Understanding Billing and Coding for the Sexual Assault Medical Forensic Examination

Jill Johnson, DNP, APRN, FNP-BC, CPC

Research. Educate. Lead.

INTERNATIONAL ASSOCIATION OF Forensic Nurses

Disclosures

- This presentation was supported by Grant No 2018-TA-AX-K014 awarded by the Office on Violence Against Women, U.S. Department of Justice.
- The International Association of Forensic Nurses is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.
- Upon attending the presentation in its entirety (due to the criticality of the content) and completing the course evaluation, you will receive a certificate that documents the continuing nursing education contact hours for this activity. The planners, presenters, and content reviewers of this presentation disclose no conflicts of interest.

Objectives

1. Discuss the history of *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM) and *Current Procedural Terminology* (CPT) codes.
2. Identify documentation requirements for the evaluation and management
3. Discuss proper use of UB-04 and CMS-1500 forms.
4. Discuss appropriate medical decision making, evaluation and management for sexual assault medical forensic examination.

Knowledge Check –

Which agency developed and maintains ICD codes?

A. American Medical Association
B. World Health Organization
C. Department of Health and Human Services

Knowledge Check –

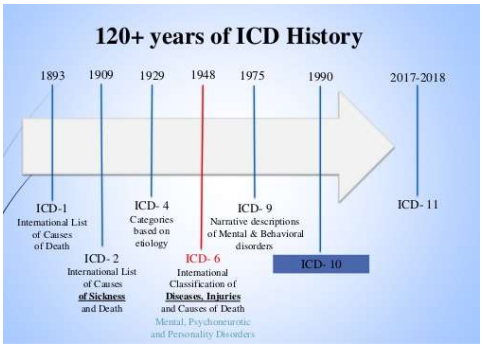
Which agency created CPT codes?

A. American Medical Association
B. World Health Organization
C. Department of Health and Human Services

Polling Questions - Yes or No

Are you aware of a patient(s) ever receiving a bill from their sexual assault medical forensic examination?

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and Current Procedural Terminology (CPT) codes



History and Overview ICD 10

- The World Health Organization (WHO) developed ICD-9 for use worldwide:
  - Global, cooperative statistical effort to report and improve public health.
  - The U.S. developed "clinical modification" (ICD-9-CM).
  - Implemented in 1979 in the U.S.
  - Expanded number of diagnosis codes.
  - Developed procedure coding system.
- ICD-9-CM diagnoses — used by all types of providers.
- ICD-9-CM procedures — used only by inpatient hospitals.

History and Overview

- What is ICD-9-CM used for?
  - Calculate payment — Medicare Severity-Diagnosis Related Groups (MS-DRGs).
  - Adjudicate coverage — Diagnosis codes for all settings.
  - Compile statistics — Original reason for WHO global standards.
  - Assess quality — Diagnoses is a important component of directing treatment.
- ICD-9-CM is outdated:
  - 30 years old — Technology has changed.
  - Many categories full.
  - Not descriptive enough, not intuitive in organization.
- What characteristics are needed in a coding system?
  - **Flexible** enough to quickly incorporate emerging diagnoses and procedures.
  - **Exact** enough to identify diagnoses and procedures precisely.
  - ICD-9-CM is **neither** of these.

Benefits of ICD-10 over ICD-9

- Incorporates much greater specificity and clinical information, which results in
  - Improved ability to measure health care services
  - Increased sensitivity when refining grouping and reimbursement methodologies
  - Enhanced ability to conduct public health surveillance
  - Decreased need to include supporting documentation with claims

Current Procedural Terminology (CPT)

- Set of codes created by the American Medical Association (AMA)
- Five-digit CPT codes are used to facilitate billing
- One of the primary ways that both public and private medical providers and healthcare institutions can report the services they have provided to patients to the government and insurance companies for reimbursement purposes.
- CPT codes are part of the national coding system under the Health Information Portability and Accountability Act (HIPAA).

Three Categories of CPT Codes

- **Category I**
  - Used to report the devices and drugs used during a procedure
  - Used to report the procedure itself to the billing department
  - Contains the billable codes needed for reimbursement
- **Category II**
  - Designed for reporting performance measures
  - Used to provide data to regulatory agencies
  - Does not contain billing codes and considered as "quality of care" codes
- **Category III**
  - Codes for documenting new procedures, clinical trials and emerging technologies
  - Must be either added to Category I or deleted within five years of being added

Evaluation and Management (E/M)

Documentation

Evaluation and Management (E/M)

Consist of three components:

- History
- Exam
- Medical Decision Making = payment determination

Evaluation and Management (E/M) Coding

Consist of three components:

- History
  - Consist of HPI, past medical/social/ family history, and Review of systems
  - History = HPI + PFSH + ROS
- Exam:
  - 1995 or 1997 CMS guidelines
- Medical Decision Making:
  - Consist of patient problem level, complexity of data, and risk
  - MDM = problem level + data complexity + risk

Let's start at the beginning to determine our code…

Chief Complaint:

- The CC is a concise statement from the patient of why they are here today – usually 1-2 words
  - The CC in NOT synonymous with the HPI.
  - Every chart must have a brief CC.

Example: CC is Sexual Assault

History of Presenting Illness

- Provides a chronological description of the CC
- The HPI starts painting the picture for the ROS, Exam, and Dx that will follow
  - Most providers use OLDCART for the HPI
  - Coders look for - D-Duration, L-Location, Q-Quality, S-severity, C-context, M-modifying factor, A-associated symptoms and T-timing.

HISTORY	Circle appropriate numbers			
HPI: Each letter in () only used once • Onset (T) • Location (L) • Duration (timing and frequency) (D) • Characteristic {quality (Q), associated signs and symptoms (A), severity or pain scale (S), context (C) = activity/events} • Aggravating Factors (makes it worse) (M) • Relieving Factors (make it better) (M) • Treatment (tried for problem) (M)	Brief 1-3 HPI Elements of TLDQASCM	Brief 1-3 HPI Elements of TLDQASCM	Expanded 4+ HPI Elements of TLDQASCM	Expanded 4+ HPI Elements of TLDQASCM
Areas of PFSH = circle areas that apply: Past medical (P), family (F), social (S) History (H)	1 element	1 elements	1 element	1 element from 2 areas
ROS—Circle all that apply: (14) • Constitutional • Eyes • ENT (Ears, Nose, Mouth, Throat) • Cardiovascular • Respiratory • GI • Musculoskeletal • Skin (includes breast) • Neuro • Psych • Endocrine • Lymph/Hemo • GU • Allergy/Immuno	0	1	2-9	10+
To determine the history level, draw a line down the column with the circle farthest to the LEFT	PF Problem Focused	EPF Expanded Problem	D Detailed	C Comprehensive

History = HPI + PFSH + ROS

HISTORY	Circle appropriate numbers			
HPI: Each letter in () only used once • Onset (T) • Location (L) • Duration (timing and frequency) (D) • Characteristic {quality (Q), associated signs and symptoms (A), severity or pain scale (S), context (C) = activity/events} • Aggravating Factors (makes it worse) (M) • Relieving Factors (make it better) (M) • Treatment (tried for problem) (M)	X	X	X	Expanded 4+ HPI Elements of TLDQASCM

HPI Brief vs Extended

- Brief HPI example
  - 32 year old female with contusions. Found unconscious, possible sexual assault, occurred 4 hours ago found,
- Extended HPI example
  - 32 year old female with alleged sexual assault 4 hours ago. Found unconscious in hotel room. Bruising on both arms, face, and genital area. Vaginal bleeding. Thighs with abrasions and contusion. Pain 7/10 is constant. The pain is worse with movement. Ice to areas with minimal relief. Pt does not remember the events. Was at bar with friends and remembers drinking. Woke up in ambulance hurting.

PFSH

Past Medical History
- Allergies
- Current Medications
- Sexual history

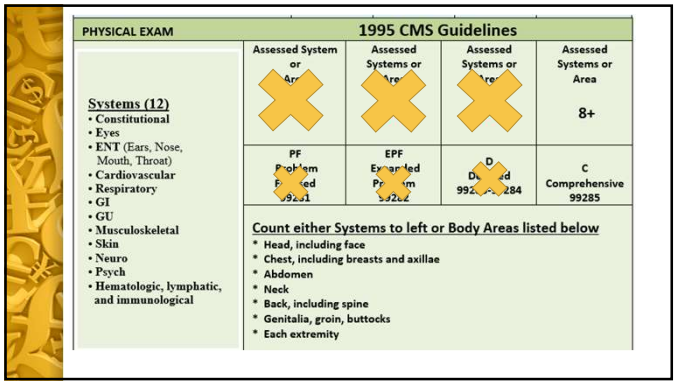
Family History – only if pertinent to this exam and treatment

Social History
- Tobacco use (and vaping)
- Alcohol
- Recreational drugs

1. Chief complaint – including acute complaints of pain or bleeding.
2. Allergies to medications, food, and latex and current medications.
3. Pertinent medical history, recent anal-genital injuries, surgeries, or diagnostic procedures, -clotting history, and other pertinent medical conditions or treatment.
4. Reproductive history – LMP, vaginal deliveries, age of first menses.
5. History of assault – time, date, location, and what occurred.
6. Acts that demonstrate threats or lack of consent – use of weapon, restraints, strangulation, or verbal threats.
7. History of drug or alcohol use prior to or during the assault.
8. History of loss of consciousness or awareness.
9. Details of all physical contact, including genital or oral contact.
10. Post-assault hygiene.
11. Recent consensual sexual activity (important for issues on DNA recovery, as well as pregnancy implications for the victim).

Review of Systems (ROS)

- Constitutional
- Eyes
- ENT (Ears, Nose, Mouth, Throat)
- Cardiovascular
- Respiratory
- GI
- Musculoskeletal
- Skin (includes breast)
- Neuro
- Psych
- Endocrine
- Lymph/Hemo
- GU
- Allergy/Immunology

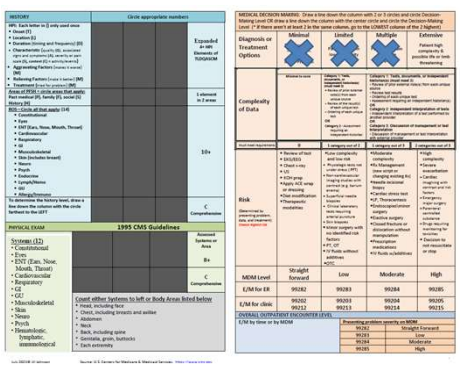


Knowledge Check – True or False

E/M codes are only applicable to nurse examinations, not physicians or providers?

Medical Decision Making

Determining level of service (LOS)

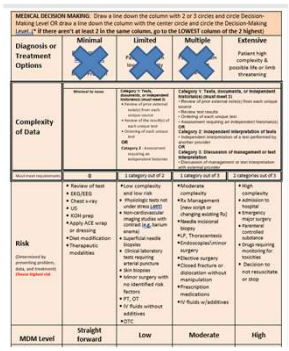


HISTORY	Circle appropriate numbers	
HPI: Each letter in [] only used once • Onset (H) • Location [L] • Duration (timing and frequency) [D] • Characteristic (quality [Q], associated manifestations [M], pertinent negatives [N], severity [S] + severity level [L]) • Aggravating Factors (maximum 4 words) [M] • Relieving Factors (maximum 4 words) [M] • Treatment (prior to problem) [M]		Expanded to HPI Elements of FOUR/MORE
Areas of PFSH = circle areas that apply: Past History [P], Family [F], social [S] History [H]		1 element in 2 areas
ROS—Circle all that apply (14) • Constitutional • Eyes • ENT (Ears, Nose, Mouth, Throat) • Cardiovascular • Respiratory • GI • Musculoskeletal • Skin (includes breast) • Neuro • Psych • Endocrine • Lymph/Immuno • GU • Allergy/Immuno		10+
To determine the history level, draw a line down the column with the circle furthest to the LEFT		C Comprehensive

PHYSICAL EXAM	1995 CMS Guidelines	
Systems (12) • Constitutional • Eyes • ENT (Ears, Nose, Mouth, Throat) • Cardiovascular • Respiratory • GI • GU • Musculoskeletal • Skin • Neuro • Psych • Hematologic, lymphatic, immunological		Assessed Systems or Area
		B+
		C Comprehensive
	Count either Systems to left or Body Areas listed below • Head, including face • Chest, including breasts and axillae • Abdomen • Neck • Back, including spine • Genitalia, groin, buttocks • Each extremity	

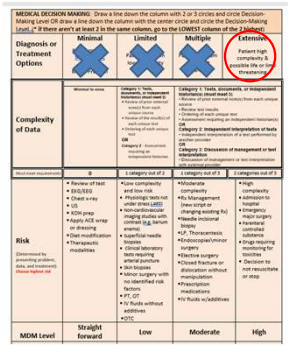
MEDICAL DECISION MAKING: Draw a line down the column with 2 or 3 circles and circle Decision-Making Level OR draw a line down the column with the center circle and circle the Decision-Making Level ("if there aren't at least 2 in the same column, go to the LOWEST column of the 2 highest)				
Diagnosis or Treatment Options	Minimal	Limited	Multiple	Extensive
				Patient high complexity & possible life or limb threatening
Complexity of Data	Minimal to none	Limited	Multiple	Extensive
		Category 1: "Tests, documents, or independent historian(s) (must meet 2) • 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	Category 1: "Tests, documents, or independent historian(s) (must meet 3) • Review of prior external note(s) from each unique source • Review test results • 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 provider OR Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external provider(s)	
Must meet requirements	0	1 category out of 2	1 category out of 3	2 categories out of 3
Risk (Determined by presenting problem, data, and treatment)	• Review of tool • ESI/LSI/I • Chest x-ray • UA • ECH prep • Apply, ACE wrap or dressing • Drug administration • Therapeutic modalities	• Low complexity and low risk • Physiologic tests not under stress (PFT) • Non-cardiovascular imaging studies with contrast (e.g. barium enema) • Clinical laboratory tests requiring a needle stick/IV • Clinical laboratory tests requiring specimen handling • Skin biopsies • Minor surgery with no identified risk factors • PT/OT • IV fluids without additives • ASC	• Moderate complexity • Rx Management (new script or changing existing Rx) • Moderate Income Topics • Cardiac stress test • GI, Thoracentesis • Endoscopic/minor surgery • Elective surgery • Prescription drugs or dislocation without manipulation • Prescription medications • IV fluids w/additives	• High complexity • Severe exacerbation • Cardiac arrest • Emergency major surgery • Emergency cardiovascular outcome • Drug therapy requiring monitoring for toxicities • Decision to not resuscitate or stop
MDM Level	Straight forward	Low	Moderate	High
E/M for ER	99282	99283	99284	99285
E/M for clinic	99202 99212	99203 99213	99204 99214	99205 99215
OVERALL OUTPATIENT ENCOUNTER LEVEL E/M by time or by MDM			Presenting problem severity on MDM	
			99282	Straight Forward
			99283	Low
			99284	Moderate
			99285	High

Risk (Determined by presenting problem, data, and treatment) *Choose highest risk*	• Review of test • EKG/EEG • Chest x-ray • US • KOH prep • Apply ACE wrap or dressing • Diet modification • Therapeutic modalities	•Low complexity and low risk • Physiologic tests not under stress (.PFT) • Non-cardiovascular imaging studies with contrast (e.g. barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies • Minor surgery with no identified risk factors • PT, OT • IV fluids without additives •OTC	•Moderate complexity •Rx Management (new script or changing existing Rx) •Needle incisional biopsy •LP, Thoracentesis •Endoscopies\minor surgery •Elective surgery •Closed fracture or dislocation without manipulation •Prescription medications •IV fluids w/additives	•High complexity • Admission to hospital • Emergency major surgery • Parenteral controlled substance • Drugs requiring monitoring for toxicities • Decision to not resuscitate or stop
MDM Level	**Straight forward**	**Low**	**Moderate**	**High**



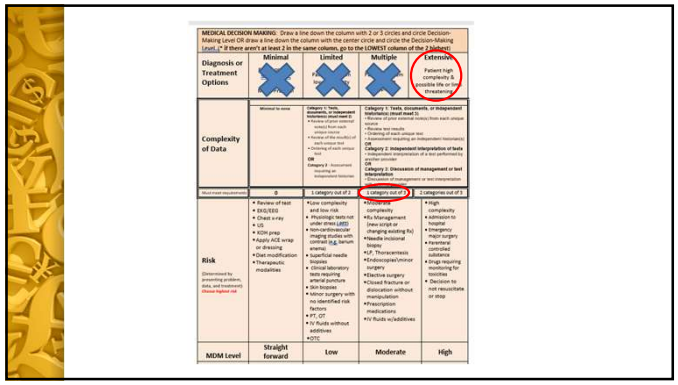
MEDICAL DECISION MAKING: Draw a line down the column with 2 or 3 circles and circle Decision-Making Level OR draw a line down the column with the center circle and circle the Decision-Making Level. *** If there aren't at least 2 in the same column, go to the LOWEST column of the 2 highest.**

	Minimal	Limited	Multiple	Extensive
Diagnosis or Treatment Options				Patient high complexity & possible life or limb threatening
Complexity of Data	Minimal to none.	**Category I: Tests, documents, or independent historian(s) must meet 1):** • 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	**Category 1: Tests, documents, or independent historian(s) must meet 2):** • Review of prior external note(s) from each unique source • Review test results • 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 provider **OR** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external provider	
Must meet requirements:	0	1 category out of 2	1 category out of 3	2 categories out of 3
Risk (Determined by presenting problem, data, and treatment) *Choose highest risk*	• Review of test • EKG/EEG • Chest x-ray • US • KOH prep • Apply ACE wrap or dressing • Diet modification • Therapeutic modalities	•Low complexity and low risk • Physiologic tests not under stress (.PFT) • Non-cardiovascular imaging studies with contrast (e.g. barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies • Minor surgery with no identified risk factors • PT, OT • IV fluids without additives •OTC	•Moderate complexity •Rx Management (new script or changing existing Rx) •Needle incisional biopsy •LP, Thoracentesis •Endoscopies\minor surgery •Elective surgery •Closed fracture or dislocation without manipulation •Prescription medications •IV fluids w/additives	• High complexity • Admission to hospital • Emergency major surgery • Parenteral controlled substance • Drugs requiring monitoring for toxicities • Decision to not resuscitate or stop
MDM Level	**Straight forward**	**Low**	**Moderate**	**High**



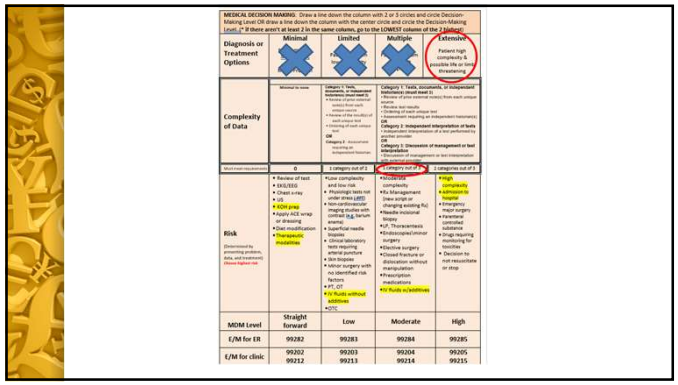
MEDICAL DECISION MAKING: Draw a line down the column with 2 or 3 circles and circle Decision-Making Level OR draw a line down the column with the center circle and circle the Decision-Making Level. *** If there aren't at least 2 in the same column, go to the LOWEST column of the 2 highest.**

	Minimal	Limited	Multiple	Extensive
Diagnosis or Treatment Options				Patient high complexity & possible life or limb threatening
Complexity of Data	Minimal to none.	**Category I: Tests, documents, or independent historian(s) must meet 1):** • 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	**Category 1: Tests, documents, or independent historian(s) must meet 2):** • Review of prior external note(s) from each unique source • Review test results • 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 provider **OR** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external provider	
Must meet requirements:	0	1 category out of 2	1 category out of 3	2 categories out of 3
Risk (Determined by presenting problem, data, and treatment) *Choose highest risk*	• Review of test • EKG/EEG • Chest x-ray • US • KOH prep • Apply ACE wrap or dressing • Diet modification • Therapeutic modalities	•Low complexity and low risk • Physiologic tests not under stress (.PFT) • Non-cardiovascular imaging studies with contrast (e.g. barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies • Minor surgery with no identified risk factors • PT, OT • IV fluids without additives •OTC	•Moderate complexity •Rx Management (new script or changing existing Rx) •Needle incisional biopsy •LP, Thoracentesis •Endoscopies\minor surgery •Elective surgery •Closed fracture or dislocation without manipulation •Prescription medications •IV fluids w/additives	• High complexity • Admission to hospital • Emergency major surgery • Parenteral controlled substance • Drugs requiring monitoring for toxicities • Decision to not resuscitate or stop
MDM Level	**Straight forward**	**Low**	**Moderate**	**High**



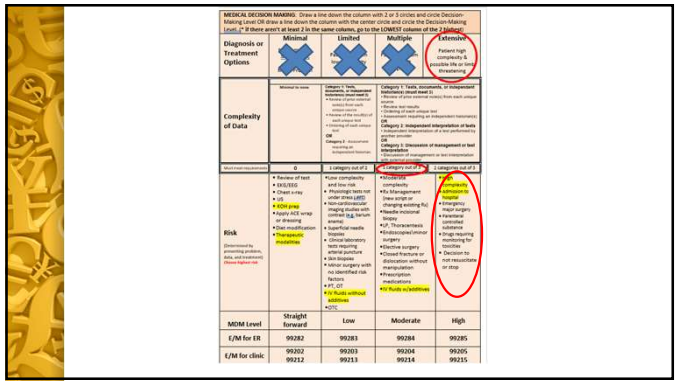
MEDICAL DECISION MAKING: Draw a line down the column with 2 or 3 circles and circle Decision-Making Level OR draw a line down the column with the center circle and circle the Decision-Making Level. **If there aren't at least 2 in the same column, go to the LOWEST column of the 2 highest**

	Minimal	Limited	Multiple	Extensive
Diagnosis or Treatment Options				Patient high complexity & possible life or limb threatening
Complexity of Data	Minimal to none	Category 1: Tests, documents, or independent historian(s) (must meet 1) • Review of prior external note(s) from each unique source • Review test results • Ordering of each unique test OR Category 2 - Assessment requiring an independent historian	Category 1: Tests, documents, or independent historian(s) (must meet 1) • Review of prior external note(s) from each unique source • Review test results • 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 provider OR Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external provider(s)	
Must meet requirement	0	1 category out of 3	1 category out of 3	2 categories out of 3
Risk (Determined by presenting problem, data, and treatment) Choose highest risk	• Review of test • EKG/EEG • Chest x-ray • US • KOH prep • Apply ACE wrap or dressing • Diet modification • Therapeutic modalities	• Low complexity and low risk • Physiologic tests not under stress (ABI) • Non-cardiovascular imaging studies with contrast (e.g. barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies • Minor surgery with no identified risk factors • PT, OT • IV fluids without additives • OTC	• Moderate complexity • Rx Management (new script or changing existing Rx) • Needle incisional biopsy • LP, Thoracentesis • Endoscopies/minor surgery • Elective surgery • Closed fracture or dislocation without manipulation • Prescription medications • IV fluids w/additives	• High complexity • Admission to hospital • Emergency major surgery • Parenteral controlled substance • Drugs requiring monitoring for toxicities • Decision to not resuscitate or stop
MDM Level	**Straight forward**	**Low**	**Moderate**	**High**



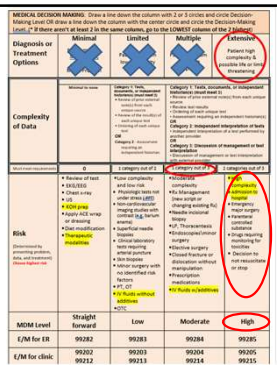
MEDICAL DECISION MAKING: Draw a line down the column with 2 or 3 circles and circle Decision-Making Level OR draw a line down the column with the center circle and circle the Decision-Making Level. **If there aren't at least 2 in the same column, go to the LOWEST column of the 2 highest**

	Minimal	Limited	Multiple	Extensive
Diagnosis or Treatment Options				Patient high complexity & possible life or limb threatening
Complexity of Data	Minimal to none	Category 1: Tests, documents, or independent historian(s) (must meet 1) • Review of prior external note(s) from each unique source • Review test results • Ordering of each unique test OR Category 2 - Assessment requiring an independent historian	Category 1: Tests, documents, or independent historian(s) (must meet 1) • Review of prior external note(s) from each unique source • Review test results • 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 provider OR Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external provider(s)	
Must meet requirement	0	1 category out of 2	1 category out of 3	2 categories out of 3
Risk (Determined by presenting problem, data, and treatment) Choose highest risk	• Review of test • EKG/EEG • Chest x-ray • US • KOH prep • Apply ACE wrap or dressing • Diet modification • Therapeutic modalities	• Low complexity and low risk • Physiologic tests not under stress (ABI) • Non-cardiovascular imaging studies with contrast (e.g. barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies • Minor surgery with no identified risk factors • PT, OT • IV fluids without additives • OTC	• Moderate complexity • Rx Management (new script or changing existing Rx) • Needle incisional biopsy • LP, Thoracentesis • Endoscopies/minor surgery • Elective surgery • Closed fracture or dislocation without manipulation • Prescription medications • IV fluids w/additives	• High complexity • Admission to hospital • Emergency major surgery • Parenteral controlled substance • Drugs requiring monitoring for toxicities • Decision to not resuscitate or stop
MDM Level	**Straight forward**	**Low**	**Moderate**	**High**
E/M for ER	**99282**	**99283**	**99284**	**99285**
E/M for clinic	**99202** **99212**	**99203** **99213**	**99204** **99214**	**99205** **99215**



MEDICAL DECISION MAKING: Draw a line down the column with 2 or 3 circles and circle Decision-Making Level OR draw a line down the column with the center circle and circle the Decision-Making Level. **If there aren't at least 2 in the same column, go to the LOWEST column of the 2 highest**

	Minimal	Limited	Multiple	Extensive
Diagnosis or Treatment Options				Patient high complexity & possible life or limb threatening
Complexity of Data	Minimal to none	Category 1: Tests, documents, or independent historian(s) (must meet 1) • Review of prior external note(s) from each unique source • Review test results • Ordering of each unique test OR Category 2 - Assessment requiring an independent historian	Category 1: Tests, documents, or independent historian(s) (must meet 1) • Review of prior external note(s) from each unique source • Review test results • 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 provider OR Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external provider(s)	
Must meet requirement	0	1 category out of 2	1 category out of 3	2 categories out of 3
Risk (Determined by presenting problem, data, and treatment) Choose highest risk	• Review of test • EKG/EEG • Chest x-ray • US • KOH prep • Apply ACE wrap or dressing • Diet modification • Therapeutic modalities	• Low complexity and low risk • Physiologic tests not under stress (ABI) • Non-cardiovascular imaging studies with contrast (e.g. barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies • Minor surgery with no identified risk factors • PT, OT • IV fluids without additives • OTC	• Moderate complexity • Rx Management (new script or changing existing Rx) • Needle incisional biopsy • LP, Thoracentesis • Endoscopies/minor surgery • Elective surgery • Closed fracture or dislocation without manipulation • Prescription medications • IV fluids w/additives	• High complexity • Admission to hospital • Emergency major surgery • Parenteral controlled substance • Drugs requiring monitoring for toxicities • Decision to not resuscitate or stop
MDM Level	**Straight forward**	**Low**	**Moderate**	**High**
E/M for ER	**99282**	**99283**	**99284**	**99285**
E/M for clinic	**99202** **99212**	**99203** **99213**	**99204** **99214**	**99205** **99215**



MEDICAL DECISION MAKING: Draw a line down the column with 2 or 3 circles and circle Decision-Making Level OR draw a line down the column with the center circle and circle the Decision-Making Level. (* If there aren't at least 2 in the same column, go to the LOWEST column of the 2 below)				
Diagnosis or Treatment Options	Minimal	Limited	Multiple	Extensive
Complexity of Data	Minimal or none	Category 1: Tests, documents, or independent historian(s) (must meet 1) • 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) Or Category 3: Discussion of management or test interpretation with external physician/other qualified health care professional(s)	Category 1: Tests, documents, or independent historian(s) (must meet 2) • 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(s) (not separately reported)	
Risk (Determined by presenting problem, data, and treatment/ Choose highest risk)	0	1 category out of 3	2 category out of 3	3 categories out of 3
	• Review of test • EKG/EEG • Chest x-ray • US • KOH prep • Apply ACE wrap or dressing • Diet modification • Therapeutic modalities	• Low complexity and low risk • Physiologic tests not under stress (ABI) • Non-contrast imaging studies with contrast (e.g. barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring simple puncture (e.g. finger/heel stick) • Minor surgery with no identified risk factors • PT, OT • IV fluids without additives • OTC	• Moderate complexity • Rx management (new script or changing existing Rx) • Needle incisional biopsy • LP, Thoracentesis • Endoscopy/minor surgery • Elective surgery • Closed fracture or dislocation without manipulation • Prescription medications • IV fluids w/additives	• High complexity (prognosis is imminent or highly probable) • Emergency major surgery • Parenteral controlled substance • Drugs requiring monitoring for toxicities • Decision to not resuscitate or stop
MDM Level	Straight forward	Low	Moderate	High
E/M for ER	99282	99283	99284	99285
E/M for clinic	99202 99212	99203 99213	99204 99214	99205 99215

ICD -10 Codes

ICD 10 – CM for Sexual Assault

- Z04. 89 can be used to specify conditions or terms like **forensic examination** abnormal or **forensic examination** done.
- Z04.41 – encounter for exam and observation following **alleged adult rape**
- Z04.42 - encounter for exam and observation following **alleged child rape**

Suspected Forced Sexual or Labor Exploitation

- If suspected case of forced sexual exploitation or forced labor exploitation is ruled out during an encounter, then code:
  - Z04.81 – Encounter for examination and observation of victim following forced **sexual exploitation**
  - Z04.82 - Encounter for examination and observation of victim following **forced labor exploitation**

Counseling Codes

- Z70 - Counseling related to sexual attitude, behavior and orientation
- Z71 - Persons encountering health services for other counseling and medical advice, not elsewhere classified

Sexual Abuse of Pregnant Patients

- O9A.3 - **Physical abuse** complicating pregnancy, childbirth, and the puerperium
- O9A.4 - **Sexual abuse** complicating pregnancy, childbirth, and the puerperium
- O9A.5 - **Psychological abuse** complicating pregnancy, childbirth, and the puerperium

These are non billable codes

Physical Abuse Complicating Pregnancy

- O9A.311 Physical abuse complicating pregnancy, first trimester
- O9A.312 Physical abuse complicating pregnancy, second trimester
- O9A.313 Physical abuse complicating pregnancy, third trimester
- O9A.319 Physical abuse complicating pregnancy, unspecified trimester
- O9A.32 Physical abuse complicating childbirth
- O9A.33 Physical abuse complicating the puerperium

Sexual Abuse Complicating Pregnancy

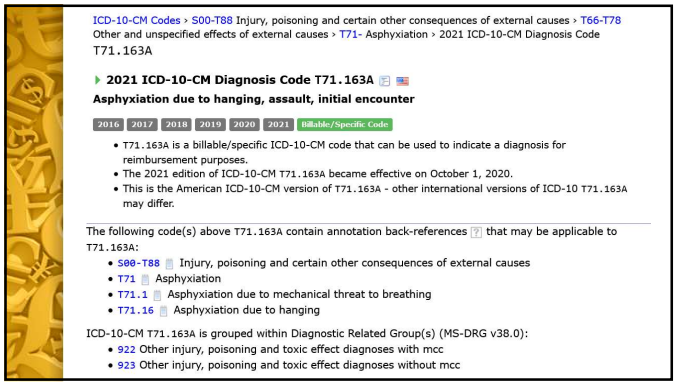
- O9A.411 Sexual abuse complicating pregnancy, first trimester
- O9A.412 Sexual abuse complicating pregnancy, second trimester
- O9A.413 Sexual abuse complicating pregnancy, third trimester
- O9A.419 Sexual abuse complicating pregnancy, unspecified trimester
- O9A.42 Sexual abuse complicating childbirth
- O9A.43 Sexual abuse complicating the puerperium

Psychological Abuse Complicating Pregnancy

- O9A.511 Psychological abuse complicating pregnancy, first trimester
- O9A.512 Psychological abuse complicating pregnancy, second trimester
- O9A.513 Psychological abuse complicating pregnancy, third trimester
- O9A.519 Psychological abuse complicating pregnancy, unspecified trimester
- O9A.52 Psychological abuse complicating childbirth
- O9A.53 Psychological abuse complicating the puerperium

Injury Codes

- Can use https://www.icd10data.com/
- Injury code examples
  - Strangulation - Asphyxiation due to hanging, assault, initial encounter T71. 163A
  - S01.81XA – Laceration without foreign body forehead, initial encounter



ICD-10-CM Codes › S00-T88 Injury, poisoning and certain other consequences of external causes › T66-T78 Other and unspecified effects of external causes › T71- Asphyxiation › 2021 ICD-10-CM Diagnosis Code T71.163A

2021 ICD-10-CM Diagnosis Code T71.163A

Asphyxiation due to hanging, assault, initial encounter

2016 2017 2018 2019 2020 2021 Billable/Specific Code

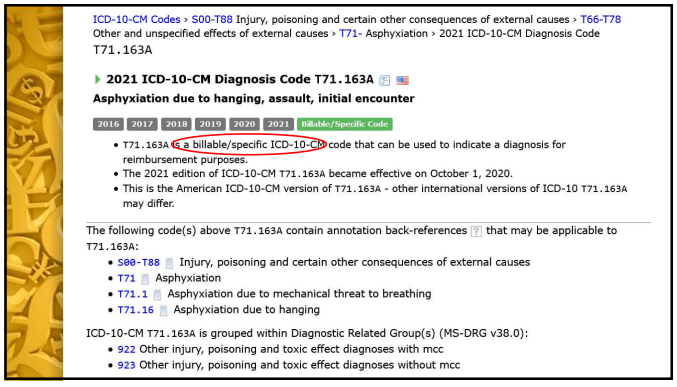
- T71.163A is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.
- The 2021 edition of ICD-10-CM T71.163A became effective on October 1, 2020.
- This is the American ICD-10-CM version of T71.163A - other international versions of ICD-10 T71.163A may differ.

The following code(s) above T71.163A contain annotation back-references that may be applicable to T71.163A:

- S00-T88 Injury, poisoning and certain other consequences of external causes
- T71 Asphyxiation
- T71.1 Asphyxiation due to mechanical threat to breathing
- T71.16 Asphyxiation due to hanging

ICD-10-CM T71.163A is grouped within Diagnostic Related Group(s) (MS-DRG v38.0):

- 922 Other injury, poisoning and toxic effect diagnoses with mcc
- 923 Other injury, poisoning and toxic effect diagnoses without mcc



ICD-10-CM Codes › S00-T88 Injury, poisoning and certain other consequences of external causes › T66-T78 Other and unspecified effects of external causes › T71- Asphyxiation › 2021 ICD-10-CM Diagnosis Code T71.163A

2021 ICD-10-CM Diagnosis Code T71.163A

Asphyxiation due to hanging, assault, initial encounter

2016 2017 2018 2019 2020 2021 Billable/Specific Code

- T71.163A is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.
- The 2021 edition of ICD-10-CM T71.163A became effective on October 1, 2020.
- This is the American ICD-10-CM version of T71.163A - other international versions of ICD-10 T71.163A may differ.

The following code(s) above T71.163A contain annotation back-references that may be applicable to T71.163A:

- S00-T88 Injury, poisoning and certain other consequences of external causes
- T71 Asphyxiation
- T71.1 Asphyxiation due to mechanical threat to breathing
- T71.16 Asphyxiation due to hanging

ICD-10-CM T71.163A is grouped within Diagnostic Related Group(s) (MS-DRG v38.0):

- 922 Other injury, poisoning and toxic effect diagnoses with mcc
- 923 Other injury, poisoning and toxic effect diagnoses without mcc

2021 ICD-10-CM Diagnosis Code S57

Crushing injury of elbow and forearm

2016 | 2017 | 2018 | 2019 | 2020 | 2021 | Non-Billable/Non-Specific Code

- S57 should not be used for reimbursement purposes as there are multiple codes below it that contain a greater level of detail.
- The 2021 edition of ICD-10-CM S57 became effective on October 1, 2020.
- This is the American ICD-10-CM version of S57 - other international versions of ICD-10 S57 may differ.

Codes

- S57 Crushing injury of elbow and forearm
  - S57.0 Crushing injury of elbow
    - S57.00 Crushing injury of unspecified elbow
      - S57.00XA ..... initial encounter
      - S57.00XD ..... subsequent encounter
      - S57.00XS ..... sequela
    - S57.01 Crushing injury of right elbow
      - S57.01XA ..... initial encounter
      - S57.01XD ..... subsequent encounter
      - S57.01XS ..... sequela
    - S57.02 Crushing injury of left elbow
      - S57.02XA ..... initial encounter
      - S57.02XD ..... subsequent encounter
      - S57.02XS ..... sequela

Pick most specific code to describe the injury

- S61.219A - Laceration without foreign body of unspecified finger without damage to nail, initial encounter
- S61.312A middle finger –laceration without foreign body, with damage to nail
- S61.213A - Laceration without foreign body of left middle finger without damage to nail, initial encounter


MEDICAL BILLING AND CODING

CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES

Examination

Laboratory Procedures

Radiology

Toxicology (80300 – 80377)

STI testing (pathology)

Special Service, Procedure, or Report

Suicide Risk Assessment

Admission

Office/Outpatient Visit, Established patient

Other E&M Services related to Exam

Ultrasound

Modifier Codes

- A **modifier** is a code that provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but has not changed in its definition or code
- For example:

  Modifier 32 (mandated services)

HCPCS

- Healthcare Common Procedure Coding System (HCPCS) is a standardized code system necessary for medical providers to submit healthcare claims to Medicare and other health insurances in a consistent and orderly manner.
- HCPCS codes are used for Medicare and Medicaid and some 3rd party payors.

UB-04 and CMS-1500 forms

Patient Example - 34 year old female who was sexually assaulted and strangled. She has contusions on her neck. Laceration on her forehead that required suturing. CT scan of her head and neck completed. Forensic exam was done with evidence collection kit.

Need DX code for

- Sexual assault
- Strangulation
- Forehead laceration

Need procedure codes for

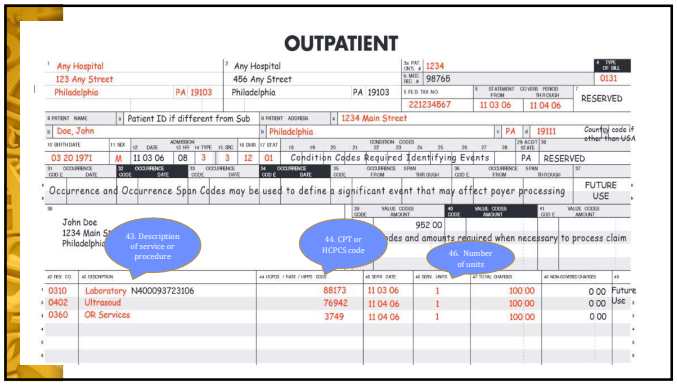
- CT scan of head and neck
- Pelvic exam with cultures
- Culture codes
- Labs drawn
- Medications

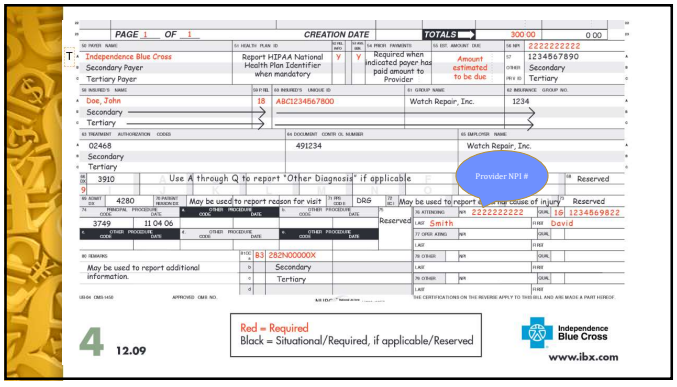
Diagnosis Codes

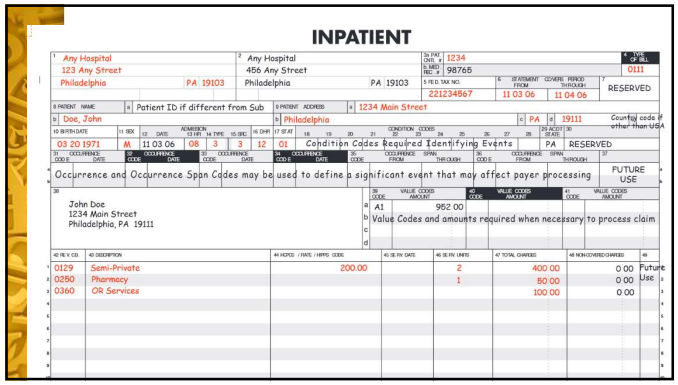
- Z04.41 – encounter for exam and observation following alleged adult rape
- T71. 163A - Asphyxiation due to hanging, assault, initial encounter
- S01.81XA – Laceration without foreign body forehead, initial encounter

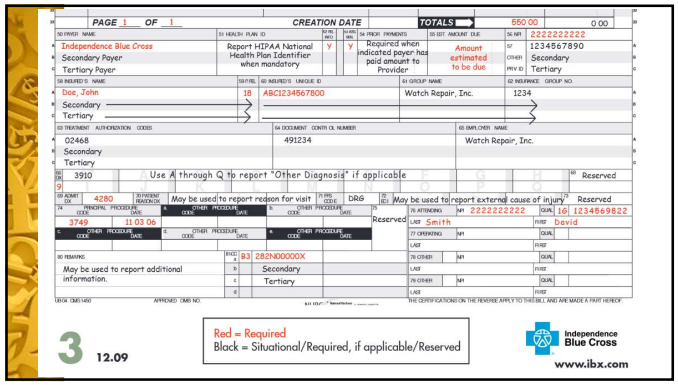
Procedure Codes

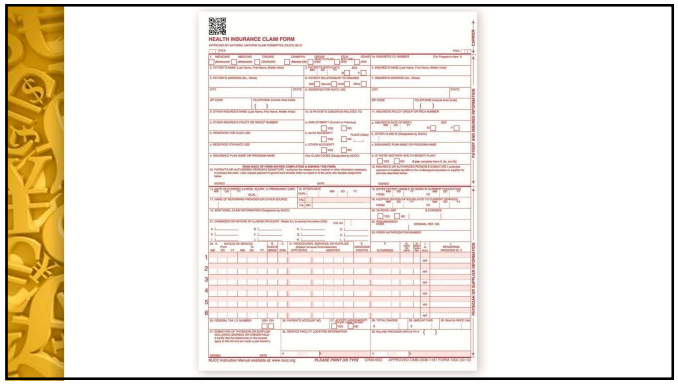
- CT scan of head and neck
  - 70450 - CT HEAD BRAIN W/O CONTRAST
  - 70490 - SOFT TISSUE NECK W/O CONTRAST
- Check if you have a forensic exam bundle CPT code (includes pelvic, evidence collection, and cultures, maybe labs) If not need CPT code each test.
- Medications
  - Zithromax 1 gram – Q0144
  - Flagyl 500 mg IV – S0030
  - Zofran 1mg injection = J2045 (orally is S0119)

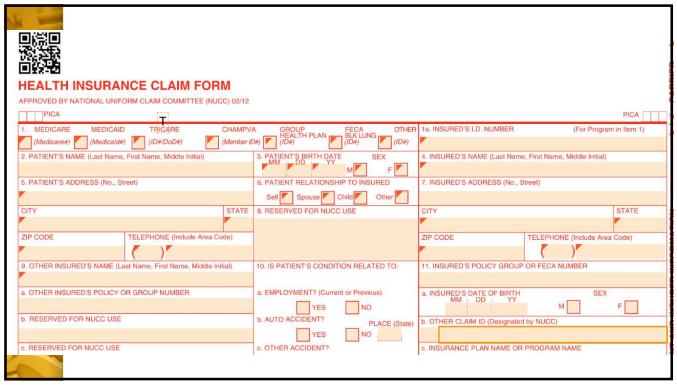





INPATIENT
Any Hospital
123 Any Street
Philadelphia PA 19103
Any Hospital
456 Any Street
Philadelphia PA 19103
1234
98765
0111
221234567
11 03 06
11 04 06
RESERVED
Patient ID if different from Sub
1234 Main Street
Doe, John
Philadelphia
PA
19111
Country code if other than USA
03 20 1971
M
11 03 06
08
3
3
12
01
Condition Codes Required Identifying Events
PA
RESERVED
Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing
FUTURE USE
John Doe
1234 Main Street
Philadelphia, PA 19111
A1
952 00
Value Codes and amounts required when necessary to process claim
0129
Semi-Private
200.00
2
400 00
0.00
0250
Pharmacy
1
50 00
0.00
0360
OR Services
100 00
0.00
Future Use


PAGE 1 OF 1
CREATION DATE
TOTALS
550 00
0.00
Independence Blue Cross
Secondary Payer
Tertiary Payer
Report HIPAA National Health Plan Identifier when mandatory
Y
Y
Required when indicated payer has paid amount to Provider
Amount estimated to be due
2222222222
1234567890
Secondary
Tertiary
Doe, John
ABC1234567800
Watch Repair, Inc.
1234
02468
491234
Watch Repair, Inc.
Secondary
Tertiary
3910
Use A through Q to report "Other Diagnosis" if applicable
Reserved
4280
May be used to report reason for visit
DRG
May be used to report external cause of injury
Reserved
3749
11 03 06
2222222222
16 1234569822
Smith
David
83 282N00000X
May be used to report additional information.
Secondary
Tertiary
3
12.09
Red = Required
Black = Situational/Required, if applicable/Reserved
Independence Blue Cross
www.ibx.com


HEALTH INSURANCE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

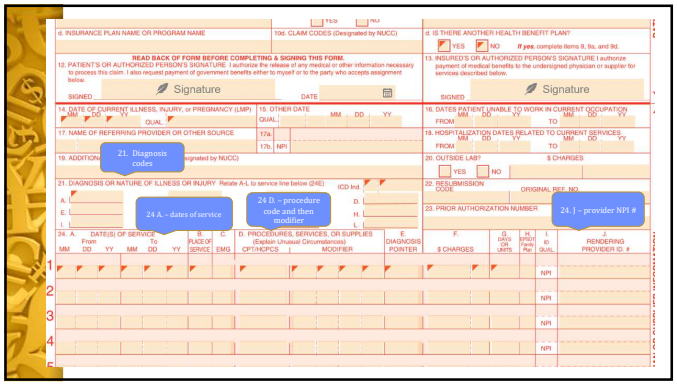
b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?

c. INSURANCE PLAN NAME OR PROGRAM NAME

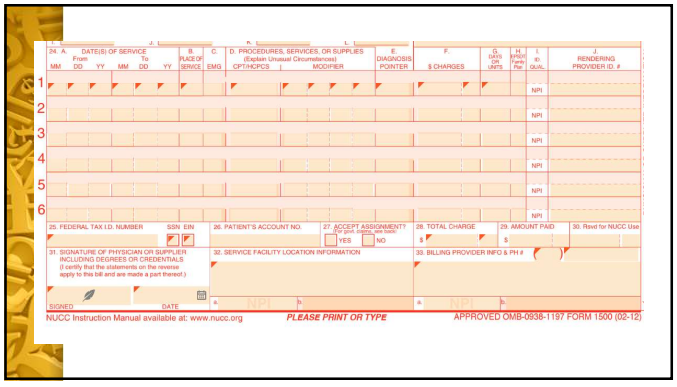


21. Diagnosis codes

24 A. - dates of service

24 D. - procedure code and then modifier

24. J – provider NPI #



Common Denials

Denials

- Wrong procedure codes
- Wrong diagnosis codes
- Documentation does not support level of service (LOS)
- Omitted documentation
- Forms filled out incorrectly

Critical Care Time

AMA defines critical care as:

"A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.."

(AMA/CPT 2008)

Critical Care Time

- Will not be used for outpatient
- No specific key elements required
- No Specific HPI, ROS, Physical Exam documentation requirements
- Time based code
- Patient must meet certain criteria

Organ System Failure

- Central nervous system failure
- Circulatory Failure
- Shock
- Renal Failure
- Hepatic Failure
- Metabolic Failure
- Respiratory Failure

Critical Care Requirements

- Clinical Requirement of high probability of deterioration
- Time requirement
- Minimum 30 minutes
- Excludes separate procedures

Full attention and provider time

- Time counted must be exclusively devoted to patient
- Does not have to be continuous
- Provider must document total time on chart
- Must document that time involved in separately billable procedures was not counted as CC time

Critical Care time	Code
< 30 minutes	Appropriate E/M code
30-74 minutes	99291
75-104 minutes	99291, 99292
105-134 minutes	99291, 99292 X2

Does not qualify for CC time

- Billable procedure time
- Telemetry boarders
- CPR is not part of CC time
- Time spent supervising CPR must be subtracted

Check Your State For Billing Requirements

- To identify what is not covered under their forensic exam payment laws and procedures
- The Violence Against Women Act (VAWA) provides specific support for patients to access medical forensic exams free of charge. A key role of health care providers is to inform patients of the availability of medical forensic exams at no cost.
  - This does not extend to medical testing and evaluation – so know your resources
- International Association of Forensic Nurses - http://www.forensicnurses.org/

Example of Procedure codes Washington State

- **Local Codes**
  - 0130C — Sexual Assault — Vitals Only, No Physical Exam
  - 0131C — Sexual Assault Examination Level 1
    - 5 to 45 minutes face-to-face with patient by medical provider(s). Requires a history and a physical examination. Include supplies (e.g. forensic evidence collection kit).
  - 0132C — Sexual Assault Examination Level 2
    - 46 to 119 minutes face-to-face with patient by medical provider(s). Requires a history and a physical examination. Includes supplies (e.g. forensic evidence collection kit) and prolonged services.
  - 0133C — Sexual Assault Examination Level 3
    - 120 minutes or more face-to-face with patient by medical provider(s). Requires a history and a physical examination. Includes supplies (e.g. forensic evidence collection kit) and prolonged services.

Do you have billing and coding questions for your facility?

References

- American Medical Association. Current Procedural Terminology. Professional Edition. Chicago, IL: American Medical Association; 2021.
- Centers for Medicare and Medicaid Services. Internet-Only Manual. Publication 100-4. Chapter 12. Section 30.6.12. Washington, DC: Centers for Medicare and Medicaid Services; 2017. https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/downloads/clm104c12.pdf.
- Center for Medicare & Medicaid ServiceCPT® Evaluation and Managements. (2020, January) Evaluation and Management Service Guide. Retrieved from www.cms.gov
- Center for Medicare & Medicaid Services. (2020, 1995 Documentation Guidelines for Evaluation and Management Services. Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
- International Association of Forensic Nurses. (n.d.). Exam Payment Tools. Retrieved from https://www.safeta.org/page/PTAtools

INTERNATIONAL ASSOCIATION OF Forensic Nurses

Medical Forensic Exam Payment TA project

info@safeta.org or projects@forensicnurses.org

Helpline: 877-819-SART

Talk to us

Contact the International Association of Forensic Nurses @ info@ForensicNurses.org 1-410-626-7805

@forensicnurses

@IAFN_forensicnurses