# MEDICAL BILLING AND DOCUMENTATION CURRICULUM


**Eyup S. Keles MD**
**Pediatric critical Care Medicine**

# Resident Billing Curriculum

Written by Eyup S. Keles MD, CPC

1 of 9 lessons completed (11%)

- Welcome
- Pre-Billing Course Survey
- Lesson 1: Introduction to CPT Codes
- Lesson 2: E/M codes
- Lesson 3: Non-E/M codes
- Lesson 4: Medical Documentation
- Lesson 5: Maximizing Revenue
- Practice Cases
- Post-Billing Course Survey

## Lesson 2: E/M codes


**CHAPTER 3 – UNDERSTANDING EVALUATION AND MANAGEMENT (E/M) CODES**

CPT codes can be practically divided into 2 groups: E/M service codes and the rest (anesthesia, surgery, radiology, pathology/lab, medicine). CPT codes in the second group are only used by a subset of providers. Codes under urology are mostly used by urologists; the code for C-section is exclusively used by obstetricians. In contrast, codes under the E/M section are used daily by all physicians, and this group therefore contains the most commonly used CPT codes. Given their frequent use, these codes are of utmost importance.

E/M service codes typically exist in groups or code sets based on their usage setting. There are code sets for office, ER, hospital floor, and ICU care. Although there are many E/M codes, most physicians need to learn only a handful to report their services.

For practical use, E/M codes can be grouped into MDM based codes and others. Most MDM-based codes also based on time, but we'll refer to them simply as MDM based codes for simplicity. MDM reflects patient complexity: higher MDM means a more complex or sicker patient. These codes have strict rules; you must meet all requirements before using them.

**1- MDM-based E/M codes**

This group is composed of codes for office, hospital, consult, and ER services.

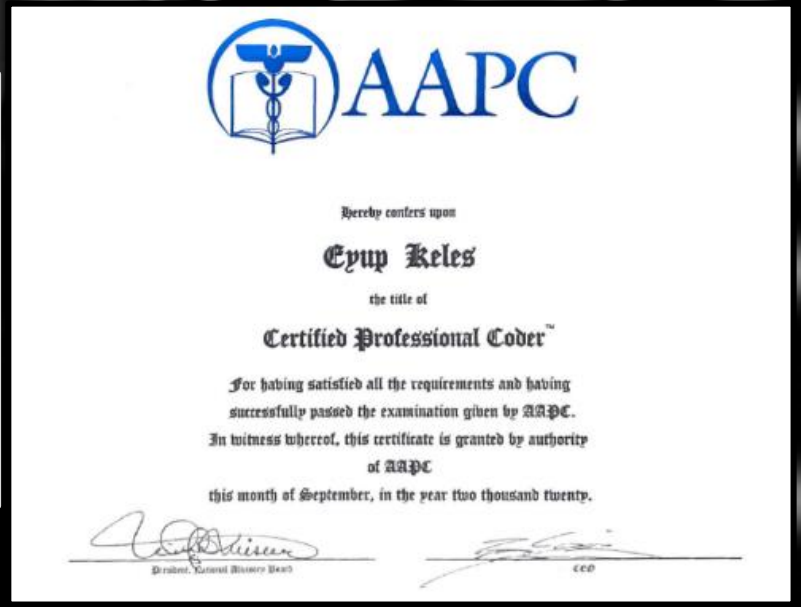
Chapter 3 Understanding ENM codes OE

Download

Take Quiz

- There is a big void that needs to be filled
- Billing and documentation is under one the **6 competencies of ACGME** yet
- **Most programs has no formal teaching on billing** and it's rare for a resident to get formal education on billing
- Most physicians are not interested in teaching billing and find it **<u>boring</u>**

- PERSONAL STORY - - - > **expert by accident** *(I was just trying to write short note)*
  - I received no training on billing- - - > learned billing from my colleagues in the PICU
  - Was asked to write long notes on resident notes - - - > refused after some time
  - Read about documentation guidelines - - - > CPT codes - - - > became expert
  - During Pandemic - - - > competed coder training - - -> became coder/CPC
  - Given the expertise started billing curriculum at UCSF Fresno
  - Outreach to other pediatric residency programs


AAPC

Hereby confers upon

Eyup Keles

the title of

Certified Professional Coder™

For having satisfied all the requirements and having successfully passed the examination given by AAPC. In witness whereof, this certificate is granted by authority of AAPC this month of September, in the year two thousand twenty.

# **Relax**, It’s not rocket science!

PART 1- INTRODUCTION

# Importance

- **Optimal billing/documentation - - > Higher revenue generation - - > Successful Practice**
  - Applies to both office physicians and physicians in academic settings
- Errors with billing/documentation - - -> loss revenue, potential legal/disciplinary problems

PART 1- INTRODUCTION

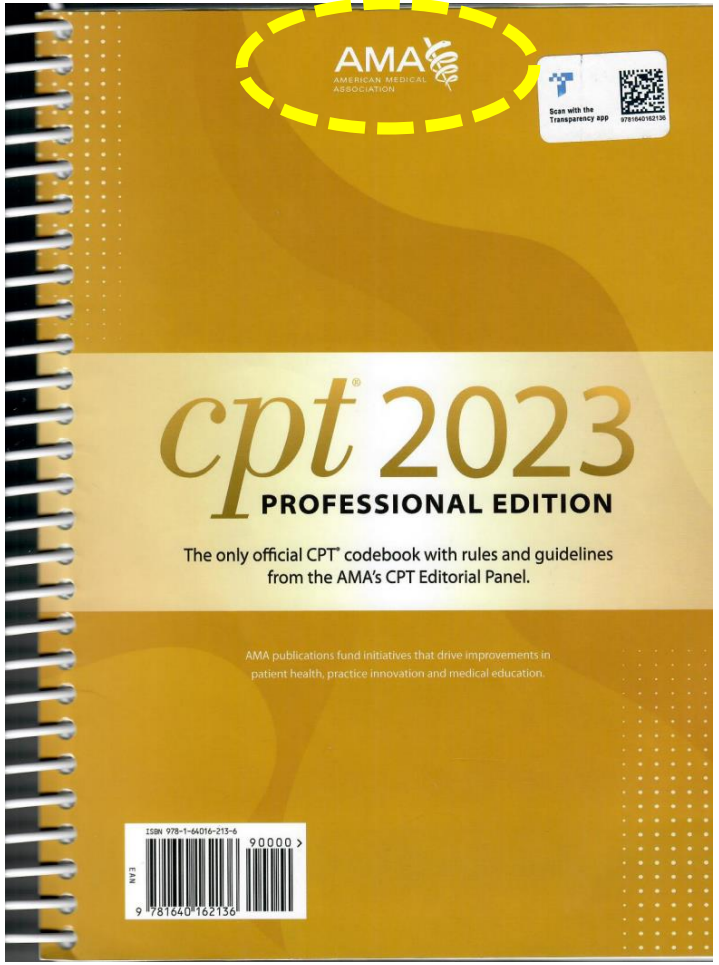
# Major Components

- There are 4 different family of codes for medical practice
  - **CPT codes - - - - >** *We will mostly cover CPT codes - - - > most frequently used codes*
  - **ICD codes - - - - >** *straightforward especially in electronic healthcare systems*
  - HCPCS codes - - - - > *are not commonly used by physicians, not covered*
  - NDC codes - - - - > *National drug code, straightforward, not covered*
- *Documentation is inherently related and dictated by these codes*

PART 1- INTRODUCTION

# CPT codes

- **CPT: C**urrent **P**rocedural **T**erminology
  - AMA Trade mark
  - Published/updated every year
  - 5 digits CODE - - -> ~ 99233 ~ 100$^{th}$ codes possible
  - *Only around 10$^{th}$ codes exist*



PART 1- INTRODUCTION

# CPT codes – What is inside the book

## Incision and Drainage

(For excision, see 11400, et seq)

**10040** Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
*CPT Assistant* Fall 92:10, Feb 08:8

**10060** Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
*CPT Assistant* Sep 12:10, Oct 21:13, Apr 23:25, Jan 24:37

**10061** complicated or multiple
*CPT Assistant* Sep 12:10, Oct 21:13, Apr 23:25

**10080** Incision and drainage of pilonidal cyst; simple
*CPT Assistant* Fall 92:13, Dec 06:15, May 07:5

**10081** complicated
*CPT Assistant* Fall 92:13, Dec 06:15, May 07:5

(For excision of pilonidal cyst, see 11770-11772)

**10120** Incision and removal of foreign body, subcutaneous tissues; simple
*CPT Assistant* Sep 12:10, Apr 13:10, Dec 13:16

**10121** complicated
*CPT Assistant* Spring 91:7, Dec 06:15, Sep 12:10, Dec 13:16, Apr 21:6

Code for I&D

Code intubation

**31367** subtotal supraglottic, without radical neck dissection
*CPT Assistant* Aug 10:4

**31368** subtotal supraglottic, with radical neck dissection

**31370** Partial laryngectomy (hemilaryngectomy); horizontal

**31375** laterovertical

**31380** anterovertical

**31382** antero-latero-vertical

**31390** Pharyngolaryngectomy, with radical neck dissection; without reconstruction

**31395** with reconstruction

**31400** Arytenoidectomy or arytenoidopexy, external approach

(For endoscopic arytenoidectomy, use 31560)

**31420** Epiglottidectomy

## Introduction

**31500** Intubation, endotracheal, emergency procedure
*CPT Assistant* Nov 99:32-33, Oct 03:2, Aug 04:8, Jul 06:4, Jul 07:1, Dec 09:10, May 16:3, Oct 16:8, Jul 21:8

PART 1- INTRODUCTION

# CPT codes – What is inside the book

**62270** Spinal puncture, lumbar, diagnostic;

- *CPT Changes: An Insider's View* 2000, 2002, 2020
- *CPT Assistant* Nov 99:32-33, Oct 03:2, Jul 06:4, Jul 07:1, Oct 09:12, Nov 10:3, Jan 11:8, Mar 12:3
- *Clinical Examples in Radiology* Spring 11:9, Winter 14:9-10, Summer 16:4, Summer 18:9, Fall 19:8, Winter 20:11

**# 62328** with fluoroscopic or CT guidance

- *CPT Changes: An Insider's View* 2020
- *CPT Assistant* Jun 20:10
- *Clinical Examples in Radiology* Fall 19:9, Winter 20:11

(Do not report 62270, 62328 in conjunction with 77003, 77012)

(If ultrasound or MRI guidance is performed, see 76942, 77021)

**62272** Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);

- *CPT Changes: An Insider's View* 2000, 2020
- *CPT Assistant* Nov 99:32-33, Nov 10:3, Dec 13:14
- *Clinical Examples in Radiology* Spring 11:10, Winter 14:9-10, Summer 16:4, Fall 19:8

Code for LP

Code Rapid Strep

**87807** respiratory syncytial virus

- *CPT Changes: An Insider's View* 2005, 2022

**87811** severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])

- *CPT Changes: An Insider's View* 2022

**87808** Trichomonas vaginalis

- *CPT Changes: An Insider's View* 2007, 2022

**87809** adenovirus

- *CPT Changes: An Insider's View* 2008, 2022
- *CPT Assistant* Apr 08:5

**87810** Chlamydia trachomatis

- *CPT Changes: An Insider's View* 2009, 2022
- *CPT Assistant* Nov 97:34, Jan 98:6

**87811** Code is out of numerical sequence. See 87804-87809

**87850** Neisseria gonorrhoeae

- *CPT Changes: An Insider's View* 2022
- *CPT Assistant* Nov 97:34, Jan 98:6

**87880** Streptococcus, group A

- *CPT Changes: An Insider's View* 2022
- *CPT Assistant* Nov 97:34, Jan 98:6, Dec 98:8

PART 1- INTRODUCTION

# CPT codes – What is inside the book

**99213** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

- *CPT Changes: An Insider's View* 2013, 2017, 2021, 2024
- *CPT Assistant* Winter 91:11, Spring 92:14, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, Jan 97:10, Jul 98:9, Sep 98:5, Aug 01:2, May 02:3, Oct 03:5, Apr 04:14, Oct 04:10, Mar 05:11, Apr 05:1, 3, Jun 05:11, Dec 05:10, May 06:1, Jun 06:1, 11, Sep 06:8, Oct 06:15, Apr 07:11, Jul 07:1, Sep 07:1, Mar 08:3, Mar 09:3, Aug 09:5, Sep 10:4, Jan 11:3, Jun 11:3, Mar 12:4, 8, Jan 13:9, Mar 13:13, Jun 13:3, Aug 13:13-14, Jan 15:12, Mar 16:11, Sep 16:6, Apr 18:10, Sep 18:14, Jan 19:3, Jan 20:3, Feb 20:3, Mar 20:3, May 20:3, Jun 20:3, Sep 20:14, Oct 20:14, Nov 20:3, Jan 21:3, Feb 21:8, Apr 21:13, Jun 21:13, Aug 21:13, Sep 21:3, 14, Nov 21:12, Jan 22:3, 17, Feb 22:13, Jun 22:19, Jul 22:17, Aug 22:3-7, Sep 22:6, Nov 22:19, Dec 22:19, Mar 23:1, Jun 23:25, Oct 23:18, Jan 24:1

Code for office visit

Codes for WCC

**99381** **Initial comprehensive preventive medicine** evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)

- *CPT Changes: An Insider's View* 2002, 2009
- *CPT Assistant* Winter 91:11, Spring 93:14, 34, Spring 95:1, Aug 97:1, Jul 98:9, Sep 98:5, Nov 98:3-4, May 02:1, May 05:1, Aug 05:15, Oct 06:15, Mar 09:3, Jul 09:7, Aug 09:5, Jan 13:9, Dec 14:18, Mar 16:7, Feb 21:8, Nov 21:12, Dec 22:15

**99382** early childhood (age 1 through 4 years)

- *CPT Changes: An Insider's View* 2009
- *CPT Assistant* Winter 91:11, Spring 93:14, 34, Spring 95:1, Aug 97:1, Jul 98:9, Sep 98:5, Nov 98:3-4, May 02:1, Aug 05:15, Oct 06:15, Jul 09:5, Aug 09:5, Jan 13:9, Dec 14:18, Mar 16:7, Feb 21:8

**99383** late childhood (age 5 through 11 years)

- *CPT Changes: An Insider's View* 2009
- *CPT Assistant* Winter 91:11, Spring 93:14, 34, Spring 95:1, Aug 97:1, Jul 98:9, Sep 98:5, Nov 98:3-4, May 02:1, Aug 05:15, Oct 06:15, Jul 09:7, Aug 09:5, Jan 13:9, Dec 14:18, Mar 16:7, Feb 21:8

**99384** adolescent (age 12 through 17 years)

- *CPT Changes: An Insider's View* 2009
- *CPT Assistant* Winter 91:11, Spring 93:14, 34, Spring 95:1, Aug 97:1, Jul 98:9, Sep 98:5, Nov 98:3-4, May 02:1, Aug 05:15, Oct 06:15, Jul 09:7, Aug 09:5, Jan 13:9, Dec 14:18, Jan 15:12, Mar 16:7, Feb 21:8

PART 1- INTRODUCTION

# Function of CPT Codes

- WHY WE NEED THESE CODES ?
- **Numbers replace the words** - - - > Claim processing becomes faster and easier
- Instead of telling the insurance company
  - I saw a sick child in the office - - - > you say/report 99205
  - I saw a well child check in the office - - > 99391
  - I performed tonsillectomy - - - > 42825
  - I seen a sick patient in the ED - - - > 99285

PART 1- INTRODUCTION

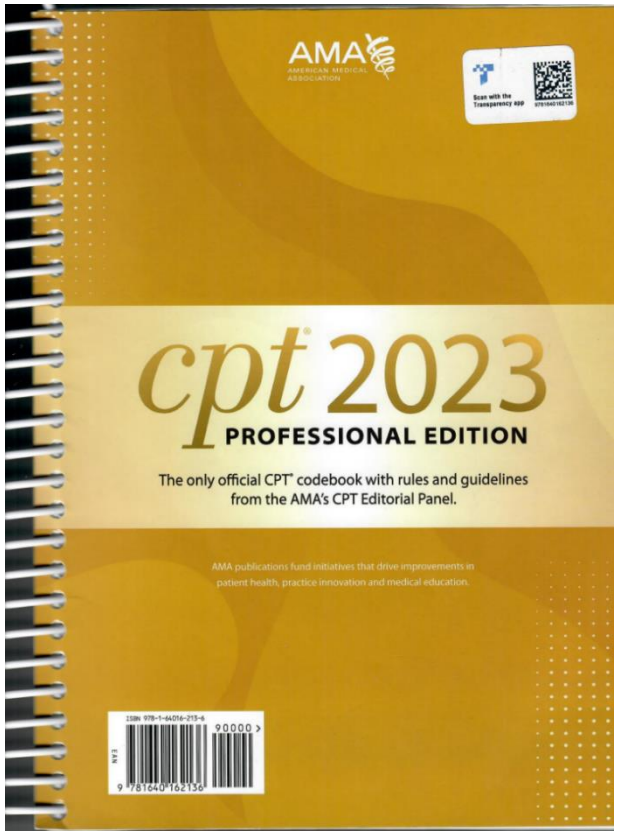
# History of CPT

- *CPT is owned and maintained by **American Medical Association** (copyright protection on CPT)*
- *1st edition of CPT was published **in 1966***
- ***In 1983**, CPT was adopted as part of the Centers for Medicare & Medicaid Services (CMS), Healthcare Common Procedure Coding System (HCPCS)*
- *Recognition of CPT as a standard tool by CMS brought wide spread acceptance of these codes*
- *Initially, use of CPT codes was voluntary, but with the implementation of 1996 HIPAA use of the CPT codes for transactions involving health care information **became mandatory***

PART 1- INTRODUCTION

# CPT code groups

- It is important to know the code groups when looking for a code.
- There are six major CPT code groups




**1-Anesthesia**
**2-Surgey**
**3-Radiology**
**4-Pathology/Laboratory**
**5-Medicine**
**6-Evaluation and Management**

PART 1- INTRODUCTION

# Code classification

- **No set rule** but mostly based on **historical usage**.

- **Surgical codes are not reserved for surgeons.**
- Medicine codes are not reserved for internist.

  - *All angiography codes - - - - > Surgery*
  - *Coronary angiography, stent placement - - - - > Medicine (likely because procedure is exclusively done by cardiologist)*

  - *Most ultrasound studies - - - - -> Radiology*
  - *Ultrasound of cranial vessels, DVT USG, ECHO - - - > medicine.*

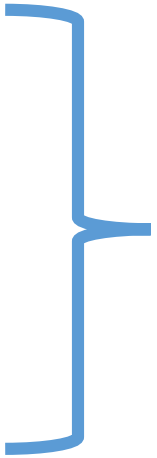
  - *All central line placement procedures including picc line - - - - -> surgery*
  - *Swan-ganz PA catheter insertion - - - - > Medicine*

PART 1- INTRODUCTION

# CPT code groups

- **Initial 2 digits will indicate the group**

- 1-Anesthesia - - - - - - - - - - - - - - - - -> 00 - 01
- 2-Surgey - - - - - - - - - - - - - - - - - - -> 10th – 60th
- 3-Radiology - - - - - - - - - - - - - - - - - - > 70th
- 4-Pathology/Laboratory - - - - - - - - - > 80th
- 5-Medicine - - - - - - - - - - - - - - - - - - > 90th
- 6-Evaluation and Management - - -- > 99th



**~ 10 thousand blocks**

PART 1- INTRODUCTION

# Anesthesia codes

- **Anesthesia codes**
  - *The first 10 thousand group*
  - Any CPT code that starts with **<u>00</u>** or **<u>01</u>** is an anesthesia code

  - *Anesthesia codes are divided according to body region/organs*
  - *Codes starting with 00: Anesthesia for head, neck, thorax, spine, Abdomen, Perineum*
  - *Codes starting with 01: Anesthesia for pelvis, extremities, radiological procedures, burn, obstetric*

PART 1- INTRODUCTION

# Surgery codes

- **Surgery Codes**
- Any CPT code that starts with **1, 2, 3, 4, 5 or 6** is a surgery code.

- Surgery codes also divided according to body regions/organs.
  - *10 thousand series: Skin, Breast procedures*
  - *20 thousand series: Musculoskeletal procedures*
  - *30 thousand series: Respiratory, cardiovascular, hematology, lymphatic system procedures*
  - *40 thousand series: Digestive system procedures*
  - *50 thousand series: Urinary, male/female genital system, maternity procedures*
  - *60 thousand series: Nervous system, eye, auditory, endocrine system procedures*

PART 1- INTRODUCTION

# Radiology and Path/Lab codes

- **Radiology codes** *(including nuclear medicine and ultrasound)*
  - *This group includes codes starting with 70 thousand.*
  - *Most are reported by radiologist.*
  - *Any CPT code that starts with **7** is a radiological procedure*

- **Pathology/Laboratory**
  - *This group includes codes starting with 80 thousand*
  - *Any CPT code that starts with **8** is a pathology/laboratory procedure*
  - **Used by physicians in the office** but **NOT** by the physicians in hospitals or inpatient settings
  - Examples: Ua, rapid strep, RSV, influenza tests
  - Inpatient doctors never bill these codes except pathologist/biochemist …

PART 1- INTRODUCTION

# Medicine codes

- **Medicine codes**
  - *This group includes codes starting with 90 thousand*
  - *Any CPT code that starts with **9** is a medicine code **except evaluation & management codes***

- There are multiple subgroups under medicine codes including
  - Immunizations, immune globulins and vaccine/toxoid codes
  - Ophthalmology, audiology, dialysis, physical therapy codes
  - Cardiology, electrophysiology, pulmonary, allergy, neurology, sleep medicine, EMG
  - Medical genetics, psychiatry, behavioral health related codes
  - Iv fluids/hydration, drug/chemotherapy injection
  - Nutrition, acupuncture, sedation codes

PART 1- INTRODUCTION

# Evaluation and Management codes

- **<u>Evaluation and Management (E/M) codes</u>** **- - - - > CORE OF THE CPT CODES**
  - *Only group that is not in numerical sequence.*
  - *This group starts with 99 thousand (99-**202** to 99-**499**)**
  - *There are medicine codes prior and after these codes*

  - **Most commonly used codes by <u>physicians in every specialty</u>** *and other health care workers*

  - ***Any time a physician evaluates and manages a patient - - - - > E/M code***
  - ***If you do anything other than evaluation/management - - > !? Separate code - - > More Revenue***

** Except the newly introduced telemedicine codes which starts with 98$^{th}$*

PART 1- INTRODUCTION

# Non-E/M codes

- **ANESTHESIA - SURGERY- RADIOLOGY - PATHOLOGY/LABORATORY - MEDICINE** codes
  - **Usage depends on specialty and subspecialty - -** *- > will not be discussed further*
  - There are thousands of non E/M CPT codes!
  - Each specialty and subspecialty should find their own interest of CPT codes and be familiar with them

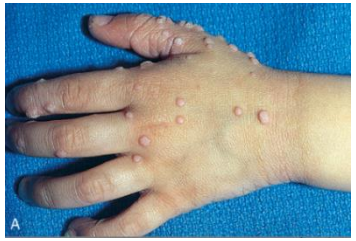
- *I strongly recommend that physicians take their time and scroll through the pages of a CPT code book and AAP billing for pediatrics book to see what non-E/M CPT codes can be reported in their practice.*
- *Billing handbook list commonly used procedures for easy access but does not include all potential codes*.

- **Commonly used non-E/M codes by subspecialties**
  - Allergy test/treatment codes, endoscopy codes, bronchoscopy codes, dialysis codes, EKG/ECHO codes, EEG codes, joint injection codes, invasive procedure codes (intubation, central line placement)…….

PART 1- OTHER CPT CODES

# Non-E/M codes

- **Commonly used non-E/M codes in the pediatric office**
  - Incision and drainage - - -> 10060
  - Removal of skin tags including congenital accessory digits - -> 11200
  - Wedge excision of skin of nail fold for ingrown toe nail - - -> 11765
  - Laceration repairs - - - > 12001
  - Suture removal - - - > 15853
  - Simple burn care - - - > 16000, 16020
  - **Destruction of benign lesions/warts - - -> 17110, 17111**
  - Chemical cauterization of granulation tissue - - -> 17250
  - Foreign body removal from skin/eye/ear/nose - - > 10120
  - Closed treatment of radial head subluxation in child, nursemaid elbow - - -> 24640
  - Controlling nose bleed - - - > 30901
  - Newborn circumcision - - - > 54150
  - Removal of impacted cerumen - - - > 69209, 69210
  - **Immunization administration codes** - - - > **90460, 90461,** 90471,90472, 90473,90474



PART 1- OTHER CPT CODES

# Non-E/M codes

- **Commonly used non-E/M codes in the pediatric floor or ICU**
  - Intubation - - - > 31500
  - Central line < age 5years - - > 36555
  - Arterial catheterization - - > 36620
  - IO insertion - - > 36680
  - Venipuncture requiring physician skills - - > 36400
  - Bladder aspiration with needle - - > 51100
  - LP - - - - > 62270
  - Bone marrow aspiration - - > 38220, 38221
  - Moderate sedation - - - > 99151 -99153, 99155-99157
  - CPR - - -> 92950

PART 1- OTHER CPT CODES

# Non-E/M codes

- All surgical codes has surgical package
  1. E/M services subsequent to the decision to surgery on the day before and/or on the day of surgery (including history and examination).
  2. Local or topical anesthesia.
  3. Immediate post-operative care, writing orders, evaluation of patient in the recovery area.
  4. Typical postoperative follow-up care

| **Global Period** | **0 day** | **10 days** | **90days** |
|---|---|---|---|
| Related E/M services before the date of procedure | Not included | Not included | All related service 1 day before surgery if after decision for surgery |
| Related E/M services on the date of procedure | E/M services typically included | E/M services typically included | All related service except E/M service at which decision for surgery is made |
| Related Postoperative E/M services | Same day (day 0 only) | All related care for 10 days | All related care for 90 days |

PART 1- INTRODUCTION

# Modifiers and NCCI edits

- Modifiers are two-digit numbers or letters that are attached to the CPT codes to show a special circumstance.
  - One special situation - - - > billing 2 CPT code for the same patient in same visit/day - - - - > modifier 25
  - Modifier 25 is the most important modifier for pediatricians.
  - Modifier 25 tells the payer that services billed was not in error or a duplicate service

- *For example: If you see a child for a well child check visit and address a significant problem like a UTI or pneumonia on top of WCC then you can bill both WCC visit and sick visit. But if you bill both of these codes payer's software may think that it's duplicative bill or an error and may deny one of the bills. In this setting modifier 25 attached to second CPT code to tell the payer that second code is not duplicative or billed in error and is an actual service. Correct coding in this scenario would be reporting a WCC code like 99292 and sick visit code like 99213 with modifier 25.*

- **NCCI edits** show **mutually exclusive codes**.
  - It is used by payers to deny services that are not typically reported together.
  - Some of these code pairs can be overridden by a modifier.

PART 1- INTRODUCTION

# ICD codes

- ICD: owned by WHO and used by whole world (**international classification of diseases**)
- CPT: owned by AMA and used only in the USA

- ICD codes are 3- 7 characters
  - 1st character is always a letter while 2nd and third are numbers (0-9)
  - Characters 4-7 can be either a letter or a number

- **In order to report a claim you need both ICD and CPT codes**
  - ICD codes tells the payer about the diagnosis, reason for visit ***(why patient came to see you)***
  - CPT codes tells the payer about preformed *services* ***(what you have done for the patient)***

  - *Patient had a broken arm - - - - > ICD - - - - > S52.541A*
  - *I reduced it and applied cast - - - > CPT - - - - - -> 25600*

  - *Patient had ear pain/infection - - - - - - - - - - - - - - -> ICD - - - - - - - - - > H65.0*
  - *I evaluated the patient and prescribed antibiotics - - > CPT - - - - - - > 99213*

PART 1- INTRODUCTION

# ICD code selection

- Selection of appropriate ICD codes ***is extremely important for reimbursement process***

- **ICD code and CPT code should align**
  - Reporting Tonsillectomy code with an ICD code for acute gastroenteritis ??!! - - - > Denial
  - Reporting highest level of office code with ICD for mild URI !!? - - - - > Denial*
  - Reporting critical care code with ICD code for knee pain !!? - - - - > Denial

- *For critical care codes: first ICD code selected should represent a critical illness*
- *Reporting higher level codes - - - > consider reporting sicker ICD codes**

- **: unless code selection is based on time.*

PART 1- INTRODUCTION

# Reimbursement process – How a claim is submitted ?

- What happens after you select the CPT and ICD codes on paper or software ?
  - Physician claims are typically submitted with: **CMS Health Insurance Claim Form 1500**

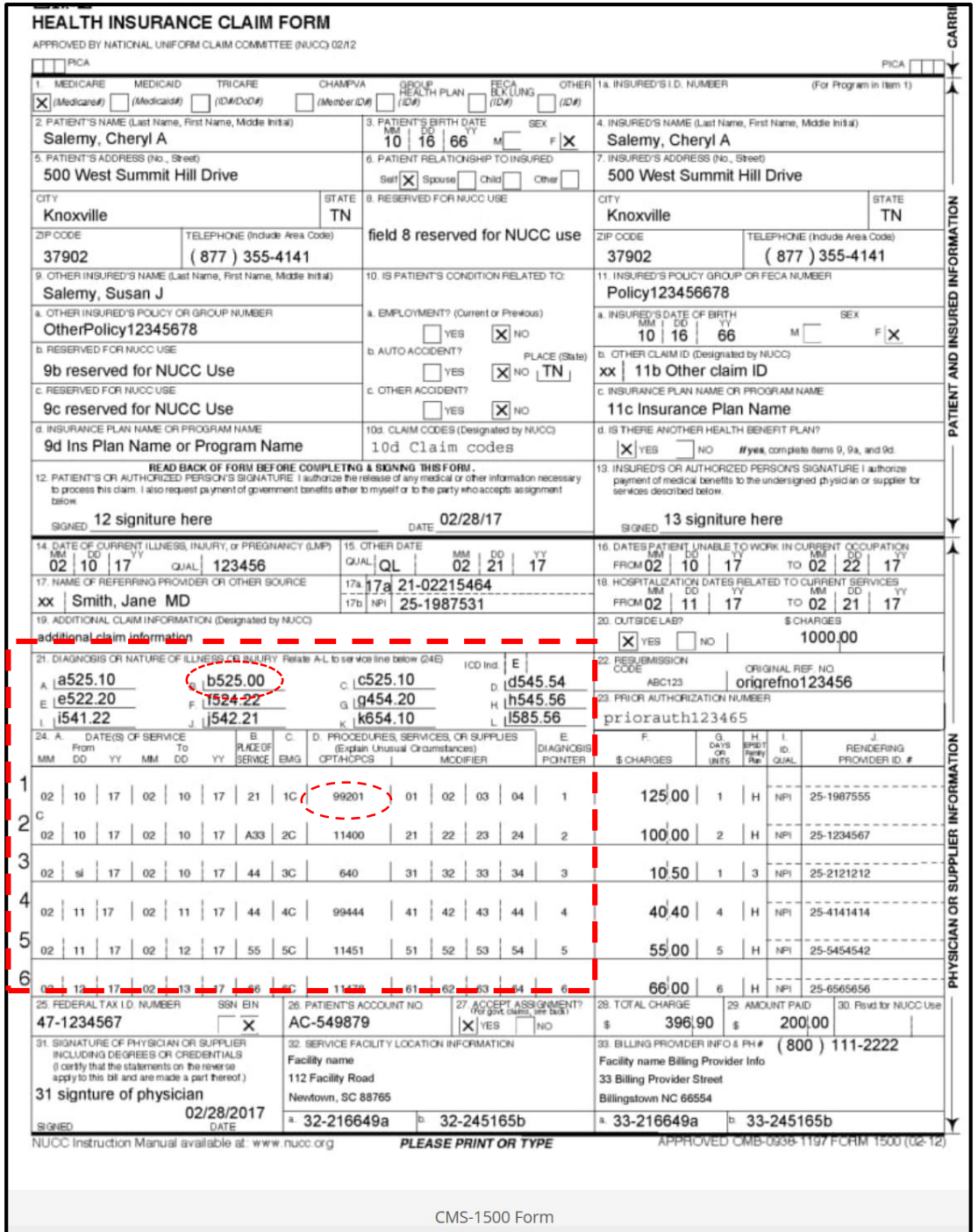
- Form 1500 is filled by 2 different ways
  - **Manually by a coder** - - > either into a paper or electronic version of form 1500
    - Happens, if the physician is using paper-based billing
    - All the fields of the form is filled by the coder
    - Slow and prone to error
  - **Automatically by a software**
    - Happens if the physician is using a software-based patient chart and billing like EPIC
    - First software auto populate most of the fields in the second software/form 1500
    - Fast but there may be less coder supervision
- *Currently most of the claims are submitted wia electronic version of form 1500 either filled manually or by a health care software*

- Form 1500 ~ has 33 fields to fill including
  - Patient demographics
  - Insurance details
  - Dates of service
  - Provider information
  - **Diagnosis codes (ICD): field 21**
  - **Procedure codes (CPT/HCPCS): field 24**
  - Charges

For a successful practice - -> Follow your claims

- Claims are submitted and compensated appropriately
- Denials are addressed
- There are no coding errors
- There are no missing claims

- No follow up - - > no idea what is missing



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Salemy, Cheryl A

3. PATIENT'S BIRTH DATE: 10 16 66 | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Salemy, Cheryl A

5. PATIENT'S ADDRESS (No., Street): 500 West Summit Hill Drive

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 500 West Summit Hill Drive

CITY: Knoxville | STATE: TN

8. RESERVED FOR NUCC USE: field 8 reserved for NUCC use

CITY: Knoxville | STATE: TN

ZIP CODE: 37902 | TELEPHONE (Include Area Code): ( 877 ) 355-4141

ZIP CODE: 37902 | TELEPHONE (Include Area Code): ( 877 ) 355-4141

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Salemy, Susan J

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Policy123456678

a. OTHER INSURED'S POLICY OR GROUP NUMBER: OtherPolicy12345678

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 10 16 66 | SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE: 9b reserved for NUCC Use

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State): TN

b. OTHER CLAIM ID (Designated by NUCC): xx | 11b Other claim ID

c. RESERVED FOR NUCC USE: 9c reserved for NUCC Use

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 11c Insurance Plan Name

d. INSURANCE PLAN NAME OR PROGRAM NAME: 9d Ins Plan Name or Program Name

10d. CLAIM CODES (Designated by NUCC): 10d Claim codes

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: 12 signiture here | DATE: 02/28/17

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: 13 signiture here

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 02 10 17 | QUAL: 123456

15. OTHER DATE: QUAL: QL | 02 21 17

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM 02 10 17 TO 02 22 17

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: xx | Smith, Jane MD

17a. 17a 21-02215464

17b. NPI 25-1987531

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 02 11 17 TO 02 21 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): additional claim information

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: 1000.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E) ICD Ind. E

A. a525.10 B. b525.00 C. c525.10 D. d545.54
E. e522.20 F. f524.22 G. g454.20 H. h545.56
I. i541.22 J. j542.21 K. k654.10 L. l585.56

22. RESUBMISSION CODE: ABC123 | ORIGINAL REF. NO.: origrefno123456

23. PRIOR AUTHORIZATION NUMBER: priorauth123465

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 02 10 17 | 02 10 17 | 21 | 1C | 99201 | 01 02 03 04 | 1 | 125.00 | 1 | H | NPI | 25-1987555 |
| 2 | C 02 10 17 | 02 10 17 | A33 | 2C | 11400 | 21 22 23 24 | 2 | 100.00 | 2 | H | NPI | 25-1234567 |
| 3 | 02 si 17 | 02 10 17 | 44 | 3C | 640 | 31 32 33 34 | 3 | 10.50 | 1 | 3 | NPI | 25-2121212 |
| 4 | 02 11 17 | 02 11 17 | 44 | 4C | 99444 | 41 42 43 44 | 4 | 40.40 | 4 | H | NPI | 25-4141414 |
| 5 | 02 11 17 | 02 12 17 | 55 | 5C | 11451 | 51 52 53 54 | 5 | 55.00 | 5 | H | NPI | 25-5454542 |
| 6 | 02 12 17 | 02 13 17 | 66 | 6C | 11470 | 61 62 63 64 | 6 | 66.00 | 6 | H | NPI | 25-6565656 |

25. FEDERAL TAX I.D. NUMBER: 47-1234567 | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: AC-549879

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 396.90

29. AMOUNT PAID: $ 200.00

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): 31 signture of physician | SIGNED | DATE: 02/28/2017

32. SERVICE FACILITY LOCATION INFORMATION: Facility name | 112 Facility Road | Newtown, SC 88765 | a. 32-216649a | b. 32-245165b

33. BILLING PROVIDER INFO & PH #: ( 800 ) 111-2222 | Facility name Billing Provider Info | 33 Billing Provider Street | Billingstown NC 66554 | a. 33-216649a | b. 33-245165b

NUCC Instruction Manual available at: www.nucc.org | PLEASE PRINT OR TYPE | APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500 Form

PART 1- INTRODUCTION

# Reimbursement process – RVU

- **RVU: relative value unit** - - - - > how much $$$ the CPT code brings
- Includes physician work/time, expenses and malpractice
- **Adjusted geographically**

- RVU of a CPT code is **not** determined by AMA/CPT but by payers/CMS

- So, **AMA only determine code number - - - > Payers determine how much to pay for that code**
  - Describe the codes further and give guidelines when a code is acceptable
  - Each payer has its own list of reimbursed CPT codes
  - Each payer may have different bundle process or mutually exclusive codes

- ***Just because there is valid CPT code defined by AMA doesn't mean that it's a covered or reimbursed service.***

- ***There's is a complex interaction between CPT codes and payer's policies***
  - *One needs to understand both in order to successfully submit a claim*

PART 1- INTRODUCTION

# FRAUD PREVENTION

- Fraud is defined as
  - Obtaining something of value through **intentional misrepresentation** or concealment of material facts.
  - Intentionality is the core feature of the fraud

- Things can happen by mistake and if that is the case then there should not be a pattern of the same mistake happening again and again.
- A consistent pattern of mistakes although can be explained with poor billing knowledge can be considered as a potential fraud.

- Billing for services that are not actually delivered is the most important fraud category
  - Billing for non existent services
  - Overbilling

PART 1- INTRODUCTION

# FRAUD PREVENTION

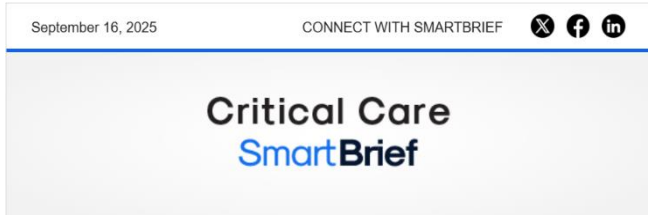
- **Billing for non existent services**
  - Billing an E/M service codes for a patients that had no show for their appointments.
  - Physician sees a patient in the office with cellulitis and prescribe antibiotics but in addition to E/M service code like 99213, physician also documents and reports CPT code for incision and drainage that is not actually performed.

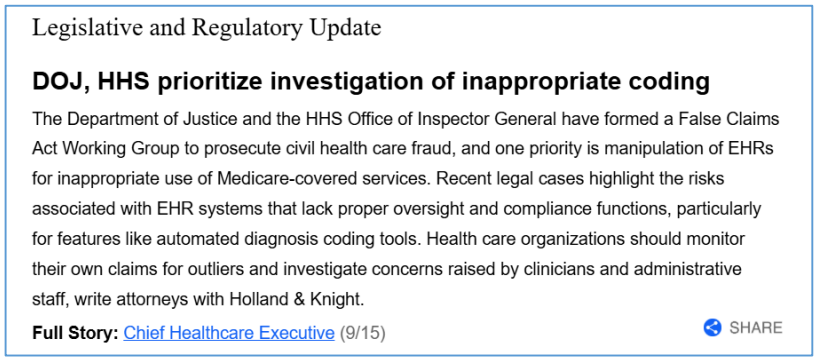
- Overbilling: billing for services that are higher than actually delivered.
- MDM based overbilling.
  - A physician sees a patient with simple URI, documents a simple URI with no delivered care time but still bills highest level of code like 99215.
  - This may be considered as fraud because this patient does not qualify for level 5 based on MDM.
- Time based overbilling
  - A physician sees an established patient in the office and spent only 10 minutes with the patient but documents 40 minutes in the chart and bill time based 99215.

PART 1- INTRODUCTION

# FRAUD PREVENTION

- Although it may be very difficult to prove single time based overbilling, it is extremely easy to prove it if it's done systematically.
- In the office
  - If an office is open for 10 hours (600 minutes, 7am-5pm) then physician can bill for only 15 patients with the 99215 based on time. 15 X 40 minutes = 600 minutes. If a physician bills more time based billing than the clinic is open for or in 24 hours than this would be considered as fraud.
- In the ICU
  - An intensivist can provide critical care to one patient at a time, so total intensive care an intensivist may provide is 24 hours in a day when time based codes are used.
  - If an intensivist bills 50 patients with 99291 (first hour of critical care, 30-75 minutes) then it may be considered fraud because maximum amount of patient can be billed by intensivist would be 48 patients. 48X 0.5hr = 24 hours.



# Use the CPT codes Luke!

PART 2- E/M CODES

# Evaluation and Management codes

- **All CPT codes can be divided into 2 groups**
  - E/M service codes - - - - - - - > most commonly used codes by every physician
  - Other CPT codes - - - - - - - > usage is based on specialty/subspecialty

- Because of its universal use, E/M codes are the most important codes to learn

- *99214: level 4 office visit: reported in more than 90 million claims/year*
- *33619: Norwood operation for HLHS : reported handful/year*

PART 2- E/M CODES

# Levels and groups

- Because all the E/M codes start with 99th , **it's easier to refer them with last 2 or 3 digits**
  - Instead of 99233 --- --- > 233 or 33
  - Some people use the last digit - - - - > 99233 becomes level 3
    - - - > 99215 becomes level 5
  - All E/M codes are in between 99202 and 99499*
    - 200 series : office, inpatient, consultation, ER, adult critical care codes
    - 300 series: prolonged care, well child check codes
    - 400 series: normal newborn, pediatric/neonatal critical care codes
- *There are many different groups under E/M codes for different type of providers*

PART 2- E/M CODES

# Code sets

- E/M codes typically come in a set of related codes
- Most physician needs to know only few code sets related to their practice

| OFFICE - OUTPATIENT CARE | |
|---|---|
| New Patient | Established Patient |
| - | 99211 |
| 99202 | 99212 |
| 99203 | 99213 |
| 99204 | 99214 |
| 99205 | 99215 |

| PREVENTETIVE CARE - WELL CHILD CHECK | |
|---|---|
| New Patient | Established Patient |
| 99381 | 99391 |
| 99382 | 99392 |
| 99383 | 99393 |
| 99384 | 99394 |
| 99385 | 99395 |
| 99386 | 99396 |
| 99387 | 99397 |

PART 2- E/M CODES

# Main E/M code sets for Primary Care Physicians

| OFFICE - OUTPATIENT CARE | |
|---|---|
| New Patient | Established Patient |
| - | 99211 |
| 99202 | 99212 |
| 99203 | 99213 |
| 99204 | 99214 |
| 99205 | 99215 |

| PREVENTETIVE CARE - WELL CHILD CHECK | |
|---|---|
| New Patient | Established Patient |
| 99381 | 99391 |
| 99382 | 99392 |
| 99383 | 99393 |
| 99384 | 99394 |

***A total of 17 codes ~ Majority of E/M codes used by PCPs***

PART 2- E/M CODES

# Main E/M code sets for Subspecialities

| OFFICE - OUTPATIENT CARE | |
|---|---|
| New Patient | Established Patient |
| - | 99211 |
| 99202 | 99212 |
| 99203 | 99213 |
| 99204 | 99214 |
| 99205 | 99215 |

| CONSULTATIONS | |
|---|---|
| Office/Outpatient | Inpatient |
| 99242 | 99252 |
| 99243 | 99253 |
| 99244 | 99254 |
| 99245 | 99255 |

PART 2- E/M CODES

# Main E/M code sets for Hospitalist/Nursery

| HOSPITAL INPATIENT/OBSERVATION CARE | |
|---|---|
| Initial day ~Admission | Subsequent day ~ Follow up |
| 99221 | 99231 |
| 99222 | 99232 |
| 99223 | 99233 |

| SAME DAY HOPSITAL ADMISSION/DISCHAGRE CARE |
|---|
| 99234 |
| 99235 |
| 99336 |

| HOSPITAL INPATIENT/OBSERVATION DISCHAGRE CARE |
|---|
| 99238 |
| 99239 |

| CONSULTATIONS | |
|---|---|
| ER | Inpatient |
| 99242 | 99252 |
| 99243 | 99253 |
| 99244 | 99254 |
| 99245 | 99255 |

| NORMAL NEWBORN CARE |
|---|
| 99460 |
| 99461 |
| 99462 |
| 99463 |

| DELIVERY ROOM ATTANDANCE RESUSCITATION |
|---|
| 99464 |
| 99465 |

PART 2- E/M CODES

# Main E/M code sets for Intensivist(NICU/PICU)

| CRITICAL CARE SERVICES | |
|---|---|
| Time based ~ Adult | Day based ~ Neonatal/Pediatric |
| 99291 -99292 | 99468-99469 |
| | 99471-99472 |
| | 99475-99476 |

| NEONATAL INTENSIVE CARE SERVICES |
|---|
| 99477 |
| 99478 |
| 99479 |
| 99480 |

| CONSULTATIONS | |
|---|---|
| ER | Inpatient |
| 99242 | 99252 |
| 99243 | 99253 |
| 99244 | 99254 |
| 99245 | 99255 |

| HOSPITAL INPATIENT/OBSERVATION CARE | |
|---|---|
| Initial day ~Admission | Subsequent day ~ Follow up |
| 99221 | 99231 |
| 99222 | 99232 |
| 99223 | 99233 |

| SAME DAY HOPSITAL ADMISSION/DISCHAGRE CARE |
|---|
| 99234 |
| 99235 |
| 99336 |

| HOSPITAL INPATIENT/OBSERVATION DISCHAGRE CARE |
|---|
| 99238 |
| 99239 |

PART 2- E/M CODES

# How do I select a code from a code set? There are many of them!!!

- In order to select a code from a code set, 1st we need to divide E/M service codes in to 2 groups

- **MDM based codes**
  - Typically based on patient complexity or spent time
  - Code selection is quite complex

- **Non-MDM based codes**
  - Not based on patient complexity
  - Code selection is simple and straightforward

PART 2- E/M CODES

# Why MDM codes exist? With quite complex level selection process!

- Let's compare a sick visit to a WCC visit using established patient: 6 months old infant.

- **WCC**: There is only one code for this WCC visit -99391-as most of the 6 months old visits are assumed to have similar complexity and requirement of similar physician's time hence one code covers all the visits.
  - One code -99391-with same RVU for all established/infant WCC - - - - > **Fair**

- **Sick visit**: When the same, 6 months old infant seen in the clinic a week later for a sick visit. The reason for the visit may vary significantly.
  - Diaper rash - - - -> very simple problem and does not require much physician's time
  - Severe bronchiolitis/pneumonia, prolonged idiopathic fever or complex social situation/? NAT - - - -> complex problem which requires much more physician's time
  - If you have one code that covers all the sick visit for this age - - **> it would not be fair** as getting same re imbursement for a simple diaper rash as for pneumonia is not respectful to physician time and effort.

- *There should be a system in place that separates sick visits to different complexity or physician time requirements so that physicians are rewarded or reimbursed more when they see more complex patients or spent more time in patient care activities.*
- ***This is basically why MDM exist and what MDM stands for. MDM creates different code levels that are associated with different complexity and bring fairness to reimbursement.***

PART 2- E/M CODES

# MDM versus Non-MDM based codes

- Currently all the MDM based E/M codes have the same basic structure
  - Setting where the code is used
  - Medically appropriate history and/or examination
  - Certain level of MDM
  - Certain amount of time (except ER codes)

- **MDM based code**: 99213: **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a **medically appropriate history and/or examination** and **low level medical decision making.** When using total time on the date of the encounter for code selection, **20 minutes** must be met or exceeded.

- *MDM based codes come with certain REQUIREMENTS* - - - > TIME and MDM
- *If you don't fulfill the requirements of an MDM based code your claim might be denied*

PART 2- E/M CODES

# MDM versus Non-MDM based codes

- **Non-MDM based codes**
  - **99381**: Initial comprehensive **preventative medicine** evaluation of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory diagnostic procedures, new patient; infant (age younger than 1 year)
  - **99239**: Hospital **discharge day** management, more than 30 minutes
  - **99460**: Initial hospital or birthing center care, per day, for E/M of **normal newborn infant**
- No specific MDM or complexity requirements
- *All critical care codes are technically MDM based codes because all of them require high level MDM.*
- *Because all critical care codes have the same MDM level, MDM doesn't affect the code selection and hence from the code selection perspective these codes are grouped with non-MDM based codes.*

PART 2- E/M CODES

# Selecting a code in a code set

- **Selection of Non-MDM based code**
  - Easy and straightforward
  - Patient complexity and spent time has no importance
  - Code selection based on different ages or other factors
  - Example: 6 months old established patient well child check - - - > 99391

- **Selection of MDM based code**
  - More difficult and complex
  - Code selection is based on patient complexity or spent time
  - Example: established sick child in the office with fever and cough - - - - > 99212 to 99215

PART 2- E/M CODES

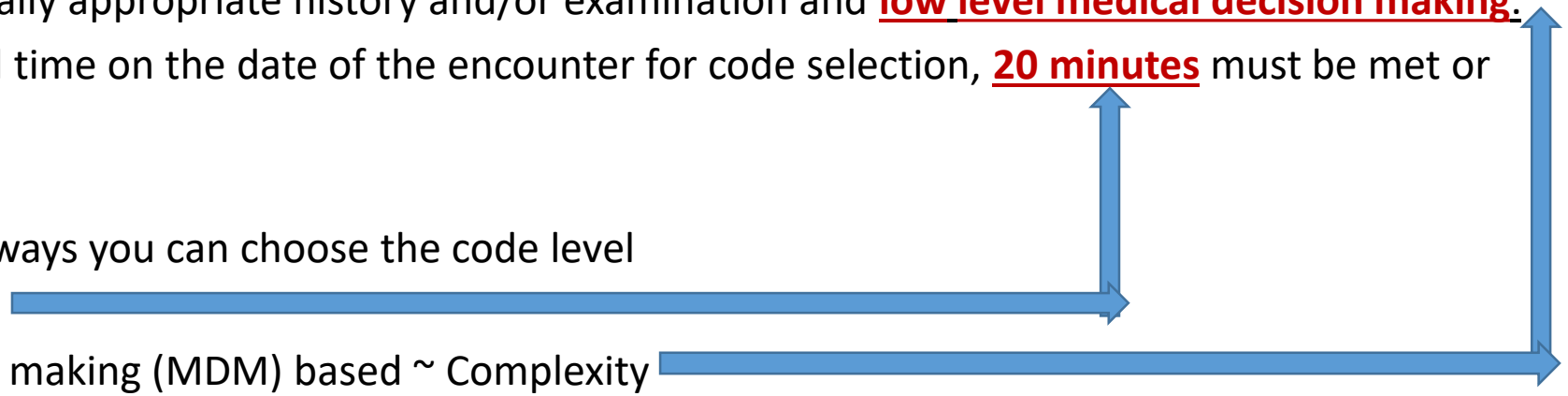
# Non-MDM based E/M codes: visit type or patient characteristics guide the code selection

| | | | | | |
|---|---|---|---|---|---|
| **Well child check Preventative care** | New Patient | <1 year | | | 99481 |
| | | 1-4 years | | | 99482 |
| | | 5-11 years | | | 99483 |
| | | 12-18 years | | | 99484 |
| | Established patient | <1 year | | | 99491 |
| | | 1-4 years | | | 99492 |
| | | 5-11 years | | | 99493 |
| | | 12-18 years | | | 99494 |
| **Critical Care** | Adult critical care codes | 1st hour | | | 99291 |
| | | each additional 30 minutes | | | 99292 |
| | Neonatal critical care codes | 1st day | | | 99468 |
| | | Subsequent days | | | 99469 |
| | Pediatric critical care codes | 1 - 24 months | 1st day | | 99471 |
| | | | Subsequent | | 99472 |
| | | 2-5 years | 1st day | | 99475 |
| | | | Subsequent | | 99476 |
| **Discharge care** | Total care <30 min | 99238 | | | |
| | Total care >30 min | 99239 | | | |
| **Normal Newborn care** | 1st day, hospital, or birthing center | | | | 9460 |
| | 1st day, other than hospital or birthing center | | | | 99461 |
| | Subsequent hospital care | | | | 99462 |
| | Admitted and discharged on the same date | | | | 99463 |
| **Neonatal Intensive Care** | 1st day | 99477 | | | |
| | Subsequent days | present body weight weight < 1500 grams | | | 99478 |
| | | present body weight of 1500-2500 grams | | | 99479 |
| | | present body weight of 2501-5000 grams | | | 99480 |

PART 2- E/M CODES

# MDM based E/M code selection – HOW?

- **Code descriptor will tell you**
- 99213 ~ a typical MDM based code
  - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **low level medical decision making**. When using total time on the date of the encounter for code selection, **20 minutes** must be met or exceeded.
- There are 2 different ways you can choose the code level
  - Total time based
  - Medical decision making (MDM) based ~ Complexity



- **In order to find the correct level, align patient's MDM or care time with the appropriate code in the set.**

PART 2- E/M CODES

# Outpatient MDM based E/M code selection: Align Time or MDM

| 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 |
| | | | | |
| Office 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 |

You saw a new patient in the office and spent 60 minutes then bill 99205

You saw an established patient in the office whose MDM las low then bill 99213

Align MDM or time to the appropriate level

PART 2- E/M CODES

# Inpatient MDM based E/M code selection = Align Time or MDM

| Code Set | CPT code | Code Level | Time | MDM level |
|---|---|---|---|---|
| Admission | 99221 | Level 1 | 40 minutes | Straightforward/Low |
| | 99222 | Level 2 | 55 minutes | Moderate |
| | 99223 | Level3 | 75 minutes | High |
| | | | | |
| Subsequent | 99231 | Level 1 | 25 minutes | Straightforward/Low |
| | 99232 | Level 2 | 35 minutes | Moderate |
| | 99233 | Level 3 | 50 minutes | High |
| | | | | |
| Same day | 99234 | Level 1 | 45 minutes | Straightforward/Low |
| | 99235 | Level 2 | 70 minutes | Moderate |
| | 99236 | Level 3 | 85 minutes | High |
| | | | | |
| Consult ER | 99242 | Level 2 | 20 minutes | Straightforward |
| | 99243 | Level 3 | 30 minutes | Low |
| | 99244 | Level 4 | 40 minutes | Moderate |
| | 99245 | Level 5 | 55 minutes | High |
| | | | | |
| Consult inpatient | 99252 | Level 2 | 35 minutes | Straightforward |
| | 99253 | Level 3 | 45 minutes | Low |
| | 99254 | Level 4 | 60 minutes | Moderate |
| | 99255 | Level 5 | 80 minutes | high |

PART 2- E/M CODES

# Medical Decision Making (MDM) explained

- There are 4 levels of MDM
  - **1- Straightforward MDM**
  - **2- Low level MDM**
  - **3- Moderate level MDM**
  - **4- High level MDM**

- These four level is determined by 3 different elements
  - 1-Number and complexity of **Problems** addressed at the encounter
  - 2- Amount and/or complexity of **Data** to be reviewed and analyzed
  - 3- **Risk** of complication and/or morbidity or morality of patient management

- Each element also has 4 different levels
  - **1- Minimal or none**
  - **2 –Low or limited**
  - **3- Moderate**
  - **4- High or extensive**

PART 2- E/M CODES

# Medical Decision Making (MDM) explained

- Each MDM level is defined by the combination of 3 elements
- To qualify for a certain level, 2/3 elements should be met

| Elements of MDM | | | |
|---|---|---|---|
| | **Problems** | **Data** | **Risk** |
| **Straightforward MDM** | Minimal | Minimal or none | Minimal risk |
| **Low level MDM** | Limited | Limited | Low risk |
| **Moderate level MDM** | Moderate | Moderate | Moderate risk |
| **High level MDM** | High | Extensive | High risk |

PART 2- E/M CODES

# MDM explained

- Definitions of elements are nuanced
- **Problem element**
  - Number and complexity of **Problems addressed at the encounter** not the total number of problem patient has
  - If a problem is not addressed during encounter it doesn't count toward problem element
- If a patient with poorly controlled DM comes in for UTI and DM is not addressed during the visit then DM can not be counted as moderate level problem.

- ***CMS*** *- - > Comorbidities/underlying disease, in and of themselves are not considered in selecting a level of E/M services UNLESS their presence significantly increases complexity of the medical decision making.*

- **Data element**
  - Data **to be reviewed** not all the data patient has
  - Patient may have lots of labs but they do not count if you don't review and analyze them

- **Risk element**
- Risk form your management not just the risk of disease itself

PART 2- E/M CODES

# MDM explained

- ***Understanding and choosing among different level of and MDMs is the single most difficult topic to learn in whole billing.*** *Nothing else even come close because lots of memorization is needed.*

- *It takes at leas several readings from the handbook and practice it in the daily clinical activities to get it right.*

| | | |
|---|---|---|
| **Straightforward MDM** | Problems | Minimal<br>• 1 self-limited or minor problem |
| | Data | Minimal or none |
| | Risk | Minimal risk of morbidity from additional diagnostic testing or treatment |

*Examples of straightforward MDM are simple URI, a mild diaper rash, a clean bug bite. All of these conditions involve only one self-limited or minor problems. there are no tests to order and the risk from the management is minimal.*

| | | |
|---|---|---|
| **Low level MDM** | Problems | **Low** *(must meet the requirement of only one of the subheading below)*<br>■ 2 or more self-limited or minor problems or<br>■ 1 stable, chronic illness or<br>■ 1 stable, acute illness or<br>■ 1 acute, uncomplicated illness or injury or<br>■ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care. |
| | Data | **Limited** *(Must meet the requirements of at least 1 out of 2 categories)*<br>**<u>Category 1: Tests and documents</u>**<br>**Each unique test, order, or document contributes to the combination of 2*<br>■ Any combination of 2 from the following<br>● Review of prior external note(s) from each unique source*<br>● Review of the result(s) of each unique test*<br>● Ordering of each unique test*<br>or<br>**<u>Category 2: Assessment requiring an independent historian(s)</u>** |
| | Risk | Low risk of morbidity from additional diagnostic testing or treatment |

Examples of low-level MDM are simple UTI, sinusitis, AOM, influenza infection, ankle sprain, well controlled DM.

For pediatrics, data element is at least at low level because we always have independent historian which is the family or care giver.

| | | |
|---|---|---|
| **Moderate level MDM** | Problems | **Moderate** *(must meet the requirement of only one of the subheading below)*<br>■ 2 or more stable, chronic illnesses, or<br>■ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment, or<br>■ 1 undiagnosed new problem with uncertain prognosis, or<br>■ 1 acute illness with systemic symptoms, or<br>■ 1 acute, complicated injury |
| | Data | **Moderate** (Must meet the requirements of at least 1 out of 3 categories)<br>**<u>Category 1: Tests, documents, or independent historian(s)</u>**<br>**Each unique test, order, or document contributes to the combination of 3*<br>■ Any combination of 3 from the following:<br>● Review of prior external note(s) from each unique source*<br>● Review of the result(s) of each unique test*<br>● Ordering of each unique test*<br>● Assessment requiring an independent historian(s)<br>or **<u>Category 2: Independent interpretation of tests</u>**<br>■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)<br>or **<u>Category 3: Discussion of management or test interpretation</u>**<br>■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) |
| | Risk | Moderate risk of morbidity from additional diagnostic testing or treatment.<br>Examples only:<br>■ Prescription drug management<br>■ Decision regarding minor surgery with identified patient or procedure risk factors<br>■ Decision regarding elective major surgery without identified patient or procedure risk factors<br>■ Diagnosis or treatment significantly limited by social determinants of health |

Examples of moderate level MDM:

A patient with well controlled hypertension and DM.

A patient with poorly controlled eczema.

Acute pneumonia or pyelonephritis.

Asthma exacerbation.

| | | |
|---|---|---|
| **High level MDM** | Problems | **High** *(must meet the requirement of only one of the subheading below)*<br>■ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment<br>or ■ 1 acute or chronic illness or injury that poses a threat to life or bodily function |
| | Data | **Extensive** (Must meet the requirements of at least 2 out of 3 categories)<br>**<u>Category 1: Tests, documents or independent historian(s)</u>**<br>**Each unique test, order, or document contributes to the combination of 3*<br>■ Any combination of 3 from the following<br>● Review of prior external note(s) from each unique source*<br>● Review of the result(s) of each unique test*<br>● Ordering of each unique test*<br>● Assessment requiring an independent historian(s)<br>or **<u>Category 2: Independent interpretation of tests</u>**<br>■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)<br>Or **<u>Category 3: Discussion of management or test interpretation</u>**<br>■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) |
| | Risk | **High risk** of morbidity from additional diagnostic testing or treatment.<br>Examples only:<br>■ Drug therapy requiring intensive monitoring for toxicity<br>■ Decision regarding elective major surgery with identified patient or procedure risk factors<br>■ Decision regarding emergency major surgery<br>■ Decision regarding hospitalization or escalation of hospital-level care<br>■ Decision not to resuscitate or to deescalate care because of poor prognosis<br>■ Parenteral controlled substances |

Examples of high-level MDM:

Severe asthma exacerbation

Severe CHF exacerbation,

Severe traumatic brain injury

Septic shock.

PART 2- E/M CODES

# MDM explained

- 6 months old in the office with diaper rash
  - Problem: Minimal
  - Data: Low (independent historian, no tests)
  - Risk: Minimal

MDM= Minimal + Low + Minimal = 2/3 Minimal
straightforward MDM

- 8 years old with well controlled ADHD
  - Problem: Low
  - Data: Low (independent historian, no tests)
  - Risk: Moderate ( prescription drug management)

MDM= low + Low + Moderate = 2/3 Low
Low-level MDM

PART 2- E/M CODES

# MDM explained

- 15 years old with poorly controlled type 1 DM
  - Problem: Moderate
  - Data: Low (independent historian, no tests)
  - Risk: Moderate (prescription drug management)

MDM= Moderate + Low + Moderate= 2/3 Moderate.
Moderate level MDM

- 8 years old with severe asthma exacerbation
  - Problem: High
  - Data: High (CBC, BMP, CRP, CXR interpretation)
  - Risk: High (Decision regarding hospitalization )

MDM= High + High + High= 3/3 High.
High-level MDM

PART 2- E/M CODES

# MDM based E/M codes - Time based level selection

- Align, total time spent for patient care during the encounter

| OFFICE OUTPATIENT CARE | |
|---|---|
| New Patient | Established Patient |
| - | 99211 |
| 99202 = 15 min | 99212 = 10 min |
| 99203 = 30 min | 99213 = 20 min |
| 99204 = 45 min | 99214 = 30 min |
| 99205 = 60 min | 99215 = 40 min |

| HOSPITAL INPATIENT/OBSERVATION CARE | |
|---|---|
| Initial day ~Admission | Subsequent day ~ Follow up |
| 99221 = 40 min | 99231 = 25 min |
| 99222 = 55 min | 99232 = 35 min |
| 99223 = 75 min | 99233 = 50 min |

PART 2- E/M CODES

# Time based level selection – Activities that count towards time

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**, education of 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 patient/family

***Anything that you do for the patient that is not reported with another CPT code****
***You don't need to be in patient floor for the time to count***

PART 2- E/M CODES

# MDM versus Time based level selection

- **More than one pathway is possible - - - - > Now what to do?**

- Use the selection method that will get the highest level
  - Always look at the spent time first then MDM because if you already spent the time that is good enough for highest level then you don not need to look in to MDM.

- ***Example:***
- *1-You saw an established patient and spent 40 minutes - - - -> 99215*

  *Time is already enough for highest level. Do not bother in looking at MDM.*

- *2-You saw an established patient in the clinic and spent 20 minutes which qualifies for level 3*

  *Because time is not able to get you to the highest level now, look in to MDM*

  *If MDM is good for level 4 then bill level 4 based on MDM*

  *If MDM is only good for level 2 then bill level 3 based on time.*

PART 2- E/M CODES

# Office Codes

| | | | | | |
|---|---|---|---|---|---|
| New Patient | | 99202 | 99203 | 99204 | 99205 |
| Established patient | 99211 | 99212 | 99213 | 99214 | 99215 |

- **New patient** is defined by CPT as a patient that has not been seen by the provider in the last 3 years.
- All these codes are for **sick visits** and not for well child checks.

- **99211** is a non-MDM based code for simple follow ups like BP or weight check, PPD read that can be done by a nurse and does not require physician's time.

- These codes are **per visit based** codes so one code from this set is reported for every one visit.
  - If you see a child twice in the same day for 2 unrelated problems then you can bill for each visits separately.

PART 2- E/M CODES

# Hospital Codes – Inpatient/Observation

| | | | |
|---|---|---|---|
| Initial Care | 99221 | 99222 | 99223 |
| Subsequent care | 99231 | 99232 | 99233 |
| Same day admission discharge | 99234 | 99235 | 99236 |

- These codes covers admission to **both inpatient and observation**

- Initial care codes only used for once during whole hospitalization.

- These are **day based codes** and reported only once per day.
  - *This is the reason why, you do not need to write a separate note (from billing perspective) if a patient gets admitted after midnight and you are rounding in the morning. In this situation you cannot bill the admission code which is already billed and you cannot bill subsequent day care code because it is not subsequent day yet.*

PART 2- E/M CODES

# **Normal newborn** care codes

| | |
|---|---|
| **Initial day** - hospital or birthing center | 99460 |
| Initial day - other than hospital or birthing center | 99461 |
| **Subsequent day -** hospital care | 99462 |
| **Admitted and discharged on the same date** - hospital or birthing center care | 99463 |

- *Limited to initial care of the normal newborn in the first days after birth prior to home discharge*
- **Do not use this codes if baby is anything other than normal.**
  - Normal, low level jaundice - - - > use normal new born codes
  - Jaundice requiring phototherapy  or any significant disease - - > use hospital inpatient/observation codes
  - Can not report normal newborn codes and hospital codes on the same day.

- *Documentation: **no specific requirements**. It's reasonable to document details of normal newborn care including maternal and/or fetal and newborn history, examination, ordering of diagnostic tests and treatments, meeting with family, anticipatory guidance.*

PART 2- E/M CODES

# Discharge codes

| | |
|---|---|
| Hospital discharge day management; 30 minutes or less | 99238 |
| Hospital discharge day management; more than 30 minutes | 99239 |

- ***These codes are to be utilized to report all E/M services provided to a patient on the date of discharge***
  - *This doesn't include non E/M services codes like  car seat test*

- These codes include as appropriate, final examination, discussion of hospital stay, instructions for continuing care to all relevant care givers, preparations of discharge records, prescriptions and referrals.

- *There are **no specific documentation guidelines** other than **documenting time** for 99328-99239 (less or more than 30 minutes) and above care details.*

PART 2- E/M CODES

# Consultation Codes

| | | | | |
|---|---|---|---|---|
| Consult - Office (ER) | 99242 | 99243 | 99244 | 99245 |
| Consult – Hospital (inpatient/Observation) | 99252 | 99253 | 99254 | 99255 |

- Only one consultation code should be reported by **a consultant/group**
- *Subsequent services are reported using appropriate **subsequent** codes*

- **Request for consult** needs to be documented in either
  - Requester note
  - Consultant note
  - With an order in the chart

- Document **reason for consult**

- *Consider using a **different diagnosis** code than the primary attending's to show that you are not providing duplicative or redundant services.*

PART 2- E/M CODES

# Critical care codes

| | | | | | |
|---|---|---|---|---|---|
| **Critical Care codes** | Neonatal critical care codes | 1st Month | 1st day | | 99468 |
| | | | Subsequent days | | 99469 |
| | Pediatric critical care codes | 1 month – 6 years | 1 - 24 months | 1st day | 99471 |
| | | | | Subsequent | 99472 |
| | | | 2-6 years | 1st day | 99475 |
| | | | | Subsequent | 99476 |
| | Adult critical care codes | 6 years and above | 1st hour | | 99291 |
| | | | Each additional 30 minutes | | 99292 |

- All these codes require **high level MDM** and presence of **critical care** as defined by CPT
  - *"A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition."*
  - *"Critical care involves high complexity medical decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition."*
- **Requirements to meet the definition of critical care ~ applies to all ages**
  - 1) Acute vital organ impairment
  - 2) High probability of deterioration, either imminent or life threatening
  - 3) High complexity decision making
  - 4) Assessment, manipulation and support of vital system functions

PART 2- E/M CODES

# Critical care codes

- **Usage of these codes is not restricted to intensivist.**
  - Critical care can be billed in the office by PCPs, in the ER or in the floor by hospitalist when definition of critical care is met like providing critical care to severe asthma attack or anaphylaxis.
  - In this setting adult codes of 99291, 99292 used for all children irrespective of age.

- *Same provider can bill inpatient **admission or subsequent day care codes and then bill critical care codes** on the same day if patient gets critically ill after the initial care.*

- Adult critical care codes are time based.
  - 1st hour of adult critical care -99291- is billed only once per day
  - Each additional 30 minutes billed separately with 99292

- Neonatal/pediatric critical care codes are day based and billed only once per day

PART 2- E/M CODES

# Neonatal intensive care codes

| | | | |
|---|---|---|---|
| **Neonatal Intensive Care** | 1st day (initial) | 99477 | |
| | Subsequent days | present body weight weight < 1500 grams | 99478 |
| | | present body weight of 1500-2500 grams | 99479 |
| | | present body weight of 2501-5000 grams | 99480 |

- Initial neonatal intensive care - - > Can only be used for babies < 28 days
- Subsequent neonatal intensive care - - > Can only be used for babies < 5000gr

- Intensive care is defined by CPT as *services for infants or neonates who are **not critically ill** but continue to **require intensive cardiac and respiratory monitoring**, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring, and constant observation by the health care team under direct supervision of the physician*. These codes are based on day rather than time.

- Usage is not restricted to NICU or neonatal intensivist.
  - These codes can be billed by other providers when definition of intensive care is met.

PART 2- E/M CODES

# ER codes

| ER care | 99211 | 99212 | 99213 | 99214 | 99215 |
|---|---|---|---|---|---|

- Although typically used by ER providers, **usage of these code set is not restricted to ER physicians.**
  - Any physician who provide care as primary physician in the ED can use these codes.
  - This apply to physician who have ER privileges and see their patients in the ER without any involvement of ER doctors.

- **Non-ER physicians** are typically get consulted on ED patients and use appropriate admission, consultation or critical care codes.

- *99281 is a non MDM code for minor problems that does not require physician's attention or time.*
- *The remaining 4 codes are all MDM based and align with 4 levels of MDM.*

- ER codes do not have any associated time levels like other MDM based codes.

PART 2- E/M CODES

# Prolonged care codes

| | | |
|---|---|---|
| Prolonged care on the same day of an E/M service | Outpatient | 99417 |
| | Inpatient | 99418 |
| Prolonged care on a different day than the day of E/M service | 1st Hour | 99358 |
| | Each additional 30 min | 99359 |

- **On the same day prolonged care**
  - Both 99417 and 99418 involve 15 minutes of extra care
  - Only reported with E/M codes that have upper time limit.
  - Highest code in the code set needs to be reported based on time, 1st.
  - 2nd, when upper limit of highest code exceeded by more than 15 minutes then prolonged care codes are reported
  - *Example: Established patient - - > highest level is 99215 - - > 40 minutes - - > when 55 minutes of care delivered to an established patient in the clinic you cam bill (99215 + 1X 99417). (70 min ~ 99215 + 2X99417)*

- **On a different day prolonged care**
  - *This code set exist so that you can ask for more revenue when you spend time for patient on any day that you have not seen the patient face to face like spending a lot of time on chart review or coordination of care.*

PART 2- E/M CODES

# Preventative Medicine codes

| | | | |
|---|---|---|---|
| **Preventative care** | New Patient | <1 year | 99481 |
| | | 1-4 years | 99482 |
| | | 5-11 years | 99483 |
| | | 12-18 years | 99484 |
| | Established patient | <1 year | 99491 |
| | | 1-4 years | 99492 |
| | | 5-11 years | 99493 |
| | | 12-18 years | 99494 |

- These codes are also known as **well child check -WCC-** codes
- This codes are only for preventative medicine/well child checks including sports participation examinations.
- **If any significant problem identified** and addressed during the encounter, then this problem should be reported with appropriate E/M service codes using modifier 25. Modifier 25 lets the payer that management of the problem was a separate service. An insignificant or trivial problem identified during well check is included in the well check and not separately reported.

- **Separately reportable services** like immunizations, office labs, screening tests like vison and hearing are not included in preventative care services and should be reported separately.

PART 2- E/M CODES

# Telemedicine codes

| | | | | | |
|---|---|---|---|---|---|
| Synchronous **audio-video** E/M services | New patient | 98000 | 98001 | 98002 | 98003 |
| | Established patient | 98008 | 98009 | 98010 | 98011 |
| Synchronous **audio only** E/M services | New patient | 98004 | 98005 | 98006 | 98007 |
| | Established patient | 98012 | 98013 | 98014 | 98015 |

- Added in 2025, not recognized by major payers like CMS yet
  - These are all MDM based codes
  - Code definition, time and MDM levels are very similar to office codes

- *98016: Non-MDM based telemedicine code used for triaging patients.*
- *Only E/M codes that does not start with 99*

# Use the CPT codes Luke!

PART 3- DOCUMENTATION GUIDELINES

# MDM based E/M codes versus the rest

- Now we figured out what code to report/bill - - > how to write the note?

- What should be in the chart??? - - - - > Depends on the code family
  - MDM based codes - - - > complex documentation guidelines
  - The rest - - - -> No specific guidelines - - - > easy, straightforward

- **Anesthesia, Surgery, Radiology, Pathology, Medicine and non-MDM based E/M codes**
  - Easy and straightforward - - - > no documentation rules, just describe the procedure or delivered care
  - Well child check: describe the anticipatory guidance, vaccines etc
  - Discharge care: describe the hospital stay and discharge process etc
  - Intubation: just describe the intubation process.
  - I&D: describe details of I&D

PART 3- DOCUMENTATION GUIDELINES

# MDM based E/M codes versus the rest

- **Documentation for MDM based E/M codes**
  - More difficult - - - > Code descriptor will tell you what to document

- **WRITING THE NOTE USED TO BE A BIG HEADACHE - - - > Much better after 2023**

## MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION

**Document what ever you think medically appropriate**

No mandatory level of history or examination. It's up to the physician to decide

*Your bill will not be denied because you have not included certain things in the history or examination*

99223

■ **Medical decision making of high complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

| | |
|---|---|
| **Detailed** | HPI: extended: 4+ elements of HPI (including chief complaint) or associated comorbidities<br>ROS: Extended: 2-9 systems (Related systems, document both relevant positives and negatives)<br>PFSH: Pertinent: Document only one specific item from any of 3 groups PH, SH or FH; pertinent to problem |
| **Comprehensive** | HPI: extended: 4+ elements of HPI (including chief complaint) or associated comorbidities<br>ROS: Complete: Document at least 10 systems (both relevant positives and negatives) or<br>Document systems with positive and pertinent negative followed by all other system are negative<br>PFSH: Complete: Document one specific item from each group PH, SH, FH for hospital services or new office pts<br>Document one specific item from 2 of the 3 groups PH, SH, FH for ED and established outpatient |

| | | | |
|---|---|---|---|
| **Expanded problem focused** | 6+ | 1+ | 6 |
| **Detailed** | 2+<br>or<br>x | 6+<br>or<br>2+ | 12<br>or<br>12 |
| **Comprehensive** | 2+ | 9+ | 18 |

PART 3- DOCUMENTATION GUIDELINES

# Documentation of MDM based E/M codes

- For billing purposes, you can write your note in 2 different ways

- **1- Based on MDM**
- **2- Based on Time**

- *You can combine both, but not required for billing*

PART 3- DOCUMENTATION GUIDELINES

# Documentation of MDM based E/M codes – MDM based

- MDM based documentation only has 2 requirements
  - **Document medically appropriate history and/or examination**
  - **Document appropriate level of MDM**
    - Align the billed MDM level and MDM level in the chart
    - 99215/99233 - - > document high level MDM

- Documentation of time is not needed or mandatory

PART 3- DOCUMENTATION GUIDELINES

# Documentation of MDM based E/M codes – Time based

- Time based documentation only has 2 requirements
  - **Document the total time spent for patient care**
    - Align the time of the billed code and total time in the chart
  - **Document what you have done or how you spent that time** including medically appropriate history and/or examination

- *Documentation of MDM is not needed or mandatory*

- ***Remember almost everything that you do for the patient care count as time including writing the note***

- ***Physician are tended to under estimate their care time***

PART 3- DOCUMENTATION GUIDELINES

# Documentation of Critical Care

- Document that care delivered meets the definition of critical care as defined by CPT

- Requirements to meet the definition of critical care ~ applies to all ages
    - **1) Acute vital organ impairment**
    - **2) High probability of deterioration, either imminent or life threatening**
    - **3) High complexity decision making**
    - **4) Assessment, manipulation and support of vital system functions**
    - **5) Time *(>30 minutes, only for time based or adult critical care codes)***

- ***One good acute critical care illness ICD code better than 10 chronic problem ICDs***
    - *Like Acute respiratory failure with hypoxemia*
    - *Report the most critical illness ICD code first*
    - *Only critical care diagnosis/ICDs counts*

PART 3- DOCUMENTATION GUIDELINES

# Documentation of surgical procedures

- No specific documentation requirements were given for these codes
- *Preferably, all procedures should be reported with a separate note*
- Under these circumstances' documentation/note should include
  - **Medical necessity for the procedure**
  - **Standard description of the performed procedure** and **important findings**
  - Additional documentation is performed if **any specific requirements were given in the code definition**

PART 3- DOCUMENTATION GUIDELINES

# CMS Teaching physicians documentation guidelines

- **<u>Non critical care notes/codes</u>** - - -> can be universal attestation *(-except time based billing)*

- It has only 2 requirement
  - 1) Attending physician either performed the service or were physically present during the key or critical portions of the service when the service is performed by the resident
    - **I was present and evaluated the patient**
    - 2) Participation of teaching physician in the management of the patient **=**
      - **and I agree with resident note.**
    - Acceptable: *<u>I saw</u> the patient with resident and <u>agree</u> with resident's findings and plan*

PART 3- DOCUMENTATION GUIDELINES

# CMS Teaching physicians documentation guidelines - *non critical care*

**Examples of acceptable attestations**

Initial or Follow-up Visit: "I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."

Follow-up Visit: "I saw the patient with the resident and agree with the resident's findings and plan."

Scenarios 3 and 4:

Initial Visit: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

Initial or Follow-up Visit: "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

Follow-up Visit: "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."

PART 3- DOCUMENTATION GUIDELINES

# CMS Teaching physicians documentation guidelines - *non critical care*

## Examples of unacceptable attestations

Following are examples of unacceptable documentation:

"Agree with above.", followed by legible countersignature or identity;

"Rounded, Reviewed, Agree.", followed by legible countersignature or identity;

"Discussed with resident. Agree.", followed by legible countersignature or identity;

"Seen and agree.", followed by legible countersignature or identity;

"Patient seen and evaluated.", followed by legible countersignature or identity; and

A legible countersignature or identity alone.

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

PART 3- DOCUMENTATION GUIDELINES

# CMS Teaching physicians documentation guidelines - *critical care*

- **Critical Care notes/codes** - - -> can **NOT** be universal attestation

- On top of above 2 previous requirement there are 4 more
  - 3) **Patent was critically ill**
  - 4) **What made the patient critically ill?**
  - 5) **Treatment/management provided by teaching physician**
  - 6) **Time teaching physician spent** (only applies to time based critical care codes)

PART 3- DOCUMENTATION GUIDELINES

# CMS Teaching physicians documentation guidelines - *critical care*

- Example of acceptable critical care attestation
  - ***Patient developed hypotension and hypoxia. I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs and oxygen***. I reviewed the resident's documentation and I agree with resident's assessment and plan of care *

- Example of unacceptable critical care attestation
  - I came and saw (the patient) and agree with (the resident)

PART 3- DOCUMENTATION GUIDELINES

# CMS Teaching physicians documentation guidelines – *non ENM codes*

- Non ENM codes

- Minor surgical procedures *(intubation, central line)*
  - Document that teaching physician was present for **the entire procedure**
  - Most of the surgical procedures fall under this category for pediatricians

- Major surgical procedure
  - Document that teaching physician was present for -at least- **key portion(s) of procedure**

PART 3- DOCUMENTATION GUIDELINES

# LEGAL DIMENSION

- **Every patient note is potential legal document!!!**

- *In the case of a legal issue - - >* ***Make sure that it will be years and you will not remember any detail***
- *The only thing that helps you will be a well written note*

- Document well!!. *Potentially more than required by billing requirements.*

- *Consider using neutral, objective, professional  language.*

- ***A well written note is the best lawyer you can ever have!***

PART 3- DOCUMENTATION GUIDELINES

# COMMUNICATION

- A well written note is one the best communication tool that exist in medicine.
- Short and concise notes are frequently more useful than long notes filled with redundant information.
- Document well for clear communication among caregivers.

# Follow Your training!

# PART 5- OPTIMIZING REVENUE GENERTAION

- **<u>1-AIM FOR THE CPT CODE WITH THE HIGHEST RVU</u>**

- This applies to MDM based multilevel code sets like office, hospital, consult codes
  - ***Use either time or MDM based approach to get to the highest level***

- Always look at how much total time you have spent first. If you have spent enough time that meets the requirement of the highest level in a code set, then you should not bother looking at MDM because irrespective of MDM you can bill highest level of code.
- If total time you spend for the patient is not good enough for the highest level, then you should check if the MDM is high enough to get you to a level that is higher than you can get to using total time.

- **As long as medical appropriate** below points may help with targeting the highest level
  - Spending more time with patient ~ anticipatory guidance, education, coordination of care
  - Addressing more problems
  - Ordering more labs, independently interpreting imaging, discussions with other physicians
  - Management involving high risk

# PART 5- OPTIMIZING REVENUE GENERTAION

- **<u>2-ALWAYS KEEP THE PROLONGED SERVICES IN MIND</u>**
  - Capture **all the time** spent in patient care activities

  - **Prolonged care on the same day** - - - - > 99417 (outpatient), 99418 (inpatient)
    - You spent 100 minutes for an established patient in the clinic with very complex social situation.
    - 99215 + 4X 99417 ( 40 min + 4x15 min = 100 minutes)

  - **Prolonged care on different day** - - - - > 99358 (1$^{st}$ hour), 99359 (each additional 30 min)
    - You reviewed the chart of an NICU grad Monday for one hour and saw the patient Tuesday.
    - 99358 on Monday + office new patient visits code on Tuesday like 99205.
    - Consulted on patient on Wednesday night for 1 hour on the phone and saw the patient Friday.
    - 99398 on Wednesday + inpatient consultation code like 99255 on Friday.

# PART 5- OPTIMIZING REVENUE GENERTAION

- **3- WELL CHILD CHEK VERSUS SICK VISIT CODES**
- Preventative medicine code sets are only for well child checks.
- If any significant problem identified and addressed during a well child check then this problem should be reported with appropriate E/M service codes using modifier 25.

- **4- NORMAL NEWBORN VERSUS HOSPITAL CODES**
- Normal newborn codes are used for normal newborns only
- If a bay in the nursey has any significant problem (not normal) like jaundice requiring phototherapy then use hospital codes which has higher RVU.
- You can not bill normal newborn code and hospital code on the same day.

# PART 5- OPTIMIZING REVENUE GENERTAION

- **<u>5-DO NOT MISS PROCEDURAL or NON-E/M CODES</u>**
  - *Know them well and use them*
  - *Codes from anesthesia-surgery-radiology-Path/lab-Medicine*
  - *Look through the CPT code book to see if you will identify any code that applies to your practice*
  - ***If you do anything beyond the E/M ask your self, if it's something separately reportable***
  - Cauterized a granuloma with silver nitrate or removed an impacted cerumen - - > report it non-E/M code

- **<u>6-TEAM MEETINGS</u>** (Medical Team Conference)
- Family present in the meeting:
  - Count time spent in the meeting toward and an appropriate E/M code and use prolonged care codes if necessary.
  - Primary attending: may use time in the meeting toward the E/M code of the day like 99233
  - Consultant may use the time in the meeting toward the E/M code of the day like 99233 or 99255.
- Family not present: use the code 99367 to report time spent in the meeting.

# PART 5- OPTIMIZING REVENUE GENERTAION

- **7-APPROPRIATELY DOCUMENT BILLED CPT CODE**
- For MDM based billing, the billed MDM level and MDM level documented in the chart should match.
  - If you bill, 99215, 99233 or 99255 then document high level MDM
- For time based billing, document the time and how the time is spent.

- **8- SELECT APPRORIATE ICD CODES**
- Make sure your ICD codes are aligned well with reported CPT codes
- If you bill highest level by MDM selection then do not report an ICD code for minor illness
- Do not report critical care for knee pain or stable chronic renal failure

# PART 5- OPTIMIZING REVENUE GENERTAION

- **9- CRITICAL CARE CODES IN NON-ICU SETTINGS**
- Critical care codes are not reserved for intensivist or ICU
- Consider billing critical care codes for critically ill patients irrespective of the setting
  - In the office: any critical illness like a severe status asthmaticus, anaphylaxis or status epilepticus
  - In the floor: any  critical illness, especially before PICU transfer
  - In the Nursey: any critical illness like respiratory distress before NICU transfer
- Non intensvists, always use adult or time based (99291, 99292) critical care codes irrespective of age

- **10-NEONATAL INTENSIVE CARE CODES IN NON-NICU SETTING**
- Neonatal intensive care codes are not reserved for neonatologist or NICU
- Can be billed by pediatric intensivist, floor/nursey attendings in other settings as long as definition of neonatal intensive care is met including intensive monitoring and other requirements.

# PART 5- OPTIMIZING REVENUE GENERTAION

- **11-CRITICAL CARE CODES IN THE ICU**
- Always target critical care codes 1st because critical care codes have higher RVUs
- Any time definition of critical care is met - - - > bill critical care codes
- For time based or adult critical care: use 99292 liberally to capture all the time spent in critical care activities, especially additional critical care delivered at night by the night attending

- **12- DO NOT FORGET TO BILL**
- Have a system in place to remind you to bill all the patients you see
- For teaching physicians: do not solely rely on residents to send you the notes to sign and bill. Have a list of patients for the day that if residents fails to send you the note then you can still figure it out and bill.

- **13- FOLLOW YOUR CLAIMS/BILLS**
- To make sure your bills are appropriately reimbursed.
- There can be errors in claim submission forms and you may loose revenue if your are not flowing your bills.

# Trust in your self – You have the coding skills!




*Lifetime Trainee support - - > any questions – anytime ( even years after graduation) - - - - > eyupmd@gmail.com*