

CHAPTER 8 - HOW TO MAXIMIZE REVENUE GENERATION IN THE OFFICE?

A review of previous chapters, especially chapters 3 and 4, is strongly recommended before reading this chapter, as it lays the foundations for optimal billing and documentation. Maximizing revenue generation is an important consideration for both private practice and academic physicians. There are many ways to maximize revenue generation. We will take a detailed look at each one.

1-AIM FOR THE HIGHEST POSSIBLE LEVEL IN AN MDM-BASED CODE SET

The highest-level codes, also known as level 5 in the office, are 99205, 99215, and 99245. As explained in Chapter 2, there are 2 different ways to get to level 5. The first one uses total time, and the second uses MDM. You should always look at how much total time you have spent first. If you have spent enough time to meet the requirement for the highest level in a code set, then you should not bother looking at MDM, because, irrespective of MDM, you can report the highest level of code. If the total time you spend with the patient is insufficient for the highest level, you should check whether the MDM is sufficient to reach a higher level. This is the golden rule. Use the pathway that gives you the highest level. You may not be able to turn level 2 into level 5 unless you spend enough time, but turning level 2 into level 3 or turning level 3 into level 4 may not be too difficult.

Total time for level 5 is 60 minutes for a new patient (99205), 40 minutes for an established patient (99215) and 55 minutes for office consultation (99245).

MDM-based E/M service codes for office use.

Code Set	CPT code	Code level	Time	MDM level
Office New Patient	99202	Level 2	15 minutes	Straightforward
	99203	Level 3	30 minutes	low
	99204	Level 4	45 minutes	Moderate
	99205	Level 5	60 minutes	High
Office Established	99212	Level 2	10 minutes	Straightforward
	99213	Level 3	20 minutes	low
	99214	Level 4	30 minutes	Moderate
	99215	Level 5	40 minutes	High
Consult	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	low
	99244	Level 4	40 minutes	moderate
	99245	Level 5	55 minutes	High

Almost everything that you do for patient care that is not reported with another CPT code is included in the total time. You don't need to be in the office or with the patient for the time to count.

1. Preparing to see the patient: **chart review, review of tests.**
2. Obtaining and/or reviewing separately obtained **history.**
3. Performing a medically appropriate **examination and/or evaluation.**
4. **Ordering** medications, tests, or procedures.
5. **Counseling** and educating the patient/family-caregiver.
6. **Referring and communicating** with other health care professionals.
7. **Coordination** of care.
8. **Documenting** clinical information in the electronic or other health record ~ writing notes .
9. Independently **interpreting results** and communicating results to the patient/family.

Example: the highest level in the clinic for an established patient has a total time of 40 minutes. If you spend 40 minutes with an established patient, then you should bill level 5 (99215) irrespective of complexity/MDM. What if you spend only 20 minutes with an established patient, which only qualifies for level 3 (99213)? Can you make it to level 4 or 5 using MDM? If the answer is yes, *“based on MDM I can report level 4”*, then report level 4 based on MDM. If MDM only qualifies level 2, then report level 3 based on total time.

Physicians tend to underestimate their time, but it's important to remember that everything you do for patient care counts toward total time, including writing your note. If your established patients have 30-minute face-to-face appointment slots, then you should probably bill level 5 because if you consider the time to review patient's chart before or after the encounter, plus time to write the note, it will probably take another 10 minutes, hence 40-minute total time, which will give you level 5. If your new patient or consultation time slot is 1 hour, then you should bill the level 5 code.

Never forget that you can increase the total time spent on patient care in various ways, including providing counseling or education, coordinating care, calling consultants, etc. Let's say you spent 10 minutes on an established patient with a diaper rash, which typically qualifies for level 2 or level 3 at most. You can still bill level 5 if you spent another 30 minutes teaching the family how to prevent and manage diaper rash. You should, of course, document your extended talk/education in the chart; otherwise, your level 5 claim will be rejected because diaper rash is not a typical level 5 problem.

It is important to note that spending more time to reach a higher level does not work for well-child check codes, because these codes are based on encounters, not on time or MDM. Whether you spend 1 hour or 10 minutes doesn't affect the reported CPT code. So you cannot generate more revenue by providing extra anticipatory guidance during a well-child check.

There is a significant problem with time-based billing for revenue generation. If you target the highest code level with time, then you can only see a handful of patients. For example, if you work nonstop from 8 am to 5 pm, which is 9 hours, you can only bill for 9 level 5 new patients or 13 level 5 established patients, based on time. Although you may bill the highest level, you will not generate much revenue because you are billing only for a few patients per day.

Medi-Cal pays \$19.75 for a level 2 established patient (10 minutes) and \$62 for a level 5 established patient (40 minutes). So if you consider an 80-minute time period, you will be able to see only 2 level 5 patients (40 minutes each) and generate \$124 in revenue. If you see 8 level 2 patients (10 minutes each), you can generate \$160, which is more than \$ 124. So it is clear that if you see many simple patients, you may end up generating more revenue than if you see a few complex patients.

MDM-based billing is very valuable for revenue generation for exactly the same above reason, as you can bill high levels even when you spend a few minutes with the patient, because when you base your code selection on MDM, then how much time you spend with the patient is not important or simply irrelevant. It is difficult to reach level 5 using MDM, but level 4 is not too difficult to reach. Any time you prescribe or continue medication to a chronic patient that is not within the target treatment goal, then you can bill level 4 even if you spend 5 minutes with the patient. Seeing a lot of patients every 10-15 minutes and billing level 3 or 4 based on MDM is probably the best overall strategy for maximal revenue generation, of course, if you have enough patient volume or complexity. This is probably the reason why 99214 is the most frequently reported code in the office code sets.

We have seen above that by spending more time or care, you can increase the code level and hence revenue generation. Can a similar strategy work in the MDM pathway? The answer is yes, but instead of time, you should identify additional problems, data, or risks to increase the MDM level.

There will be many patients with 1 self-limited or minor problem in the clinic, like a simple URI. These patients only qualify for level 2 based on MDM, but you can change them to level 3 if you can identify and address other problems. For example, a simple URI is typically a level 2 problem, but you can turn it into level 3 billing if you find a diaper rash and address it. This is because 1 self-limited or minor problem qualifies for level 2, but 2 such problems qualify for level 3 with an independent historian. Another example is for chronic diseases. If you address 1 stable, chronic illness, this qualifies for level 3 with an independent historian, but if you address 2 stable chronic illnesses, it can qualify for level 4 if you write or renew a prescription. By addressing more problems, you can increase revenue generation. Example: you are seeing a patient with stable ADHD in the clinic. By addressing patient stable eczema, you can turn level 3 billing into level 4 billing. Your documentation should reflect what you did for these 2 conditions.

Use the details about MDM elements from Chapter 2 to target the highest level of code. One high-yield combination is a combination of one **chronic illness with exacerbation or progression, plus prescription drug management**. Any chronic illness that is not within treatment goal targets fits into this category. Any time you prescribe or renew a prescription, this is called prescription drug management. This combination will get you to level 4, which is not difficult to reach. Example: you see a patient in the clinic with acne that is not well controlled, and prescribe the previous medication or add a new one.

The sicker the patient or the more complex the problem, the higher the level you can target. Acute life-threatening illness > complicated acute illness with complication > uncomplicated acute illness > self-limited or minor problem. Severe exacerbation of chronic illness > exacerbation of chronic illness > stable chronic illness.

Another way of increasing MDM and hence billing at a higher level is by ordering more labs or imaging. Medically appropriate labs and imaging will help you get to the highest level. For example, if you have an independent historian and 2 labs (CBC, BMP), then this patient qualifies for level 4 if you are prescribing a medication, irrespective of the problem. If you add one independent interpretation of CXR, this qualifies for level 5 billing if you have an appropriate problem. Example: You have seen a patient with a large VSD and started the patient on Lasix. If you order CBC, BMP, independently interpret CXR, and monthly BMP for electrolyte monitoring, then this patient qualifies for level 5 billing because both data and risk elements is high enough for high MDM. In this example, monthly BMP to monitor side effects of Lasix qualifies for high-risk (intense drug monitoring).

The last way to target a higher MDM, hence a higher code level, is to use the risk element. Prescription drug management and social limiting factors qualify for level 4 billing. Drug therapy requiring intensive monitoring for toxicity, decision regarding hospitalization, or escalation of hospital-level care qualifies for level 5 billing.

Summary of targeting higher levels in a code set

Time based higher level code targeting	
Spend more time <i>(that is medically appropriate)</i>	Provide counseling, education, address concerns in length
	Coordination of care~ talk with consultants
	More detailed chart review
	More detailed history, examination <i>(medically appropriate)</i>
	Writing more detailed notes

MDM based higher level code targeting	
Problems. <i>Address more problems or more complex problems</i>	1 self-limited or minor problem < 2 self-limited or minor problem
	1 stable chronic illnesses < 2 stable chronic illnesses
	Stable chronic illnesses < chronic illness with exacerbation < chronic illness with severe exacerbation
	Acute, uncomplicated illness < acute illness with systemic symptoms < acute life threatening illness
Data <i>Order and review more medically appropriate data elements</i>	Have independent historian
	Order and review more tests
	Review external notes
	Provide independent interpretation of tests or imaging
	Management discussions with other providers
Risks	Prescription drug management <i>(giving or renewing prescription)</i>
	Diagnosis or treatment significantly limited by social determinants of health
	Drug therapy requiring intensive monitoring for toxicity
	Decision regarding hospitalization or escalation of hospital-level care

2- USE PROLONGED CARE CODES

Please refer to Chapter 3 for details on prolonged care codes. There are basically 2 different types of prolonged care codes. The first code group consist of 99417 and 99418, and only 99417 is used in the outpatient setting. It is used when you see a patient and then spend too much time with the patient during the same day/date. Second code group 99358 and 99359 is to report extra time for the patient care on the day/date that you have not seen the patient. These code sets exist so that you can bill, for example, extra time for reviving a discharged neonatal ICU patient's chart 2 days prior to the appointment, or for talking with a neurologist after the patient's MRI is back, on a day when you have not seen the patient.

99417 is for each 15-minute block. 99358 is for the first hour, and 99359 is for each additional 30 minutes.

Typical things that may count toward prolonged time include prolonged face-to-face care time, like an asthma exacerbation in the clinic requiring multiple evaluations/nebs, counselling, education, coordination of care, like calling the insurance company for a denial, chart review, interpretation of the labs or imaging, talking with other providers, writing notes/reports.

3-CONSULTING ON A PATIENT WITHOUT SEEING THE PATIENT

There are many instances in which a consultant spends a lot of time on the phone for patient care but does not see the patient that day. In this instance, the consultants can report their time spent on that day using prolonged care codes 99358 and 99359, as long as they see the patient in the following days.

4-PREVENTETIVE MEDICINE SERVICE ARE ONLY FOR WELL CHILD CHECKS AND NOT FOR SICK VISISTS

Preventive medicine code sets 99381-99384 and 99391-99394 are only for well-child checks. If any significant problem is identified and addressed during the encounter, it should be reported with appropriate E/M service codes using modifier 25. Modifier 25 lets the payer know that management of the problem was a separate service. An insignificant or trivial problem identified during a well check is included in the well check and not separately reported.

For example, if you see a six-year-old for WCC and discover that his asthma is poorly controlled, you can provide asthma management in addition to WCC and report both the WCC code and the sick office visit code.

5- MEDICAL TEAM CONFERENCE

Please refer to Chapter 3 for details on the medical team conference (team meeting). Office physicians or consulting physicians may report their time using an appropriate E/M service code, such as 99233, and use prolonged care codes if needed when a family member or patient is present during the meeting. When a family member or caregiver is not present in the meeting, then code 99367 can be billed.

6-OTHER E/M SERVICES

Report other E/M services when you provide them, like telemedicine codes or online digital E/M services, interprofessional telephone/internet/electronic health record consultation, digitally stored data services/remote physiologic monitoring, and advanced care planning services.

7- CRITICAL CARE SERVICES

Although rare, if you manage a critically ill patient in the office prior to transfer to the hospital, you may report time-based critical care codes if the time spent is more than 30 minutes. Example: one of your patients had severe anaphylaxis or severe asthma exacerbation in the clinic, and you provided 40 minutes of care, gave epinephrine and albuterol nebs, then you may bill 99291 irrespective of age.

8- DO NOT FORGET NON-E/M SERVICES OR PROCEDURES

E/M services or codes only cover evaluation and management. They basically involve examination and talking. If you perform anything other than examination or talking, there can be a separate code for it. For example, an ear exam is part of the physical examination and, hence, part of normal E/M service, but removal of impacted cerumen is not. There is a separate code for impacted cerumen removal; if you perform one, report it separately.

What non-E/M services an office physician may report heavily depends on specialty and subspecialty. Examples are vaccination codes, wart removal codes, and reduction of nursemaid's elbow. It is strongly recommended that physicians scroll through the pages of a CPT code book, find relevant codes for their practice, and use them to generate more revenue. You will be surprised by how many procedures you are already performing that are separately reportable. Chapter 4 provides useful information on common non-E/M service codes used by pediatricians.

9-APPROPRIATE DOCUMENTATION OF SELECTED CPT CODE

The importance of documentation cannot be overemphasized, as reimbursement doesn't depend on delivered care but rather on documentation. If a reported CPT code (or a claim) lacks appropriate documentation, it may be denied. Please refer to section 6 for guidelines on appropriate documentation.

So, do not just select the highest level of code; also, document in your note that the patient actually qualifies for that level. If you are billing 99215, then either document high-level MDM or 40 minutes of total time.

10- APPROPRIATE USE OF ICD CODES

CPT codes are always reported with ICD codes. ICD codes tell the payer about the reason for service, while CPT codes tell the payer about the nature of the service. You should align your CPT codes with ICD codes. If you report high-level codes, then you should list sicker-looking ICD codes, unless time-based

billing is used. For example, if the sickest ICD code listed is URI, it may be difficult to justify 99215, and the claim may be denied; however, it will likely be reimbursed if severe RAD exacerbation is used.

Reported ICD codes should reflect the patient's active problems being addressed, not inactive problems that are not addressed at that encounter. Chronic problems that are not contributing to medical decision-making are not relevant in selecting the level of MDM. Although ICD for unaddressed chronic problems may be listed, they are not as important as the acute problems. If you are reporting higher-level codes, list the appropriate sick ICD codes first, at the top, before ICD codes for other unaddressed chronic problems.

11- DO NOT FORGET TO BILL

Physicians frequently lose revenue when they forget to bill. It's a good idea to have a system that reminds you to bill for every patient that you see. This can be a computer-generated or handwritten patient list, with a check mark for every patient who is seen and billed. If you are a teaching physician, it's a good idea to write down the list of the patients you have seen that day so that if a resident forgets to write a note, you can still detect the missing note and bill for it. If you do not have your own list, then you may not realize when a resident forgets to place a note, especially if you are signing your notes and billing days after being on service.

12- FOLLOW YOUR CLAIMS

Follow your claims closely to ensure they are submitted appropriately and denials are addressed. If you do not have a system in place to follow your claims, then you would have no idea how much revenue you are losing.