Coding and Billing 101: Getting Paid for What You Do

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Coding and Billing 101:
The Basics of Outpatient Billing
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Disclosure of Financial Relationships
Jeannine Engel, MD

Has no relationships with any proprietary entity producing health care goods or services consumed by or used on patients.

Background
• HCFA, now CMS (Center for Medicare and Medicaid Services) issued guidelines for documentation of different service codes in 1995. They were revised in 1997. Either can be used.
• In general, the 1995 guidelines are more favorable for General Internists
• In TN, Medicaid (TennCare) does NOT follow CMS guidelines- must check in your state

Who am I??
• Academic Primary Care MD
• UCSD; Vanderbilt Residency
• 12 years on Faculty at Vanderbilt
• 7 years of learning and teaching rules of coding and documentation to MDs
• What I have learned: The more you delve into the rules, the less you know…

Coding: Why do we care?
• Institutional Benefit: Avoid Penalties
  – U Penn 1995 $30M
  – Thomas Jefferson 1996 $12M
  – U Virginia 1997 $8.6M
  – U Texas, San Antonio 1998 $17.2M
  – Georgetown 1999 $5.3M
  – University of CA 2001 $22M

Why do we care?
• Group Benefits
  – Increased collections
  – Decreased claims-denials
**Why should we care?**

- **Individual Benefits**
  - **Thought vs. Action: General IM reimbursement** traditionally lower than procedure-based specialties
  - **Getting paid for what we do**: reimbursement for institution and individual can increase with proper coding
  - “Playing the game” vs. “Changing the game”

**Vanderbilt GIM experience**

- **Impact of coding education**
  - Anecdotal evidence:
    - 1 MD rarely coded above level 2 return
    - 1 MD (presenter) never coded Ann/Preventative
    - RVU/clinic session, 8 providers: 12.9% increase
    - RVU/visit, entire Division: 12.2% increase
    - 1.032 -> 1.158 RVU/visit
    - Largest shift seen in increase Level 4 return visits

**Disclaimer**

- This session will provide basic information regarding documentation and coding. Before applying this information at your institution or practice site, YOU MUST CHECK WITH YOUR COMPLIANCE OFFICE or local Medicare Carrier to be sure these general principles are appropriate for your practice situation.

**How Confident are you??**

- **NOVICE-** 9921…WHAT???
- **BEGINNER-** I probably won’t go to jail.
- **ADVANCED-** throwing around the –25 modifier.
- **EXPERT-** come join me at the front, I may get tired.
Session Objectives

- Review Documentation requirements for Basic Outpatient Office Visits, including Annual Exams (Jeannine)
- Learn efficient documentation of Medical Decision Making (Jeannine)
- Provide access to ACP resources for coding (Brian)
- Leave time for Questions

On with the SHOW!

Basic Coding Rules and Regulations

Three Questions

- Is the patient new or established?
- What level of history, PE and Medical Decision Making (MDM) is (will be) recorded?
  - Corollary: Is this a problem-based or Annual Exam?
- What is the appropriate Service Code for the care documented?

New vs. Return

- A new patient has not received professional services from your group in the past 3 years
- Hospital = clinic
- Residents = Faculty = Physician extenders
- If established patient has not been seen in 3 years, bill them as New
Three Elements for E&M visits

- History
- Exam
- Decision Making

Elements for E&M visits

- History
  - CC
  - HPI
  - ROS
  - PFSH (past, family, social history)
- Exam
  - number of organ systems (1995 guidelines)
- Decision making
  - #diagnoses or management options
  - Amount of data/complexity
  - risk level to patient

New Patient - outpatient visit
3/3 needed

<table>
<thead>
<tr>
<th>CPT</th>
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<tr>
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<td>Moderate</td>
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Coding New Patient Visits

- Need 3 of 3 elements documented (history, exam, decision making)
- MDM and MEDICAL NECESSITY SHOULD DRIVE CODING

Return Patient - outpatient visit
2/3 needed

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</tr>
<tr>
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<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
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<td>Time</td>
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<td>15 min</td>
<td>25 min</td>
<td>40 min</td>
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</table>

Coding Return patient visits

- Only need 2 of 3 elements documented to meet level of service coded (History, PE, MDM)
- MDM and MEDICAL NECESSITY STILL DRIVE CODING
MDM and MEDICAL NECESSITY SHOULD DRIVE CODING

Documenting Medical Decision Making

The Real Meat of Internal Medicine

Medical Decision Making

• Number of diagnoses
  – Self-limited; established; new problem
  – Stable, worsening, additional testing planned
• Amount/complexity of data reviewed
  – Ordering tests, reviewing tests, obtaining record
• Overall risk of complications
  – See chart

Number of diagnoses

• Self-limited or minor: 1 pt each (2 max)
• Established problem, stable: 1 pt
• Established problem, worsening: 2 pts
• New problem, no add’l w/u: 3 pts
• New problem, with further w/u: 4 pts
• Complexity (and thus level of service)
  – Straight-forward=1; Low=2, moderate=3, high=4

Amount and complexity of data

• Review and/or order of clinical test: 1 pt
  – Basically all labs
• Review and/or order of radiology: 1 pt
• Review and/or order of medical test: 1 pt
  – Includes vaccines, eg, echo, pfts
• Discussion of test with performing MD: 1 pt
• Independent review of test: 2 pts
• Old records or hx from another person
  – Decision to do this: 1 pt
  – Doing it and summarizing: 2 pts

Overall Risk table

• Learn and Love the overall risk table
• 3 categories: presenting problem, dx procedures, management options
• Pearls:
  – Prescription drug management: moderate
  – 2+ stable chronic illness: moderate
  – Abrupt MS change: high
  – 1 chronic illness w/severe exacerbation: high
Overall Decision Making Table
need 2 of 3 elements to qualify for given level

<table>
<thead>
<tr>
<th>Level of MDM</th>
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<th>Moderate</th>
<th>High</th>
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<td>99214</td>
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<td># dx</td>
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<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Amt data</td>
<td>0 or 1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Overall risk</td>
<td>minimal</td>
<td>low</td>
<td>moderate</td>
<td>high</td>
</tr>
</tbody>
</table>

Case #1

- I did review labs with him. Glucose, lipids, HgA1c, PSA. Discussed generic prescriptions. Encouraged him to schedule PE with PCP.
- Assessment: 1. Type II DM 2. Depression 3. HTN 4. Reflux
- Plan: I refilled his medication, return as needed.

Case #1: MDM

- Presenting Problems: 3 chronic, stable (maybe 4th- reflux, but no specific documentation) 3 points-moderate
- Data: labs 1 point-straightforward (SF) 3 points-moderate
- Risk: prescription drugs: Moderate
- Overall: MODERATE
- From MDM perspective, 99214

Case #2: new patient

- Assessment: Dyspepsia. Possible HH as well, she also describes some spasming and I would wonder about delayed gastric emptying even.
- Plan: will try Prevacid twice daily as well as small dose reglan. Decide about referral to GI upon f/u. I did also refill her ativan for her anxiety. She will f/u with DG regarding lexapro and any further ativan refills.

Case #2: MDM

- Presenting Problems: 2 new, no w/u (dyspepsia and anxiety) 6 pts- High
- Data: hard to tell from note, possibly reviewed old records (stress echo) 0 or 2 pts-SF or Low
- Risk: prescription drugs: Moderate
- Overall MDM: MODERATE
- From MDM perspective: 99204
Pearls for documenting MDM

- Diagnosis
  - 1 new problem without w/u = level 4 diagnosis
  - 1 new problem with w/u = level 5 diagnosis
- Risk: Moderate Risk=level 4 visit
  - Prescription drugs
  - 1 chronic illness w/ progression or side effect of tx
  - 2+ stable illnesses
  - undiagnosed new problem

Elements for E&M visits

- History
  - CC
  - HPI
  - ROS
  - PFSH (past, family, social history)
- Exam
  - number of organ systems (1995 guidelines)
- Decision making
  - #diagnoses or management options
  - Amount of data/complexity
  - risk level to patient

Elements for E&M visits

- History
  - CC
  - HPI
  - ROS (14)
    - Constitutional-fever/wt
    - Eyes
    - Ears/nose/mouth/throat
    - CV
    - Respiratory
    - GI
    - GU
    - Musculoskeletal
    - Skin
    - Neurologic
    - Psychiatric
    - Endocrine
    - Heme/lymphatic
    - Allergic/immunologic
  - Past Medical History
  - Family history
  - Social history
**Pearls for documenting History**

- Can refer to previously documented elements: “problem list updated as part of today’s visit”
- “Complete ROS o/w negative”
- Taking history from someone other than the pt increases level of MDM
- Single bullets satisfy PFSH requirements—does not need to be exhaustive

**Pearls for documenting History**

- 1997 guidelines: An extended HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions
- For level 4 of 5 return visit, can document, “pt here to f/u HTN, DM, and rash”
- 4 HPI elements is most needed
- 10 ROS is most needed

**Elements for E&M visits**

- History
- Exam
  - # of organ systems (12)
    - Constitutional-VS, general appearance
    - Eyes
    - Ears, nose, mouth, throat
    - CV (incl edema)
    - Respiratory
    - GI
    - GU
    - Musculoskeletal
    - Skin
    - Neurologic
    - Psychiatric
    - Heme/lymph/immunologic

**Physical Exam**

- How many PE elements can you document before you “examine” the patient?
- 7  General appearance
  - Eyes- sclera anicteric/injected
  - HENT- hearing intact (hard of hearing)
  - MSK- normal gait/limping
  - Psych-normal (depressed/flat) affect
  - Skin-no rash on face, arms
  - Immunologic-NKDA (use for PMH or PE)

**Pearls for Documenting Exam**

- Notations such as “negative” or “normal” are sufficient to document normal findings related to unaffected body areas or asymptomatic organ systems
- HEENT-Normal: only counts as 1 organ system
Counseling

- When time spent counseling >50% of total visit, then TIME becomes the deciding factor for coding
- Total billing provider (residents don’t count) face to face time
- 99213:15 min  99214:25 minutes
- Must document time spent and reason for counseling

Counseling is:

“a discussion with the pt and/or family concerning one or more of the following areas” CPT book
- Recommended tests, diagnostic results, impressions
- Prognosis
- Risks/benefits of treatment (management) options
- Instructions for treatment (management) options and follow up
- Importance of compliance with treatment (management) options
- Risk factor reduction
- Patient and family education

Counseling Case

- CC: I’m here for a recheck of my back
- Pt is a lovely 78 yo white female with known long-time chronic back pain…sent to Dr S for consult…tried lyrica, did not tolerate…nerve block that did not take…one day took 75 mg tramadol…had visual hallucinations…took 1-2 days to resolve. She is mostly here to discuss her options, we are pretty much at the end of her options. Her daughter is here as well.
- PE: 4 organ systems documented
- A/P: Chronic back pain, Colon resection with colostomy

Counseling Case

- CPT billed: 99213
- Recommendation: If face to face time spent with patient 25 minutes or more, can bill 99214 (0.92 –1.42 wRVUs)
- Documentation must include: “I spent 25 minutes face to face with patient (and daughter). 15 minutes was spent counseling them regarding treatment options for patient’s chronic back pain.”

Preventative Service Visits

- NO Chief complaint or HPI
- MUST HAVE
  - Comprehensive ROS (10 organ systems)
  - Comprehensive or interval PMH, FH, SH
  - Comp. assessment of RF appropriate to age
  - Multi-system PE appropriate to age and RF
  - Assessment/Plan which includes counseling, anticipatory guidance and RF reduction

Preventative Service Visits

- New vs. Return rules are the same
- Coding based on age of patient
- NO specific guidelines for what to include with each age group
- Documentation of anticipatory guidance/RF reduction is the common missing element in my group (residents are frequent culprits)
- Can refer to previous ROS, PMH, FH, etc
Case #1

• Subjective: Pt sees DR for HTN, Lipids and DM. He ran out of meds and comes for refill. Labs drawn 12/07. He reports doing well on Lexapro 10mg. BP well controlled on Lisinopril 10mg and he is on lipitor 20 mg ½ tab. He denies acute sx including chills, fever, cough; no CP, tightness, wheeze, N, V, D. He did have URI over past week, but that is resolving.
• He tells me he was not prepared to do PE today, he plans to see DR.

Case #1

• CC: Med refill
• HPI: status 3 chronic illnesses level 4/5
• ROS: Gen/pulm/CV/GI 4
• PFSH: 1 History- 99214
• PE:none
• MDM: Moderate
• Overall code????

Case #2

• CC: F/U for Hiatal Hernia (actually New Pt to this practice)
• HPI: Pt is 41 yo female without PCP who will establish with JD and was placed on my schedule as she could not wait until January to be seen.
• She lost her baby in October after 2nd trimester missed AB. She had D&C, and is f/b NP in psych for post-partum depression. She started having problems with chest discomfort. She admits to significant anxiety. She had full cardiac w/u including stress echo, which was perfect. She is still having this chest discomfort. She describes it as a substernal gnawing pain. She sometimes will have a burning sensation. She does not really have any problems with burping. No bowel changes. No urinary sx. She does feel like her upper abd is bloated sometimes. She is taking Nexium and thought it helped a little bit. She was changed to Prevacid. There are no diet changes that have helped or aggravated the situation.
Case #2 PE

- VS: BP 110/68 HR 76
- GEN: A&O X3. Pleasant affect, NAD
- HEENT-Neg
- Neck-supple, normal ROM
- CV-RRR, no m,r,g
- Lung-clear
- Abd- tender in substernal region, no guarding, rebound, no masses, organomegaly
- Ext- no clubbing, cyanosis, edema

Case #2

- CC: Hiatal Hernia/Chest Pain
- HPI: 4 (location, quality, mod factors, assoc sx)
- ROS: 3 (psych, GI, GU) “Essentially negative”
- PFSH: 1 (PMH) History: 99203
- PE: 8 (Gen, Neuro, Psych, HEENT, MSK, CV, Pulm, GI)
- PE: 99204/05
- MDM: moderate
- Overall Code???

Case #2

- With minimal increase documentation, could be 99204
- Add SH, FH
- Add “10 organ ROS otherwise negative”
- Now this is 99204 (wRVU 1.34 -2.30)
- Can only capture new pt visit once- should maximize this opportunity as medical necessity allows

Point counting vs. building block approach

- Point counting
  - Retrospective
  - What level of billing is supported by my note?
  - the physician provides the service, completes the documentation, and then mentally processes the note through the coding scheme
  - counting points, circling boxes, and drawing lines through the coding grid to determine level of service.

Point counting vs. building block approach

- Building Block
  - Prospective
  - At what point in the composition of my note do I reach a given coding level?
  - The physician determines what level of service the situation requires and then mentally insures that the needed elements are performed and documented.
THANK YOU!!

Questions??
Case #1  Return Patient

Subjective: Pt sees DR for HTN, Lipids and DM. He ran out of meds and comes for refill. He did have labs drawn 12/07. He reports doing well on Lexapro 10mg. BP well controlled on Lisinopril 10mg and he is on lipitor 20 mg ½ tab. He denies acute sx including chills, fever, cough; no CP, tightness, wheeze, N, V, Diarrhea. He did have URI over past week, but that is resolving.

He tells me he was not prepared to do PE today, he plans to see DR.

I did review labs with him. His fasting glucose was 127 and creatine 0.9. His lipid panel is excellent with total cholesterol of 155 and LDL of 90. His HgA1C is 5.9%, which is down from previous visit of 5/07 of 6.1%. His PSA is 1.1. He did have a couple of questions regarding generic prescriptions. I encouraged him to schedule PE with PCP.

Assessment:
1. Type II DM
2. Depression
3. HTN
4. Reflux

Plan: I refilled his medications, return as needed.

Case #2  New Patient

CC: F/U for Hiatal Hernia

HPI: Pt is 41 yo female without PCP who will establish with JD and was placed on my schedule as she could not wait until January to be seen.

She lost her baby in October after 2nd trimester missed AB. She had D&C, and is f/b NP in psych for post-partum depression. She started having problems with chest discomfort. She admits to significant anxiety. She had full cardiac w/u including stress echo, which was perfect. She is still having this chest discomfort. She describes it as a substernal gnawing pain. She sometimes will have a burning sensation. She does not really have any problems with burping. No bowel changes. No urinary sx. She does feel like her upper abd is bloated sometimes. She is taking Nexium and thought it helped a little bit. She was changed to Prevacid. There are no diet changes that have helped or aggravated the situation.

PMH
1. Anxiety and Depression with Panic attacks
2. Recent Miscarriage

Current Meds
1. Lexapro 20mg ½ tablet daily
2. Nexium 40 mg daily
3. Ativan as needed
4. Naproxen as needed
5. Ambien as needed

Allergies: Doxyxycline
ROS: Essentially negative other than HPI.
Assessment: Dyspepsia. Possible HH as well, she also describes some spasming and I would wonder about delayed gastric emptying even.

Plan: will try Prevacid twice daily as well as small dose reglan. Decide about referral to GI upon f/u with new PCP. I did also refill her ativan for her anxiety. She will f/u with DG regarding lexapro and any further ativan refills.
### III. TABLE OF RISK

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedures Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>One self-limited or minor problem (rash or oral ulcers, cold, insect bites)</td>
<td>Lab tests requiring venipuncture, EKG/ECG, UA, Ultrasound</td>
<td>Rest, Splints, Superficial dressings</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Two or more self-limited or minor problems or symptoms</td>
<td>MRIC/T, PFT’s, MRIC/T, PFT’s, MRI/CT, PFT’s, Ultrasound</td>
<td>IV fluids w/o additives, Minor surgery w/ no identified risk factors, PT/OT, OTC drugs</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>One or more chronic illness w/ mild exacerbation, progression, or side effect of treatment</td>
<td>Diagnostic endoscopies with no identified risk factors, Diagnostic endoscopies with no identified risk factors</td>
<td>Electrolyte therapy, IV fluids, Intensive monitoring for side effects, Intensive monitoring for side effects</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>One or more chronic illnesses w/ severe exacerbation, progression, or side effects of tx</td>
<td>Cardiac EP tests, Cardiac EP tests, Cardiac EP tests, Discography</td>
<td>Cardiac EP tests, Cardiac EP tests, Cardiac EP tests, Cardiac EP tests</td>
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</tbody>
</table>

**The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s) or management options) determines the overall risk.**

**To qualify for a given type of decision making, two of the three elements in the table must be either met or exceeded:**

<table>
<thead>
<tr>
<th>Type of Decision Making:</th>
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<td>4 (+)</td>
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<td>High</td>
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