

Billing and Coding

1. What are CPT and E/M codes?
 - Current Procedural Terminology – Standardized 5 digit codes that describe what services and/or procedures were provided during the medical encounter.
 - Evaluation and Management codes refer to CPT codes for an office visit
 - Other CPT codes used in clinic include procedures such as ear lavage
 - Must be used in conjunction with and ICD-9 code for example: Periodic preventive infant (CPT 99392) for routine well baby care (ICD9 V20.2) OR ear lavage (CPT 69210) for cerumen impaction (ICD-9 380.4)
 - Level of service is determined by whether patient is new or established and complexity of services provided – see attached examples
 - New patient is a patient that has not been seen by any physician in the practice for at least 3 years
 - Must document appropriate elements of the history, physical exam, and complexity of medical decision making for appropriate code (**see attached for details of each code**) OR
 - If counseling and care coordination dominates the encounter (>50% of total time) CPT code may be determined by time of service, this must be documented clearly with amount of time and description of counseling given

2. What is an ICD-9 code?
 - International Classification of Diseases (9th edition)
 - Assigns a code to a medical diagnosis, symptom. Establishes medical necessity for the visit, affects reimbursement.
 - V codes used for health care supervision visits or to indicate status (ie.g-tube)
 - Do not use “rule out” or “suspected” diagnoses until confirmed
 - Code to the best detail possible (if no diagnosis use symptoms, abnormal lab test if relevant)
 - Chronic conditions are only coded if addressed or treated in that visit

3. What is a modifier 25?
 - Used to describe *separate, distinctly identifiable* services from other services or procedures rendered during the same visit. Always attach the modifier to the evaluation and management code.
 - Example – 3 y/o pt is seen for a well child check, but complains of ear pain and you diagnose and otitis media
 - Bill 99392 for well check linked to V20.2, then add a modifier 25 AND bill 99213 (level 3 sick visit) linked to 382.00 for AOM
 - You must write a separate note for the added billing

4. How do you complete a charge ticket in the PCH clinic?
 - See sample ticket

Elements of Medical Decision Making

TYPE OF DECISION MAKING	NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED	RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Coding Tips for Outpatient Sick Visits—Established Patients

Complexity of Medical Decision Making Determines Level:

MDM	Straightforward	Low	Moderate	High
Diagnosis/Management Options	0-1 points	2 points	3 points	4 points
Complexity of Data	0-1 points	2 points	3 points	4 points
Level of Risk	Minimal	Low	Moderate	High

If two in one column, that column is chosen. If none align, middle column is chosen.

Level 1 = RN Visit—Neither Resident nor Attending see Pt

- f/u weight check without further hx/exam
- suture removal without wound check by MD
- bp documentation by RN
- PPD reading by RN

Level 2 = Straightforward Medical Decision Making (HPI x 1-3, no ROS, Exam x1)

- f/u ear check—everything is fine
- Mom worried about occipital LN—reassured
- Mom worried about circumcision—reassured
- Resolved minor injury
- Resolved URI

Level 3 = Low Complexity Medical Decision Making (HPI x 1-3, ROS x1, Exam x2-4)

- New illness—Dx Virus

- 3 points for Dx/Mgmt Options—New problem to examiner
- 1 point for Data—Hx from Mom
- 2 points for Risk=Low (OTC meds—Tylenol, Robitussin)
- 2 self-limited problems that would be level 2 otherwise
 - 2 points for Dx/Management Options—1 point for each problem
 - 1 point for Data—Hx from Mom
 - 2 points for Risk=Low (2 problems)
- Asthma exacerbation in known asthmatic → Medical management
 - 2 points for Dx/Mgmt Options—worsening of preexisting problem
 - 1 point for Data—Hx from Mom
 - 3 points for Risk=Moderate (medication management of prescription meds)
- OME >1 month after previous AOM → Recheck in 1 more month
 - 2 points for Dx/Mgmt Options—preexisting problem, not resolving in expected timeframe
 - 1 point for Data—Hx from Mom
 - 2 points for Risk=Low (follow-up appt made in 1 month)

Level 4 = Moderate Complexity Medical Decision Making (HPI x 4+; ROS x2-9; Past/Fam/Social Hx x1; or Exam x5-7, and Attending sees patient)

- New febrile illness—Dx Virus, but CXR ordered
 - 4 points for Dx/Mgmt Options—New problem to examiner with additional work-up
 - 3 points for Data—Hx from Mom =1; independent review of CXR = 2;
 - 2 points for Risk=Low (OTC meds—Tylenol, Robitussin)
- Febrile infant/toddler—Dx Acute Otitis Media
 - 3 points for new problem to examiner
 - 1 point for Data—Hx from Mom
 - 3 points for Risk = Moderate (Rx meds)
- Ear recheck → OME >6 months after previous AOM → Refer to ENT
 - 2 points for Dx/Mgmt Options—preexisting problem, not resolving in expected timeframe
 - 4 points for Data—Hx from Mom =1; consult = 2; tympanometry = 1)
 - 3 points for Risk=Moderate (consult needed, possible hearing loss)
- Asthma exacerbation in known asthmatic → Medical management + CXR
 - 2 points for Dx/Mgmt Options—worsening of preexisting problem
 - 3 point for Data—Hx from Mom = 1; independent review of CXR = 2
 - 3 points for Risk=Moderate (medication management of prescription meds)
- Asthma exacerbation in known asthmatic → Medical management + Pulm C/S
 - 2 points for Dx/Mgmt Options—worsening of preexisting problem

- 3 point for Data—Hx from Mom = 1; Consult = 2
- 3 points for Risk=Moderate (medication management of prescription meds)
- Asthma exacerbation plus eczema—Medical management
 - 3 points for Dx/Mgmt Options—worsening asthma plus other problem
 - 1 point for Data—Hx from Mom
 - 3 points for Risk=Moderate (medication management of prescription meds)

Level 5 = High Complexity Medical Decision Making (HPI x 4+; ROS x10; Past/Fam/Social Hx x2; or Exam x8+; **and Attending sees patient**)

- New febrile respiratory illness—CXR ordered + CBC/other labs
 - 4 points for Dx/Mgmt Options—New problem to examiner with additional work-up
 - 4 points for Data—Hx from Mom =1; independent review of CXR = 2; labs ordered = 1
 - 3-4 points for Risk = Varies depending on results of CXR/labs, but doesn't need to be high since above 2 categories have 4 points
- New cough in pt with CF, or increasing hypoxia in pt with BPD on O2
 - 4 points for Dx/Mgmt Options—new problem to examiner with additional w/u
 - 4-6 points for Data—Hx from Mom, 1 point for CBC or sputum culture or other labs, 2 points for review of CXR, 2 points for phone call to Pulmonologist
 - 4 points for Risk = High
- Severe asthma exacerbation with URI; multiple SVN's in office, reassessments
 - 5 points for Dx/Mgmt Options—2 points for established problem, worsening (asthma) plus 3 points for new problem, no w/u (viral URI)
 - 1 point for Data—Hx from Mom
 - 4 points for Risk = High (gave equivalent therapy to ED)
- Febrile illness in patient with transplant
 - 4 points for Dx/Mgmt Options—new problem to examiner with additional w/u
 - 4-6 points for Data—Hx from Mom; 2 points for phone call to Subspecialist; 1 point for CBC or sputum culture or other labs, +/- 2 points for review of CXR,
 - 4 points for Risk = High
- Any level 4 problem above with an separate problem managed on same visit

Take Home Points—Any of following should be at least Level 4 (unless pt not seen by attending):

- Consult
 - Data = 2 pts for consult; 1 point for d/w Mom
 - Risk is at least moderate or we wouldn't be consulting
- Diagnostic CXR ordered and reviewed on Radin
 - Data = 2 points for independent review of film; 1 point for d/w Mom
 - Risk is at least moderate or we wouldn't need CXR
- Diagnostic labs + radiology
 - Data = 1 point for labs, 1 for radiology (image review=2), 1 for d/w Mom
 - Risk is at least moderate if we need to order labs
- 2 separate problems, if at least 1 is a new or newly exacerbated, and there is some management of prescription medicines
 - Dx/Mgmt Options = 3 (2 points for exacerbation + 1 for additional minor)
 - Risk is at least moderate level because Rx given

New Patients

You use the same medical decision making as above with slightly increased requirements for documentation of the history and exam portions. With new patients, you must have complete documentation of both history and exam components (whereas with established patients, you only need either the history or exam components completely documented).

Level 1 New HPI x1-3; no PFSHx, no ROS; Exam x 1; MDM = Straightforward
 Level 2 New HPI x1-3; no PFSHx, ROS x1; Exam x 2-4; MDM = Straightforward
 Level 3 New HPI x4+; PFSHx x1; ROS x2-9; Exam x 5-7; MDM = Low
 Level 4 New HPI x4+; PFSHx x3, ROS x10; Exam x 8+; MDM = Moderate
 Level 5 New HPI x4+; PFSHx x3, ROS x10; Exam x 8+; MDM = High

Coding for Time

If you spend a lot of time with the patient, but the encounter is not very complex according to the point system above, you can bill for time rather than complexity of medical decision making. This only makes sense for the higher codes when the criteria for complexity is not easily met (since it doesn't take much complexity to bill for levels 1-3).

Code	Established Patient	New Patient
Level 1	zero (you didn't see patient)	10 minutes
Level 2	10 minutes	20 minutes
Level 3	15 minutes	30 minutes
Level 4	25 minutes	45 minutes
Level 5	40 minutes	60 minutes

What to document?

- Total time spent with patient (if >25 minutes, qualifies for level 4 established; if >40 minutes, qualifies for level 5 if established)
- Time spent in counseling family, and/or coordinating care, must be >50% of total time.

Established Patients--Examples:

- “Total time = 25 min; Counseling about sexuality = 15 min” → Level 4 established
- “Total time = 45 min; Phone call to school psychologist and counseling mother = 25 min” → Level 5 established

New patient—Examples:

- “Total time = 45 min; reviewing records from NICU, gastroenterology, pulmonology = 20 min” → Level 4 new patient
- “Total time = 60 min; reviewing old records, making referrals to local subspecialists and counseling family about upcoming adolescence = 45 min” → Level 5 new patient