Oakland Physician Network Services

Billing and Coding Tips

Claims and Remittances

Either an Electronic Remit Advice (ERA) or a Standard Paper Remit (SPR) is sent including payment information and final claim adjudication once a claim is processed. Your healthcare remittance advice is a notification showing that an invoice has been paid:

1. Standard Paper Remittance (SPR)
   Format: A physical paper statement (often called an Explanation of Benefits or paper copy) mailed to the provider. Includes the proper denial codes and descriptions.
   Retrieval/Duplicates: If you need paper copies or duplicates, you can request them through your MAC portal, via Interactive Voice Response (IVR), or by submitting a written request containing the check or RA number and issue date.

2. Electronic Remittance Advice (ERA)
   Format: Delivered in the national HIPAA-standard X12 835 (version 5010) digital format.
   Viewing Tools: Free software such as Medicare Remit Easy Print (MREP) for professional providers or PC Print for institutional providers allows you to view, print, and export data (such as into Excel).
   Portal Access: You can retrieve digital copies directly through your Medicare Administrative Contractor (MAC) or payer portal (such as WPS Government Health Administrators or Noridian).Most health plans have online provider portals such as Availity, Prism, and Medicare. Please note that not all Electronic Funds Transfers (EFT) will be automatically distributed to your practice. Please see plan rules and obtain accordingly, some payors might have time frames on when to retrieve those documents.

Coding

Make sure to code the condition to the highest specificity means assigning the most detailed and precise code available that is fully supported by the patient's medical record documentation.

Key Rules of Highest Specificity:

• Use all available characters: Select codes that use the full number of digits, letters, or 7th-character extensions required by the classification system (ranging from 3 to 7 characters).

• Avoid unspecified codes: Reserve "unspecified" codes strictly for situations where the medical record genuinely lacks any further clinical detail to support a more specific choice.

• Document key clinical elements: Include anatomical site/laterality (left vs. right), severity, stage, or the relationship to an initial versus subsequent encounter whenever noted by the provider.

• Prevent claim denials: Payers frequently reject or deny claims that are truncated or mapped to overly broad, generic codes instead of the maximum available digits.

- More specific coding = Accurate billing
- Appropriate supporting documentation = Appropriate Reimbursement

- Accurate diagnosis leads to meaningful data analysis to promote proper care provided to patients.

Tips for coding to the highest specificity

- Use the most current ICD-10 codes
- When there are multiple forms of a chronic diagnosis, document and select the exact code that identifies the condition.
    - Accurately document conditions that can be coded as a combination code. Ex: "Due to" or "Associated with"
- Utilize the "history of" Z codes available for conditions the patient no longer has
- 4 C's": **Clear, Concise, Consistent, & Complete**

  • **Clear**: Use simple, precise language and avoid unnecessary jargon so the audience easily grasps the main point.

  • **Concise**: Eliminate wordiness, filler, and repetitive details to get straight to the point with maximum meaning.

  • **Consistent**: Maintain a uniform style, tone, voice, and formatting throughout your message or document.

  • **Complete**: Provide all necessary context, facts, evidence, and background so the audience is left with no unanswered questions.
    - Documentation should include lab/pathology results to identify code assignments.
    - Certain diagnosis codes can only be billed in the first-listed or primary diagnosis code field
    - Avoid using unspecified diagnosis codes when there is a more specified code
    - Avoid selecting a diagnosis for the chronic condition when the patient has acute condition
        - **J41.0 – Simple chronic bronchitis**
          VS
        - **Acute bronchitis code range J20-J20.9**

Diabetes Coding

Each type of diabetes has specific code, and diabetic complications must be documented accurately.

- Documenting complications: Each complication has specific ICD-10 code that must be used in conjunction with the diabetes code. Use as many codes as necessary to capture all complications of diabetes
    - ✓ Example: diabetic retinopathy, nephropathy, or peripheral vascular disease
- Combination codes: many diabetes codes are combination codes that include the type of diabetes and associated complications
- Casual relationships: The ICD-10 coding guidelines presume a causal relationship between diabetes and many associated conditions
    - ✓ Example: if the patient has diabetes and chronic kidney disease, the coding should reflect this relationship in the documentation

- Control Status
    - ✓ Well controlled diabetes might use a code ending in “9” (E11.9), while uncontrolled diabetes uses a different code depending on the complication

Be diligent when choosing type of diabetes, complications, or control status for appropriate reimbursement

Documentation Tips

Best Practice

Each encounter is a stand-alone record. Documentation in medical record needs to be supported at each visit. When auditing, only that specific encounter will be referenced. Documentation needs to be supported every time a diagnosis is reported.

1. Problem List: an accurate and complete list can promote patient safety and care by providing a centralized, reliable overview of a patient's active and historical health conditions.
2. Medication List: A complete medication list linking drugs to diagnoses and supporting documentation requires specific clinical, administrative, and diagnostic details to ensure safety, compliance, and accurate care.
3. Comorbidity capture is the process of accurately documenting and coding coexisting secondary medical or psychiatric diagnoses alongside a patient's primary reason for care.
4. Documentation of all cause-and-effect relationships clearly linking a primary medical condition to its complications, manifestations, or secondary effects using specific clinical language rather than leaving them as isolated or co-existing diagnoses.
5. Documentation specificity: Clear, Complete, and Specific documentation = Proof of quality and continuity of care. In healthcare, the legal and professional gold standard remains: "If it wasn't documented, it didn't happen." Detailed records ensure that any provider stepping in can understand the patient's history and seamlessly continue treatment without gaps or medical errors.
6. "History of" (Personal History) is strictly reserved for conditions that are fully resolved and no longer exist. According to official ICD-10-CM guidelines, a true "history" code (Z85–Z87, Z91–Z92) signifies that the patient is no longer receiving active treatment for that condition, even though the condition may require continued surveillance or have a risk of recurrence. inactive conditions
7. Active vs. Inactive Tracking Framework

Tracking Element	Active Conditions	Inactive Conditions
Primary Goal	Acute management, symptom control, and daily treatment.	Prevention, early detection of recurrence, and historical reference.
Frequency	Frequent visits (weeks to months).	Annual or multi-year check-ins.
Intervention	Actively prescribing or adjusting therapies.	Observation, lifestyle counseling, and screening.

8. Confirmed diagnoses only: chronic conditions assessed at least one time per year
    - ➢ Condition status: Is it relevant to treatment? Is it influencing the plan of care?
    - ➢ Management of the condition
    - ➢ Follow up of the condition