

NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

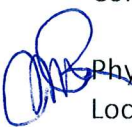
ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

DANNY STALEY • Director, Division of Public Health

MEMORANDUM

To: Local Health Directors, Nursing Directors and Nursing Supervisors, DPH
Consultants

From:  Phyllis M. Rocco, MPH, BSN, RN, Chief Public Health Nurse and Branch Head,
Local Technical Assistance and Training

Subject: Choice of Staff to Conduct CPT Coding and Billing

Date: August 2, 2018

This memo has been developed in response to the question: Is there a law or rule that prohibits non-clinicians from selecting a diagnosis and/or CPT code for the purposes of local health department (LHD) coding and billing?

Background:

The Division of Public Health's stance on whom is the correct staff to perform medical coding and billing has evolved over the past several years. We have always recommended as a best practice that the provider of care should be the one who selects and assigns the ICD 10, HCPCS, and CPT codes. This recommendation has its roots in the 2000 unbundling of NC designated public health Medicaid reimbursable service codes to adopting the universal ICD 10 codes and American Medical Association CPT code nomenclature. Fast forward 18 years, we now have electronic health records that suggest appropriate diagnosis codes just based on the documentation a clinician enters. Additionally, as part of meaningful use rules, CMS requires all providers to clearly document a diagnosis or impression and a treatment of care to be meet meaningful use documentation requirements. In turn, the "health care environment" has evolved to support a more accurate documentation of care, ease of documentation and more specificity in the selection of diagnosis codes. In addition, very few health departments operate without either an APRN, PA, or MD/DO on site daily.

There are no laws/rules that stipulate the clinician must be the person to select CPT/HCPCS/ICD-10 codes. Requiring that all the coding and billing be conducted by the clinician

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may limit the ability of the clinician to maximize their service capacity. Therefore, we would like to share the Division of Public Health's new guidance regarding medical coding and billing.

1. The key to correct coding and billing is being able to understand the medical documentation **and** correlate it to a matching diagnosis and /or CPT code.
2. While the provider is ultimately responsible for the codes (ICD-10, CPT, HCPCS) upon audit, coding selection authority may be delegated to other trained staff if that is the agency's practice and it is captured in policy.
3. Training and periodic competency validation should be included with any policy/process change and upon new hire orientation.
4. Work flow should be considered as policies/processes are evaluated and changed.
5. Consideration of whether the clinical provider is available on site to interpret documentation or assist in clarifying diagnosis choices may assist in agency decisions regarding changing policies/processes.
6. The LHD should consider risk management policies and consultation with the medical director and providers in planning these changes.
7. The LHD should have routine billing/coding audits to assure quality and risk management.
8. For health departments with certified coder(s):
 - a. It is a relatively common and established practice in private practice and hospitals for certified coders to select CPT, HCPCS, and/or ICD-10 codes based upon the provider's documentation.
 - b. Agencies may use the certified coder as a resource for clinicians and other billing staff when there are complicated services and diagnoses.
 - c. Some or all code selection may be delegated to a certified coder.
9. For health departments without certified coder(s):
 - a. Agencies may still opt to either only let providers select codes.
 - b. Nurses or clinical providers may be appropriate in the LHD work flow to assign additional codes based on the provider's documentation.
 - c. Non-clinical staff may be identified to add codes from a specified list in specific instances determined by the agency. For example, trained billing staff may be allowed to add a vaccine administration procedure code when the chart reflects a vaccine was administered.