Optimizing Revenue with Correct Documentation and Coding

OAAPN
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Objectives

Review OAAPN Reimbursement Goals, Member Services, Current Issues

Documentation, Coding and Billing Foundations

Coding, Documentation and Reimbursement for Evaluation and Management Services

Procedure Documentation and Coding

Medicare Preventive Services

Data Mining and Benchmarking

OAAPN Reimbursement Goals

Recognition as credentialed and contracted providers

Full recognition of APRNs as PCPs by all public and commercial insurance payers

Promotion of :

- Equitable and fair reimbursement for APRN health care services – equal pay for equal work and equitable copays
  - No discrimination against all qualifying APRNs as credentialed and contracted providers
  - Removal of requirement that the APRN's collaborating physician be a recognized and credentialed network provider with the APRN's insurance payers (with retirement of the SCA – no need for contracted physician collaborator)
  - Credentialed as primary or specialty care APRN providers to include full taxonomy with CMS

Ohio Specific Payer Reimbursement Issues

Insurance Matrix:

- Payers:
  - Medicaid, Aetna, Anthem, Caresource, CIGNA, Paramount, SummaCare, MediGold, Buckeye, Molina, Medical Mutual, Humana, Ohio Health Choice, The Health Plan, UnitedHealth Care, Golden Rule and more
- Review Insurance Matrix: (see handouts)
- Movement from 85% to 100% reimbursement – equal pay for better outcomes
- Medicare and other insurer denial of the first visit to specialty or primary care APRN when under same Tax ID of another APRN provider
- Refusal of insurer to note the APRN PCP name on member's ID card

Reimbursement & Practice Barriers Addressed by OAAPN

Multi-insurer requirement that the collaborating physician must be credentialed and contracted as a provider in the insurer's network before recognition of APRN as a credentialed provider – **myth busters**

Requirement that the collaborating physician carry additional insurance coverage, to cover the APRN collaborating agreement (SCA) – **myth busters**

Requirement that the collaborating physician cease collaborating with the APRN to keep his/her liability coverage – **myth busters**

APRN Medicaid Rules- **update**

Reimbursement and Practice Barriers Addressed by OAAPN (cont.)

Regularly address individual member concerns

Responding to issues by email, or direct communication with APRN or practice staff

Request APRN credentialing and contracting policies from all payers to be included in the insurance matrix

Ongoing meetings held with all licensed Ohio insurers to discuss the value of APRN practice available to their covered lives

Practice Barriers Addressed

Board of Nursing Rule – changes and updates

Medicaid and APRN Telemedicine services

Medicaid and APRN admissions

Provide education and assistance regarding LTC billing

Medicaid/Medicare billing audits

Insurer recognition of PCP status in statute

OAAPN Provides Member Services:

Engages legal counsel to assist in addressing member reimbursement problems

Answers all practice and scope questions with legal service

Meets with all insurance companies to resolve member problems

Promotes ongoing discussions with Medicaid and Medicare to maintain cooperative communication channels

Seeks expert billing & coding advice for member questions

OAAPN Provides Member Services: (cont.)

Engages national leadership in addressing Ohio-National practice barriers requiring national solutions, such as: Ordering Diabetic Shoes and Home care referrals

Provides regular practice, legal and reimbursement updates to all members

OAAPN CAN HELP!

Reimbursement Improves with FPA

Ohio is a restrictive practice state – seeking FPA

FPA states have advanced reimbursement policies:

- Reimbursement is more equitable when no physician oversight is required for practice, and..
  - Insurers are less likely to discriminate
  - States are more likely to mandate equal recognition
- In General: State policies affecting APRN autonomy have a greater effect on the private insurance market than state mandates banning insurance discrimination
- In Ohio, all insurers recognize NPs as PCPs

Architecture

- All aspects of the medical encounter contribute to the building/billing of CPT codes.

This involves the proper registration of the patient, the appropriate assessment of the patient's situation, the care given, the documentation of this care and the mechanism for turning all of this information into billable code.

Foundations

Documentation

- Clinical Arena
  - What is documentation?
  - Why do we document?

Clinical Arena

What is documentation?

A chronological record of patient care composed of pertinent facts, findings and observations. This includes a health history containing past and present illnesses, examinations, tests, treatments and outcomes.

Clinical Arena

Why do we document?

- Enhances the provider's ability to evaluate and plan the patient's immediate treatment and to monitor that care/treatment over time.
- Promotes communication and continuity of care among providers
- Provides for accurate and timely claim review and payment
- Permits utilization review and quality of care evaluation
- Collects data used in research and education

Foundations

Payer Arena

- What do Payers wants to see?
- Why?

Payer Arena

What do Payers want to see?

- Place of Service
- Medical Necessity
- Appropriateness of therapeutic / diagnostic services provided
- Accurate reporting of services rendered

Payer Arena

Why?

- Payers have contractual obligation to those who pay for coverage
- Documentation standards may be present in contracts (example CPT versus CMS)
- $$Cash Management$$

Foundations

General Principles of Medical Documentation

Neat and Legible

In each encounter:

- Reason for the encounter – Medical Necessity
- Relevant History and Physical
- Assessment, Clinical Impression/ Diagnosis
- Plan of Care
- Date and Legible Identification of Provider

Foundations

General Principles of Medical Documentation

If not documented, rationale for ordering diagnostics or other ancillary services should be easily inferred

Past and present diagnoses should be accessible

Health risk factors should be identified

Foundations

General Principles of Medical Documentation

Progress, response to and changes in treatment and revisions in diagnosis should be present

CPT and ICD-10-CM codes on the claim form should be supported by the documentation in the medical record

Diagnosis Coding

Diagnosis code(s) selected must be reflected in the documented medical record

- Always distinguish between acute, chronic and acute on chronic conditions
- Identify how an injury occurred – this will require an ICD-10 code of "W", "X" and/or "Y"
- Always assign the ICD-10 code to the highest level of specificity (4^{th}, 5^{th}, 6^{th} or 7^{th} character)
- Always code all diagnoses addressed and documented in the medical record
- Always code all diagnoses which were considered when creating your assessment and plan
- When ordering diagnostic testing, use the ICD-10 code that supports the reason for the testing

Diagnosis Coding

Diagnosis code(s) selected must be reflected in the documented medical record

- "Rule-out's" do not have ICD-10 codes – use signs and/or symptoms if a definitive diagnosis is not available
- Routine lab tests performed in the absence of symptoms use:
  - Z00.00 – Encounter for general adult medical examination without abnormal findings
  - Z00.01 – Encounter for general adult medical examination with abnormal findings
- Routine tests ordered due to a personal or family history use the corresponding "Z" diagnosis code

Proper Selection

Evaluation and Management Coding is always based on two things:

1. What you are doing and
2. Where you are

Where – Place of Service

Place of Service (POS) tells the payer what fee schedule to use

- Walk-in Retail Health Clinic (POS) 17
- Office is Place of Service (POS) 11
- Outpatient Hospital (Off Campus) is (POS) 19
- Outpatient Hospital (On Campus) is (POS) 22
- Inpatient is Place of Service (POS) 21
- Skilled Nursing Facility is Place of Service (POS) 31
- Nursing Facility is Place of Service (POS) 32

Where – Place of Service

Place of Service (POS) tells the payer what fee schedule to use

Here's why POS is so important:

	Office (POS 11)	wRVU	Outpatient Hospital (POS 22)	wRVU
99201	$44.23	0.48	$26.71	0.48
99202	$74.09	0.93	$50.29	0.93
99203	$105.49	1.42	$75.74	1.42
99204	$160.95	2.43	$128.23	2.43
99205	$202.68	3.17	$167.23	3.17

What is the Minimal Information Required to Create a Billing Encounter?

Minimum of Five Pieces of Data:

- Patient
- Provider of Service
- Date of Service
- Actual Service
- Diagnosis to Support Performing the Service

What is the Minimal Information Required to Create a Billing Encounter That is Likely to Be Paid?

Information from the prior slide plus:

- Correct Demographics
- Correct Insurance Information
- Accurate Charge Entry
- Accurate Edits
- Accurate Claim Submission
- Accurate Claim Adjudication

Components of E & M's

History *

Physical Examination *

Medical Decision Making *

Counseling

Coordination of Care } Time

* Indicates a "key" component

Components of the History

Doctor's Office or Outpatient Hospital New Patient Visits Requires 3 of 3 Components - History, Exam, MDM or Time						
NEW PATIENT		99201	99202	99203	99204	99205
HISTORY	CHIEF COMPLAINT	Required	Required	Required	Required	Required
	HPI	1 Element	1 Element	4 Elements	4 Elements	4 Elements
	ROS	N/A	1 System	At Least 2 Systems	At Least 10 Systems	At Least 10 Systems
	PMFSH	N/A	N/A	1 History	3 Histories	3 Histories

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Components of the History

Comprised of the following:

Chief Complaint (CC)

History of Present Illness (HPI)

Review of Systems (ROS)

Past Medical, Family and/or Social Histories (PFSH)

Chief Complaint

A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is reason for the encounter.

i.e.- Why is the patient being seen?

May be in the patient's own words

May be gathered by ancillary staff

History of Present Illness

A chronological description of the development of the present illness. It can include:

- **1)location, 2)quality, 3)severity, 4)duration, 5)timing, 6)context, 7)modifying factors, and 8)associated signs and symptoms**
- **L I T T – Location, Intensity (Severity), Timing and Treatment (Modifying Factors)**

Extended HPI requires at least four elements **OR**

the status of at least three chronic or inactive conditions – this change is effective for dates of service 9/10/2013 and after

Review of Systems

An inventory of body systems seeking to identify signs and/or symptoms that the patient has been and/or is experiencing

Recognized Body Systems for Review of Systems

- Constitutional
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Psychiatric
- Neurologic
- **Endocrine**
- Hematologic/Lymphatic
- Allergy/Immunologic

Review of Systems

Think Review of **Symptoms**

When a *comprehensive* ROS is needed, the correct documentation is:

- *"All other systems have been reviewed and are negative except as previously noted"*
- *"Unless noted in the HPI, all other systems have been reviewed and are negative for complaint"*
- *"Unremarkable"* and *"Noncontributory"* must be avoided

Past Medical, Family and Social Histories

Past History: patient's past experiences with illnesses, operations, injuries, and treatments

Family History: review of medical events in the patient's family including diseases which may be hereditary or place patient at risk

Social History: age appropriate review of past and current activities; alcohol, tobacco, illicit drug use

Proper Coding Documentation

Correct documentation is:

Past, family, and social history ***obtained*** but not pertinent to current problem.

"Unremarkable" and *"Noncontributory"* must be avoided

Proper Coding Documentation

Anyone can gather the ROS, PMFSH information

The information can be prepared by the patient or family and reviewed by you during the encounter

Components of the Physical Examination

Doctor's Office or Outpatient Hospital New Patient Visits
Requires 3 of 3 Components - History, Exam, MDM or Time

NEW PATIENT		99201	99202	99203	99204	99205
PHYSICAL EXAM	1995	1 System	2 - 7 Systems	2 - 7 Systems (1 Detailed)	8 Systems	8 Systems
	1997	At Least 1 Bullet	At Least 6 Bullets	At Least 12 Bullets (At Least 9 Bullets Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes

Physical Examination – General Information

The following body areas are recognized: (applicable to 1995 CMS)

- head including the face
- neck
- chest including the breasts and axilla
- abdomen
- genitalia, groin, buttocks
- back, including spine
- each extremity

1995 Physical Examination Guidelines

- Constitutional (vital signs and general appearance)
- Eyes
- Ears/Nose/Mouth/Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/ Immunologic

Physical Examination – CPT Guidelines

The levels of E/M services are based on 4 types of examination. These types are dependent upon the number of body areas and/or organ systems examined for the general examination.

The types are:

- Problem Focused
- Expanded Problem Focused
- Detailed
- Comprehensive

Physical Exam – CPT versus CMS Guidelines

Type of Examination	1995	1997
Problem Focused	Limited Exam, affected area/system (one)	1 to 5 bullets
Expanded Problem Focused	2 to 7 systems	At least 6 bullets
Detailed	2 to 7 systems (more detail)	At least 12 bullets **(At least 9 bullets for Eye and Psych)**
Comprehensive	8 or more systems	Perform and document every element identified by a bullet in a shaded system/ body area and document at least one element in an unshaded system/body area

1997 Cardiovascular Examination Requirements

1997 Documentation Guidelines: Cardiovascular Examination	
Content and Documentation Requirements	
Level of Exam	Perform and Document
Problem Focused	**One to five** elements identified by a bullet
Expanded Problem Focused	**At least six** elements identified by a bullet
Detailed	**At least twelve** elements identified by a bullet
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with **a shaded border** and at least one element in each box with an unshaded border

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven vital signs:** 1. Sitting or Standing Blood Pressure 5. Temperature 2. Supine Blood Pressure 6. Height 3. Pulse Rate and Regularity 7. Weight 4. Respirations • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Cardiovascular	• Palpation of heart (e.g, location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) • Auscultation of heart including sounds, abnormal sounds and murmurs • Measurement of blood pressure in two or more extremities when indicated (e.g., aortic dissection, coarctation) Examination of: • Carotid arteries (e.g., waveform, pulse amplitude, bruits, apical-carotid delay) • Abdominal aorta (e.g., size, bruits) • Femoral arteries (e.g., pulse amplitude, bruits) • Pedal pulses (e.g., pulse amplitude) • Extremities for peripheral edema and/or varicosities

System/Body Area	Elements of Examination
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place and person • Mood and affect (e.g., depression,anxiety, agitation)
Eyes	• Inspection of conjunctivae and lids (e.g., xanthelasma)
Ears, Nose, Mouth and Throat	• Inspection of teeth, gums and palate • Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	• Examination of jugular veins (e.g., distension; a, v or cannon a waves) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Musculoskeletal	• Examination of the back with notation of kyphosis or scoliosis • Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs • Assessment in muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
Extremities	• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., stasis dermatitis, ulcers, scars, xanthomas)

Components of Medical Decision Making

Doctor's Office or Outpatient Hospital New Patient Visits Requires 3 of 3 Components - History, Exam, MDM or Time					
NEW PATIENT	99201	99202	99203	99204	99205
MEDICAL DECISION MAKING	Straight-forward	Straight-forward	Low Complexity	Moderate Complexity	High Complexity

Medical Decision Making

Medical Decision Making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- (A) Number of diagnoses or options;
- (B) Amount and/or complexity of data to be reviewed;
- (C) Risk of complications and/or morbidity or mortality

Important Topics*

Documentation of Medical Decision Making

- Remember to document the additional "by the way" problems that occur during the visit
- Use severity terminology, i.e., moderate or severe
- Document testing as ordered/reviewed vs. independently interpreted
- Document discussions with other providers
- Document history obtained from and/or discussions with family members or other caregivers

*All of these items are routinely missing from documentation

Number of Diagnoses or Management Options

The number of possible diagnoses and/or the number of management options is based on the:

- number and types of problems addressed during the encounter,
- complexity of establishing a diagnosis and
- management decisions that are made by the physician

Medical Decision Making

Nature of the Presenting Problem –

- New Problem with or without Work-Up
- Established Problem improving, stable or not improving

Number of Diagnoses or Management Options

MEDICAL DECISION MAKING						
A	Number of Diagnoses or Treatment Options				© Practical Coding Solutions LLC 2013	
	Problems to Patient		Number	X	Points =	Results
	Self-limited or minor (stable, improved or worsening)		(Max = 2)		1	
	Established Problem; stable, improving				1	
	Established Problem; worsening				2	
	New Problem; no additional work-up planned		(Max = 1)		3	
	New Problem; additional work-up planned				4	
	Bring total to **Line A** in the Final Results for Complexity				**Total**	

Medical Decision Making

Data –

- Labs, Radiology Studies or Medical Testing – ordered or report reviewed
- Personal review of an image or tracing
- Discussion of the case with another healthcare provider
- Using an interpreter
- Gathering information from a source other than the patient (e.g. family member or caregiver)
- Decision to obtain old medical records from another source
- Summarization of external medical records

Amount and/or Complexity of Data to be Reviewed

Amount and/or Complexity of Data to be Reviewed Data to be Reviewed	Points	Total Points
Review and/or order of clinical lab tests in the pathology/lab section of CPT	1	
Review and/or order of tests in the radiology section of CPT	1	
Review and/or order of tests in the medicine section of CPT	1	
Discussion of test results with performing physician	1	
Decision to obtain old records and/or obtain history from someone other than the patient	1	
Review and summarization of old records and/or discussion of case with another **health care provider**	2	
Independent visualization of image, tracing or specimen itself (not simply review of report)	2	
Bring total to **Line B** in the Final Results for Complexity	**Total**	

Risk of Significant Complications, Morbidity and/or Mortality

Based on the risks associated with:

- Presenting Problem(s)
- Diagnostic Procedure(s)
- Possible Management Options.

MEDICAL DECISION MAKING			
C	Risk of Complication and/or Morbidity or Mortality		
Level	The highest level of risk in any ONE category determines the overall risk.		
of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Option Selected
MIN	One self-limited or minor problem,	Laboratory tests requiring venipuncture	Rest
	e.g. cold, insect bite, tinea corporis	Chest X-ray	Gargles
		EKG/EEG	Elastic Bandages
		Urinalysis	Superficial Dressings
		Ultrasound	
		KOH Prep	
LOW	Two or more self-limited or minor problem(s)	Physiologic tests not under stress,	Minor surgery with no identified risk factors
	One stable chronic illness, e.g.well controlled	e.g. pulmonary function tests	Over-the-counter drugs
	hypertension or noninsulin dependent	Noncardiovascular imaging studies with contrast	Physical Therapy
	diabetes, cataracts, BPH	e.g. barium enema	Occupational Therapy
	Acute uncomplicated illness or injury,	Superficial needle biopsies	IV fluids w/thout additives
	e.g. cystitis, allergic rhinitis, simple sprain	Clinical laboratory tests requiring arterial puncture	
		Skin biopsies	

MEDICAL DECISION MAKING			
C	Risk of Complication and/or Morbidity or Mortality		
Level	The highest level of risk in any ONE category determines the overall risk.		
of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Option Selected
MODERATE	One or more chronic illnesses with mild exacerbation, progression or side effects of treatment	Physiologic tests under stress, e.g. cardiac stress test, fetal contraction stress test	Minor surgery with identified risk factors
		Diagnostic endoscopies with no identified risk factors	Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors
	Two or more stable chronic illnesses		**Prescription drug management**
	Undiagnosed new problem with uncertain prognosis, e.g. lump in breast	Deep needle or incisional biopsies	Therapeutic nuclear medicine
		Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram, cardiac catheterization	IV fluids with additives
	Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis		Closed treatment of fracture or dislocation without manipulation
	Acute complicated injury, e.g. head injury with brief loss of consciousness	Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis	
HIGH	One or more chronic illnesses with severe exacerbation, progression or side effects of treatment	Cardiovascular imaging studies with contrast with identified risk factors	Elective major surgery (open, percutaneous or endoscopic) with identified risk factors
		Cardiac electrophysiological tests	Emergency major surgery (open, percutaneous or endoscopic)
	Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g. multiple trauma, pulmonary embolus, acute MI, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure	Diagnostic endoscopies with identified risk factors	**Parenteral controlled substances**
		Discography	**Drug therapy requiring intensive monitoring for toxicity**
			Decision not to resuscitate or de-escalate care because of poor prognosis
	An abrupt change in neurologic status, e.g. seizure, TIA, weakness, sensory loss		**© Practicall Coding Solutions LLC 2013 UHHS**
Bring the highest level of risk to Line C in the Final Result for Complexity			

Medical Decision Making

There are four types of decision making:

- Straightforward
- Low Complexity
- Moderate Complexity
- High Complexity

Medical Decision Making Calculation

A) Total up score for Number of Diagnoses or Treatment Options

B) Total up score for Amount and/or Complexity of Data to be Reviewed

C) Risk of Complications and/or Morbidity or Mortality is the highest risk determined from the Presenting Problem or Diagnostic Procedure Ordered or Management Options

Two of above three (A, B, C) have to be at same level for that level of service

Medical Decision Making Calculation

	Final Results for Complexity				
A	Number of Diagnoses or Treatment Options	≤ 1 Minimal	2 Limited	3 Moderate	≥ 4 Extensive
B	Amount and/or Complexity of Data to be Reviewed	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥ 4 Extensive
C	Risk of Complication and/or Morbidity or Mortality	Minimal	Low	Moderate	High
D	Type of Medical Decision Making	Straight-Forward	Low Complexity	Moderate Complexity	High Complexity

MDM Example:

CC: Sinus pressure and pain with sore throat
HPI: Patient presents with right-sided sinus pain and pressure for three days. Running a fever for two days, about 100.3 on home thermometer. Has used ibuprofen with some relief. Additional symptoms: headache, ear fullness, nasal congestion, moderate sore throat; no cough or chest pain. All other systems have been reviewed and are negative for complaint.
PMH: History or sinus/allergy issues with season changes.
SH: Never a smoker
PE: Vitals: BP: 156/84; P: 80; Height: 5'4"; Weight 134lbs
Constitutional: General appearance: well developed, well nourished, in no acute distress.
Eyes: Inspection of the conjunctiva and lids: Normal, no injection, no shiners.
ENT: Inspection of the nasal mucosa, septum and turbinates: Normal. Otoscopic examination: Tympanic membranes: Normal with no congestion and no discharge Otic Canals: Normal without tenderness, congestion or discharge but slightly erythematous. Inspection of lips, teeth and gums: Normal, good dentition, no polyps. Examination of the oropharynx: Abnormal with erythema, edema and postnasal drainage.
Neck: Examination of the neck: Normal, supple, symmetric, trachea midline, no masses.
Pulmonary: Assessment of respiratory effort: No increased work of breathing or signs of respiratory distress. Auscultation of lungs: Clear to auscultation and percussion bilaterally.
Cardiovascular: Auscultation of heart: regular rate and rhythm, no murmurs, rubs or gallops.
Lymphatic: Palpation of lymph nodes in neck: mild lymphadenopathy noted.

Assessment and Plan:
Rapid Strep in Office: Negative

Diagnosis: Sinusitis, Acute and Pharyngitis

Patient was given a prescription for azithromycin 250 mg tablets. Two tablets today and one tablet daily for the next four days. Increase hydration, additional rest, call the office if symptoms worsen. Call the office if symptoms have not cleared in one week.

MDM – Section A

	MEDICAL DECISION MAKING				
A	Number of Diagnoses or Treatment Options				© Practical Coding Solutions LLC 2013
	Problems to Patient	Number	X	Points	= Results
	Self-limited or minor (stable, improved or worsening)	(Max = 2)		1	
	Established Problem; stable, improving			1	
	Established Problem; worsening			2	
	New Problem; no additional work-up planned	(Max = 1)		3	
	New Problem; additional work-up planned	1		4	4
	Bring total to **Line A** in the Final Results for Complexity			Total	4

	Final Results for Complexity				
A	Number of Diagnoses or Treatment Options	≤ 1 Minimal	2 Limited	3 Moderate	≥ 4 Extensive
B	Amount and/or Complexity of Data to be Reviewed	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥ 4 Extensive
C	Risk of Complication and/or Morbidity or Mortality	Minimal	Low	Moderate	High

MDM – Section B

B	Amount and/or Complexity of Data to be Reviewed	Points	Total Points
	Data to be Reviewed		
	Review and/or order of clinical lab tests in the pathology/lab section of CPT	1	1
	Review and/or order of tests in the radiology section of CPT	1	
	Review and/or order of tests in the medicine section of CPT	1	
	Discussion of test results with performing physician	1	
	Decision to obtain old records and/or obtain history from someone other than the patient	1	
	Review and summarization of old records and/or discussion of case with another **health care provider**	2	
	Independent visualization of image, tracing or specimen itself (not simply review of report)	2	
	Bring total to **Line B** in the Final Results for Complexity	**Total**	1

	Final Results for Complexity				
A	Number of Diagnoses or Treatment Options	≤ 1 Minimal	2 Limited	3 Moderate	≥ 4 Extensive
B	Amount and/or Complexity of Data to be Reviewed	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥ 4 Extensive
C	Risk of Complication and/or Morbidity or Mortality	Minimal	Low	Moderate	High

MDM – Section C

MEDICAL DECISION MAKING			
C	Risk of Complication and/or Morbidity or Mortality		
Level of Risk	The highest level of risk in any ONE category determines the overall risk.		
	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Option Selected
MODERATE	One or more chronic illnesses with mild exacerbation, progression or side effects of treatment	Physiologic tests under stress, e.g. cardiac stress test, fetal contraction stress test	Minor surgery with identified risk factors
		Diagnostic endoscopies with no identified risk factors	Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors
	Two or more stable chronic illnesses		**Prescription drug management**
	Undiagnosed new problem with uncertain prognosis, e.g. lump in breast	Deep needle or incisional biopsies	Therapeutic nuclear medicine
		Cardiovascular imaging studies with contrast	IV fluids with additives
	Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis	and no identified risk factors, e.g. arteriogram, cardiac catheterization	Closed treatment of fracture or dislocation without manipulation
	Acute complicated injury, e.g. head injury with brief loss of consciousness	Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis	
	Bring the highest level of risk to Line C in the Final Result for Complexity		

	Final Results for Complexity				
A	Number of Diagnoses or Treatment Options	≤ 1 Minimal	2 Limited	3 Moderate	≥ 4 Extensive
B	Amount and/or Complexity of Data to be Reviewed	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥ 4 Extensive
C	Risk of Complication and/or Morbidity or Mortality	Minimal	Low	Moderate	High

Calculating the Level of MDM

	Final Results for Complexity				
A	Number of Diagnoses or Treatment Options	≤ 1 Minimal	2 Limited	3 Moderate	≥ 4 Extensive
B	Amount and/or Complexity of Data to be Reviewed	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥ 4 Extensive
C	Risk of Complication and/or Morbidity or Mortality	Minimal	Low	Moderate	High
D	Type of Medical Decision Making	Straight-Forward	Low Complexity	Moderate Complexity	High Complexity

Time-Based Billing

Coding can be based on either

History +
Physical Exam +
Medical Decision Making

or

Time

Components of Time-Based Billing

Doctor's Office or Outpatient Hospital New Patient Visits Requires 3 of 3 Components - History, Exam, MDM or Time					
NEW PATIENT	99201	99202	99203	99204	99205
TYPICAL TIME	10 Min.	20 Min.	30 Min.	45 Min.	60 Min.

Time-Based Billing Statement – Billing Providers Only

Documentation Requirements for Counseling and/or Coordination of Care:

"I spent _____ minutes with this patient and/or family. Greater than 50% of this time was spent in counseling and/or coordination of care."

This means face to face time in the office or outpatient setting; floor/unit time in the inpatient setting or nursing facility.

New vs. Established Patient

A new patient is one who has not received any professional services from the provider or another provider of the same specialty in your billing practice within the past 3 years.

Best Practice: If the patient was seen by you in the past three years, regardless of what practice you were associated with, treat the encounter as an established patient visit. Many payers view the relationship of the patient to the provider as the defining factor, not the fact that you may be working for a different practice (different tax ID).

New Patients – Office / Outpatient Hospital

New Patient Encounters
- 99201 – 99205
- Coding Requirements
  - Require all three components (History, Physical Examination and Medical Decision Making)
  - OR Time Based

99201 - 99205

Doctor's Office or Outpatient Hospital New Patient Visits
Requires 3 of 3 Components - History, Exam, MDM or Time

NEW PATIENT			99201	99202	99203	99204	99205
HISTORY	CHIEF COMPLAINT		Required	Required	Required	Required	Required
	HPI		1 Element	1 Element	4 Elements	4 Elements	4 Elements
	ROS		N/A	1 System	At Least 2 Systems	At Least 10 Systems	At Least 10 Systems
	PMFSH		N/A	N/A	1 History	3 Histories	3 Histories
PHYSICAL EXAM		1995	1 System	2 - 7 Systems	2 - 7 Systems (1 Detailed)	8 Systems	8 Systems
		1997	At Least 1 Bullet	At Least 6 Bullets	At Least 12 Bullets (At Least 9 Bullets Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes
MEDICAL DECISION MAKING			Straight-forward	Straight-forward	Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME			10 Min.	20 Min.	30 Min.	45 Min.	60 Min.

99201 – 99205 wRVU's and Reimbursement

CPT Code	Description	wRVU	Medicare FFS Reimb - Office	Medicare FFS Reimb - Outpt
99201	New Patient Visit, Level 1	0.48	$44.23	$27.39
99202	New Patient Visit, Level 2	0.93	$74.09	$51.54
99203	New Patient Visit, Level 3	1.42	$105.49	$77.48
99204	New Patient Visit, Level 4	2.43	$160.95	$131.18
99205	New Patient Visit, Level 5	3.17	$202.68	$171.19

Established Patients – Office / Outpatient Hospital

Established Patient Encounters

- 99211 – 99215
- Coding Requirements
  - Require two of the three components (History, Physical Examination and Medical Decision Making)
  - OR Time Based

99211 - 99215

Doctor's Office or Outpatient Hospital Established Patient Visits

Requires 2 of 3 Components - History, Exam, MDM or Time

		99211	99212	99213	99214	99215
ALL PATIENTS						
HISTORY	CHIEF COMPLAINT	Required	Required	Required	Required	Required
	HPI	N/A	1 Element	1 Element	4 Elements	4 Elements
	ROS	N/A	N/A	1 System	At Least 2 Systems	At Least 10 Systems
	PMFSH	N/A	N/A	N/A	1 History	2 Histories
PHYSICAL EXAM	1995	N/A	1 System	2 - 7 Systems	2 - 7 Systems (One Detailed)	8 Systems
	1997	N/A	At least 1 Bullet	At least 6 Bullets	At least 12 Bullets (At least 9 Bullets Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes
MEDICAL DECISION MAKING		N/A	Straight-forward	Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME		5 Min.	10 Min.	15 Min.	25 Min.	40 Min.

99211 – 99215
wRVU's and Reimbursement

CPT Code	Description	wRVU	Medicare FFS Reimb - Office	Medicare FFS Reimb - Outpt
99211	Established Patient Visit, Level 1	0.18	$21.72	$9.37
99212	Established Patient Visit, Level 2	0.48	$43.53	$25.95
99213	Established Patient Visit, Level 3	0.97	$72.19	$51.90
99214	Established Patient Visit, Level 4	1.50	$105.93	$80.01
99215	Established Patient Visit, Level 5	2.11	$142.28	$112.80

Differences between 99213 and 99214

Established Patient Visits			
ALL PATIENTS		99213	99214
HISTORY	CHIEF COMPLAINT	Required	Required
	HPI	1 Element	4 Elements
	ROS	1 System	At Least 2 Systems
	PMFSH	N/A	1 History
PHYSICAL EXAM	1995	2 - 7 Systems	2 - 7 Systems (One Detailed)
	1997	At least 6 Bullets	At least 12 Bullets (At least 9 Bullets Eye & Psych)
MEDICAL DECISION MAKING		Low Complexity	Moderate Complexity
TYPICAL TIME		15 Min.	25 Min.

Differences between 99213 and 99214

History should be the same for every encounter
- Chief Complaint – make it a separate statement
- HPI
  - Location
  - Intensity
  - Timing
  - Treatment

  Or status of three or more chronic illnesses

Differences between 99213 and 99214

Review of Systems
- As they pertain to the Chief Complaint
  - Ask all body systems, note pertinent positive and pertinent negative issues then
    - "All other systems have been reviewed and are negative except as noted in the HPI."

Past Medical, Family and Social Histories
- Review for any changes at each visit, note any changes and sign
- Reference PMFSH in the medical record

Differences between 99213 and 99214

Physical Examination
- 99213 – 2 – 7 Body System Elements
- 99214 – 2 – 7 Body System Elements with one being "detailed"

Be very aware of how many body systems are actually examined

"Detailed" is in the eye of the provider

Differences between 99213 and 99214

Medical Decision Making
- Multiple Established Problems
- New Problem without Additional Work-Up
- New Problem with Additional Work-Up
- Labs, X-Rays, Other Medical Testing
- Risk – Prescription Drug Management
  - Start
  - Stop
  - Change
  - Continue as currently prescribed

wRVU Differences – New and Established Patients

Procedure Code	Description	wRVU
99201	New Patient Visit Level 1	0.48
99202	New Patient Visit Level 2	0.93
99203	New Patient Visit Level 3	1.42
99204	New Patient Visit Level 4	2.43
99205	New Patient Visit Level 5	3.17
Procedure Code	**Description**	**wRVU**
99211	Established Patient Visit Level 1	0.18
99212	Established Patient Visit Level 2	0.48
99213	Established Patient Visit Level 3	0.97
99214	Established Patient Visit Level 4	1.50
99215	Established Patient Visit Level 5	2.11

Consultations – Office / Outpatient Hospital

Office / Outpatient Consultation Encounters

- 99241 – 99245
- Coding Requirements
  - Require all three components (History, Physical Examination and Medical Decision Making)
  - **OR** Time Based

99241 - 99245

Doctor's Office or Outpatient Hospital Consultation Visits

Requires 3 of 3 Components - History, Exam, MDM or Time

		99241	99242	99243	99244	99245
HISTORY	CHIEF COMPLAINT	Required	Required	Required	Required	Required
	HPI	1 Element	1 Element	4 Elements	4 Elements	4 Elements
	ROS	N/A	1 System	At Least 2 Systems	At Least 10 Systems	At Least 10 Systems
	PMFSH	N/A	N/A	1 History	3 Histories	3 Histories
PHYSICAL EXAM	1995	1 System	2 - 7 Systems	2 - 7 Systems (1 Detailed)	8 Systems	8 Systems
	1997	At Least 1 Bullet	At Least 6 Bullets	At Least 12 Bullets (At Least 9 Bullets Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes
MEDICAL DECISION MAKING		Straight-forward	Straight-forward	Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME		15 Min.	30 Min.	40 Min.	60 Min.	80 Min.

Consultation Requirements: Request, Recommendation and Report

99241 – 99245
wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Outpatient	Medicaid Office	Medicaid Outpatient
99241	Outpatient/Office Consult Level 1	0.64	15	N/A	N/A	$ 23.55	$ 11.56
99242	Outpatient/Office Consult Level 2	1.34	30	N/A	N/A	$ 38.93	$ 20.84
99243	Outpatient/Office Consult Level 3	1.88	40	N/A	N/A	$ 57.76	$ 32.94
99244	Outpatient/Office Consult Level 4	3.02	60	N/A	N/A	$ 88.07	$ 56.15
99245	Outpatient/Office Consult Level 5	3.77	80	N/A	N/A	$ 110.67	$ 72.01

Consultations – Inpatient Hospital

Inpatient Consultation Encounters
- 99251 – 99255
- Coding Requirements
  - Require all three components (History, Physical Examination and Medical Decision Making)
  - **OR** Time Based

99251 - 99255

Inpatient Hospital Consultation Visits
Requires 3 of 3 Components - History, Exam, MDM or Time

		99251	99252	99253	99254	99255
HISTORY	CHIEF COMPLAINT	Required	Required	Required	Required	Required
	HPI	1 Element	1 Element	4 Elements	4 Elements	4 Elements
	ROS	N/A	1 System	At Least 2 Systems	At Least 10 Systems	At Least 10 Systems
	PMFSH	N/A	N/A	1 History	3 Histories	3 Histories
PHYSICAL EXAM	1995	1 System	2 - 7 Systems	2 - 7 Systems (1 Detailed)	8 Systems	8 Systems
	1997	At Least 1 Bullet	At Least 6 Bullets	At Least 12 Bullets (At Least 9 Bullets Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes
MEDICAL DECISION MAKING		Straight-forward	Straight-forward	Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME		20 Min.	40 Min.	55 Min.	80 Min.	110 Min.

Consultation Requirements: Request, Recommendation and Report

99251 – 99255 wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Inpatient	Medicaid Office	Medicaid Inpatient
99251	Inpatient Consultation Level 1	1.00	20	N/A	N/A	N/A	$ 23.15
99252	Inpatient Consultation Level 2	1.50	40	N/A	N/A	N/A	$ 36.96
99253	Inpatient Consultation Level 3	2.27	55	N/A	N/A	N/A	$ 49.25
99254	Inpatient Consultation Level 4	3.29	80	N/A	N/A	N/A	$ 69.17
99255	Inpatient Consultation Level 5	4.00	110	N/A	N/A	N/A	$ 92.32

"Consultations" and Medicare Patients

Outpatient or Office

- Use New Patient Visit Codes unless the patient is known to your practice and has been seen within the past three years
- Includes patients in Observation Status

"Consultations" and Medicare Patients

Inpatient, Nursing Facilities and Partial Hospital Settings

- Use Initial Hospital Care or Initial Nursing Facility Care Codes
- Follow-up encounters are billed with Subsequent Hospital Care or Subsequent Nursing Facility Care Codes

"Consultations" and Medicare Patients

Positive Changes –

- When using Time-Based Coding the New Patient and Established Patient Codes have lower time requirements
- When using the traditional History, Physical Examination and Medical Decision Making, **the requirements are equal or less**

"Consultations" and Medicare Patients

Negative Changes

- Payments will be less
- Patients with new problems that are known to your practice must be treated as established patients

Inpatient Encounter Coding

Initial Hospital Care Encounters

- 99221 – 99223
- Coding Requirements
  - Require all three components (History, Physical Examination and Medical Decision Making)
  - **OR** Time Based

99221 - 99223

Initial Hospital Inpatient Care Requires 3 of 3 Components - History, Exam, MDM or Time				
ALL PATIENTS		99221	99222	99223
HISTORY	CHIEF COMPLAINT	Required	Required	Required
	HPI	4 Elements	4 Elements	4 Elements
	ROS	At Least 2 Systems	At Least 10 Systems	At Least 10 Systems
	PMFSH	1 History	3 Histories	3 Histories
PHYSICAL EXAM	1995	2 - 7 Systems (1 Detailed)	8 Systems	8 Systems
	1997	At Least 12 Bullets (At Least 9 Bullets for Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes
MEDICAL DECISION MAKING		Straightforward or Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME		30 Min.	50 Min.	70 Min.
Used to report the first hospital encounter by the admitting physician (regardless of day).				
Discharge Day Management				
99238 - Hospital Discharge Day Management 30 minutes or less ©Practical Coding Solutions LLC 2018				
99239 - Hospital Discharge Day Management more than 30 minutes (document time)				

99221 – 99223 wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Inpatient	Medicaid Office	Medicaid Inpatient
99221	Initial Hospital Day, Level 1	1.92	30	N/A	$ 100.86	N/A	$ 37.61
99222	Initial Hospital Day, Level 2	2.61	50	N/A	$ 136.04	N/A	$ 55.71
99223	Initial Hospital Day, Level 3	3.86	70	N/A	$ 200.81	N/A	$ 76.84

Inpatient Encounter Coding

Subsequent Hospital Visit Encounters

- 99231 – 99233
- Coding Requirements
  - Require two of the three components (History, Physical Examination and Medical Decision Making)
  - **OR** Time Based

99231 - 99233

Subsequent Hospital Inpatient Care				
Requires 2 of 3 Components - History, Exam, MDM or Time				
ALL PATIENTS		99231	99232	99233
HISTORY	CHIEF COMPLAINT	Required	Required	Required
	HPI	1 Element	1 Element	4 Elements
	ROS	N/A	At Least 1 System	At Least 2 Systems
	PMFSH	N/A	N/A	1 History
PHYSICAL EXAM	1995	1 System	2 - 7 Systems	2 - 7 Systems (1 Detailed)
	1997	At Least 1 Bullet	At Least 6 Bullets	At Least 12 Bullets (At Least 9 Bullets for Eye & Psych)
MEDICAL DECISION MAKING		Straightforward or Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME		15 Min.	25 Min.	35 Min.
Used to report subsequent care days after initial admission visit day or consultation				
Discharge Day Management				
		99238 - Hospital Discharge Day Management 30 minutes or less		
		99239 - Hospital Discharge Day Management more than 30 minutes		

99231 – 99233 wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Inpatient	Medicaid Office	Medicaid Inpatient
99231	Subsequent Hospital Day, Level 1	0.76	15	N/A	$ 39.15	N/A	$ 17.49
99232	Subsequent Hospital Day, Level 2	1.39	25	N/A	$ 72.22	N/A	$ 28.18
99233	Subsequent Hospital Day, Level 3	2.00	35	N/A	$ 103.26	N/A	$ 40.28

Inpatient Discharge Day Management

Discharge Day Management
- 99238
- 99239 (Time based – more than 30 minutes)

99238 and 99239 wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Inpatient	Medicaid Office	Medicaid Inpatient
99238	Discharge Day Management	1.28	N/A	N/A	$ 72.19	N/A	$ 31.62
99239	Discharge Day Management > 30 min	1.90	>30	N/A	$ 105.87	N/A	$ 41.78

Observation (OP Hospital) Encounter Coding

Observation Codes –

- Admitted and Discharged on Different Calendar Days
  - 99218 – 99220 – Initial Observation Care
  - 99224 – 99226 – Subsequent Observation Care
  - 99217 – Discharge Day Management
- Admitted and Discharged the Same Calendar Day
  - 99234 – 99236

Initial Observation Day

Initial Observation Encounters

- 99218 – 99220
- Coding Requirements
  - Require all three components (History, Physical Examination and Medical Decision Making)
  - **OR** Time Based

99218 – 99220

Initial Observation Care				
Requires 3 of 3 Components - History, Exam, MDM or Time				
ALL PATIENTS		99218	99219	99220
HISTORY	CHIEF COMPLAINT	Required	Required	Required
	HPI	4 Elements	4 Elements	4 Elements
	ROS	At Least 2 Systems	At Least 10 Systems	At Least 10 Systems
	PMFSH	1 History	3 Histories	3 Histories
PHYSICAL EXAM	1995	2 - 7 Systems (1 Detailed)	8 Systems	8 Systems
	1997	At Least 12 Bullets (At Least 9 Bullets for Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes
MEDICAL DECISION MAKING		Straightforward or Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME		30 Min.	50 Min.	70 Min.
Used to report the first hospital encounter by the supervising physician (calendar day 1).				
Discharge Day Management				
99217 - Observation Discharge Day Management (when discharge is after calendar day 1)				

99218 – 99220
wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Outpatient	Medicaid Office	Medicaid Outpatient
99218	Observation, Initial Day, Level 1	1.92	30	N/A	$ 99.12	N/A	$ 34.60
99219	Observation, Initial Day, Level 2	2.60	50	N/A	$ 134.95	N/A	$ 55.79
99220	Observation, Initial Day, Level 3	3.56	70	N/A	$ 184.28	N/A	$ 75.30

Subsequent Observation Day

Subsequent Observation Encounters

- 99224 – 99226
- Coding Requirements
  - Require two of the three components (History, Physical Examination and Medical Decision Making)
  - **OR** Time Based

99224 – 99226 and 99217

Subsequent Observation Care				
Requires 2 of 3 Components - History, Exam, MDM or Time				
ALL PATIENTS		99224	99225	99226
HISTORY	CHIEF COMPLAINT	Required	Required	Required
	HPI	1 Element	1 Element	4 Elements
	ROS	N/A	At Least 1 System	At Least 2 Systems
	PMFSH	N/A	N/A	1 History
PHYSICAL EXAM	1995	1 System	2 - 7 Systems	2 - 7 Systems (1 Detailed)
	1997	At Least 1 Bullet	At Least 6 Bullets	At Least 12 Bullets (At Least 9 Bullets for Eye & Psych)
MEDICAL DECISION MAKING		Straightforward or Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME		15 Min.	25 Min.	35 Min.
Used to report subsequent care days after initial observation care day or consultation				
Discharge Day Management				
99217 - Observation Discharge Day Management (when discharge is after calendar day 1)				

99224 – 99226 and 99217 wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Outpatient	Medicaid Office	Medicaid Outpatient
99224	Observation, Subsequent Day, Level 1	0.76	15	N/A	$ 39.48	N/A	$ 12.51
99225	Observation, Subsequent Day, Level 2	1.39	25	N/A	$ 72.55	N/A	$ 22.03
99226	Observation, Subsequent Day, Level 3	2.00	35	N/A	$ 103.89	N/A	$ 33.00
99217	Observation, Discharge Day Management	1.28	N/A	N/A	$ 72.19	N/A	$ 34.20

Admit/Discharge or Observation – In and Out on Same Day

Admit/Discharge or Observation – In and Out on the Same Date of Service

- 99234 – 99236
- Coding Requirements
  - Require all three components (History, Physical Examination and Medical Decision Making)
  - **OR** Time Based

99234 - 99236

Admission and Discharge on the Same Date of Service
Observation or Inpatient Care Services
Requires 3 of 3 Components - History, Exam, MDM or Time

			99234	99235	99236
HISTORY	CHIEF COMPLAINT		Required	Required	Required
	HPI		4 Elements	4 Elements	4 Elements
	ROS		At Least 2 Systems	At Least 10 Systems	At Least 10 Systems
	PMFSH		1 History	3 Histories	3 Histories
PHYSICAL EXAM		1995	2 - 7 Systems (1 Detailed)	8 Systems	8 Systems
		1997	At Least 12 Bullets (At Least 9 Bullets for Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes
MEDICAL DECISION MAKING			Straightforward or Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME			40 Min.	50 Min.	55 Min.

Used to report either Observation or Admission and Discharge services when the entire patient stay occurs on ONE CALENDAR DAY.

99234 – 99236
wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Inpatient	Medicaid Office	Medicaid Inpatient
99234	Admit/Discharge, Same Day, Level 1	2.56	40	N/A	$ 132.22	N/A	$ 58.36
99235	Admit/Discharge, Same Day, Level 2	3.24	50	N/A	$ 168.06	N/A	$ 79.55
99236	Admit/Discharge, Same Day, Level 3	4.20	55	N/A	$ 216.03	N/A	$ 96.73

Critical Care

99291 – 30 – 74 minutes

99292 – each additional 30 minutes
- Time Based Charging Only
- REQUIREMENT: In the provider's judgment there must be a high probability of the imminent failure of a body system.
- Best Practice: Name the body system

Must be time devoted to the patient's care but is not limited to face-to-face time (may include time for review of information pertinent to the care of the patient)

Must document the amount of time in the medical record

99291 and 99292 wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Non-Facility	Medicare Facility	Medicaid Non-Facility	Medicaid Facility
99291	Critical Care 30 - 74 minutes	4.50	30	$ 273.13	$ 222.24	$ 98.58	$ 69.33
+99292	Critical Care ea addl 30 minutes	2.25	16	$ 121.71	$ 111.47	$ 49.37	$ 37.08

Emergency Medicine Visits Outpatient Hospital

Emergency Medicine Encounters
- 99281 – 99285
- Coding Requirements
  - Require all three components (History, Physical Examination and Medical Decision Making)

99281 - 99285

Emergency Medicine Patient Visits
Requires 3 of 3 Components - History, Exam, MDM

NEW PATIENT		99281	99282	99283	99284	99285
HISTORY	CHIEF COMPLAINT	Required	Required	Required	Required	Required
	HPI	1 Element	1 Element	1 Element	4 Elements	4 Elements
	ROS	N/A	At Least 1 System	At Least 1 System	At Least 2 Systems	At Least 10 Systems
	PMFSH	N/A	N/A	N/A	1 History	2 Histories
PHYSICAL EXAM	1995	1 System	2 - 7 Systems	2 - 7 Systems	2 - 7 Systems (1 Detailed)	8 Systems
	1997	At least 1 Bullet	At least 6 Bullets	At least 6 Bullets	At Least 12 Bullets (At Least 9 Bullets Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes
MEDICAL DECISION MAKING		Straight-forward	Low Complexity	Moderate Complexity	Moderate Complexity	High Complexity

99281 – 99285
wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Outpatient	Medicaid Office	Medicaid Outpatient
99281	Emergency Medicine Visit Level 1	0.45	N/A	N/A	$ 21.30	N/A	$ 11.62
99282	Emergency Medicine Visit Level 2	0.88	N/A	N/A	$ 41.55	N/A	$ 19.95
99283	Emergency Medicine Visit Level 3	1.34	N/A	N/A	$ 62.22	N/A	$ 35.55
99284	Emergency Medicine Visit Level 4	2.56	N/A	N/A	$ 118.11	N/A	$ 59.35
99285	Emergency Medicine Visit Level 5	3.80	N/A	N/A	$ 174.08	N/A	$ 88.90

Nursing Facility Coding

Initial Nursing Facility Care Encounters

- 99304 – 99306
- Coding Requirements
  - Require all three components (History, Physical Examination and Medical Decision Making)
  - **OR** Time Based

99304 - 99306

Initial Nursing Facility Care Requires 3 of 3 Components - History, Exam, MDM				
ALL PATIENTS		99304	99305	99306
HISTORY	CHIEF COMPLAINT	Required	Required	Required
HISTORY	HPI	4 Elements	4 Elements	4 Elements
HISTORY	ROS	At Least 2 Systems	At Least 10 Systems	At Least 10 Systems
HISTORY	PMFSH	1 History	3 Histories	3 Histories
PHYSICAL EXAM	1995	2 - 7 Systems (1 Detailed)	8 Systems	8 Systems
PHYSICAL EXAM	1997	At Least 12 Bullets (At Least 9 Bullets for Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes
MEDICAL DECISION MAKING		Straightforward or Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME		25 Min.	35 Min.	45 Min.
Used to report the first nursing facility encounter by the admitting physician (regardless of day).				
Discharge Day Management				
99315 - NF Discharge Day Management 30 minutes or less 99316 - NF Discharge Day Management more than 30 minutes (document time)				

99304 – 99306
wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Facility	Medicaid Office	Medicaid Facility
99304	Initial Nursing Facility Day, Level 1	1.64	25	N/A	$ 89.23	N/A	$ 34.05
99305	Initial Nursing Facility Day, Level 2	2.35	35	N/A	$ 128.82	N/A	$ 45.28
99306	Initial Nursing Facility Day, Level 3	3.06	45	N/A	$ 165.08	N/A	$ 55.71

Nursing Facility Coding

Subsequent Nursing Facility Care Encounters

- 99307 – 99310
- Coding Requirements
  - Require two of the three components (History, Physical Examination and Medical Decision Making)
  - **OR** Time Based

99307 - 99310

Subsequent Nursing Facility Patient Visits Requires 2 of 3 Components - History, Exam, MDM					
ALL PATIENTS		99307	99308	99309	99310
HISTORY	CHIEF COMPLAINT	Required	Required	Required	Required
	HPI	1 Element	1 Element	4 Elements	4 Elements
	ROS	N/A	1 System	At Least 2 Systems	At Least 10 Systems
	PMFSH	N/A	N/A	1 History	3 Histories
PHYSICAL EXAM	1995	1 System	2 - 7 Systems	2 - 7 Systems (One Detailed)	8 Systems
	1997	At Least 1 Bullet	At Least 6 Bullets	At Least 12 Bullets (At Least 9 Bullets Eye & Psych)	All Bullets in Shaded Boxes and 1 Bullet in All Unshaded Boxes
MEDICAL DECISION MAKING		Straight-forward	Low Complexity	Moderate Complexity	High Complexity
TYPICAL TIME		10 Min.	15 Min.	25 Min.	35 Min.
Used to report subsequent care days after initial care visit day or consultation					
Discharge Day Management					
99315 - NF Discharge Day Management 30 minutes or less					
99316 - NF Discharge Day Management more than 30 minutes (document time)					

99307 – 99310 wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Facility	Medicaid Office	Medicaid Facility
99307	Subsequent Nursing Facility Day, Level 1	0.76	10	N/A	$ 43.41	N/A	$ 18.11
99308	Subsequent Nursing Facility Day, Level 2	1.16	15	N/A	$ 67.84	N/A	$ 29.76
99309	Subsequent Nursing Facility Day, Level 3	1.55	25	N/A	$ 90.25	N/A	$ 41.58
99310	Subsequent Nursing Facility Day, Level 4	2.35	35	N/A	$ 133.78	N/A	$ 51.54

Nursing Facility Discharge Day Management

Discharge Day Management

- 99315
- 99316 (Time based – more than 30 minutes)

99315 and 99316 wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Office	Medicare Facility	Medicaid Office	Medicaid Facility
99315	Nursing Facility Discharge Day Management	1.28	N/A	N/A	$ 72.52	N/A	$ 31.99
99316	Nursing Facility Discharge Day Management > 30 min	1.90	>30	N/A	$ 104.58	N/A	$ 41.91

Newborn Care Services

99460 – Initial hospital or birthing center care, per day, for normal newborn infant

99461 – Initial care, per day, of normal newborn infant seen in other than hospital or birthing center

99462 – Subsequent hospital care, per day, of normal newborn

99463 – Initial hospital or birthing center care, per day, of normal newborn infant admitted and discharged on the same date

99460 – 99463 wRVU's and Reimbursement

Procedure Code	Description	wRVU	Time/ Min	Medicare Non-Facility	Medicare Facility	Medicaid Non-Facility	Medicaid Facility
99460	Initial Hospital Care, Per Day, for Evaluation and Management of Normal Newborn Infant - Hospital or Birthing Center	1.92	Per Diem	$ 95.58	$ 95.58	N/A	$ 74.73
99461	Initial Hospital Care, Per Day, for Evaluation and Management of Normal Newborn Infant - Other than Hospital or Birthing Center	1.26	Per Diem	$ 89.29	$ 62.85	$ 67.94	$ 47.18
99462	Subsequent Hospital Car, Per Day, for Evaluation and Management of Normal Newborn	0.84	Per Diem	$ 42.03	$ 42.03	N/A	$ 33.10
99463	Initial Hospital Care, Per Day, for Evaluation and Management of Normal Newborn Infant Admitted and Discharged on the Same Date	2.13	Per Diem	$ 110.26	$ 110.26	N/A	$ 88.52

Prolonged Services with Direct Patient Contact

Prolonged services codes can be utilized in the office/outpatient hospital and inpatient hospital environments

Prolonged services codes are only add-on codes

Prolonged Services with Direct Patient Contact

Office or Outpatient

- +99354 – Prolonged provider services (face-to-face); first hour (30 – 74 minutes)
- +99355 – each additional 30 minutes

Inpatient

- +99356 – Prolonged provider services requiring unit/floor time; first hour (30 – 74 minutes)
- +99357 – each additional 30 minutes

Prolonged Services

Two ways to use these codes

- If the history, examination and medical decision making are use to select the appropriate CPT code for your services, then the time spent with the patient must be 30 minutes or more longer than the typical amount of time for that CPT code
- If counseling and/or coordination of care (time) is used to determine the CPT code for your services, then the time spent with the patient must be 30 minutes or more longer than the highest level of Evaluation and Management code in the appropriate category

Prolonged Services

Here's how it works:

Example: An evaluation of the patient requires a comprehensive history, comprehensive examination and medical decision making of moderate complexity – 99204

But the patient requires prolonged, direct, face-to-face care of 30 minutes or more beyond the typical time for a 99204 visit (45 min) – so the time spent is at least 75 minutes

Billed services would be:

99204 and 99354

Prolonged Services

If the Evaluation and Management Code is selected based on Time – Counseling and/or Coordination of Care

The amount of time must be 30 minute or more beyond the highest Evaluation and Management Code in the appropriate category.

Prolonged Services

Same new patient and the time is still the same

– 75 minutes

Billed service would be: 99205

Because the typical time for 99205 is 60 minutes and the time spent would need to be at least 90 minutes to utilize Prolonged Services coding

99354 – 99357 wRVU's and Reimbursement

CPT Code	Description	wRVU	Medicare FFS Reimb Office	Medicare FFS Reimb Facility	Medicaid FFS Reimb Office	Medicaid FFS Reimb - Facility
99354	Prolonged Services, Office/OutPt, First Hour	1.77	$128.76	$121.16	N/A	$61.24
+99355	Prolonged Services, Office/OutPt, ea addl 30 r	1.77	$98.21	$91.60	N/A	$60.79
99356	Prolonged Services, Inpatient, First Hour	1.71	N/A	$91.39	N/A	N/C
+99357	Prolonged Services, Inpatient, ea addl 30 min	1.71	N/A	$91.72	N/A	N/C

Prolonged Services without Direct Patient Contact

All Places of Service

- 99358 – Prolonged provider services before and/or after direct patient care; first hour (30 – 74 minutes)
- +99359 – each additional 30 minutes

99358 and 99359 wRVU's and Reimbursement

CPT Code	Description	wRVU	Medicare FFS Reimb Office	Medicare FFS Reimb Facility	Medicaid FFS Reimb Office	Medicaid FFS Reimb - Facility
99358	Prolonged Services, without patient contact, First Hour	2.10	$110.86	$110.86	N/A	N/A
+99359	Prolonged Services, without patient contact, ea addl 30 min	1.00	$53.45	$53.45	N/A	N/A

Preventative Visits

Age of Patient	New Patient	Est. Patient
< 1 Year of Age	99381	99391
Age 1 - Age 4	99382	99392
Age 5 - Age 11	99383	99393
Age 12 - Age 17	99384	99394
Age 18 - Age 39	99385	99395
Age 40 - Age 64	99386	99396
Age 65 and Older	99387	99397

Preventative Visit and Sick Visit on the Same Day

When an issue is encountered or a pre-existing condition is addressed during the preventative visit

Bill an established patient visit code that has independent documentation to support the level chosen

This should involve a significant work effort

Use modifier -25 on the established patient visit CPT code to indicate a separate service

Preventive Visits with Medicare Managed Care

Medicare Advantage Plans Accepting Preventive Medicine CPT Codes (99387 and 99397)

- Anthem
- Aetna
- Humana
- United Healthcare

Telemedicine Constraints

Medicare – must be classified as a rural area (underserved)

- A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract; **or**
- In a county outside of an MSA

Medicaid – basically a five mile restriction per the Ohio Administrative Code

Telemedicine

CY 2019 LIST OF MEDICARE TELEHEALTH SERVICES	
Code	**Short Descriptor**
90785	Psytx complex interactive
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90833	Psytx pt&/fam w/e&m 30 min
90834	Psytx pt&/family 45 minutes
90836	Psytx pt&/fam w/e&m 45 min
90837	Psytx pt&/family 60 minutes
90838	Psytx pt&/fam w/e&m 60 min
90845	Psychoanalysis
90846	Family psytx w/o patient
90847	Family psytx w/patient

CY 2019 LIST OF MEDICARE TELEHEALTH SERVICES	
Code	**Short Descriptor**
96116	Neurobehavioral status exam
96150	Assess hlth/behave init
96151	Assess hlth/behave subseq
96152	Intervene hlth/behave indiv
96153	Intervene hlth/behave group
96154	Interv hlth/behav fam w/pt
96160	Patient-Focused health risk assessment
96161	Caregiver health risk assessment

Telemedicine

CY 2019 LIST OF MEDICARE TELEHEALTH SERVICES	
Code	**Short Descriptor**
90951	Esrd serv 4 visits p mo <2yr
90952	Esrd serv 2-3 vsts p mo <2yr
90954	Esrd serv 4 vsts p mo 2-11
90955	Esrd srv 2-3 vsts p mo 2-11
90957	Esrd srv 4 vsts p mo 12-19
90958	Esrd srv 2-3 vsts p mo 12-19
90960	Esrd srv 4 visits p mo 20+
90961	Esrd srv 2-3 vsts p mo 20+
90963	Esrd home pt serv p mo <2yrs
90964	Esrd home pt serv p mo 2-11
90965	Esrd home pt serv p mo 12-19
90966	Esrd home pt serv p mo 20+

CY 2019 LIST OF MEDICARE TELEHEALTH SERVICES	
Code	**Short Descriptor**
90967	Esrd < a full month <2yrs
90968	Esrd < a full month 2-11yrs
90969	Esrd < a full month 12-19yrs
90970	Esrd < a full month 20+yrs
G0420	Ed svc ckd ind per session
G0421	Ed svc ckd grp per session

Telemedicine

CY 2019 LIST OF MEDICARE TELEHEALTH SERVICES	
Code	**Short Descriptor**
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est

CY 2019 LIST OF MEDICARE TELEHEALTH SERVICES	
Code	**Short Descriptor**
99231	Subsequent hospital care
99232	Subsequent hospital care
99233	Subsequent hospital care
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99310	Nursing fac care subseq
99354	Prolonged service office
99355	Prolonged service office
99356	Prolonged service inpatient
99357	Prolonged service inpatient

Telemedicine

CY 2019 LIST OF MEDICARE TELEHEALTH SERVICES	
Code	**Short Descriptor**
G0438	Annual Wellness Visit, initial visit
G0439	Annual Wellness Visit, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
99406	Behav chng smoking 3-10 min
99407	Behav chng smoking > 10 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15m
99497	Adv Care Planning 30 min
99498	Adv Care Planning ea add 30 min
G0513	Prolonged Prev. Svcs, First 30 Min
G0514	Prolonged Prev. Svcs, Addl 30 Min

CY 2019 LIST OF MEDICARE TELEHEALTH SERVICES	
Code	**Short Descriptor**
G0406	Inpt/tele follow up 15
G0407	Inpt/tele follow up 25
G0408	Inpt/tele follow up 35
G0425	Inpt/ed teleconsult30
G0426	Inpt/ed teleconsult50
G0427	Inpt/ed teleconsult70
G0508	Telehealth Consult, Crit Care, initial 60 min
G0509	Telehealth Consult, Crit Care, subseq 50 min
G0459	Telehealth inpt pharm mgmt

CY 2019 LIST OF MEDICARE TELEHEALTH SERVICES	
Code	**Short Descriptor**
97802	Medical nutrition indiv in
97803	Med nutrition indiv subseq
97804	Medical nutrition group
G0108	Diab manage trn per indiv
G0109	Diab manage trn ind/group
G0270	Mnt subs tx for change dx
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
G0396	Alcohol/subs interv 15-30mn
G0397	Alcohol/subs interv >30 min
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel>10min
G0445	High inten beh couns std 30m
G0296	Counseling Visit for Lung Cancer Screening
G0506	Comp. Assessment for CCM

Unlisted Codes

Unlisted CPT codes correspond to the various sections of the CPT book

Documentation is even more important than usual - paint a picture of the service provided

Generally, a service reported with an unlisted code will require the documentation to be sent along with the billing

Check the index of the CPT book to see if the procedure may have been reported in a different section

Review the Category III codes for possible codes

Incident-To Visits

Incident-to is a CMS invention

Not appropriate in Outpatient Hospital environment

Appropriate only in Office or Free-Standing Clinic Environments

APRN must be in the employ of the provider who will be billing for the service

Incident-To Visits

The physician must first see the patient and establish a plan of care

Subsequent services must be performed at "a frequency that reflects the physician's continuing active participation in, and management of, the course of treatment."

Not applicable for New Patient Visits

Not applicable for New Problems

Split/Shared Visits

The APRN and the physician must be from the same practice

Location and type of service determines the type of visit

The CPT code used for billing must reflect the combined service and documentation of both the APRN and the physician

Ancillary personnel may document the Review of Systems, Past Medical, Family and Social Histories as in any other E/M service

Split/Shared Visits

Documentation guidelines are the same regardless of the provider's credentials

Medical record should clearly show the documentation of each provider

Each provider must document independently

Visits must occur on the same date of service

Split/Shared Visits

Places of Service Where Split/Shared Visits May Occur

- Hospital Outpatient
- Hospital Emergency Room
- Hospital Inpatient
- Hospital Discharge Day Management

Subject to Hospital By-Laws

Split/Shared Visits

Appropriate CPT Codes for Billing in the Outpatient Environment

- New Patient Visits (99201 – 99205)
- Established Patient Visits (99211 – 99215)
- Observation Care (99218 – 99220, 99217)
- Same Day Admit/Discharge – (99234 – 99236)

Split/Shared Visits

Places of Service NOT appropriate for split/shared visits

- Skilled Nursing Facility
- Nursing Facility
- Domiciliary
- Home Care Visits

Split/Shared Visits

CPT Codes where Split/Shared Visits are NOT Appropriate:

- Consultations (99241 – 99245)
- Critical Care Services (99291 – 99292)

Split/Shared Visits

Outpatient Hospital Billing Requirements

- Physician performed a portion of the face-to-face evaluation and management service
  - Key or critical component(s)
  - **OR** provides and documents counseling and/or coordination of care (time based)
- May be billed by **either** the APRN or the physician

Split/Shared Visits

Outpatient Hospital Billing Requirements

- If no face-to-face evaluation and management service provided by the physician
  - This includes participation by only reviewing the medical records
- Must be billed by the APRN

Split/Shared Visits

Appropriate CPT Codes for Billing in the Inpatient Environment

- Initial Hospital Visits (99221 – 99223)
- Subsequent Hospital Visits (99231 – 99233)
- Discharge Day Management – (99238 – 99239)

Split/Shared Visits

CPT Codes where Split/Shared Visits are NOT Appropriate:

- Consultations (99251 – 99255)
- Critical Care Services (99291 – 99292)

Split/Shared Visits

Inpatient Hospital Billing Requirements

- Physician performed a portion of the face-to-face evaluation and management service
  - Key or critical component(s)
  - **OR** provides and documents counseling and/or coordination of care (time based)
- May be billed by **either** the APRN or the physician

Split/Shared Visits

Inpatient Hospital Billing Requirements

- If no face-to-face evaluation and management service provided by the physician
  - This includes participation by only reviewing the medical records
- Must be billed by the APRN

Scribing

Benefits:

Anyone can scribe for anyone

- Includes your ancillary team members

Layman's environment

Writes exactly what the clinician says

Scribing

Limitations:

Anyone can scribe for anyone

- Includes your ancillary team members – meaning that there may be limited knowledge about what you are talking about

Writes exactly what the clinician says – verbatim

Global Period

Period of time where routine patient care (related to the surgical procedure) is generally included in the reimbursement for the surgical procedure

"Minor" procedure – 0 – 10 days

"Major" procedure – 90 days

Global Period

Items included:

- Dressing changes.
- E&M services related to the original surgery, all settings.
- Incisional care.
- Postoperative pain management by the provider.
- Removal of staples, tubes, drains, casts, splints and cutaneous sutures.

Global Period

Items included:

- Routine, typical postoperative care or treatment (including complications) that are related to the original surgery but do not require a return trip to the operating room.
- Insertion, irrigation and removal of catheters.

Global Period – Medicare Project

Medicare Data Collection Project

- Ohio is a participating state
- Report all post-operative encounters (IP, OH and Office) using CPT code 99024 through your usual charge capture process
- Claims must be submitted for these services
- MACRA requirement
- Collection period 7/1/2017 – 12/31/2019 (at least)

Global Period – Medicare Project

Why is this important?

- Medicare Professional Fees for Surgical CPT Codes are calculated based on several factors but the most important factors are the RVU's (relative value units) and the distribution of the pre-, intra- and post-operative percentages
- Below is a small sample of five high-volume CPT codes used by UHPS providers

CPT CODE	SHORT DESCRIPTION	WORK RVU	GLOBAL PERIOD	PRE OP	INTRA OP	POST OP
17000	Destruct premalg lesion	0.61	10	10%	80%	10%
27447	Total knee arthroplasty	20.72	90	10%	69%	21%
66984	Cataract surg w/iol 1 stage	8.52	90	10%	70%	20%
69436	Create eardrum opening	2.01	10	10%	80%	10%
47562	Laparoscopic cholecystectomy	10.47	90	9%	81%	10%

Global Period – Medicare Project

Why is this important?

- Medicare is testing the validity of the RVU's assigned to each CPT code
  - MOST IMPORTANT RIGHT NOW – Was the value of the post-op component calculated correctly?
  - Did the clinician provide the amount of post-op care that would require paying the listed percentage of the global payment?

Global Period – Medicare Project

Why is this important?

- The potential for loss is great.
- Loss of RVU's and actual payment is possible if post-op visits are not captured and reported to Medicare
- Medicare is looking for ways to revalue and refine the payment amounts for surgical services

Modifiers to Use with Evaluation and Management Codes

These modifiers are used to send a very precise message about the visit

-AI

-24

-25

-32

-57

Modifier - AI

For Medicare Only

Indicates that the Provider reporting 99221 – 99223 is the Admitting Provider

Is only applicable on Initial Hospital Care CPT Codes

Modifier - 24

Indicating that an unrelated evaluation and management service was performed by the same provider during the global period

Modifier - 25

Indicates a significant, separately identifiable evaluation and management service by the same provider was performed on the same day of the procedure or other service

Use this modifier if charging a established patient visit along with a preventative visit

Use this modifier if a surgical procedure with a global period of 0 – 10 days is performed

Modifier - 32

Indicates a mandated service

- Often related to second opinions required by an insurance company
- May be required in cases covered by Workers' Compensation

Modifier - 57

Indicates that the decision for surgery has been made during this evaluation and management encounter

- It is extremely important to use this modifier when the patient will be taken to surgery on the same day as the evaluation and management service
- This modifier is used if the expected surgery has a global period of 90 days

Additional Modifiers

- RT – Right side
- LT – Left side
- 50 – Bilateral
- 53 – Discontinued Service
- 55 – Postoperative Care Only
- Q0 – Investigational clinical service provided in a clinical research study that is in an approved clinical research study
- Q1 – Routine clinical service provided in a clinical research study that is in an approved clinical research study

Additional Modifiers

- - FA – Left hand, thumb
- - F1 – Left hand, second digit
- - F2 – Left hand, third digit
- - F3 – Left hand, fourth digit
- - F4 – Left hand, fifth digit
- - TA – Left foot, great toe
- - T1 – Left foot, second digit
- - T2 – Left foot, third digit
- - T3 – Left foot, fourth digit
- - T4 – Left foot, fifth digit
- - F5 – Right hand, thumb
- - F6 – Right hand, second digit
- - F7 – Right hand, third digit
- - F8 – Right hand, fourth digit
- - F9 – Right hand, fifth digit
- - T5 – Right foot, great toe
- - T6 – Right foot, second digit
- - T7 – Right foot, third digit
- - T8 – Right foot, fourth digit
- - T9 – Right foot, fifth digit

Sports Exams

- Comprehensive Sports Exam – Non-symptomatic Patient
  - History – includes a comprehensive body system review and comprehensive or interval past medical, family and social history as well as a comprehensive assessment/history of pertinent risk factors
  - Physical Examination – Multi-system examination with the understanding that the extent of the exam is based on the age of the patient and the risk factors identified
  - Suggested Billing: 99381 – 99397 (Preventive Medicine Visits)
  - Diagnosis Coding: Z02.5 – Encounter for examination for participation in sports

Sports Exams

- Limited Sports Exam – Non-symptomatic Patient
  - Limited History and Physical Examination is expected
  - This, generally, would not be reported to insurance
  - Suggested Billing: 99080 – Special reports such as insurance forms, more than the information conveyed in the usual medical communication or standard reporting form
  - Diagnosis Coding: Z02.5 – Encounter for examination for participation in sports
- Limited Sports Exam – Symptomatic Patient
  - This becomes a regular New Patient or Established Patient Visit
  - Coding: 99201 – 99215 as appropriate for the situation
  - Diagnosis Coding: Based on the findings during the encounter
  - No additional billing for the Sports Exam portion of the encounter

Work Exams

- May be provided under contract with a company
- Suggest a "Special Code" or Mnemonic Code to represent service
- No actual CPT code for this purpose
- Possible Diagnosis Code: Z02.1 – Encounter for pre-employment examination

Cerumen Removal

69209 – Removal impacted cerumen using irrigation/lavage, unilateral

69210 – Removal impacted cerumen requiring instrumentation, unilateral

- There must be documentation that supports the medical necessity for these services
  - Cerumen impairs the clinical examination of the external auditory canal, tympanic membrane or middle ear
  - Cerumen is extremely hard, dry, and irritative causing pain, itching, hearing loss, etc.
  - Cerumen is associated with foul odor, infection or dermatitis
  - Obstructive copious amounts of cerumen cannot be removed without magnification and instrumentation requiring a provider's skill
- These are **unilateral codes**
- Use modifiers RT and/or LT for additional information about the location
- If both ears are involved code either two units, two charges with RT and LT modifiers or one charge with -50 modifier (bilateral)

Foreign Body Removals and Other Skin Procedures

10120 – Incision and removal of foreign body, subcutaneous tissue; simple

10121 – Incision and removal of foreign body, subcutaneous tissue; complicated

11740 – Evacuation of subungual hematoma

16000 – Initial treatment, first degree burn, when no more than local treatment is required

- Always list the percentage of body surface involved and depth of burn

69200 – Removal foreign body from external auditory canal; without general anesthesia

Suture/Staple Removal

Unless you performed the procedure that placed the sutures or staples,

bill this as an Evaluation and Management Code

Brief History: How did the patient get to this point?

Physical Examination: Constitutional (fever?), Integumentary, Other Body Systems as appropriate to evaluate post-operative condition

Medical Decision Making: New Problem to Examiner; Likely no data; Minor Problem – Straightforward Medical Decision Making

Suggested Billing Code: 99201 – 99202 or 99212 – 99213

If complications, possibly a higher level of service

Immunization Administration

90460 – Immunization administration **through 18 years of age** via any route of administration, **with counseling** by qualified health care professional; first or only component of **each** vaccine or toxoid administered

+90461 - each additional vaccine or toxoid component administered

Immunization Administrations with counseling are based on the number of vaccine components in the vaccine and not the number of injections/administrations given

- A component refers to all antigens in a vaccine that prevent diseases caused by one organism
- Combination vaccines are vaccines that contain multiple vaccine components (e.g. DTaP contains three (3) components
- Billing for a DTaP would be 90460 +90461 + 90461
- Counseling must be face-to-face; suggest providing data sheets for each vaccine or combination vaccine administered

Immunization Administration

Vaccine	Number of Components	Immunization Administration Code(s) Reported
HPV	1	90460
Influenza	1	90460
Meningococcal	1	90460
Pneumococcal	1	90460
Td	2	90460 + 90461
DTaP or TdaP	3	90460 + 90461 x 2
MMR	3	90460 + 90461 x 2
DTaP-Hib-IPV (Pentacel)	5	90460 + 90461 x 4
DTaP-HepB-IPV (Pediarix)	5	90460 + 90461 x 4

Immunization Administration

Recommended Diagnosis Coding for Immunization Administration

Patients age 17 years or younger

- Z00.129 – Routine infant or child health check; **without** abnormal findings
- Z00.121 – Routine infant or child health check; **with** abnormal findings
- Z23 – Encounter for immunizations

Adult Influenza, Pneumococcal and Hepatitis B

Criteria to determine the correct influenza vaccine:

- Type of influenza vaccine being administered
  - Preservative free or not specified as preservative free
  - Trivalent or quadrivalent
  - Increased antigen
  - Pandemic formulation
- How will the vaccine be administered:
  - Intramuscular (IM)
  - Intranasal
  - Intradermal (ID)

Effective 1/1/2019 –

90689 – Influenza virus vaccine quadrivalent (IIV4) inactivated, adjuvanted, preservation free, 0.25 mL dosage, for intramuscular use

Medicare Seasonal Influenza Virus Vaccine
Administration Code: G0008
Diagnosis Code: Z23
Frequency: Once per influenza season

90653 – Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use
90662 – Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90672 – Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
90674 – Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 ml dosage, for intramuscular use
90682 – Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemaglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90685 – Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use
90686 – Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90687 – Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use
90688 – Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use
90756 – Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use

Pneumococcal Vaccine
Administration Code: G0009
Diagnosis Code: Z23
Frequency: Per schedule

90670 – Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90732 – Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use

Hepatitis B Vaccine
Administration Code: G0010
Diagnosis Code: Z23
Frequency: Per schedule

90739 – Hepatitis B vaccine (HepB), adult dosage, 2 dose schedule, for intramuscular use
90740 – Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use
90743 – Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use
90744 – Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use
90746 – Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use
90747 – Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use

Psychiatry Documentation Basics

Generally, time is required

Templates which contain the basic components of the Psychiatric Diagnostic Evaluation

Specific documentation components which are CPT code specific

Diagnostic Interview Procedure

90791 – Psychiatric Diagnostic Interview

90792 – Psychiatric Diagnostic Interview with Medical Services

Psychotherapy

Important Changes:

1. Only three codes
2. No longer site specific
3. Time listed is specific, not a range*

* However, a range is still used per CPT

Psychotherapy

Code	90832	90834	90837
Description	Psychotherapy, 30 min with patient	Psychotherapy, 45 min with patient	Psychotherapy, 60 min with patient
Comment	Use for psychotherapy 16 - 37 minutes	Use for psychotherapy 38 - 52 minutes	Use for psychotherapy 53 or more minutes
Code with E/M	+90833	+90836	+90838
Description	Psychotherapy, 30 min with patient with E/M service	Psychotherapy, 45 min with patient with E/M service	Psychotherapy, 60 min with patient with E/M service

Family Psychotherapy

90846 – Family psychotherapy without the patient present

90847 – Family psychotherapy (conjoint psychotherapy) with the patient present

Psychotherapy for Crisis

90839 – Psychotherapy for crisis; first 60 minutes

Session requiring an urgent assessment and history of the crisis state, mental status exam and disposition.

Presenting problem must typically be life threatening or complex and require immediate attention to a patient in high distress.

Psychotherapy for Crisis

+90840 – Psychotherapy for crisis; each additional 30 minutes

May only be used in conjunction with 90839

If the session lasts 76 – 105 minutes, the billing would be 90839, 90840

Womens' Wellness Examination

Should include at least seven of the following:

Breast examination and inspection

Digital rectal examination

Pelvic examination including:
- External genitalia
- Urethra and urethral meatus
- Bladder
- Vagina
- Cervix
- Uterus
- Adnexa/parametria
- Anus and perineum

Womens' Wellness Examination

Medicare – Coding of Service

G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination

Q0091 – Screening Pap smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Womens' Wellness Examination

Medicare – Diagnosis Coding of Service

Low Risk – Once every 24 months/2 years

Diagnosis Codes:

- Z12.4 – Special screening for malignant neoplasm of the cervix

or

- Z12.72 – Special screening for malignant neoplasm of the vagina (status post-hysterectomy for non-malignant condition

or

- Z01.411 - Special screening for malignant neoplasm of other sites

or

- Z01.419 – Routine Gynecological Examination

Womens' Wellness Examination

Medicare – Diagnosis Coding of Service

High Risk – Once every 12 months/1 year

Diagnosis Codes:

- Z91.89 – Other specified personal history presenting hazards to health; other
  - Are of childbearing age and have had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding three years
  - Had multiple sex partners (five or more in a lifetime)
  - Engaged in sexual activity before the age of 16
  - Have a history of a sexually transmitted disease
  - Had fewer than three negative Pap tests within the previous seven years

Womens' Wellness Examination

Medicaid Traditional and Commercial Products

Patients age 20 and under

- Use Preventive Medicine codes (99383 – 99385, 99393 – 99395)
- Diagnosis Codes: Z00.00 or Z00.01 (Adult)
- Diagnosis Codes: Z00.121 or Z00.129 (Child)

Patients age 21 and over

- Preventive Medicine Codes may be applicable (Plan Specific)
- Use regular Evaluation and Management Code (99201 – 99215)
- Diagnosis Codes: Z00.00 or Z00.01 (Adult)

Variations on Preventive Examinations

Preventive Examination with Pap/Pelvic/Breast :
- Bill with the appropriate preventive examination code only
- (99381 – 99397)

Preventive Examination with deferred Pap/Pelvic/Breast:
- Bill with the appropriate preventive examination code only
- (99381 – 99397)

Medicare Wellness Visits

G0402 – IPPE – Welcome to Medicare Visit – limited to a new beneficiary during the first 12 months of Medicare enrollment

G0438 – Annual Wellness Visit – Initial Visit

G0439 – Annual Wellness Visit – Subsequent Visit (must be at least 11 months after G0438)

Medicare Wellness Visits

G0402 – Initial Preventive Physical Examination - IPPE
- Collect Past Medical and Family History, History of Alcohol, Tobacco and Illicit Drug Use
- Current Medications and Supplements
- Diet and Physical Activities
- Pay close attention to opioid use
- Review potential risk factors for Depression
- Review functional ability and level of safety – ADL's, Fall Risk, **Hearing Impairment**, Home Safety
- Assessment – Height, weight, BMI, BP and **Visual Acuity Screening**
- Provide information about Advanced Directives and carrying out beneficiaries wishes
- Establish a written screening schedule
- Establish a list of risk factors and conditions for which interventions are recommended or underway
- Furnish health advice or referral to health education or preventive counseling services
- May provide a once-in-a-lifetime screening ECG as appropriate (G0403 complete)

Excellent guidance available on CMS website

https://www.cms.gov/Medicare/Medicare.html

Medicare Wellness Visits

G0438 – Annual Wellness Visit – Initial Visit

- Health Risk Assessment
- Establish of past medical and family history
- Review potential risk factors for depression
- Review functional ability and level of safety
- Assessment – Height, weight, BMI, BP and **Hearing Impairment**
- Establish a list of current providers and suppliers
- Assess for cognitive impairment
- Establish a written screening schedule
- Establish a list of risk factors and conditions for which interventions are recommended or underway
- Furnish health advice or referral to health education or preventive counseling services

Medicare Wellness Visits

G0439 – Annual Wellness Visit – Subsequent Visit -
(must be at least 11 full months after G0438)

- Update the Health Risk Assessment
- Update the past medical and family history
- Assessment – Weight and BP
- Update the list of current providers and suppliers
- Assess for cognitive impairment
- Update the written screening schedule
- Update the list of risk factors and conditions for which interventions are recommended or underway
- Furnish health advice or referral to health education or preventive counseling services

Medicare Wellness Visits

Medicare Wellness Visits			
	Office	**Outpatient**	**wRVU's**
G0402	$ 169.02	$ 129.02	2.43
G0438	$ 174.43	$ 174.43	2.43
G0439	$ 118.21	$ 118.21	1.50

Medicare Wellness Visits with Medicare Advantage Plans

Medicare Advantage Plan	Parameter for Annual Wellness Visit
Anthem	Calendar
Aetna	Rolling*
Buckeye	Calendar
Humana	Calendar
The Health Plan	Calendar
SummaCare	Calendar
United Healthcare	Calendar
* Once every 366 days	

Advanced Care Planning

99497 – Advanced Care Planning

- Advanced care planning including explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate
- +99498 – each additional 30 minutes
- Payable when performed the same day as an Annual Wellness Visit **(G0438 or G0439 but NOT G0402)** – Deductible and coinsurance applies if not billed correctly
- Billed with modifier -33

Advanced Care Planning

99497 – Advanced Care Planning; +99498 – each additional 30 minutes

- Voluntary interaction
- Goal is to document the wishes of the patient pertaining to their medical treatment at a future time if they cannot decide for themselves at that time
- No place of service limitations – you can provide this service in a hospital or nursing care facility as appropriate
- No limit on the number of times you can report Advanced Care Planning in a given time period – you must document the change in the patient's health status and/or their wishes regarding end-of-life care
- No specific diagnosis requirement

Alcohol Use Screening and Counseling

G0442 – Alcohol Use Screening

- May be billed annually; up to 15 minutes in duration
- Recommended diagnosis code: Z13.89 – Screening for other disorder

G0443 – Alcohol Use Counseling

Recommended diagnosis code: F10.10 – Alcohol abuse, uncomplicated

205

Cardiovascular Intensive Behavioral Therapy

G0446 – Cardiovascular Intensive Behavioral Therapy, Individual, Annual and Face-to-Face, 15 minutes

Must meet all of the following criteria **(documented in medical record)**:

- Encourage aspirin use for the primary prevention of Cardiovascular Disease when the benefits outweigh the risks for men age 45 – 79 years and women 55 – 79 years;
- Screening for high blood pressure in adults age 18 years and older and;
- Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age and other know risk factors for cardiovascular and diet-related chronic disease

No specific diagnosis code is required but should use diagnosis codes that influence Cardiovascular Health (i.e. hypertension, diabetes mellitus, hyperlipidemia, obesity)

206

Depression Screening

G0444 – Depression Screening; 15 Minutes

May be billed annually

Staff must be able to facilitate and coordinate referrals to mental health treatment for positive screenings

Cannot be billed in conjunction with IPPE or Initial AWV **(cannot bill with G0402 or G0438, can bill with G0439)**

Diagnosis Code: Z13.89 – Screening for other disorder

207

Lung Cancer Screening Using Low Dose CT Scan – Counseling Visit to Discuss This Need

G0296 – Counseling Visit for Lung Cancer Screening Using Low Dose CT Scan; Annual

Must meet all of the following criteria **(documented in medical record)**:

Be 55 – 77 years of age;

Be asymptomatic (no signs or symptoms of lung cancer);

Have a tobacco smoking history or at least 30 pack-years (one pack-year = smoking one pack per day for one year; one pack = 20 cigarettes)

Be a current smoker or one who has quit smoking within the last 15 years; and

Receive a written order for lung cancer screening with LDCT that meets the requirements in the National Coverage Determination

208

Lung Cancer Screening Using Low Dose CT Scan – Counseling Visit to Discuss This Need

G0296

Order must contain the following information:

- Date of Birth
- Actual pack-year smoking history (number of pack-years)
- Current smoking status, for former smokers, the number of years since quitting smoking
- Statement that the patient is asymptomatic (no signs or symptoms of lung cancer)
- Ordering Provider's NPI number

Diagnosis Codes: Z87.891 - Personal history of tobacco use/ personal history of nicotine

Suggested Documentation:

- Recent Non-Smoker
- Current Smoker

209

Smoking and Tobacco Cessation Counseling

99406 – Smoking and Tobacco Cessation Counseling; 3 – 10 minutes; may be billed annually

Diagnosis codes: F17.2 – Nicotine dependence; Z87.891 Personal history of tobacco use/ personal history of nicotine

99407 – Smoking and Tobacco Cessation Counseling; >10 minutes; may be billed annually

Diagnosis codes: F17.2 – Nicotine dependence; Z87.891 Personal history of tobacco use/ personal history of nicotine

210

Obesity Counseling - Individual

G0447 – Obesity Counseling, Individual

Requirements:

- BMI >30
- Alert and competent
- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2 – 6; and
- One face-to-face visit every month for months 7 – 12, if beneficiary meeting the 3kg (6.6 lbs.) weight loss requirement during the first 6 months as required to continue for eligible visits in months 7 – 12.
- If the required 3kg (6.6 lbs.) weight loss did not occur, the patient may be reassessed after an additional 6 months.

Diagnosis Coding: Z68.30 – Z68.45 – BMI 30.00 – 39.99 to BMI 70 or greater

Limit: 22 visits in 12 month period

211

Obesity Counseling – Group (2-10) People

G0473 – Obesity Counseling, Group - (2-10) People

Requirements:

- BMI >30
- Alert and competent
- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2 – 6; and
- One face-to-face visit every month for months 7 – 12, if beneficiary meeting the 3kg (6.6 lbs.) weight loss requirement during the first 6 months as required to continue for eligible visits in months 7 – 12.
- If the required 3kg (6.6 lbs.) weight loss did not occur, the patient may be reassessed after an additional 6 months.

Diagnosis Coding: Z68.30 – Z68.45 – BMI 30.00 – 39.99 to BMI 70 or greater

Limit: 22 visits in 12 month period

212

Transitional Care Management

Level of Medical Decision Making	Face-to-face Visit within 7 days	Face-to-face Visit within 8 to 14 days
Moderate Complexity	99495	99495
High Complexity	99496	99495

213

Transitional Care Management

Three Components of Transitional Care Management

Communication of patient and/or caregiver within two business days of discharge

Non-Face-to-Face Services
- Review discharge information
- Follow-up on any needed testing or treatment
- Interact with other healthcare providers who will provide care and arrange for follow-up or needed services
- Provide Education to patient, family, guardian or caregiver(s)
- Establish referrals and assist with scheduling with community providers and services

Face-to-Face Visit
- One visit is required within 14 days of discharge

214

Transitional Care Management

99495 – Transitional Care Management

Covers 30 days beginning on the date of discharge

Communication of patient and/or caregiver within two business days of discharge

Medical decision making must be of **at least moderate complexity**

Face-to-face visit within 14 calendar days of discharge

215

Transitional Care Management

99496 – Transitional Care Management

Covers 30 days beginning on the date of discharge

Communication of patient and/or caregiver within two business days of discharge

Medical decision making must be of **high complexity**

Face-to-face visit within 7 calendar days of discharge

216

Chronic Care Management

99490 – Chronic Care Management

Requires at least 20 minutes of clinical staff time directed by a qualified health care professional, per calendar month when the following requirements are met:

- Two or more chronic conditions expected to last at least 12 months or until death and
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline and
- Comprehensive care plan established , implemented, revised or monitored

217

wRVU's and Reimbursement

Procedure Code	Description	wRVU	Medicare Office	Medicare Outpatient
99406	Smoking and Tobacco Cessation, 3 - 10 Min	0.24	$ 14.66	$ 12.35
99407	Smoking and Tobacco Cessation, >10 Min	0.50	$ 28.06	$ 25.75
99495	Transitional Care Mgmt, Mod MDM, 14 Days	2.11	$ 159.40	$ 109.50
99496	Transitional Care Mgmt, High MDM, 7 Days	3.05	$ 225.23	$ 158.80
99497	Advanced Care Planning; First 30 min, Face-to-Face	1.54	$ 84.12	$ 78.50
+99498	Advanced Care Planning; Each Additional 30 min, Face-to-Face	1.40	$ 74.20	$ 73.87
99490	Chronic Care Management Services, at least 20 minutes per calendar month	0.61	$ 41.12	$ 31.89
G0296	Counseling Visit for Lung Cancer Screening with Low Dose CT Scan	0.52	$ 28.42	$ 26.44
G0442	Annual Alcohol Misuse Screening, Face-to-Face, 15 Min	0.18	$ 17.42	$ 9.49
G0443	Behavioral Counseling for Alcohol Misuse, Face-to-Face, 15 Min	0.45	$ 25.90	$ 23.58
G0444	Annual Depression Screening, 15 Min	0.18	$ 17.42	$ 9.49
G0446	Intensive Behavioral Therapy for Cardiovascular Disease, Individual, 15 Min	0.45	$ 25.90	$ 23.58
G0447	Obesity Behavioral Counseling, Individual, 15 Min	0.45	$ 25.57	$ 23.58
G0473	Obesity Behavioral Counseling, Group (2 - 10 people), 30 Min	0.23	$ 12.62	$ 11.63

218

Proposed Changes to Medicare

Proposed changes to be effective **1/1/2021**

1) Delete 99201
2) Parameters for level of service selection will be Medical Decision Making or Time
3) How "Time" is defined
4) Medical Decision Making has been reworked by the AMA
5) Prolonged Services with Direct Patient Care can only be billed based on time and in conjunction with 99205 and 99215
6) New HCPCS code "GPC1X" will be created to describe additional work and resource costs associated with ongoing care of single, serious or complex chronic conditions

These are just highlights – more to come in the next year

10/2019 OAAPN STATEWIDE 2019 219

Data Mining and Benchmarking

Data Mining –

The process of analyzing data from different perspectives and summarizing it into useful information

This information may be used to highlight areas of risk, opportunities for revenue enhancement or both

Benchmarking –

The process of understanding how your organization compares with similar organizations

Data Mining

Process of analyzing data from different perspectives

Summarizing the data into useful information

Locating the needle in a haystack

Data Mining

Useful for:

- Identification of potential errors that may pose risk
- Establishing a baseline
- Identification of areas for potential education
- Locating opportunities for pre-bill edits or reviews

Data Mining

Most Important Reason

- This is what CERT, RAC and CMS are doing to locate problems
  - Find the potential issues first
  - Be proactive
  - Take the opportunity to find issues and fix them before an outside entity finds the issues for you
- Used by Medicare, Medicaid and Commercial Payers

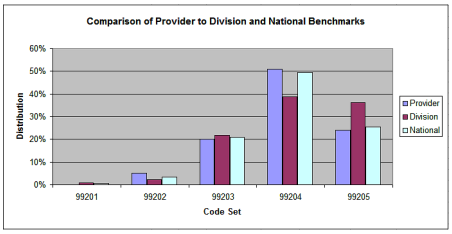
Data Mining and Benchmarking

- Look for what is reasonable and explainable
- Usually, the aberration will stand out
- Medicare has paid claims data in the CMS website (2017) – make your own benchmarks
- Data may be available through vendors or your professional associations
- You will find both Risk and Reward
- Always research what you find
- Always discuss opportunities armed with facts

Data Mining – New Patient Office/Clinic Visits
Provider "C" Data – Consistent with Benchmarks

New Office Visit - Four Quarters Ending 09/30/2019								
YOUR PRACTICE								
DIVISION	BILLING PROV	CPT	SUM UNIT	SUM CHGS	% per provider	Nat'l Benchmark	Difference	Division Distribution
ANY DEPARTMENT	PROVIDER "C"	99201	0	$ -	0%	1%	-1%	1%
		99202	5	$ 575	5%	4%	1%	2%
		99203	20	$ 3,500	20%	21%	-1%	22%
		99204	51	$ 16,830	51%	49%	2%	39%
		99205	24	$ 8,400	24%	26%	-2%	36%
	PROVIDER "C"		100	$ 29,305				

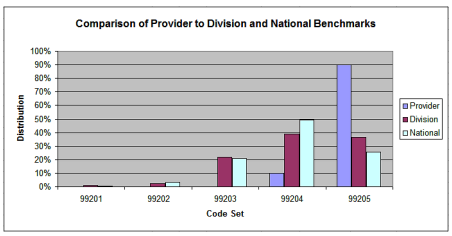
Data Mining – New Patient Office/Clinic Visits
Provider "C" Graph – Consistent with Benchmarks



Data Mining New Patient Office/Clinic Visits
Provider "A" Data – Above Benchmarks

New Office Visit - Four Quarters Ending 09/30/2019								
YOUR PRACTICE								
DIVISION	BILLING PROV	CPT	SUM UNIT	SUM CHGS	% per provider	Nat'l Benchmark	Difference	Division Distribution
ANY DEPARTMENT	PROVIDER "A"	99201	0	$ -	0%	1%	-1%	1%
		99202	0	$ -	0%	4%	-4%	2%
		99203	0	$ -	0%	21%	-21%	22%
		99204	10	$ 3,300	10%	49%	-39%	39%
		99205	90	$ 31,500	90%	26%	64%	36%
	PROVIDER "A"		100	$ 34,800				

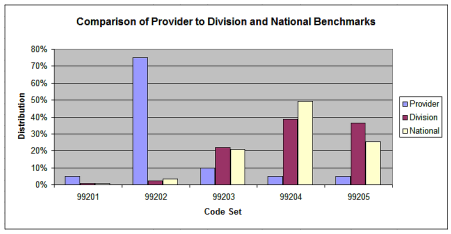
Data Mining New Patient Office/Clinic Visits
Provider "A" Graph – Above Benchmarks



Data Mining New Patient Office/Clinic Visits
Provider "B" Data – Below Benchmarks

New Office Visit - Four Quarters Ending 09/30/2019								
YOUR PRACTICE								
DIVISION	BILLING PROV	CPT	SUM UNIT	SUM CHGS	% per provider	Nat'l Benchmark	Difference	Division Distribution
ANY DEPARTMENT	PROVIDER "B"	99201	5	$ 295	5%	1%	4%	1%
		99202	75	$ 8,625	75%	4%	71%	2%
		99203	10	$ 1,750	10%	21%	-11%	22%
		99204	5	$ 1,650	5%	49%	-44%	39%
		99205	5	$ 1,750	5%	26%	-21%	36%
	PROVIDER "B"		100	$ 14,070				

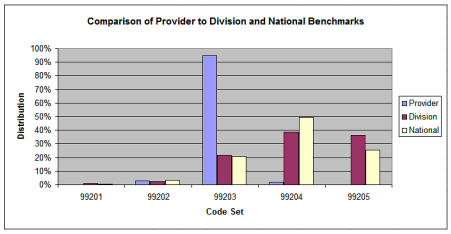
Data Mining New Patient Office/Clinic Visits
Provider "B" Graph – Below Benchmarks



Data Mining New Patient Office/Clinic Visits
Provider "D" Data – Clustered

New Office Visit - Four Quarters Ending 09/30/2019								
YOUR PRACTICE								
DIVISION	BILLING PROV	CPT	SUM UNIT	SUM CHGS	% per provider	Nat'l Benchmark	Difference	Division Distribution
ANY DEPARTMENT	PROVIDER "D"	99201	0	$ -	0%	1%	-1%	1%
		99202	3	$ 345	3%	4%	-1%	2%
		99203	95	$ 15,400	95%	21%	74%	22%
		99204	2	$ 660	2%	49%	-47%	39%
		99205	0	$ -	0%	26%	-26%	36%
	PROVIDER "D"		100	$ 16,405				

Data Mining New Patient Office/Clinic Visits
Provider "D" Graph – Clustered



Data Mining Exercise

Utilizing the forms in the next slides, create data mining information using the following information:

New Patient Visit Totals (Units)
- 99201 – 22
- 99202 – 15
- 99203 – 16
- 99204 – 32
- 99205 – 15

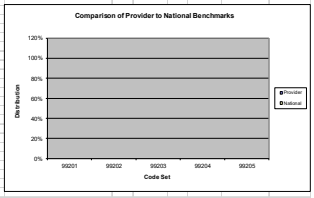
Data Mining Exercise

Utilizing the forms in the next slides, create data mining information using the following information:

New Patient Visit Benchmarks
- 99201 – 1%
- 99202 – 5%
- 99203 – 27%
- 99204 – 45%
- 99205 – 22%

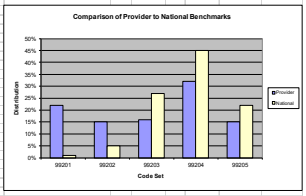
New Office Visit - Four Quarters Ending 09/30/2019

	SOURCE: YOUR BILLING SYSTEM						
DEPARTMENT	BILLING PROVIDER		CPT	SUM UNIT	% per provider	Nat'l Benchmark	Difference
YOUR PRACTICE	PROVIDER "A"		99201				
			99202				
			99203				
			99204				
			99205				
	PROVIDER "A"	Total					



New Office Visit - Four Quarters Ending 09/30/2019

	SOURCE: YOUR BILLING SYSTEM						
DEPARTMENT	BILLING PROVIDER		CPT	SUM UNIT	% per provider	Nat'l Benchmark	Difference
YOUR PRACTICE	PROVIDER "A"		99201	22	22%	1%	21%
			99202	15	15%	5%	10%
			99203	16	16%	27%	-11%
			99204	32	32%	45%	-13%
			99205	15	15%	22%	-7%
	PROVIDER "A"	Total		100			



What the Data Tells You and What You Should Be Asking

Possibly under billing – very high volumes of lower level codes

- What does the documentation support?
- Possible missed revenue opportunities
- Undervaluing the work of the provider
- What is the acuity of the patient base?

Data mining should be done on all code sets that are regularly used by each provider and for the group in total

Questions?

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