,000-code set is made up of codes for conditions and disease, poisons, neoplasms, injuries, causes of injuries, and activities being performed when the injuries were incurred. Codes are “smart codes” of up to seven alphanumeric characters that specifically describe the patient’s complaint to the highest level of specificity.

Medical Coding Code Sets

HCPCS Level II (Health Care Procedural Coding System, Level II)

Developed originally for use by Medicare, Medicaid, Blue Cross/Blue Shield, and other providers to report procedures and bill for supplies, HCPCS Level II's 7,000-plus alphanumeric codes are used for many more purposes, such as quality measure tracking, outpatient surgery billing, and academic studies.

CPT® (Current Procedure Terminology)

This code set, owned and maintained by the American Medical Association, includes more than 8,000 five-character alphanumeric codes describing services provided to patients by physicians, paraprofessionals, therapists, and others. Most outpatient services are reported using the CPT® system. Physicians also use it to report services they perform in inpatient facilities. Here's a little behind the scene on the making of CPT® codes.

Importance of Documentation

WHAT IS THE IMPORTANCE OF CLINICAL DOCUMENTATION?

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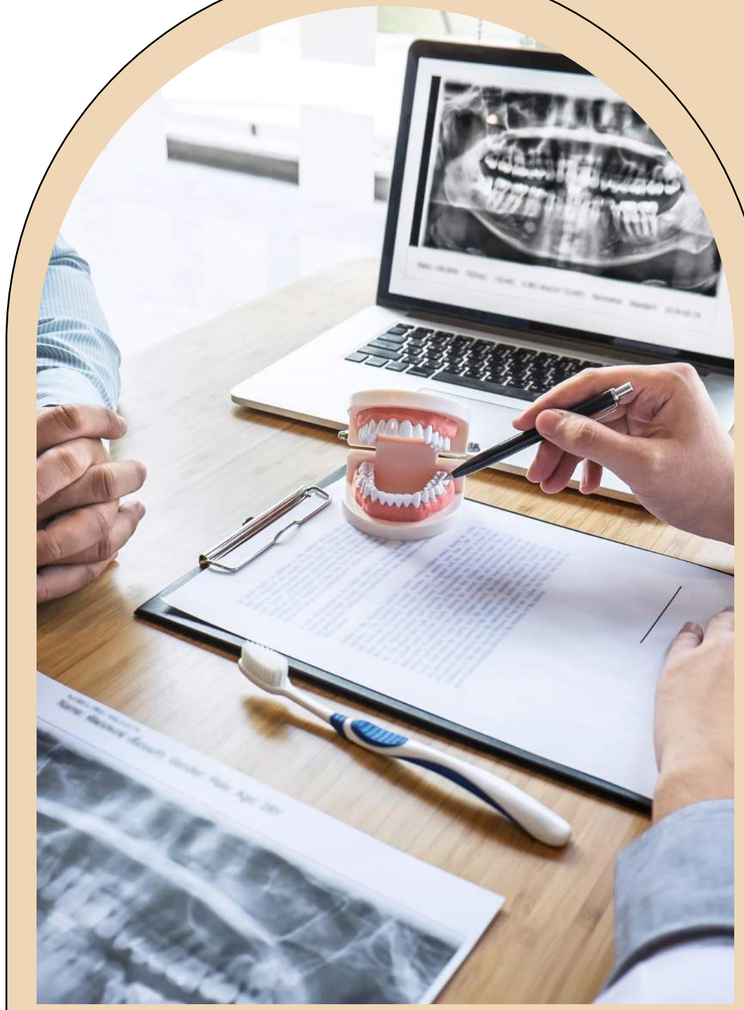


"Documentation is a cornerstone of quality healthcare, providing a roadmap for patient care and ensuring continuity and accuracy in treatment."

Importance of Documentation

CONTINUITY OF CARE

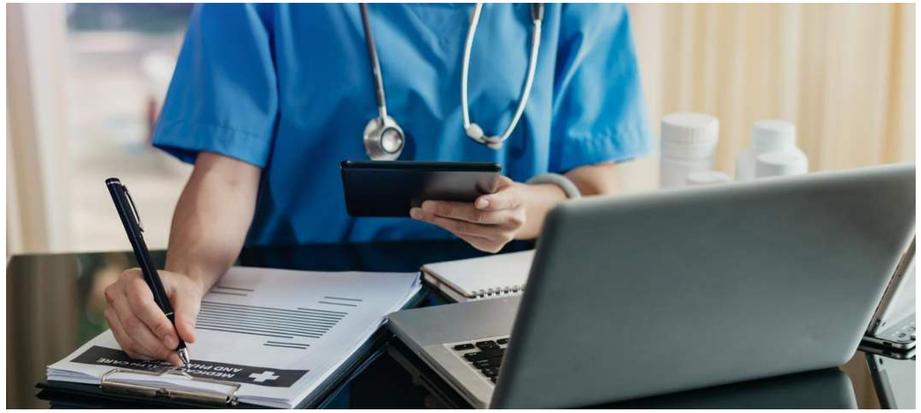
LEGAL PROTECTION

REIMBURSEMENT

COMPLIANCE

RESEARCH AND EDUCATION

QUALITY IMPROVEMENT



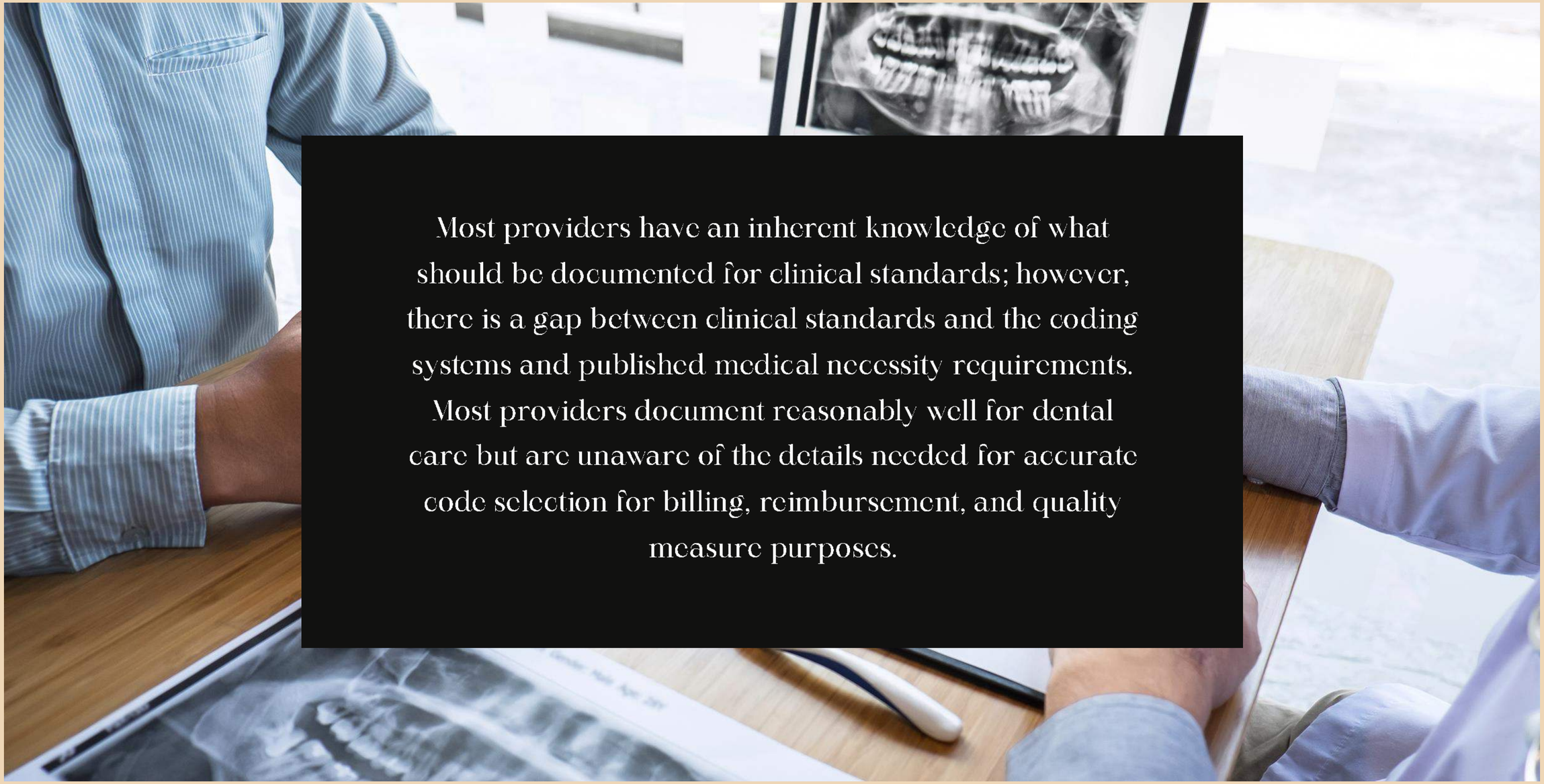
The importance of clinical documentation for providers goes beyond just patient care. It plays a crucial role in many key aspects of healthcare delivery. Thorough and accurate clinical documentation is essential for providing high-quality care, protecting providers legally, ensuring proper reimbursement, and driving continuous improvement in healthcare delivery.

Documentation

Documentation tells a story of why the patient needs to be seen and the impression or decision for next steps.

All pertinent discussions/findings/summary of counseling should be documented in order to assist with supporting the service.

Documentation is essentially a provider’s “Proof of Thought”



Most providers have an inherent knowledge of what should be documented for clinical standards; however, there is a gap between clinical standards and the coding systems and published medical necessity requirements. Most providers document reasonably well for dental care but are unaware of the details needed for accurate code selection for billing, reimbursement, and quality measure purposes.

Medical Necessity

Medical Necessity

One of the most important requirements to receive payment for services is to establish medical necessity. You must justify care provided by presenting the appropriate facts.

Payers require the following information to determine the need for care:

1. Knowledge of the emergent nature or severity of the patient's complaint or condition.
2. All signs, symptoms, complaints, or background facts describing the reason for care.
3. The facts must be substantiated by the patient's healthcare record, and that record must be available to payers on request.

For example, a patient complains of pain in her UL molar (#15) and the provider performs an x-ray which shows extensive decay requiring an onlay. When the claim is submitted, the payer needs to know why the service was performed. The narrative on the dental claim (diagnosis code on the medical claim) will indicate the reason or the medical necessity of the procedure.

Introduction to the SOAP Note

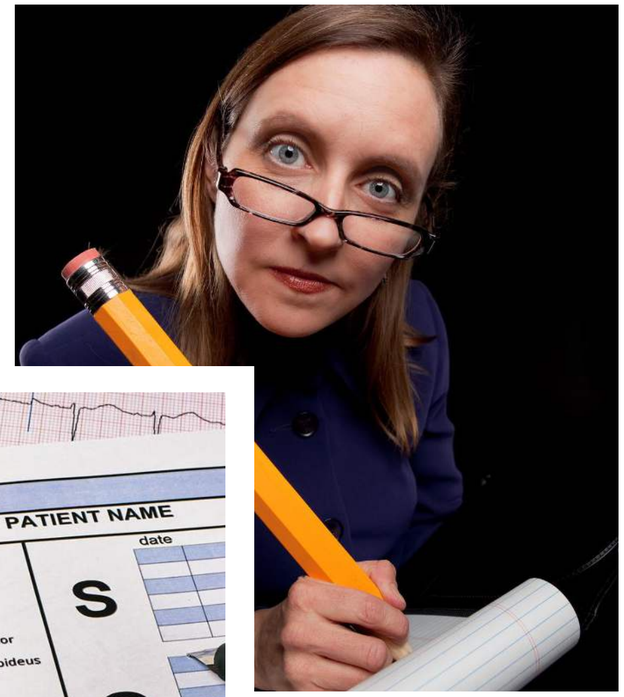
WHAT ARE THE VARIOUS ASPECTS OF THE SOAP NOTE?

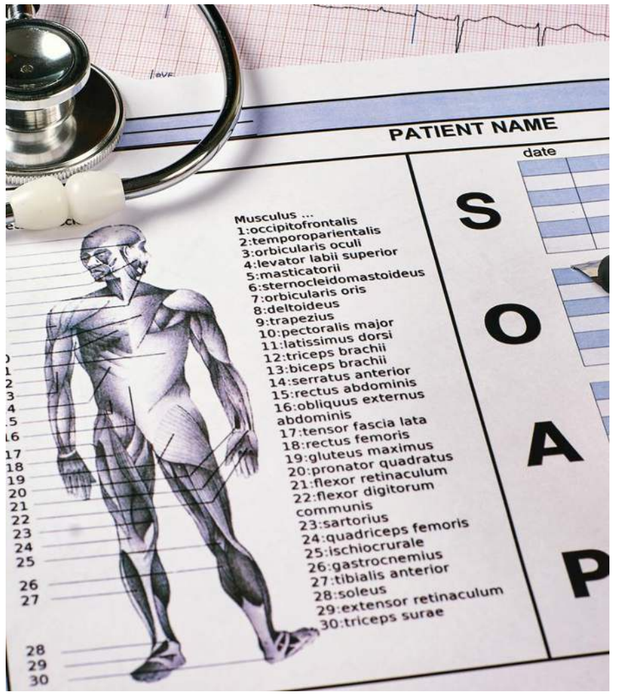
What Exactly Is A SOAP Note?

A SOAP note is a method of documentation used by healthcare providers to write notes in a patient‘s medical chart. The acronym SOAP stands for:

S = Subjective: Information provided by the patient, including symptoms, feelings, and concerns.
O = Objective: Measurable data gathered during the physical examination or diagnostic tests.
A = Assessment: Provider's professional assessment of the patient's condition, including a diagnosis if available.
P = Plan: Proposed plan of action for further evaluation, treatment, medications, follow-up, or referrals.

SOAP notes are structured to ensure a systematic approach to documenting patient encounters, allowing for clear communication among healthcare team members and supporting continuity of care.





SUBJECTIVE - Documentation Tips

- Key tips for effectively documenting the Subjective section include:
  - Use the patient's own words - Document the patient's description of their symptoms or concerns to provide a clearer understanding of the patient's experience.
  - Be thorough and specific - Capture all relevant details including onset, duration, intensity, and character of symptoms which can assist in making an accurate assessment.
  - Include pertinent negatives - Note important symptoms that the patient denies having, which can be as critical as the symptoms reported to help rule out certain conditions.
  - Chronological order - A sequence of events provided by the patient may help in understanding the progression of the condition or complaint.
  - Record patient's concerns and expectations
  - Include lifestyle factors - Dietary habits, physical activity levels, alcohol and tobacco use, stress levels - as these can impact health.
  - Use open ended questions - Encourages comprehensive responses.
  - Review with patient and clarify.

OBJECTIVE - Documentation Tips

- Physical exam findings, vital signs, laboratory results, imaging studies, and other diagnostic data
- Key tips for effectively documenting the Objective section include:
  - Be precise and detailed - Document specific findings and results, including exact measurements, locations, and descriptions.
  - Record vital signs - Provides critical information about patient's current state.
  - Describe abnormal findings - Clearly identify any abnormalities observed during the examination and provide a detailed description of the findings.
  - Include relevant normal findings
  - Document diagnostic test results - If tests are pending document that as well.
  - Use chronological order when documenting a series of tests over time to show trends or changes in patient's condition.
  - Review and update as new data becomes available or as the patient's condition changes.
  - Maintain objectivity - This section should be free from subjective interpretations or assumptions, only documenting what is observed or measured.

ASSESSMENT - Documentation Tips

- Ask yourself:
  - Does my documentation clearly delineate my “Proof of Thought”
  - Have I provided a plan of action for every assessment provided
  - Are there outside determinates complicating my assessment
  - Does my documentation use Uncertain Diagnosis descriptive words when documenting my assessment (i.e. probable, suspected, likely, consistent with, etc.)

PLAN - Ties it All Together

- Outline a specific treatment plan to include any of the following:
  - What happened as a result of you seeing the patient?
  - Further investigations
  - Treatment options
  - Referrals for procedures or additional treatment
  - Prescription drug management
  - Prescribed therapies
  - Patient education
  - The frequency the patient is to be seen in follow-up.

Note: This hints at the severity of the problem. A patient not returning for a year likely has a less complex condition than one who is seen frequently. It could indicate a condition is stable.

Providers should consider incorporating the SOAP format into their documentation practices for several reasons:

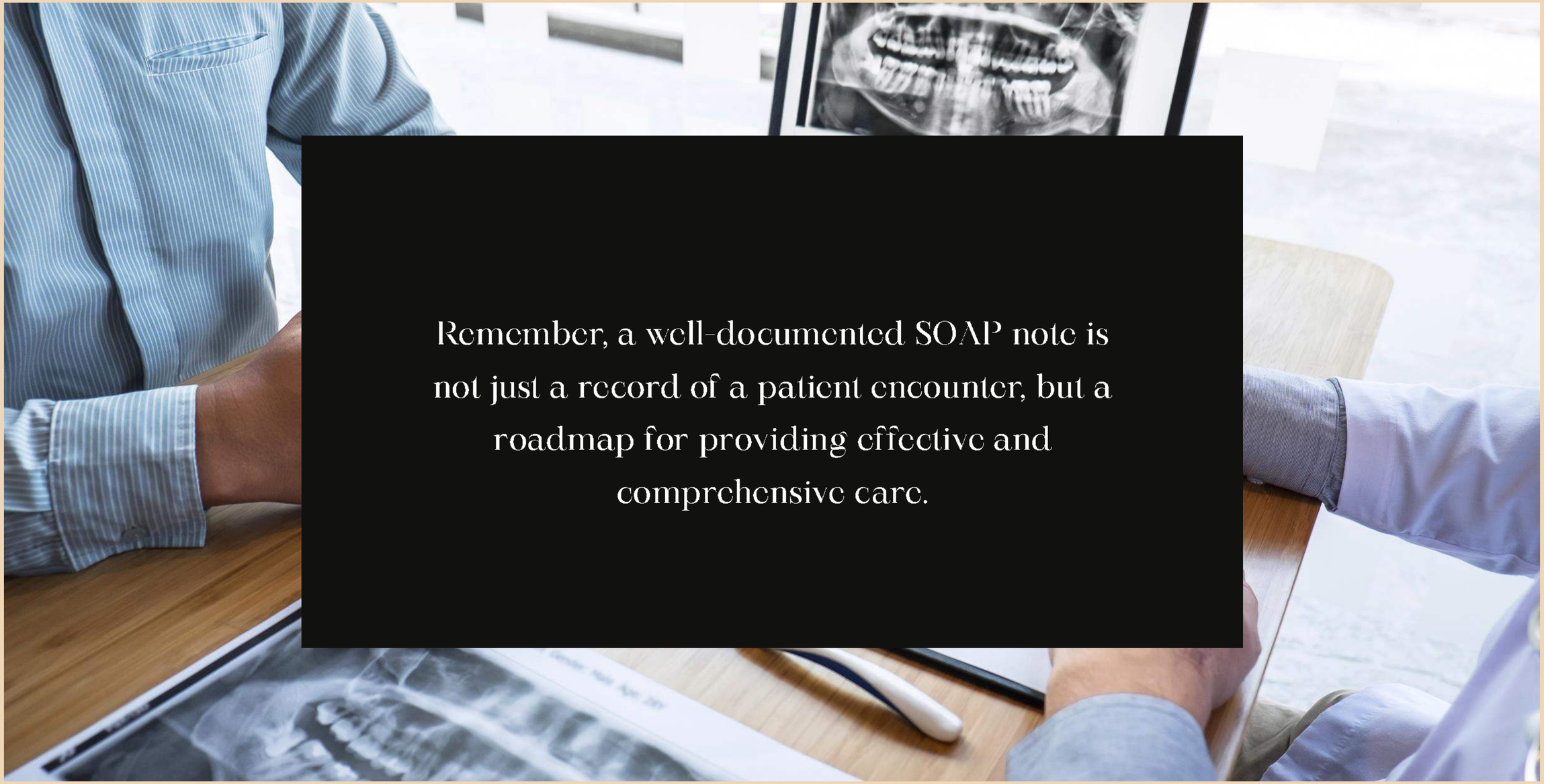
1. Structured Organization: The SOAP format provides a systematic framework for organizing patient information, ensuring all relevant details are captured in a logical sequence.

2. Comprehensive Assessment: By following the Subjective, Objective, Assessment, and Plan structure, dentists can conduct a thorough evaluation of the patient's oral health status and treatment needs.

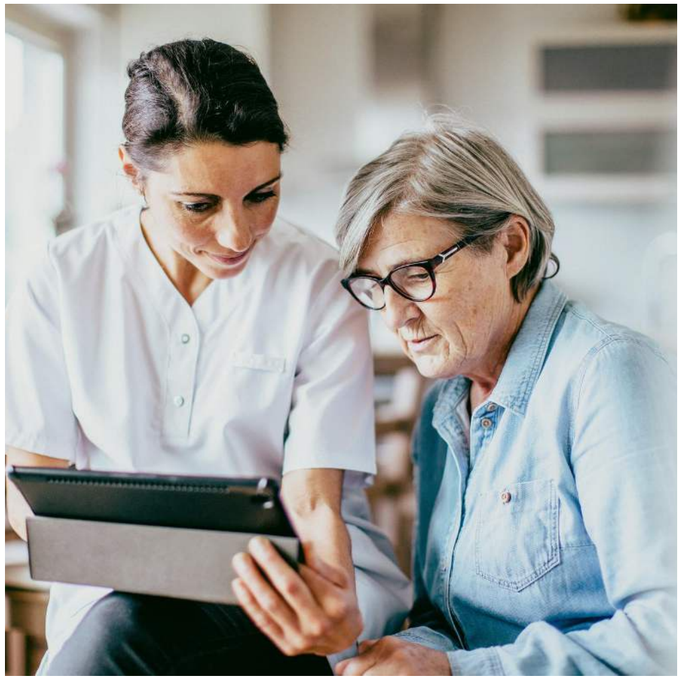
3. Clear Communication: Using the SOAP format facilitates effective communication among dental team members, promoting a shared understanding of the patient's condition and treatment plan.

4. Clinical Decision-Making: The structured nature of the SOAP format helps dentists analyze patient data, make informed clinical decisions, and tailor treatment plans accordingly.

5. Legal Protection: Proper documentation in the SOAP format serves as a detailed record of the care provided, which can be essential for legal protection case of disputes or malpractice claims.


Remember, a well-documented SOAP note is not just a record of a patient encounter, but a roadmap for providing effective and comprehensive care.

Auditing Operations



Auditing

It is essential to audit every aspect of operations, including the revenue cycle, to ensure accuracy, compliance, and efficiency. Regular audits help identify and rectify discrepancies, optimize processes, and maintain adherence to regulatory standards. By thoroughly auditing all operational areas, organizations can enhance financial performance, reduce risks, and improve overall operational integrity and accountability.

An auditor's responsibilities include:

• Review of the record for documentation to support the CDT, CPT, HCPCS Level II, and ICD-10- CM codes selected, and the coding and billing processes, after the claims have been submitted.

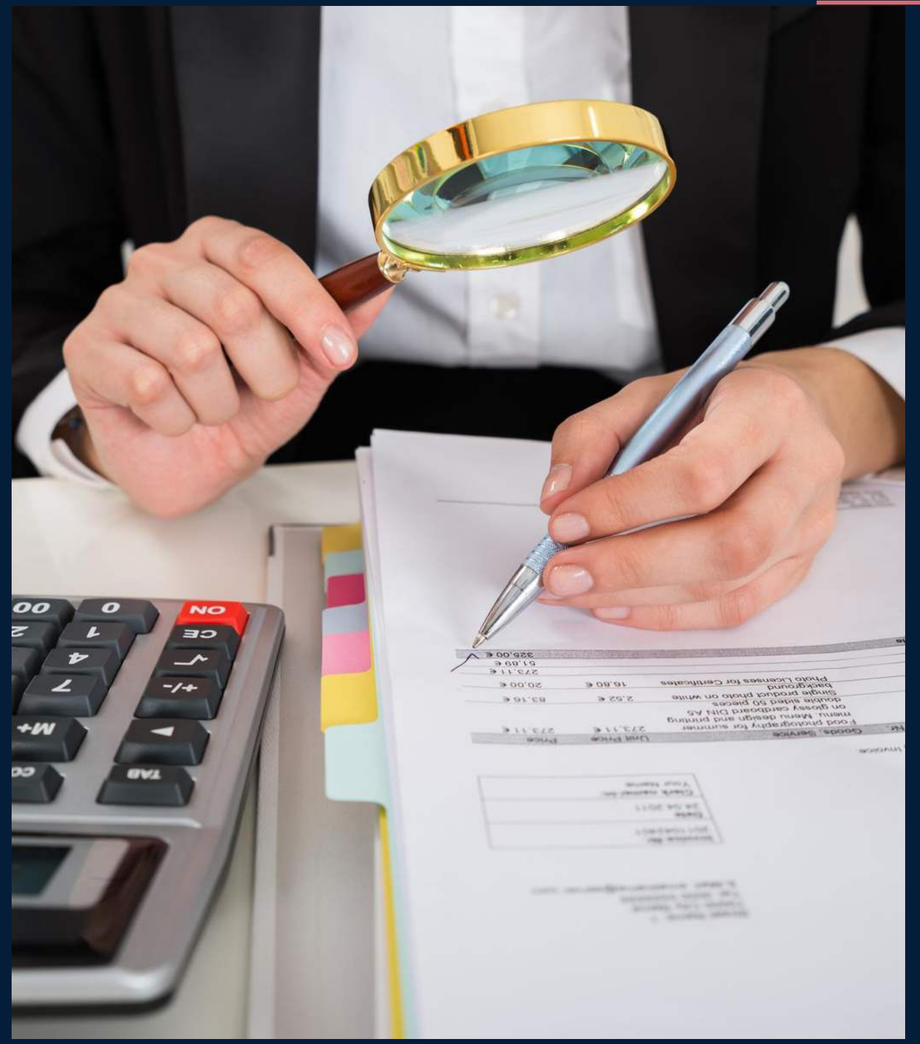
• Routinely run frequency reports for code utilization compared to national, state, or specialty benchmarks.

• Develop reports related to the audit findings.

• Identify coding and documentation deficiencies that cause financial impact (overcoding or undercoding).

• Analyze data for missed charges.

• Provide education based on audit findings to the staff and providers.



Case Studies

SAMPLE CASE STUDIES TO REVIEW
DOCUMENTATION DO'S AND DONT'S

Case Study 1

Missing Documentation

> If you did not document it, it did not happen.

The Charting Mistake

John Doe visited ABC Dental Practice for a routine check-up and minor dental work. Over the course of several visits, Dr. Smith performed various treatments, including fillings, extractions, and a root canal. However, Dr. Smith did not properly document procedures performed, the materials used or the patient's response to treatments.

John Doe started experiencing severe pain and complications which led to a second opinion. The new dentist discovered issues, including infection and a missed canal. Due to the lack of detailed records from ABC Dental, it was challenging to determine origins and specifics of the treatments previously administered, complicating the new dentist's plan to provide effective treatment. As a result of redoing treatment, John Doe's insurance denied the claims from the new provider, leaving John Doe with a high out of pocket expense.

The Result

John Doe sued ABC Dental Practice for medical negligence, arguing that the lack of documentation prevented timely and accurate diagnosis and treatment of his dental issues. He claimed the failure to document treatments properly directly contributed to the complications and extensive corrective work needed. John Doe sought compensation for medical expenses, pain and suffering and of lost income due to missed work.

Case Study 2

COPY AND PASTING INACCURATE INFORMATION

The Charting Mistake

Two patients in a practice were seen back-to-back. A dental assistant copied and pasted notes from Patient A into the chart of Patient B to save time, forgetting to go back in and edit the note when the provider ran over in the procedure room. Dr. Smith left immediately after treatment for an important meeting. The inaccurate documentation was used to submit a claim to Patient B's insurance.

The Result

The billing team relied on the inaccurate documentation to submit the claim to the payer. When the radiograph and narrative did not support the medical necessity of the code billed to the payer, the claim was denied. As a result, the patient received a denial EOB from the payer which caused him to lose trust in the office team. The practice had to addend the note and resubmit the claim, requiring additional resources and time.

Your Takeaway

Avoid copying and pasting information into another patient's chart. Providers should ensure documentation is signed off on prior to submitting the claim for adjudication.

Case Study 3

Not Documentating As Soon As Possible

The Charting Mistake

A clinician didn't enter a note into the patient's chart until several days after the visit. The delay meant that another clinician, who was treating the patient in the meantime, prescribed them a potentially dangerous medication.

How It Happened

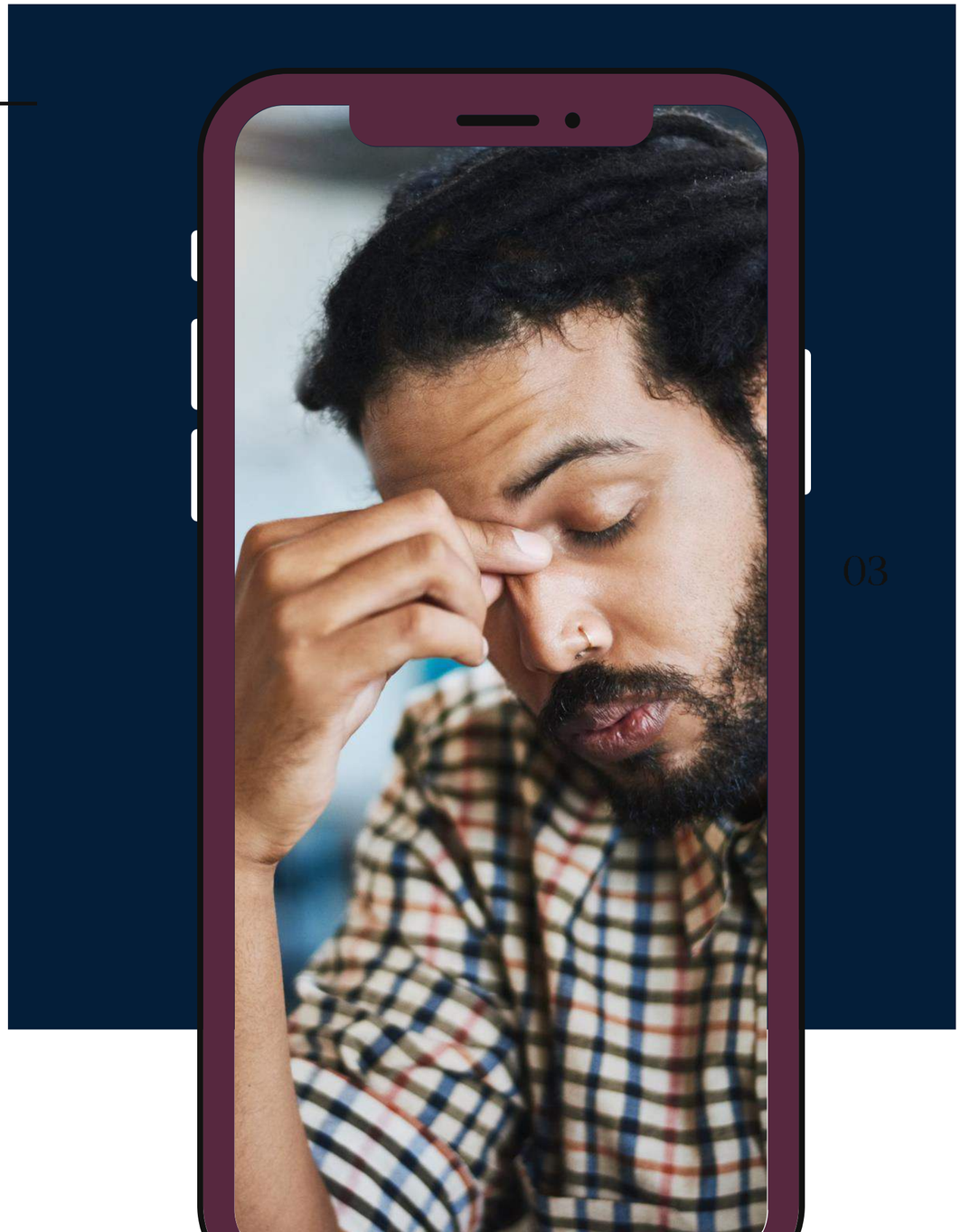
After seeing a patient just before lunchtime, the clinician got sidetracked and didn't record his notes in the patient's chart. Four days later, the clinician returned to work after a long weekend and noticed his mistake. He added his notes but backdated them so they would be associated with the day the patient was seen.

The Result

During the patient's initial visit, the patient described experiencing symptoms that were possible reactions to a prescribed medication. Because the first clinician didn't enter his notes the day the patient was seen, the second clinician to care for the patient over the long weekend didn't know about the possible reaction and prescribed the very same medication.

Your Takeaway

Input the patient data as soon as you can. If life happens and there's a delay between seeing the patient and inputting your documentation, follow your organization's guidelines on changing the reference date in the EHR. Even if the time you enter the note is hard-coded into the system, associating the note with a previous date of service may confuse (or even mislead) other clinicians who rely on your notes to decide and administer care. Starting the note with a quick "Late Entry," followed by the date and time of the patient contact, can help avoid any confusion.



In Closing...

Dental and medical coding, documentation and charting may not be the most glamorous part of the job for providers. However, it is very important. It serves as a critical foundation for ensuring high-quality patient care, driving reimbursement, facilitating effective communication among healthcare team members, and safeguarding legal and ethical standards within the practice. Moreover, accurate and detailed documentation supports the continuity of care across different healthcare settings and providers, enables the tracking of a patient's progress over time, and plays a pivotal role in healthcare billing and reimbursement processes. While it may seem tedious, the effort invested in meticulous charting pays dividends in enhancing patient outcomes, reducing the likelihood of errors, and ensuring a smoother healthcare delivery process. Therefore, embracing documentation as a fundamental aspect of patient care is essential for all healthcare providers, as it ultimately contributes to the overall well-being of the patients we serve and the efficiency of the healthcare system at large.

Q&A

ASK ME ANYTHING!

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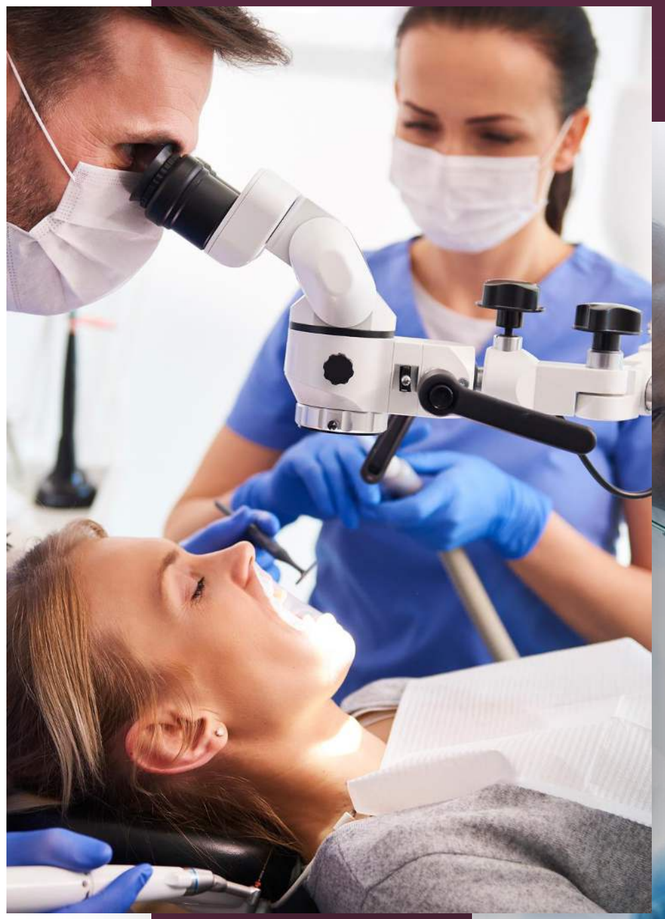
Evaluation & Management Services (E&M)

HOW DO AUDITORS USE THE AUDIT TOOL TO EDUCATE PROVIDERS ON E&M DOCUMENTATION GUIDELINES?

E&M Services

The E/M section consists of:

- Office visits (exams)
- Hospital inpatient
- Observation care visits
- Consultations



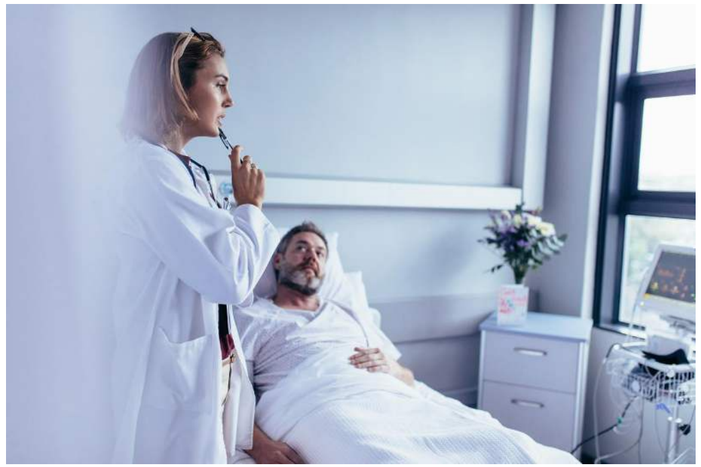
Levels of E/M Services

Level of Service

01
MDM

02
Time

Medical Decision Making



01

Amount & Complexity of Problems Addressed

02

Data to Be Reviewed & Analyzed

03

Risk of Complications and/or Mortality or Morbidity

Medical Decision Making Table

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable, chronic illness; **or** • **1** acute, uncomplicated illness or injury **or** • **1** stable acute illness **or** • **1** acute, uncomplicated illness or injury requiring hospital or observation level of care	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** o Review of prior external note(s) from each unique source*; o Review of the result(s) of each unique test*; o Ordering of each unique test* ***or*** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**

Medical Decision Making Table

Moderate	**Moderate**
	• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• **2** or more stable chronic illnesses;
	or
	• **1** undiagnosed new problem with uncertain prognosis;
	or
	• **1** acute illness with systemic symptoms;
	or
	• **1** acute complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 from the following**:
		  • Review of prior external note(s) from each unique source*;
		  • Review of the result(s) of each unique test*;
		  • Ordering of each unique test*;
		  • Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

Medical Decision Making Table

High	**High** • **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** o Review of prior external note(s) from each unique source*; o Review of the result(s) of each unique test*; o Ordering of each unique test*; o Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Medical Decision Making

Table A: Number and/or Complexity of Problems Addressed	
Minimal	❑ 1 Self-limited or minor problem
Low	❑ 2+ Self-limited or minor problems ❑ 1 Stable chronic illness ❑ 1 Stable acute illness ❑ 1 Acute uncomplicated illness/injury ❑ 1 Acute uncomplicated illness/injury requiring hospital Inpatient or observation level of care.
Moderate	❑ 1+ Chronic illness w/ exacerbation, progression, or treatment side effects ❑ 2+ Stable chronic illness ❑ Undiagnosed problem w/ uncertain prognosis ❑ Acute illness w/ systemic symptoms ❑ Acute complicated injury
High	❑ Chronic illness w/ severe exacerbation, progression, or treatment side effects ❑ Acute/chronic illness/injury that poses threat to life or bodily function

Medical Decision Making

Table B: Amount and Complexity of Data to be Reviewed and Analyzed

Category 1

- ❑ QTY:____ Review of prior external note(s) from each unique source
- ❑ QTY:____ Review of the result(s) of each unique test
- ❑ QTY:____ Ordering of each unique test

Independent Historian (IH) (Category 2 for Limited; Category 1 for Moderate/High)

- ❑ Assessment requiring independent historian(s)

Category 2

- ❑ Independent interpretation of a test performed by another physician/other QHP (not separately reported)

Category 3

- ❑ Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)

Total	**0 or 1**	**1 of 2**	**1 of 3**	**2 of 3**
	❑ 1-Category 1 or less	❑ 2-Category 1 ❑ IH	❑ 3-Category 1/IH ❑ 1-Category 2 ❑ 1-Category 3	❑ 3-Category 1/IH ❑ 1-Category 2 ❑ 1-Category 3
Data Level	**Minimal or None**	**Limited**	**Moderate**	**Extensive**

Medical Decision Making

Table C: Risk of Complications and/or Morbidity or Mortality of Patient Management		
Minimal	☐	Minimal risk of morbidity from additional diagnostic testing or treatment Examples: Rest, gargle, elastic bandages, superficial dressings
Low	☐	Low risk of morbidity from additional diagnostic testing or treatment Examples: Minor surgery w/o identified risks, PT/OT therapy, IV fluids w/o additives
Moderate	☐	Moderate risk of morbidity from additional diagnostic testing or treatment Examples: Prescription drug management Decision regarding minor surgery with identified patient or TX risks Decision regarding major elective surgery w/o identified patient or TX risks Diagnosis or treatment significantly limited by social determinates of health
High	☐	High risk of mortality from additional diagnostic testing or treatment Examples: Drug therapy requiring intensive monitoring for toxicity Decision regarding elective major surgery w/ identified patient or treatment risk factors Decision regarding emergency major surgery Decision regarding hospitalization Decision not to resuscitate or to de-escalate because of poor prognosis

Medical Decision Making Calculation

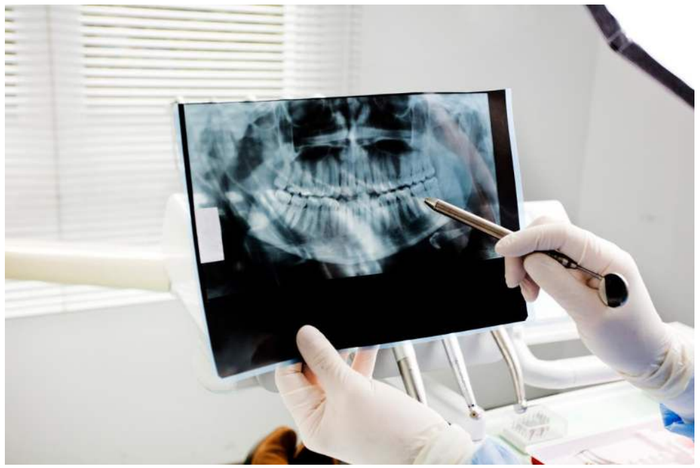
Medical Decision Making

Final Results of Tables A, B, C = Level of Medical Decision Making (MDM)

- **Must consider 2 of the 3 MDM elements for the overall MDM level**
  - **Use any two components that meet or exceed**
  - **Drop the lowest one**

Table A	Number/Complexity of Problems Addressed	Minimal	Low	Moderate	High
Table B	Amount and/or Complexity of Data to be Reviewed and Analyzed	Minimal or none	Limited	Moderate	Extensive
Table C	Risk of Complications and/or Morbidity or Mortality of Patient Management	Minimal	Low	Moderate	High
MDM Level		Straightforward	Low	Moderate	High

Time Based Documentation Guidelines



**Total Time spent ON DAY OF ENCOUNTER. Please refrain from using “approximately.”

** Includes both face and non-face to face time.

**Time spent by ancillary staff does not count. Only time spent by Provider is billable.

- Preparing to see the patient such as reviewing the patient record
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate history and examination
- Counseling and educating the patient, family, and/or caregiver
- Ordering prescription medications, tests, or procedures
- Referring and communicating with other health care providers when not separately reported during the visit
- Documenting clinical information in the electronic or other health record
- Independently interpreting results when not separately reported
- Communicating results to the patient/family/caregiver
- Coordinating the care of the patient when not separately reported

Time Table

Code	Description	MDM	Time
99202	New patient office or other outpatient visit	Straightforward	15 mins must be met or exceeded
99203	New patient office or other outpatient visit	Low	30 mins must be met or exceeded
99204	New patient office or other outpatient visit	High	45 mins must be met or exceeded
99205	Est patient office or other outpatient visit	Straightforward	60 mins must be met or exceeded
99212			10 mins must be met or exceeded
99213	Est patient office or other outpatient visit	Low	20 mins must be met or exceeded
99214	Est patient office or other outpatient visit	Moderate	30 mins must be met or exceeded
99215	Est patient office or other outpatient visit	High	40 mins must be met or exceeded
99417	Prolonged service (used with 99205)	-	75 mins or longer
99417	Prolonged service (used with 99215)	-	55 mins or longer

Medical Coding Modifiers

A medical coding modifier is a two-character code (letters or numbers) that is added to a CPT or HCPCS level II code to provide more information about a medical procedure, service, or supply. Modifiers can be used to describe special circumstances, such as the anatomical location of a procedure, or if a procedure was more complicated than normal. They can also be used to indicate that not all services in a bundle were performed.

There are two types of medical coding modifiers:

- CPT Modifiers: These modifiers, copyrighted by the AMA® and updated annually, typically consist of two digits. They convey essential information for claims, such as whether multiple procedures were performed, the necessity of a particular procedure, the site of the procedure, the number of surgeons involved, and more.

- HCPCS Modifiers: HCPCS Level II modifiers, copyrighted and updated by the CMS, are alphanumeric, with the first character being a letter. Like CPT modifiers, they provide additional information about a procedure or service without redefining the nature of the service provided.

Medical Coding Modifiers

Modifier 22: Increased Procedural Services

- Modifier 22 is used when a procedure requires additional work beyond the usual level of effort and complexity. This modifier is used to justify the need for increased reimbursement due to the extra time, skill, or difficulty involved in performing the procedure. When appending modifier 22, it is essential to provide sufficient documentation that supports the additional work performed.

Modifier 25: Significant, Separately Identifiable Evaluation and Management (E/M) Service by the Same Physician on the Same Day

- Modifier 25 is frequently used when a physician provides a separate and distinct E/M service to a patient on the same day as another procedure or service. This modifier allows providers to be reimbursed for both the procedure and the E/M service, as long as the E/M service was significant and separately identifiable. By appending modifier 25 to the E/M code, it indicates that the E/M service was beyond the usual preoperative and postoperative care associated with the procedure.

Modifier 26: Technical Component (TC)

- Another commonly used modifier is Modifier 26, which indicates that only the professional component of a service was provided. This modifier is primarily used when the technical component, such as the use of equipment or facility, is provided separately by another entity. By appending Modifier 26, healthcare professionals can indicate that they are billing only for their professional services, separate from the technical component.

Medical Coding Modifiers

Modifier 50: Bilateral Procedure

- When a medical procedure is performed on both sides of the body during the same session or encounter, modifier 50 is used to indicate that it was a bilateral procedure. This modifier ensures that providers receive appropriate reimbursement for the additional complexity and resources required when performing a procedure on both sides.

Modifier 51: Multiple Procedures

- Modifier 51 is used to indicate that multiple procedures were performed during the same session or encounter. It alerts the payer that the provider should receive a reduced reimbursement rate for the subsequent procedures performed. By appending modifier 51, it helps prevent the overpayment of claims by ensuring that each procedure is appropriately accounted for.

Modifier 59: Distinct Procedural Service

- Modifier 59 is used to identify procedures or services that are separate and distinct from other services performed on the same day. It indicates that the procedure was different in nature or performed at a different anatomic site. This modifier is crucial in avoiding claim denials due to the bundling of services. By appending modifier 59 to the distinct procedure, it distinguishes it from other procedures and increases the likelihood of reimbursement.

References

- AMA 2024 Guidelines
- Centers for Medicare and Medicaid Services www.cms.gov
- CMS Policy – Electronic Health Records (Provider)
- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-prevention/Medicaid-Integrity-Education/electronic-health-records.html
- A step-by-step guide to taking perfect clinical notes - Mobius MD
- https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule
- Clean Up E/M Documentation With SOAP - AAPC Knowledge Center