Enhance Your Awareness of Revenue Opportunities in CPT & ICD-10 Coding

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Today’s Agenda

- Why is Documentation Important?
  - Who is Looking?
  - What Triggers an Audit?

- Clinical Documentation Improvement (CDI)

- E/M Documentation Services Review
  - New Versus Established Patients
  - Medical Decision Making (MDM)
  - Clinical Examples
  - Billable Time

- Coding for E/M and Preventive Services
  - Modifier 25
  - Preventative Counseling

- Additional Revenue Opportunities
  - Transition of Care Management (TCM)
  - Annual Wellness Visits (AWV)
  - Advanced Care Planning (ACP)
  - Other Screenings, Counseling & Assessments

- Incident-To

- HCC Acuity Coding

- The Future of E/M Coding
Why is Documentation Important?

The medical record is a legal document. The documentation of each patient encounter should include:

- The reason for the visit.
- Relevant history, physical exam findings and/or prior diagnostic test results.
- Assessment, clinical impression or diagnosis and a plan for care.
- Date and legible identity of the observer.
- The rationale for ordering diagnostics and other ancillary services is easily inferred.
- The patient’s progress, response to and changes or revisions in treatment should also be documented.
Who Reviews Your Notes?

Many individuals review your patient notes including:

- Attorneys
- Clinicians for Treatment purposes
- Department of Public Health and Human Services
- Hospital Joint Commission
- Insurance Companies for Payment and Quality Purposes
- Patient, Family
What Can Trigger An Audit?

Health Plans typically audit provider groups by identifying aberrant patterns of coding such as:

- Inconsistent coding patterns among members of same specialty/same group/same location.
- Frequency of visits not supported by medical necessity.
- Excessive use of one procedure code.
- Excessive number of patient visits in same day, same provider with high level coding.
- Employees who report possible fraud or abuse practices to the health plan surrounding billing or clinical practice.
Clinical Documentation Improvement (CDI)

- Clinical documentation is the **core** to every patient encounter.

- Documentation must be **accurate**, **timely** and **reflect the full scope** of services provided.

- CDI efforts help providers to capture the most accurate representation of a patient’s current health condition(s) which can translate into **improved/accurate**:
  - CPT/ICD-10 coding and reimbursement,
  - Quality reporting,
  - Physician RVUs,
  - Public health data,
  - Disease tracking and trending
M.E.A.T. the New S.O.A.P.

S.O.A.P – Subjective, Objective, Assessment & Plan

Managed – What does HPI really mean?
- What is the patient presenting with today? New or Chronic? What is the history behind the condition? Has this condition improved or are there new signs and symptoms?

Evaluated – Hands on Process
- How is this condition doing? Stable or Worsening? Your exam should never be general like “normal cardiovascular, benign respiratory”. NOTE: Just listing medications does not meet medical documentation requirements to substantiate that an evaluation for a condition was performed.

Assessed
- What is the diagnosis? What lab or radiology tests are needed? Were old records reviewed and summarized?

Treated
- Does the patient need medication or was their medication changed? Does the patient need a referral to a specialist? Do they need a procedure or an injection? OR are you keeping the same plan because patient is responding well to treatment? What was your discussion with the patient? Did it take time to coordinate care or provide counseling?
Example:
How to code a visit from the coder’s perspective

- **Medical record indicates the patient’s:**
  - blood sugar is 37
  - “mental frailty” is stable
  - lab results of increased potassium

- **Clinical validation for physician might be:**
  - Diabetic hypoglycemia
  - Alzheimer’s disease
  - Hyperkalemia

- **IF Coder were to abstract ICD-10 codes they would code as follows:**
  - E11.9 Type 2 diabetic without complications
  - **NOTE:** Mental Frailty is not a diagnosis and clarification would be needed from the provider. Coders cannot abstract diagnoses from lab results. Providers need to document all of their findings.
**Bottom Line for CDI**

- **Documentation Counts**
  - **Code and capture all** the conditions (acute or chronic) that you are assessing today.

- **Document the Evidence**
  - Document **the severity** and specificity of each condition **and include any co-morbidities** that the patient may have that impacts your care at today’s visit.

- **Signs and Symptoms can be used**
  - If you cannot confirm a diagnosis that is okay! Just code the S&S for the visit. NOTE: Only list “history of” if the patient has been cured of the condition and the history of a condition is relevant to the conditions actively being managed today.

- **Get credit for the work that you do!**
What is a New vs Established Patient?

New Patient

- A new patient is defined as one who **has not:**
  - Received any face-to-face professional services from a physician or physician group practice (same physician specialty) within the previous **3 years.**
  - Professional services are: Evaluation and Management (E/M) services (99201-99215), surgical procedures or other face-to-face services.

Established Patient

- A patient who **has:**
  - received face-to-face professional services from a physician or physician group practice (same physician specialty) within the previous **3 years.**
# Evaluation and Management (E/M) Levels 1-5

There are 5 levels of Evaluation and Management Coding for New and/or Established Patients. A CPT code is selected based on the extent of documentation you provide under the History, Exam and Medical Decision making portions of your visit note. Exception: If >50% of your total visit time was spent in counseling and/or coordination of care, then you must document time spent along with a high level summary of what was discussed.

## New Patient E/M Codes

**Requires 3/3 areas** be met under 1) History (HPI); 2) Exam and 3) Medical Decision Making (MDM). These areas are further described as being Problem Focused (PF), Expanded Problem focused (EPF); Detailed (D); or Comprehensive (C).

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>HPI</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10 min</td>
<td>PF, PF</td>
<td>PF</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99202</td>
<td>20 min</td>
<td>EPF, EPF</td>
<td>PF</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203</td>
<td>30 min</td>
<td>D, D</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>99204</td>
<td>45 min</td>
<td>C, C</td>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>99205</td>
<td>60 min</td>
<td>C, C</td>
<td>High Complexity</td>
<td></td>
</tr>
</tbody>
</table>

## Established Patient E/M Codes

**Requires 2/3 areas** be met under 1) History (HPI); 2) Exam and 3) Medical Decision Making (MDM). These areas are further described as being Problem Focused (PF), Expanded Problem focused (EPF); Detailed (D); or Comprehensive (C).

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>HPI</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>5 min</td>
<td>does not require the presence of an MD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td>10 min</td>
<td>PF, PF</td>
<td>PF</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99213</td>
<td>15 min</td>
<td>EPF, EPF</td>
<td>PF</td>
<td>Low</td>
</tr>
<tr>
<td>99214</td>
<td>25/min</td>
<td>D, D</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>99215</td>
<td>40 min</td>
<td>C, C</td>
<td>High Complexity</td>
<td></td>
</tr>
</tbody>
</table>
What are the Documentation Elements for History, Exam and Medical Decision Making?

The type of History, Exam and Medical Decision Making is determined by the extent of information provided within the HPI, Exam and MDM.

1. **History of the Present Illness (HPI)**
   - Indicate the reason(s) for the visit (Chief Complaint)
   - Presenting Factors (PF)
   - Review of Systems (ROS) and,
   - Past, Family and Social Information (PFSHI)

2. **Physical Exam (PE)**
   - Indicate all body areas and/or organ systems reviewed on exam
   - Do not indicate an abnormal finding without elaboration

3. **Medical Decision Making (MDM)**
   - List all problems evaluated, including any differential diagnoses
   - Indicate all diagnostic tests ordered, reviewed, or discussed with other specialists
   - Document all problems reviewed, their status (stable, poor) and the management plan. Example: “Continue med dosage; frequency or follow-up with Dr. Smith”.
What is a Problem Focused, Expanded Problem Focused, Detailed or Comprehensive HPI or Exam?

The definition of a Problem Focused, Expanded Problem Focused, Detailed or Comprehensive HPI or Exam is as follows:

**HISTORY:**
- HPI: Problem Focused = 1 PF, 0 ROS, 0 PFSH
- HPI: Expanded Focused = 1 PF, 1 ROS, 0 PFSH
- HPI: Detailed = 4+ PF, 2-9 ROS, 1 PFSH
- HPI: Comprehensive = 4+ PF, 10 ROS, 2/3 PFSH or 3/3 if new pt.

**EXAM:**
- Exam: Problem Focused = 1 body area or organ system
- Exam: Expanded Problem Focused = 2-4 body areas or organ systems
- Exam: Detailed = 5-7 body areas or systems
- Exam: Comprehensive = 8+ systems only
Medical Decision Making (MDM) is based on the calculation/estimation of a 3 category system;

- **Category A – Presenting Problems**
  - Minimal = 1 point
  - Limited = 2 points
  - Multiple = 3 points
  - Extensive = 4 points

- **Category B – Diagnostic Procedures Ordered or Reviewed**
  - Minimal = 1 point
  - Limited = 2 points
  - Moderate = 3 points
  - Extensive = 4 points

- **Category C – Table of Risk**
  - Straightforward
  - Low
  - Moderate
  - High
# Category A & B

**Category A & B** represents the # and nature of the presenting problems

## A. Presenting Problems. The # of diagnoses require Active Management or Affect Treatment Options.

<table>
<thead>
<tr>
<th>Description</th>
<th>Max</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Limited / minor (stable, improved or worsening)</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Est. problem (to patient); stable; improved</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Est. problem (to patient); worsening</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>New problem (to patient); no additional workup planned</td>
<td>Max</td>
<td>3</td>
</tr>
<tr>
<td>New problem (to patient); additional workup planned</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## B. Amount and/or Complexity of Data to be Reviewed

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review of order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decide to obtain old records or to obtain history from someone else</td>
<td>1</td>
</tr>
<tr>
<td>Review &amp; summarize old records or obtain Hx from someone other than the patient and/or discuss with other provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing, or specimen itself (not simply review of the paper copy report)</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>
Category C is the “Table of Risk”. It determines if the overall medical decision making is minimal, low, moderate or high.

<table>
<thead>
<tr>
<th>LEVEL OF RISK</th>
<th>PRESENTING PROBLEM(S)</th>
<th>DIAGNOSTIC PROCEDURE(S) ORDERED</th>
<th>MANAGEMENT OPTIONS SELECTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One self-limited or minor problem (e.g., cold, insect bite, tinea corporis)</td>
<td>Laboratory tests requiring venipuncture, Chest x-rays, ENG, EEG, Urinalysis, Ultrasound (e.g., echocardiography), KOH prep</td>
<td>Rest, Gargles, Elastic bandages, Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems</td>
<td>Physiologic tests not under stress (e.g., pulmonary function tests), Non-cardiovascular imaging studies with contrast (e.g., barium enema), Superficial needle biopsies, Clinical laboratory tests requiring arterial puncture, Skin biopsies</td>
<td>Over-the-counter drugs, Minor surgery with no identified risk factors, Physical therapy, Occupational therapy, IV fluids without additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test), Diagnostic endoscopies with no identified risk factors, Deep needle or incisional biopsy, Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization), Obtain fluid from body cavity (e.g., lumbar puncture, thoracentesis, culdoscopy)</td>
<td>Minor surgery with identified risk factors, Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors, Prescription drug management, Therapeutic nuclear medicine, IV fluids with additives, Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>Cardiovascular imaging studies with contrast with identified risk factors, Cardiac electrophysiologic tests, Diagnostic Endoscopies with identified risk factors, Discography</td>
<td>Elective major surgery (open, percutaneous or endoscopic) with identified risk factors, Emergency major surgery (open, percutaneous or endoscopic), Parenteral controlled substances, Drug therapy requiring intensive monitoring for toxicity, Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
## Final Calculation

Example: If Category A is minimal, Category B is Limited and Category C is Moderate Complexity then the patient’s overall medical decision making type would be low complexity - 99213.

<table>
<thead>
<tr>
<th>Category A</th>
<th>Category B</th>
<th>Category C</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>= 99212</td>
</tr>
<tr>
<td>= 99213</td>
</tr>
<tr>
<td>= 99214</td>
</tr>
<tr>
<td>= 99215</td>
</tr>
</tbody>
</table>
Appropriate Code Selection

Medical necessity of a service should be the overarching criterion for code selection in addition to the documentation requirements.

- **Minimal**
  - A problem that may **not require the present of the physician**, but service is provided under the physician’s supervision

- **Self-limited or minor**
  - A problem that **runs a definite and prescribed course**, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance

- **Low severity**
  - A problem where the risk of morbidity **without treatment is low**; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected

- **Moderate severity**
  - A problem where the risk of morbidity **without treatment is moderate**; there is a moderate risk without treatment; uncertain prognosis OR increased probability of prolonged functional impairment

- **High severity**
  - A problem where the risk of morbidity **without treatment is high to extreme**; there is a moderate to high risk of mortality without treatment OR increased probability of severe, prolonged functional impairment

- It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.

- The volume of documentation should not be the primary influence upon which a specific level of service is billed.
Clinical Examples - 99212

- Follow Up of a URI w/o fever (no meds given)
- Rashes (that are not concerning)
- Bug bite
- BP check by NP, MD
- Medication check by NP, MD
- TIME: 10 Minutes - 10 minute discussion on treatment options or lab results
Clinical Examples - 99213

- URI
- Sinusitis
- Pharyngitis
- Low back pain that is not sciatica
- Bronchitis that has not progressed
- Otitis Media
- Vaginitis
- F/U of 2 stable chronic (HTN, DM)

TIME: 15 Minutes - 15min (greater than 50%) spent counseling on management options, treatment plan or self-management.

NOTE: Remember billable time is not time spent securing HPI, Exam Information.
Clinical Examples - 99214

- The review of 3 or more stable chronic illnesses (as long as patient was not in recently)
- Exacerbation of 1 chronic illness with a NEW sign or symptom (Example DM uncontrolled with syncope)
- Abdominal Pain w/blood in stool
- Headache with vision problems, nausea, vomiting
- Swollen lymph nodes, w/fever
- Back pain, with limited ROM, Sciatica
- Pneumonia

TIME: 25 Minutes - Documentation of 50% or more of 25 minutes time spent in spent counseling on management options, treatment plan or self-management.
Clinical Examples - 99215

- Patient presents with acute chest pain, call ambulance.
- Pt presents with severe abdominal pain, significant weight loss, fever.
- Sending patient to the E.R.
- TIME: 40 Minutes - Documentation of 50% or greater of 40 minutes was spent in for patient who is suicidal, or just diagnosed with cancer, discuss treatment options etc.
When the patient is present, counseling includes discussions on:

- Diagnostic results, impressions, and/or recommended studies; prognosis;
- Risks and benefits of management (treatment) options;
- Instructions for management (treatment) and/or follow-up;
- Importance of compliance with chosen management (treatment) options;
- Risk factor reduction; and patient and family education.
- Coordination of Care w/other health care professionals

Medicare Requires that you indicate how much of the total time was spent in counseling. i.e. >50% of ____ was spent in discussion and/or in coordination of care regarding ____________.

<table>
<thead>
<tr>
<th>NEW/EST</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>E/M Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Visit Time</td>
<td>20</td>
<td>30</td>
<td>45</td>
<td>60</td>
<td>10</td>
<td>15</td>
<td>25</td>
<td>40</td>
</tr>
</tbody>
</table>
## Modifier 25

- In general, modifier 25 is applied to the office visit code (99212-99215) unless noted otherwise below.

- To ensure compliance with payer rules, all Modifier 25 visits must:
  - Be supported by proper documentation in the medical record
  - Be able to stand on their own as billable services

<table>
<thead>
<tr>
<th>Description of Service</th>
<th>CPT Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPE</td>
<td>99391-99397</td>
<td>Z00.00 or Z00.01</td>
</tr>
<tr>
<td>Office Visit</td>
<td>99212-99215 – MF 25</td>
<td><strong>NEW</strong> problem addressed and/or re-management of chronics.</td>
</tr>
<tr>
<td>Annual Wellness Visit</td>
<td>G0438-G0439</td>
<td>Z00.00 or Z00.01</td>
</tr>
<tr>
<td>Office Visit</td>
<td>99212-99215 – MF 25</td>
<td><strong>ANY</strong> problem discussed during the AWV (i.e. cough, managing chronics, etc.)</td>
</tr>
</tbody>
</table>
Modifier 25 – informs payers that you are providing a significant, separately identifiable E&M service on the same day as another service / procedure.

Preventative Physical Exam (CPE) Consists Of:
1. The review of “stable” chronic problems
2. Routine Screenings (i.e. Pap smear, breast & pelvic, manual rectal)
3. Risk Factor Counseling in the absence of established signs/symptoms

Do **NOT** bill additionally for an office visit with a physical unless:
- A patient presents with a “significant” new or exacerbation of a pre-existing condition that requires re-evaluation and management

**Significant is NOT:**
- A minor problem supporting a level 2 service (i.e.. Bug Bite)
- Reassurance
- Monitor
- Patient requested referrals
- Observe
- Continue meds, Refills
- return in 3+ months
Prevention Risk Factor Counseling

- 99401 - Requires Documentation of 15 min
- 99402 - Requires Documentation of 30 min

*Risk Factor Counseling Codes should be used in the absence of signs, symptoms or pre-established conditions.*

Diagnosis codes – examples

- Z30.011 Prescription of oral contraceptives
- Z30.02 Initiation of other contraceptive measures (diaphragm fitting/foams, creams…)
- Z30.012 Encounter for emergency contraceptive counseling and prescription
- Z30.02 Counseling and instruction in natural family planning to avoid pregnancy
- Z30.09 Other - family planning advice
Transitional Care Management (TCM)

- 99495 - requires moderately complex medical decision-making and a face-to-face visit within 14 days.

- 99496- requires highly complex medical decision-making and a face-to-face visit within 7 days.

TCM codes should be billed for patients who are transitioning from an Inpatient hospital setting (including acuity, rehabilitation, or long-term acute care), partial hospitalization, or observation status in a hospital, skilled nursing facility, or other nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living).

- Use the E/M Risk Table for Medical Decision Making to determine whether to use CPT code 99495 (Moderate) or 99496 (High).

- If the patient falls under the minimal or low section of the table of risk then they will not qualify for either of these codes.
TCM Documentation Requirements

Documentation Details/Requirements:

- Communication with the patient or caregiver within two (2) business days of discharge by telephone, direct contact, or electronic means, and that, by the first face-to-face visit following discharge
- Medication reconciliation
- Review of the discharge information
- Review of any follow-up of pending diagnostic tests and treatments.
- Interaction with other qualified health care professionals who will assume or re-assume care of the patient's condition
- Education of patient, family, guardian, and/or caregiver.
- Establishment or re-establishment of referrals.
- Scheduling of any required follow-up with providers and/or other community services when applicable

**NOTE:** Clinical staff under direction from a physician or other provider can provide non-face-to-face services as communicating aspects of care, self-management and treatment regimen compliance with the patient, caregiver, or other decision maker, as well as communicating with home health agencies or other community services the patient is using.
Welcome to Medicare Physical

G0402 - Initial Preventive Physical Examination; face-to-face visit, services limited to new beneficiary during the first 12 months of enrollment

Documentation Requirements:
1. The goals of the program are to promote good health as well as disease detection. The following components must be provided on the examination:
2. Review and documentation of the patient’s medical and social history
3. Review and documentation of patient’s potential risk factors for depression and/or other mood disorders.
4. Review and documentation of patient’s functional ability and level of safety
5. Physical examination, including measurement of body mass index
6. End-of-life planning (voluntary)
7. Education, counseling and referral (if necessary) based on the five items above
8. Education, counseling and referral for other preventive services
Annual Wellness Visit

NOTE: THIS IS NOT A PHYSICAL

G0438 - Annual wellness visit, after the “Welcome to Medicare Physical” is billed; including personalized prevention plan services; Initial Visit

G0439 - Annual wellness visit, subsequent including personalized prevention plan services; Subsequent Visit

Documentation Requirements:
1. Establish medical / family hx
2. Review of risk factors for depression / other mood disorders
3. Review functional ability/ level of safety
4. Exam including ht, wt, visual acuity, BMI
5. Establish list of current providers involved in patient care
6. Detect any cognitive impairments
7. Establish written screening schedule for next 5-10 years
8. Establish list of risk factors and intervention recommendations
9. Furnish health advice regarding prevention and referrals (i.e. smoking cessation, fall prevention, nutrition, weight loss, physical activity).

NOTE: The completion of a Health Risk Assessment (HRA) form is a requirement in order to bill a AWV.
**Advanced Care Planning**

99497 - Advanced Care Planning involves; learn about the health care options that are available for end-of-life care, determine which types of care best fit their personal wishes and share their wishes with family, friends, and their physicians; 15-30 minutes

+99498 – add-on code providing for additional 30 minutes

- Patients whose death in the next 12 months is likely, a chronic, life-limiting illness who are experiencing increased symptoms and hospitalizations and/or patients aged 55 and over, in any state of health
- These codes can be billed along with an E&M service (i.e. 99213, 99316) or Annual Wellness Visit (AWV G0438 and G0439)
- Modifier 33 will need to be appended to the Advanced Care Planning CPT codes when billed with an AWV.
- Not limited to one time annually.

**Documentation Guidelines**

- Incorporate the patient’s goals, preferences, and choices into the advance care plan
- Encourage the patient to discuss their preferences and care plan with the surrogate, family member, spiritual counselor and others and/or identify surrogate to make decisions on patients behalf
- Encourage the patient to complete an Advance Directive; Health Care Proxy, Durable Power of Attorney for Healthcare, living will, and/or Medical Orders for Life-Sustaining Treatment (MOLST).
- No active management of the patient’s problem(s) is required.
Cerumen Removal

69209 – removal impacted cerumen using irrigation / lavage unilateral

69210 – removal impacted cerumen requiring instrumentation unilateral

- The service is personally performed by a physician or non-physician (NP, PA, CNS)

- **Documentation Requirements**
  - Cerumen must be impacted to support reporting removal via irrigation, lavage or instrumentation
  - Non impacted cerumen is included in the evaluation and management service
  - Identify the anatomic site by appending modifier LT or RT
  - When reporting bilateral – append modifier 50
  - Both irrigation / lavage and the utilization of instrumentation cannot be reported on the same ear during the same encounter
  - Report the most extensive procedure
Pap Smears and Pelvic Exams

Q0091 - Collection of the pap smear; Screening

Diagnosis codes:
- Z12.4 - low risk – encounter for screening of malignant neoplasm of cervix
- Z91.89 - high risk – other specified personal risk factors.
- Coverage every 2 yrs – unless high risk – then annual

G0101- Screening pelvic exam requires the review and documentation of 7 out of 11 areas.

Diagnosis codes:
- Z01.411 - low risk – encounter for gynecological exam
- Z91.89 - high risk – other specified personal risk factors
- Coverage every 2 yrs. – unless high risk
Pelvic Exam Documentation Requirements

Documentation Guidelines - A screening pelvic examination, with or without specimen collection for smears and cultures, should include at least seven of the following eleven elements:

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge
2. Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses
3. External genitalia (for example, general appearance, hair distribution, or lesions)
4. Urethral meatus (for example, size, location, lesions, or prolapse)
5. Urethra (for example, masses, tenderness, or scarring)
6. Bladder (for example, fullness, masses, or tenderness)
7. Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele)
8. Cervix (for example, general appearance, lesions or discharge)
9. Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support)
10. Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity)
11. Anus and perineum
Smoking Cessation Counseling

99406 – Smoking and tobacco use cessation visit: intermediate; **3 minutes up to 10 minutes**

99407 – Smoking and tobacco use cessation visit; intensive, greater than **10 minutes**

- **Benefit Coverage:**
  - A maximum of 8 sessions in a 12 month period are covered
  - “TIME” must be documented
  - Patient may present with or without signs/symptoms
  - Document counseling discussion

**ICD-10: F17.200 – Nicotine Dependence**
Depression Screening

G0444 – Depression Screening; 8-15 Minutes

- Suggestions from CMS on what the depression screen “discussion” can/should be detailed in your note are as follows
  - Inform patients about the prevalence of depression
  - Introduce the PHQ 2/9 screening form and its use
  - Review all 9 questions with the patient, if applicable
  - Explain the results of the tool
  - Describe signs / symptoms of depression with patient for future awareness
  - Provide resources (handout) to patient
  - “TIME” must be documented 8-15 Minutes
Emotional/Behavior Assessment

96127 - Brief assessment of a patient presenting with signs/symptoms of depression, ADHD, anxiety whereby a screening tool is utilized (PHQ-9, CAGE, GAD-7, SCARED)

Documentation requirements:

- Scored screening tool
- Course of treatment
- Bill 96127 for each tool used in visit. (i.e. If PHQ-9 and CAGE performed = 96127 x2 units
- Can be billed up to 4 times per year.
- Can be billed with an E & M service (modifier 25)
- Code ICD-10 as the assessed diagnosis (i.e. Major depression)
Alcohol Screening & Counseling

G0442 – Alcohol Misuse Screening; **8-15 minutes**

- **Eligibility**
  - Adults who misuse alcohol, but *don't meet* the medical criteria for *alcohol dependency* can get the screening

G0443 – Counseling; **8-15 minutes**

- **Documentation Requirements**
  - If your primary care doctor determines you're misusing alcohol, you can get 4 brief face-to-face counseling sessions per year
  - Counseling for alcohol misuse must be based on the **Five A’s** (Assess, Advise, Agree, Assist, and Arrange)
  - Can be billed with an E&M service (if another problem is addressed during same visit.)
Low-Dose Lung Cancer Screening

G0296 – Counseling visit to discuss need for lung cancer screening use low dose CT scan (LDCT)

- **Coverage Requirements:**
  - Beneficiaries must be 55-77 years of age;
  - Be asymptomatic (no signs/symptoms of lung cancer);
  - Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
  - Be a current smoker or one who has quit within the last 15 years
  - ICD-10 Codes: F17.210, F17.211, F17.213, F17.218, F17.219, Z87.891

- **Documentation Requirements:**
  - Actual pack-year smoking history (number);
  - Current smoking status or number of years since quitting;
  - A statement that the beneficiary is asymptomatic;
  - NPI of ordering provider

- **Frequency**
  - First year: Before the first lung cancer LDCT screening, beneficiaries must receive a counseling and shared decision making visit.
  - Subsequent years: Beneficiary must receive a written order at a visit by a provider.
High Intensity Behavioral Counseling (HIBC) to Prevent STI’s

G0445 - High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes.

ICD -10 Codes - Z11.3, Z11.59, Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, Z72.51, Z72.52, Z72.53, Z72.89, O09.90, O09.91, O09.92, and O09.93

- **Coverage Requirements**
  - Sexually active adolescents and adults at increased risk for STIs;
  - Referred for this service by a PCP and provided by a Medicare-eligible PCP in a primary care setting

- **Documentation Requirements**
  - Must have counseling and time documented (at least 16 minutes).

- **Frequency**
  - Up to 2 – 30 minute, face-to-face HIBC sessions annually
# Chronic Care Management (CCM)

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Clinical Staff Time</th>
<th>Care Planning</th>
<th>Assumed “work/time” for billing practitioner</th>
<th>Billing</th>
</tr>
</thead>
<tbody>
<tr>
<td>99490 – CCM</td>
<td>20 minutes a month</td>
<td>Established, implemented, revised or monitored</td>
<td>Assumes 15 minutes of additional work including ongoing oversight, direction and management by billing practitioner</td>
<td>Criteria: 2+ chronic conditions expected to last at least 12 months or until the death of patient and that place the patient at significant risk of death, acute exacerbation/decomposition, or functional decline. Documented verbal consent is allowed</td>
</tr>
<tr>
<td><em>NEW</em> 99491 – CCM</td>
<td>30 minutes a month</td>
<td>Established, implemented, revised or monitored</td>
<td>Assumes 20 minutes of additional work including ongoing oversight, direction and management by billing practitioner</td>
<td>CCM includes; 1. Est, implement, revise or monitor care plan 2. Coordinating the care of other professionals and agencies 3. Educating the patient or caregiver about the patient’s condition, care plan and prognosis</td>
</tr>
<tr>
<td>99487 – Complex CCM</td>
<td>60 minutes a month Medical decision making of moderate to high complexity</td>
<td>Established or substantially revised</td>
<td>Assumes 25 minutes of additional work including ongoing oversight, direction and management by billing practitioner</td>
<td></td>
</tr>
<tr>
<td>99489 – Complex Care “Add-On” Code</td>
<td>Each additional 30 minutes of clinical staff time a month Medical decision making of moderate to high complexity</td>
<td>Established or substantially revised</td>
<td>Assumes 13 minutes of additional work including ongoing oversight, direction and management by billing practitioner</td>
<td></td>
</tr>
<tr>
<td>G0506 – Initiating Visits “Add-On” Code</td>
<td>N/A</td>
<td>Payment to establish a care plan</td>
<td>Billing provider can initiate this service during an AWV or an E/M</td>
<td>Personally performs extensive assessment and CCM care planning beyond the usual efforts of the CCM initiating visit</td>
</tr>
</tbody>
</table>
Virtual Check-Ins

- G2012 – A virtual check-in is a patient initiated telephone encounter lasting 5-10 Minutes

  - Coverage Requirements
    - A virtual check-in **may not** originate from a related E/M provided within 7 days prior to the call nor lead to an E/M within 24 hours or the soonest available appointment after the call
    - Patient must be an “established” patient
    - The billing practitioner must furnish the virtual check-in
    - Physicians and qualified healthcare professionals i.e. NP, PA
    - No location limitations – patient can call from home

  - Documentation Requirements
    - Time 5-10 minute discussion
    - Documentation of “verbal consent” from the patient as co-pays and deductibles apply

  - Frequency
    - No frequency limitations
    - Note: Behavioral health treatments are recommended for this type of service
What is “Incident-to”? 

- “Incident-to” services are defined as those services that are furnished incidental to physician’s professional services in the physician’s office or in a patient’s home.

- “Incident-to” services are also relevant to services supervised by certain non-physician practitioners such as a physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists. These services are subject to the same requirements as physician-supervised services.
What qualifies as “incident-to”?

“Incident-to” services must be...

- Part of your patient’s normal course of treatment,
- During which a physician personally performed an initial service and,
- The physician remains actively involved in the course of treatment
- The physician co-signs every note
Can an NP bill incident-to for new problems or treatments?

- No. When an NPP sees a patient for a new problem, he/she will need to bill under their own PIN.

- “Incident-to” guidelines do not allow an NPP to bill “incident-to” a physicians services when a new problem is addressed.

- For example: This could happen in a situation when a patient was scheduled to be seen for an established problem follow up but during the visit they bring up a new problem. Once a new problem is introduced, the visit needs to be billed under the NPP’s PIN, not the physicians PIN.
  - Therefore if the NPP is not credentialed than they should not be seeing any new patients or any new problems if the center wishes to receive reimbursement for those visits.
How often does the MD need to see the patient before it can become “incident-to”?

- The MD must first, independently, see the patient and establish a plan of care for the condition.

- Therefore, as long as the patient has been seen initially by the MD, for that problem, then the very next follow up visit could be billed “incident-to”.

- A specific time frame of a physician’s involvement and management is not stipulated but is left to the physician’s medical judgement based on the patient’s condition and needs.
Can an MD perform a CPE and the NP perform an E/M incident-to on the same day?

No. Since both services need to be billed on the same day they should be performed by and billed by the same physician.
Remember if there is …

New Problem
New Patient
No Plan of Care
No Physician in the Suite
No Physician Signature on the Note

You must bill under…

N P number!
Director Supervision: You do not need to be physically present in the patient’s treatment room while these services are provided, but you must provide direct supervision, that is, you must be present in the office suite to render assistance, if necessary.

If you are in a group practice, any physician member of the group may be present in the office to supervise
Documentation Requirements

The patient record should document the essential requirements for incident-to services:

- That the service is an integral part of the patient's treatment course
- That the service is a follow-up service to an initial service done by the physician with an established plan of care
- That no new treatments or problems were addressed during that visit
- A co-signature on every visit
Examples

Services performed by the NPPs “incident-to” a physician's professional services include not only services ordinarily rendered by a physician's office staff person e.g. Office Visits, medical services such as taking blood pressure and temperatures, giving injections and changing dressings but also include services ordinarily performed by the physician him/herself such as:

- Minor Surgery,
- Setting a cast or simple fractures
- Cardiac rehabilitation
- Providing non-self-administrable drugs and other biologicals
- Reading X-Rays
- Supplies usually furnished by the physician in the course of performing his/her services
  - Gauze
  - Ointment
  - Bandages
  - Oxygen
- Other services that require follow-up evaluation and treatment of a patient's condition
Billing Requirements

- Patient must have an established diagnosis and treatment plan prior to the NPP’s “incident-to” visit

- Attach an SA modifier to all services rendered by the NPP to indicate that it was “incident-to”

- Assign a supervising MD to each visit to indicate to patient accounts who to bill the service under (NOTE: similar to current resident billing)
HCC – Risk Adjusting Model

The CMS-HCC risk adjustment model uses base year diagnoses and demographic information to predict the next year’s spending.

Chronic conditions that represent additional conditions that affect patient care in terms of
- requiring clinical evaluation
- therapeutic treatment
- diagnostic procedures
- or increased care and/or monitoring

New Problems that require evaluation and some type of therapeutic care
- HCC codes should represent;
  - Clinically-significant
  - Well-defined
  - Costly Medical Conditions
  - .....that are likely to be diagnosed, coded, and treated if they are present
Commonly Missed HCC Codes

- E11.65 – Type 2 diabetes mellitus with hyperglycemia
  - Z79.4 - Long term (current) use of insulin
  - Z99.2 – Dependence on renal Dialysis

- E11.22 - Type 2 diabetes mellitus with diabetic chronic kidney disease

- N18.1-N18.6 – Chronic Kidney Disease (CKD) stages 1 thru ESRD

- E66.01 - Morbid (severe) obesity due to excess calories
  - Z68.41 - Body mass index (BMI) 40.0-44.9, adult
  - Z68.42 - Body mass index (BMI) 45.0-49.9, adult
  - Z68.43 – Body mass index (BMI) 50-59.9 , adult
  - Z68.44 - Body mass index (BMI) 60.0-69.9, adult

- I11.0 – Hypertensive heart disease with heart failure
  - I12.0 – Hypertensive CKD with stage 5 CKD or ESRD
  - I13.0 – Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD
  - I13.11 – Hypertensive heart and CKD with heart failure, with stage 5 through ESRD

- F32.9 – Major Depressive Disorder, single episode
  - F33.0-F33.42 – Major Depressive Disorder, recurrent, single episode, mild, moderate, severe
How to Code Diabetes

- **E11 – Type II DM – Base Code**
  - **NOTE**: Use additional code to identify control i.e. Insulin (Z79.4) or Oral Antidiabetic Drugs/Oral Hypoglycemic Drugs (Z79.84)
  - E11.0 – Type II DM w/hyperosmolarity
  - E11.1 – Type II DM w/ketoacidosis
  - E11.2 – Type II DM w/CKD
    - **Note**: use additional code to identify stage of CKD i.e. N18.1-N18.6
  - E11.3 – Type II DM w/Ophthalmic Complication
    - **Note**: Use additional code if billing for Diabetic Glaucoma i.e. H40-H42
  - E11.4 – Type II DM w/neurological complications
  - E11.5 – Type II DM w/circulatory complications
  - E11.6 – Type II DM w/other circulatory complications
    - **Note**: Use additional code for foot ulcer (L97.4-L97.5) or skin ulcer (L97.1-L97.9, L98.41-L98.49)
  - *E11.65 – Type II DM w/hyperglycemia (No Complications – Most Commonly Used)
The “FUTURE” of E/M Coding Medicare

- CMS is finalizing a number of documentation, coding and payment changes to reduce administrative burden and improve payment accuracy for office/outpatient evaluation and management (E/M) visits over several years.

- CMS is finalizing the following policies:
  - Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit
  - For EST patient office outpatient visits, when relevant information is already “in the medical record”, providers may choose to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the provider reviewed the previous information and updated it as needed.
    - NOTE: You should still document if you reviewed prior data, updated as necessary and indicate the medical reasoning for doing so.
  - Ancillary staff or the beneficiary will be allowed to document the chief complaint and history without the information needing to be re-documented by the provider
  - Removal of potential duplicative documentation requirements that may have been previously done by residents or other members of the medical team for the E/M visit furnished by teaching physicians
The “FUTURE” of E/M Coding
Medicare CY 2021

- A “Single Rate” payment for E/M visits levels 2-4 for new and established patients while maintaining the payment variation for Level 5 visits - as an effort to better account for the care and need of complex patients

- Permitting providers to choose to document E/M visits Levels 2-5 using MDM or time instead of applying the current 1995/1997 E/M documentation guidelines

- E/M levels 2-5 will be allowed flexibility in how visit levels are documented
  - Medicare would only require documentation to support a level 2 E/M for visit levels 2-4
  - When time is used, providers will document the medical necessity for use of time and the actual face-to-face time spent with the patient
  - Adoption of “extended visit” add-on codes for levels 2-4 to account for the additional resources required when providers need to spend extended time with the patient but the MDM does not reach a level 5
Thank you for your time today!

Lauren Hartigan, CPC, PCA

Email: Lauren@ScribePartners.Net