Back to School for Basic Coding: What Optometrists Need to Know

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NROC
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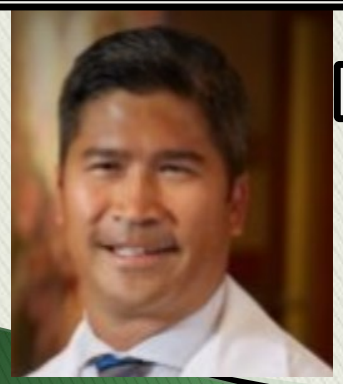

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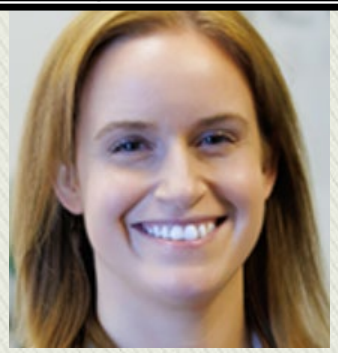

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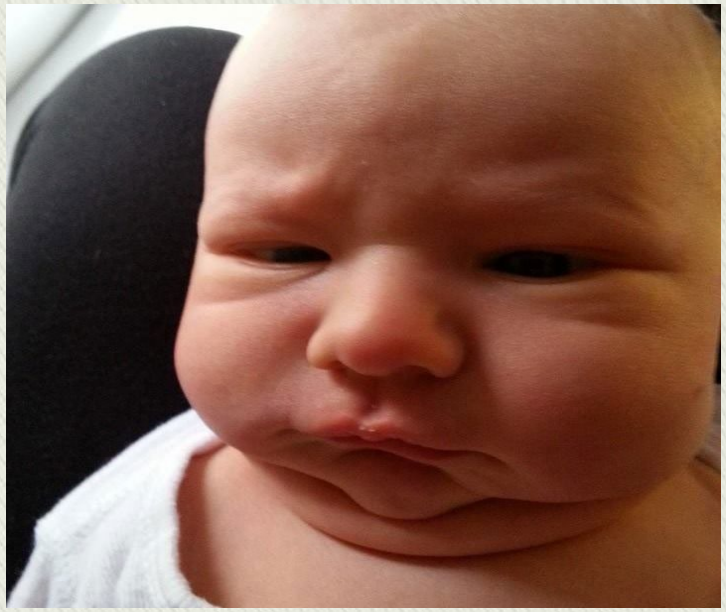
Eye Care Coding

- CPT, HCPCS,ICD-10-CM
- Review of 99 codes and application of codes
- Review of 92 codes and application of codes
- Review of S codes and application of codes
- Medical vs Vision Coding
- Documentation Guidelines

The Code Sets



The Code Sets

ICD-10-CM (World Health Organization)
International Classification of Disease-
- Diagnostic Codes
  - What you find
  - Reason for treatment

(Updated - October and April)

CPT® (AMA)
Current Procedural Terminology
- Procedures
  - What you do
  - Treatments/Exams/Surgeries

(Updated - January)

HCPCS (CMS)
Healthcare Common Procedure Coding System
- Material Codes and some procedures
  - V codes & S codes

(Updated – January)

ICD-10-CM Diagnosis Codes

- Identify diagnoses ► medical records/reimbursement
- Owned by the World Health Organization (WHO)
- Changes effective April 1 and October 1 every year

ICD-10-CM Diagnosis Codes

- Code to highest level of specificity
- Contains 3 to 7 digits; be specific
  - Find diagnosis in Alphabetical Index
  - Verify diagnosis code in Numerical Index

ICD-10-CM Diagnosis Codes

- Documentation must be precise and complete
- Always code to highest level specified
- Must check that codes are current -yearly
- Need new resource twice yearly → on-line
- Incorrect codes are common reason for denial

ICD-10-CM Diagnosis Codes Implemented Oct 1, 2015

- Organized by:
  - Index and Tables
    - Index to diseases and injury
    - Index to external causes of injury
    - Table of Neoplasms
    - Table of Drugs and Chemicals
  - Alphabetical list of terms with codes
  - Tabular list, a numerical list
    - Divided into chapters based on body system or condition

Beginning in 2023, Updated Twice a Year !!

ICD-10 Codes (Routine?)

- **Z01.00** Encounter for examination of eyes and vision without abnormal findings
- **Z01.01** Encounter for examination of eyes and vision with abnormal findings
- **Z01.020** Encounter for examination of eyes and vision following failed vision screening without abnormal findings
- **Z01.021** Encounter for examination of eyes and vision following failed vision screening with abnormal findings
- **Z97.3** Presence of spectacles and contact lenses
- **H52 series of codes** Refractive diagnoses

CPT Coding Systems You Need to Know

- **CPT**
  - CPT I Procedure Codes

    Procedures and services
  - CPT II Codes

    Supplemental tracking codes used for performance measurement - PQRS
  - CPT III Codes

    Temporary codes for emerging technology, services, & procedures
  - Modifiers

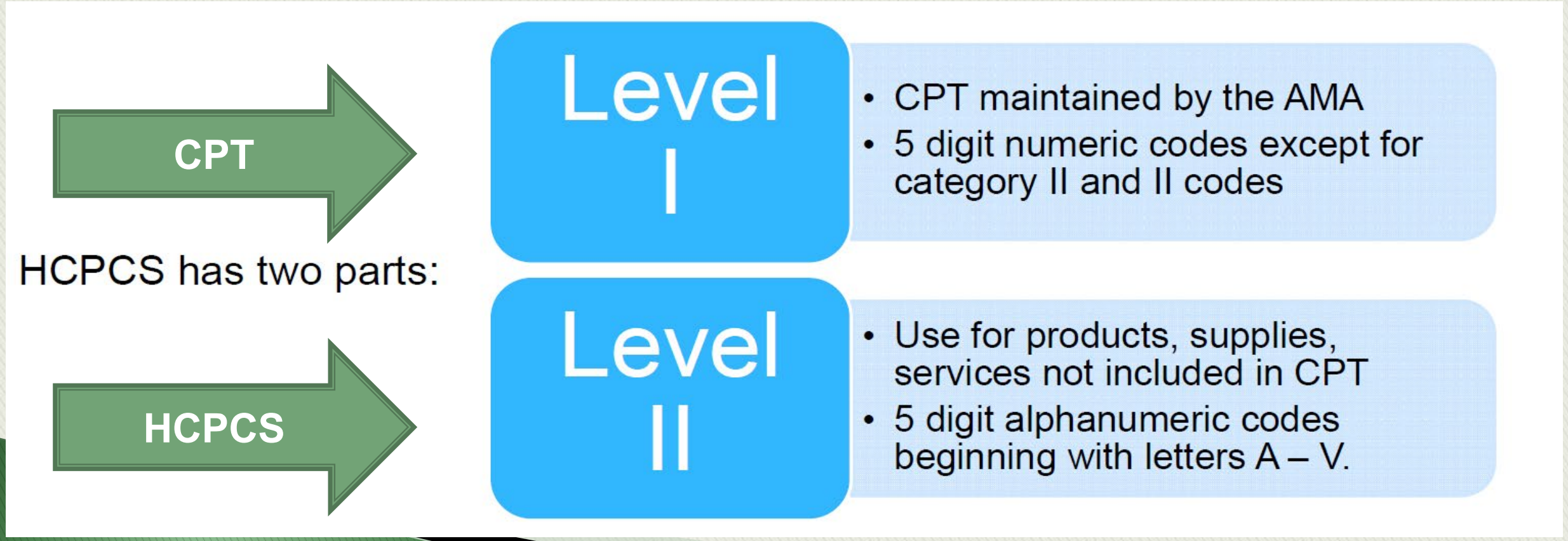
    Used to further define what is different about procedure or service

HCPCS Codes

- **Medicare/Medicaid and Other Carriers**
  - HCPCS Codes V2020 – V2799 (materials)
  - HCPCS Codes S series
    - Some services and material (S0500-S0625)
      - Note not all are ophthalmic codes
    - Contact Lens and Spectacle Services/materials
    - Ocular Prosthetics
- **CMS Often adds G-codes**

HCPCS Codes

- Common Procedure Coding System (HCPCS)
- Developed in 1983 to standardize codes on claims for Medicare
- Name change in 2002



HCPCS Code Categories

HCPCS Level II are categorized into medical products and supplies to ease coding.

Sections:

A: Transportation Services, Including Ambulance, Medical and Surgial Supplies (A0000-A9999)

B: Enteral and Parenteral Therapy (B4000-B9999)

C: Outpatient PPS (C1000-C9999)

D: Dental Procedures (D0000-D9999)

E: Durable Medical Equipment (E0100-E9999)

G: Procedures/Professional Services (G0000-G9999)

H: Alcohol and drug abuse treatment services (H0001-H2037)

J: Drugs administered other than oral method (J0000-J9999)

K: Temporary Codes (K0000-K9999)

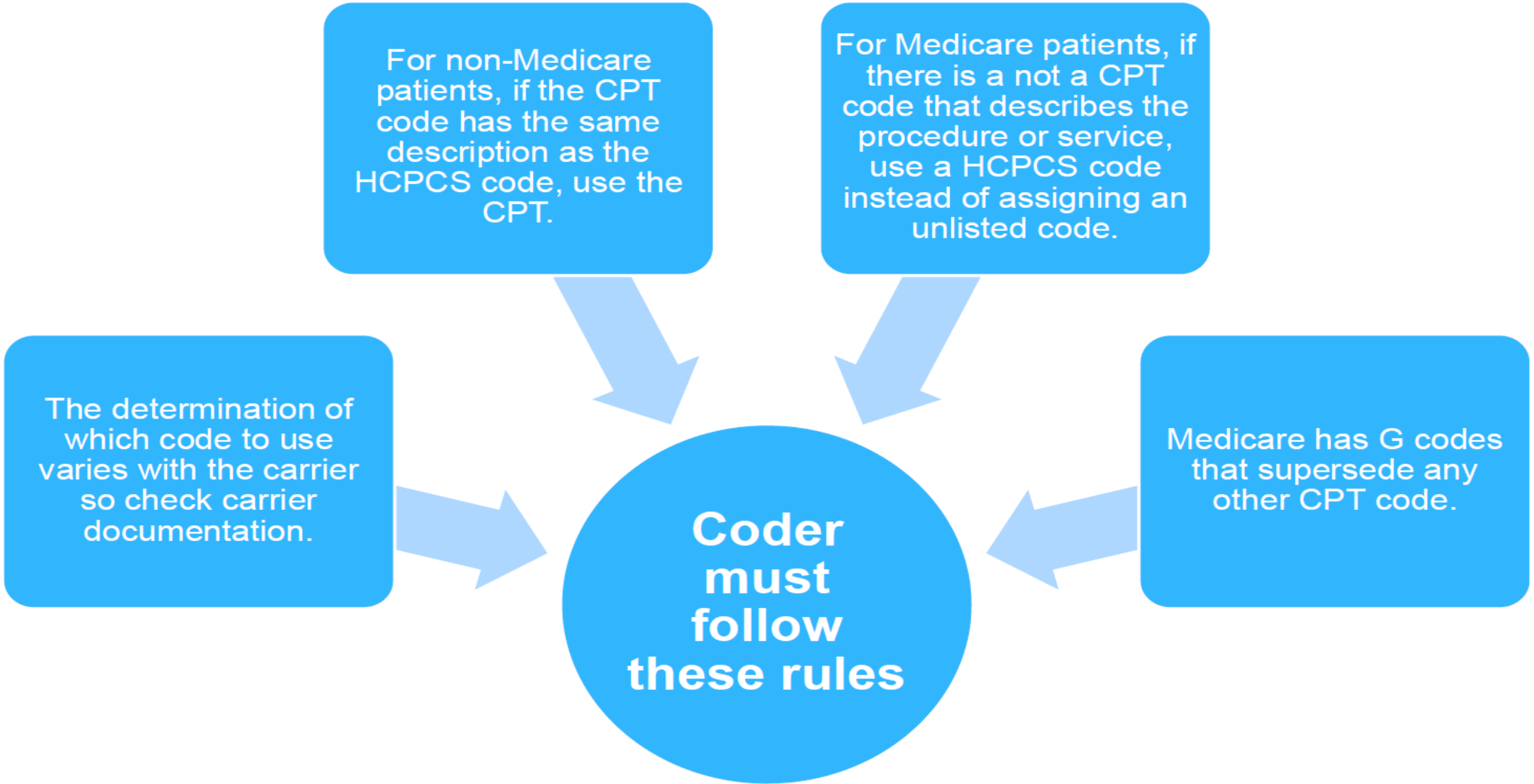
HCPCS Code Categories

Sections:

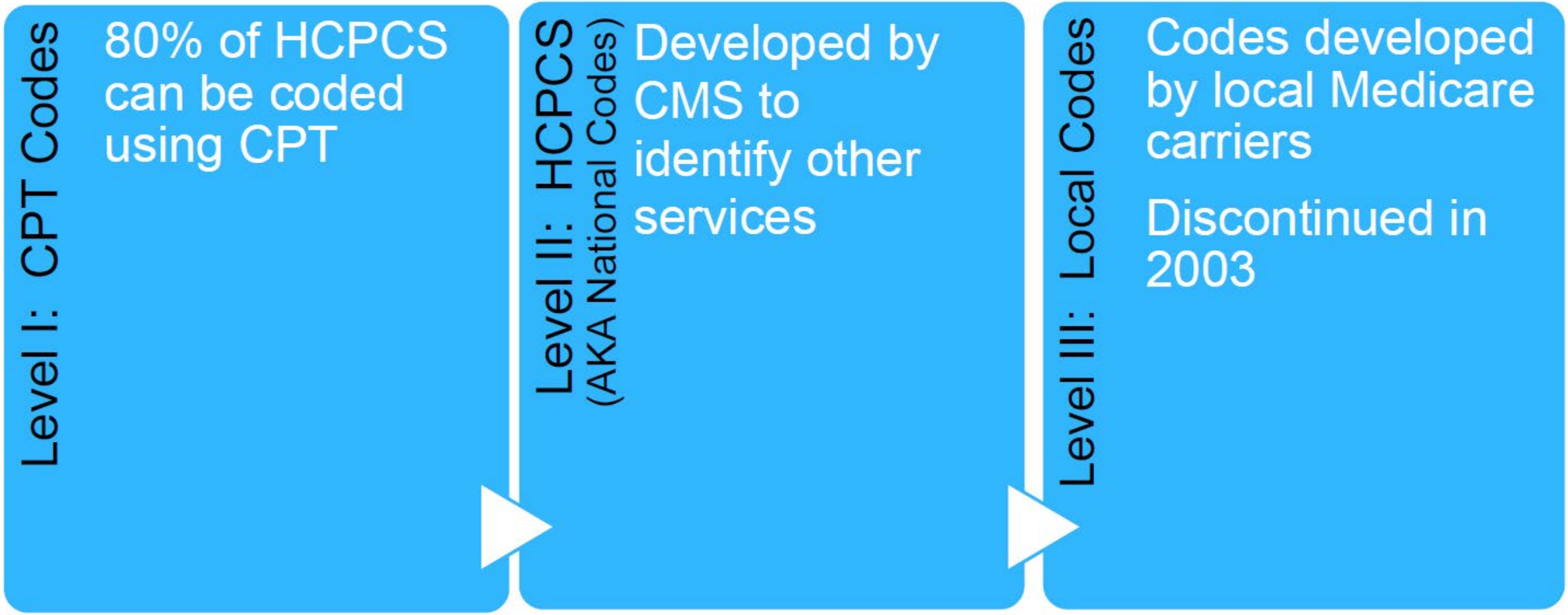
- L: Orthotic Procedures (L0000-L4999)
- M: Medical Services (M0000-M0301)
- P: Pathology and Laboratory Services (P0000-P9999)
- Q: Temporary Codes (Q0000-Q9999)
- R: Diagnostic Radiology Services (R0000-R5999)
- S: Temporary National Codes (Non-Medicare) (S0000-S9999)
- T: National T Codes (T1000-T9999)
- V: Vision and Hearing Services (V0000-V2999)

Unclassified codes – a number of unclassified codes exist in each section of HCPCS

CPT Code or HCPCS Code?



Components of HCPCS



Resources

- **AOACodingToday.com**
  - AOA free member benefit, ONLINE
  - CPT, ICD-10-CM, HCPCS, Modifiers and MUCH MORE
- **Codes for Optometry** –New Edition Yearly
  - Available from the AOA Marketplace
- **CPT® Manual**
  - Available from AOA
  - Available from AMA, etc
- **ICD-10-CM**
  - Common Codes included in Codes for Optometry
  - Available free On-line –CDC, other free sites
  - Available from AMA, etc

CPT Codes for Evaluation and Management

CPT Definitions

- **HIPAA requires all providers and insurers to use CPT codes and definitions for describing services provided to patients**
- **CPT copyright requires anyone who uses the codes to comply with the definitions for the codes**
- **Choosing codes by matching the content of the record to the CPT definition provides effective support in the case of a payer audit**

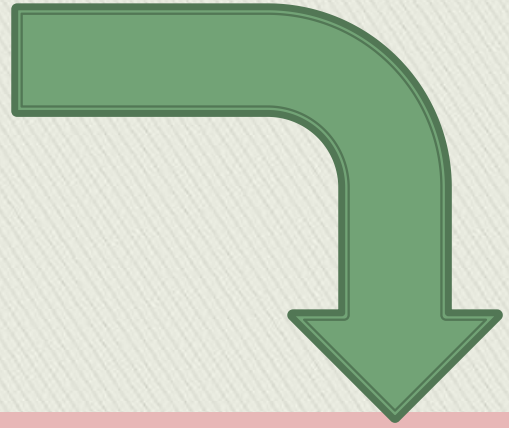
New Patient Defined

- A **new** patient is one who has not received any professional services from the physician or another physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years

- An **established** patient is one who has received professional services from the physician or another physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

General Ophthalmologic Codes vs Evaluation and Management (E&M) Codes?

- **No mandated use of one code set over other**
- **Report code(s) most accurately identifies service(s) or procedure(s) performed**
- **General ophthalmological service codes are specific for services typical of ophthalmological visit**



Note that *some* carriers state:
Services that require minimal ophthalmologic examination techniques are reported with the E/M CPT codes (99201 through 99499)

92000 versus 99000 code choices

- Allowed to use BOTH systems BUT both are documentation dependent
- General ophthalmologic services as opposed to E&M:
  - Intermediate & comprehensive examination types under 92000 codes
  - Do not require same criteria required for 99000 code choices

A. Medical Decision Making
   - Problem
   - Data
   - Risk

OR

B. Time

92000 codes:

- Do not use E&M documentation guidelines from CMS for proper code selection
- Use the introductory section language in CPT® and CPT® Assistant Article

CPT CODE BASICS

What You Should Know

92000 Code choice is based on number of examination elements necessary to address the patient problem(s)

Elements of E & M Codes

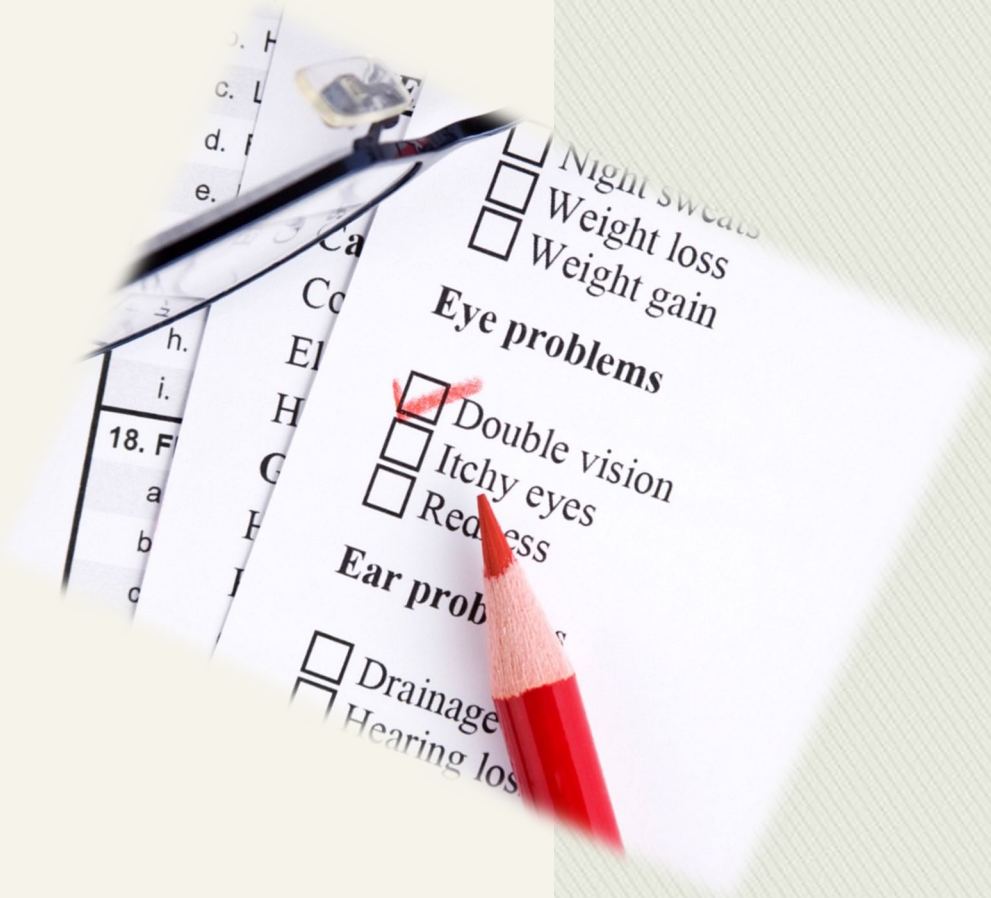
- Chief Complaint – Always
- Still need, as necessary
  - History
  - Examination

Now used for E&M coding levels

- Medical decision-making

Or

- Time



2021 Time for Office – (99201-99215)

- Inclusion of time as an explicit factor began CPT 1992 was done to assist in selecting most appropriate level of E/M services
- Beginning with CPT 2021, time for Office/Outpatient Visit Codes (99201-99215) will be based on minimum total physician/other qualified health care professional time
- Physician or QHP time but NOT TECH TIME

Time for Office or Other Outpatient Services (99201-99215)

When time alone Is being used to select the appropriate code level, the codes describe minimum total time spent by the physician or other qualified health care professional assessing and managing the patient

Time does NOT include your technicians time

Physician/other QHP time includes:

- Preparing to see patient
- Obtaining history
- Performing exam/evaluation
- Counseling the patient/family
- Ordering medications, tests or procedures

6. Referring/communicating to other health care professionals
7. Responding to/documentation for prior authorization and other compliance/regulatory/external requests
8. Documenting clinical Information in EMR
9. Interpreting results and communicating to the patient/family (when performed on DOS)

2021 E&M Code Changes -TIME

Code	Time
99211	Not application
99202	15-29 minutes
99212	10-19 minutes
99203	30-44 minutes
99213	20-29 minutes
99204	45-59 minutes
99214	30-39 minutes
99205	60-74 minutes
99215	40-54 minutes

MUST DOCUMENT TIME SPENT IN MEDICAL RECORD

2021 E&M Code Changes
Medical Decision Making (MDM)

3 Elements of MDM

1. **Number/complexity of problem(s)**
2. **Amount and/or complexity of data reviewed and analyzed**
3. **Risk**

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	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
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 inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)* **Category 1: Tests and documents** ■ **Any combination of 2 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* **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**

99211 (staff only)

99202
99212

99203
99213

2023

Elements of MDM

Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**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**
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

99204
99214

2023

Elements of MDM

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	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
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:** • 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)	**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 care ■ Decision not to resuscitate or to de-escalate care because of poor prognosis ■ Parenteral controlled substances◀

99205
99215

2023

Elements of MDM

E&M Decision Making

# Diagnoses/ Management Options	Amount/ Complexity Data Reviewed	Risk : Complications Morbidity Mortality	Decision Making type
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low complexity
Multiple	Moderate	Moderate	Moderate complexity
Extensive	Extensive	High	High complexity

https://www.aoa.org/optometrists/tools-and-resources/medical-records-and-coding

“Problem” Defined

- Disease
- Condition
- Illness
- Injury
- Symptom
- Sign
- Finding
- Complaint
- Other issues noted at encounter

May be with or without diagnosis being established at encounter

"Problem" Defined

Problem is *addressed or managed* when it is evaluated/ treated during visit by physician

- **Includes consideration of further testing or treatment that may not be chosen due to risk/benefit analysis or patient (parent/guardian/surrogate) choice**

Problem NOT Addressed if:

Note in record that problem managed by another professional and no documentation of additional assessment or care coordination

Referral made without evaluation/treatment consideration for problem being documented

Medically Necessary-CMS

Small “Segway” for Medical Necessity

Medicare.gov

Medically necessary is defined as:

“health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.”

In any of those circumstances, if your condition produces debilitating symptoms or side effects, then it is also considered medically necessary to treat those

Medical Necessity-AMA

“Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

a) in accordance with generally accepted standards of medical practice;

b) clinically appropriate in terms of type, frequency, extent, site, and duration

c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.”

Hope you are still awake!

920xx Code Choice

- Medical decision making cannot be separated from exam techniques
- Itemization of service components is not applicable
  - Slit lamp examination
  - Keratometry
  - Routine ophthalmoscopy
  - Retinoscopy
  - Tonometry
  - Motor evaluation

920xx Code Choice

- Appropriate when service includes several routine optometric/ophthalmologic examination techniques
  - Integrated procedures not separated from diagnostic evaluation
- Common physical examination elements must be documented
- Exam elements are indicated by issues being evaluated

General Ophthalmologic Services

92002	92012
92004	92014

Per One Carrier (Palmetto):

Services that require minimal ophthalmologic examination techniques are reported with the E/M CPT codes (99201 through 99499)

General Ophthalmic Codes

92002

Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient

92004

… ;comprehensive, new patient, 1 or more visits

- **Note: Current Procedural Terminology(© American Medical Association) is the *only* accepted source of definitions for these services.**

General Ophthalmic Codes

92012

Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

92014

… ;comprehensive, established patient, 1 or more visits

Comprehensive 92004 and 92014

Introduction in CPT®

General evaluation of the complete visual system (1 + sessions)

Includes:

- History
- General medical observation**
- External examination
- Ophthalmoscopic examination
- Gross visual fields
- Basic sensorimotor examination

Often includes:

- Biomicroscopy
- Examination with cycloplegia or mydriasis
- Tonometry

Always includes:

- Initiation/continuation of diagnostic and treatment programs

Intermediate 92002 and 92012

Introduction in CPT®

Evaluation of new/existing condition complicated by new diagnostic/management problem not necessarily related to primary diagnosis

Includes

- History
- General medical observation **
- External examination
- Adnexal examination

May Include

- Other diagnostic procedures
- Mydriasis of ophthalmoscopy

Always includes

- Initiation/continuation of diagnostic & treatment programs

Diagnostic and Treatment Program

Includes, but <u>not complete list</u>:

1. **Prescription of medication**
2. **Special ophthalmological diagnostic/treatment services**
3. **Consultations**
4. **Laboratory procedures**
5. **Radiological services**
6. **OTHER PLANS: LIKE MONITORING FOR COMPLICATIONS**
7. **ETC**

Elements Per CPT Assistant Article

1. Confrontation fields **
2. Eyelids/adnexa
3. Ocular motility
4. Pupils/iris
5. Cornea
6. Anterior Chamber
7. Lens
8. Intraocular pressure
9. Retina (vitreous, macula, periphery, and vessels)
10. Optic disc

(Should be 12 elements including *acuity* and *bulbar and palpebral conjunctiva* but not listed in article)

Another Way to think about Elements of Examination

- Comprehensive has been described as→
  - 8 or more elements including
    - Fundus examination with dilation**
    - Motor evaluation
- Intermediate has been described as→
  - 7 or fewer elements

Still good "rule of thumb" since examination will vary depending on reason for visit

Some insurance payers are vague on requirements while other payers are specific on the required elements for 92000 codes

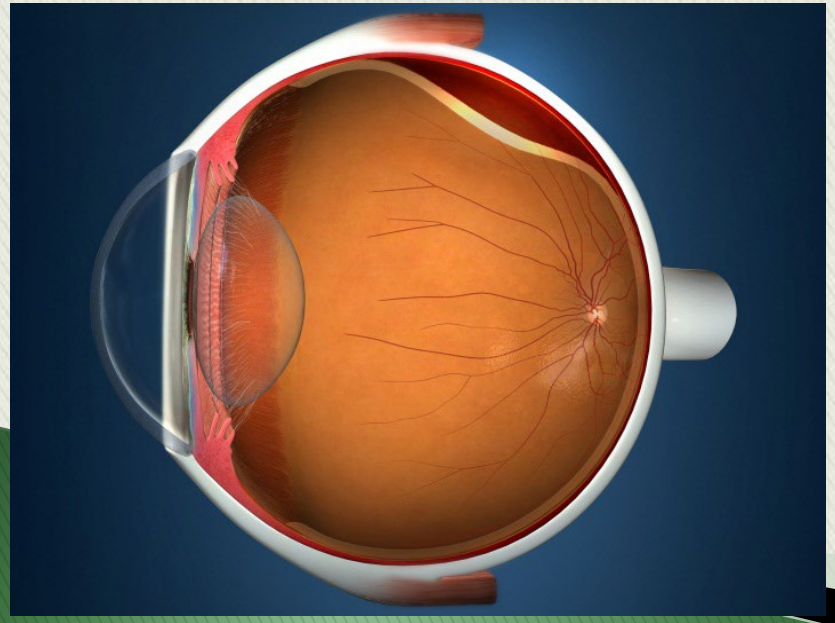
**Note that CPT definitions do NOT require dilation but is suggested in introduction of codes and some carriers do while other carriers further state "with dilation unless contraindicated"

General Ophthalmologic Services

Example of Comprehensive Services

From CPT®

The comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract or retinal disease, or to rule out disease of the visual system



General Ophthalmologic Services

Examples of Intermediate Examination

From CPT®

- **Acute complicated condition (eg, iritis) not requiring comprehensive ophthalmological ser**
- **Review of history**
- **External examination**
- **Ophthalmoscopy**
- **Biomicroscopy**

General Ophthalmologic Services

Examples of Intermediate Services

From CPT®

- **Established patient with known cataract not requiring comprehensive ophthalmological services**
- **Review of interval history**
- **External examination**
- **Ophthalmoscopy**
- **Biomicroscopy**
- **Tonometry**

E&M Codes 99201 - 99499

- **No where do the rules state that you cannot use 92002/92012 when there is not a new issue or symptom as some lecturers have stated**
- **Remember-**
  - **CPT introductory language is for both new and established**
  - **Actual wording of CODE takes precedence over introduction**

92012 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

Coding Guidelines 920xx Codes

- **Chief Complaint**
  - Still necessary
- **Documentation**
  - Establish medical necessity
- **General medical observations**
- **Require (?) dilation for 92004/92014**
- **Initiation of diagnostic and treatment programs**

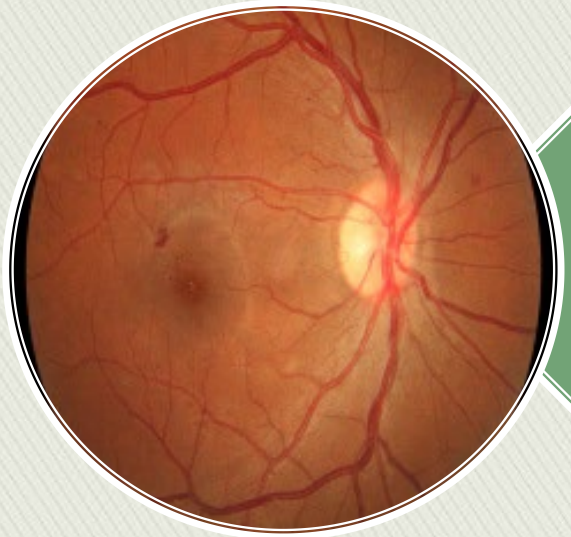
Do I have to dilate with 92004 - 92014 That is the question

- Yes some technology that allows good fundus view without dilation
- HOWEVER consider the following:
  - Medico-legal issues of not dilating patient
  - Dilation in American Diabetic Association guidelines
  - Cases of serious disease missed because of no dilation
- Yes, inconvenient for patient but educate them
- No, you cannot charge patient if they return for just for dilation
- Use this true story if patient resists:
  - 40 year old, malignant melanoma

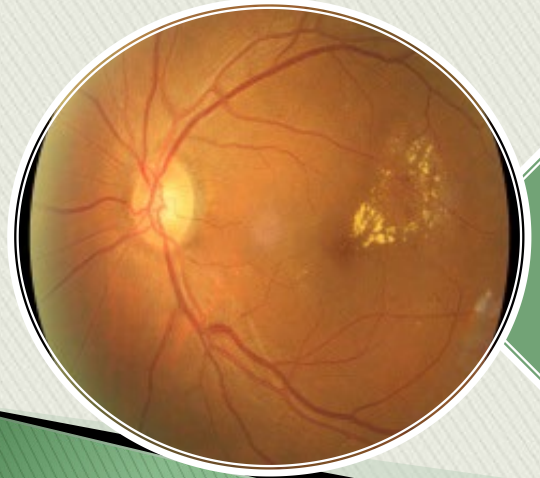
Diabetes and Retinal Examinations

- American Diabetes Association and the National Institutes of Health's positions
- Retinopathy : estimated to take at least 5 years to develop after the onset of hyperglycemia
- Patients with type 1 diabetes should have an initial dilated and comprehensive eye examination within 5 years after the onset of diabetes
- Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination soon after diagnosis.
- Subsequent examinations for type 1 and type 2 diabetic patients are generally repeated annually

Diabetes and Retinal Examinations

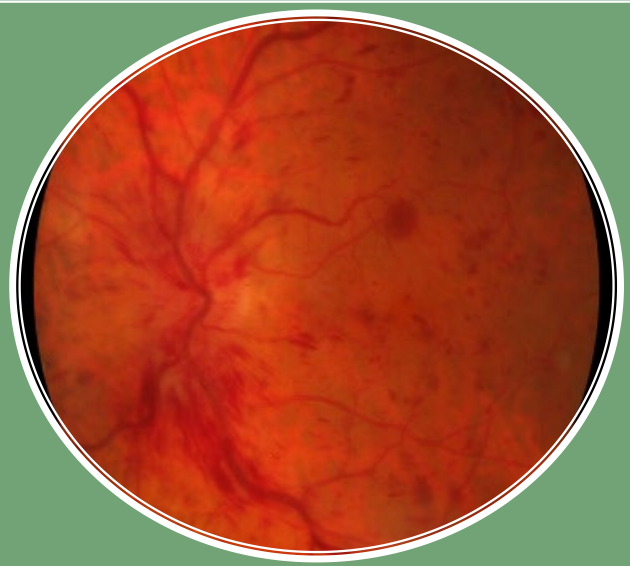


American Diabetes Association and the National Institutes of Health's position



Photos are not a substitute for a comprehensive eye exam

92250 Purpose



CPT® 92250 considered medically necessary to monitor pathology

Reimbursed by Medicare and other third party payers per guidelines for fundus photography

Coding Guidelines 920xx Codes

- Refraction (92015) not element of 92XXX or 99XXX
- Refraction not covered by Medicare
  - May file for denial
  - Some carriers require use GY modifier

    Indicates service statutorily excluded from Medicare coverage
- Medicare covers annual dilated exam for diabetics (after 11 months)
- Special code for glaucoma screening
  - G0117 with Z13.5

Routine examination codes (HCPCS Codes)

- S0620 – Routine ophthalmologic/New Patient
- S0621 – Routine ophthalmologic/Establish Patient
  - Both includes refraction
  - Becoming more common
  - Some Medicaid now using
  - Optional/required for many vision plans
  - AOA strongly discouraging insurer use
  - No valuation thus problematic

Routine examination codes (HCPCS Codes)

- Some carriers either require or allow the use of S codes for ROUTINE, WELL VISION Patients

Some examples

- BCBS
- Private pay
- VSP

General Ophthalmologic Services

Summary

- General ophthalmologic code set requirements is more straight forward than E&M code set requirements
- Does NOT include refraction
- Some carriers have specific definitions for intermediate and comprehensive levels apparently beyond what CPT® states

IMPORTANT: Initiation of diagnostic & treatment program seems to be the most audited item by Medicare

92000 Codes
Special Ophthalmological Services

Describe services in which a special evaluation of part of the visual system is made, which goes beyond the services, or in which special treatment is given.

Special ophthalmological services may be reported in addition to the general ophthalmological services or evaluation and management services.

92000 Codes
Special Ophthalmological Services

92015 to 92140

Reported in addition to general ophthalmological services or E&M services

Interpretation and report by the physician or QHP is integral part of special ophthalmological services where indicated

92000 Codes
Special Ophthalmological Services

- Extended Ophthalmoscopy
  - Not a Routine BIO
    - Angiography (Fluorescein / Indocyanine Green)
- Fundus Photography
- Scanning Laser Technology
- Color Vision Examination
- Gonioscopy
- External Ocular Photography
- Sensorimotor Evaluation
- Visual Fields

Choosing the RIGHT Code Set

- Code what you do and do what you code!
- Either set allowable
- General Ophthalmologic Services less complex, perhaps
- Bit more open interpretation of service levels with E&M
- Important to UNDERSTAND how to apply both

Guiding Principles to Consider

1.Chief complaint & examination findings should *RULE* examination content AND coding

My vision has gradually gotten worse, especially at near, no known ocular disease

1. **Findings- presbyopic shift, no medical issues → Well vision examination**
2. **Findings – early ARMD → Medical examination**

- **Examination content and technique for each similar but findings require more extensive examination, more knowledge and more risk**
- **Medical examination findings often lead to other testing**

Guiding Principles to Consider

2. Plans accepted MAY have contract limitations on when must use well vision plans and if coordination of benefits may occur

- Some plans allow Coordination of benefits (COB)
- Some plans are changing their guidelines to force medical care under the well vision plan service
- Some plans are rolling more medical testing under their well vision plans
- Some plans are requiring the listing of medical diagnoses in addition to the refractive diagnoses applicable

PROVIDERS MUST READ AND UNDERSTAND THEIR CONTRACTS SO ARE ABIDING BY THE RULES!

Guiding Principles to Consider

3.Understand your office policies and approaches to this common issue THEN stick to them!!

- Avoid making rules for rare exceptions
- Ensure excellent education of staff and patients
- Understand consequences of your office policy decisions- you cannot go wrong with well thought out polices
- Accept the fact that you may lose a few patients
- Review your policies yearly to ensure these policies still meet the needs of your practice

Guiding Principles to Consider

4.Do apply CPT codes and coding rules correctly and across the board

- **Remember: waiving copays without clear case by case hardship documentation is considered fraud**
- **Remember: that waiving charges for procedures without clear case by case hardship documentation is considered fraud**
- **Remember: to develop policies that prevent fraud and abuse and uphold HIPAA rules**

Contacts and Websites

- Most material referenced on web
- Use available tools
  - **CPT, ICD-10-CM, HCPCS**
- Use AOACodingToday.com
  - **Instant updates**
  - **Extra coding tools**
  - **Notes**
  - **Clarifications**

AOA Resource

www.aoa.org/coding

Go to Ask the Coding Experts
Questions will be answered in 1-3 days

Now you have all been to school!

Finally

Questions???

Thank You!!!