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HealthyCT Participating Provider Update
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The Importance of Proper Coding

Coding is critical to obtaining proper reimbursement, maintaining patient records and ensuring a valid record of patient care history. An accurate claim is dependent upon factors such as staying up-to-date on annual coding changes, following standard coding guidelines and keeping detailed patient records.

Many offices use electronic health record (EHR) systems, offering tremendous opportunities to increase care quality, efficiency, and reduce waste. Whether you submit electronic or paper claims, compliant documentation and proper coding are a must!

You should especially be mindful of the copy and paste or "cloned documentation" functions when using EHR systems. Random chart reviews have shown near-identical documentation in a number of patient records. These shortcuts, often the fault of the copy and paste functions, are being utilized to cut down on administrative time. Keep in mind that automation is not documentation.

This educational document is intended to assist practitioners and coders on compliant coding practices. Your reimbursement can be in jeopardy if the documentation is not supported and/or if it appears the medical records have been copied and pasted (cloned) to inflate the level of service.

For example, the chart below can assist you when determining if you should use a high-level E/M code (99214, 99215). As indicated, a 99215 should be reserved for your most serious and complex patients.

Key Components (2 of 3 Required)	99214	99215
History	• 4 or more HPI* or 3 or more chronic diseases • Review of 2-9 systems • 1 PFSH** element	• 4 or more HPI* or 3 or more chronic diseases • Review of 10 or more systems • 2 PFSH** elements
Exam	12 or more exam elements of 2 or more systems (6 notes in at least 2 systems)	18 exam elements; 2 exam elements from each of 9 systems (2 notes for each of 9 systems)
Medical Decision Making	Moderate Complexity: • Prescription drug management • Minor surgery with risk factors • IV fluids with additives • Closed treatment of fracture	High Complexity: • Drug therapy requiring intensive monitoring • Parenteral controlled substance • Emergency major surgery • Elective major surgery

*HPI- History of Present Illness; **PFSH- Past, Family and Social History

In addition, document the encounter's duration in the chart, including total time spent in counseling/care coordination. As always, refer to your Current Procedural Terminology (CPT®) book to ensure compliance with all coding guidelines.

HealthyCT may audit medical records from time to time.