Compliant EM Coding and Documentation
doing it right the first time

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The Coding Educator

For 20 years I've approached consulting with a simple purpose - help providers convert their work into maximum compliant revenue.
WEBSITES

Joel S. Duhl, Inc.
Sherry Taylor - MD Messages
Amy Fouts, Esquire
Kevin Little, Esquire
Dr. Troy - Smart House Calls
CMS Provider Manual
CMS Preventive Manual
Discussion Points

• **E and M Coding for:**
  - Office Visits
    - New Patient Visits
    - Established Patient Visits
  - Modifiers
    - E/M Only
      - 24 unrelated in global
      - 25 minor surgery
      - 57 major surgery
  - Preventive Services (CMS and Commercial)
    - IPPE
    - AWV
Code Selection

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. 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. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.
A Work on “Cloning”

Cloning occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment. This “cloned documentation” does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information.
Outpatient EM Services
Outpatient Visit

New / Consults

99201 - 99245

“Requires All Three Key Elements”
New Patients – Think:

- **99202** – No treatment
- **99203** – Short term meds, OTC, minor surgery
- **99204** – Long term meds, major surgery
- **99205** – Sick enough to admit / major surgery with risks / extensive data

Also check grid to make sure you document correct history and examination!!
Initial Visits

New Outpatient

<table>
<thead>
<tr>
<th>Code</th>
<th>Peer Data</th>
<th>Dr. Gotcha</th>
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<tbody>
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<td>1%</td>
<td>4%</td>
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<td>5%</td>
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<td>99203</td>
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<td>54%</td>
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<tr>
<td>99205</td>
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<td>6%</td>
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Dr. Gotcha
<table>
<thead>
<tr>
<th>Code</th>
<th>Minutes</th>
<th>History</th>
<th>Examination</th>
<th>Decision-Making</th>
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<tbody>
<tr>
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<td>Problem Focused</td>
<td>Problem Focused</td>
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<tr>
<td></td>
<td></td>
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<tr>
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<td>Data – Minimal or None</td>
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<tr>
<td>99251</td>
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<td>Risk – Minimal</td>
</tr>
<tr>
<td>99202</td>
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<td>Exp. Problem Focused</td>
<td></td>
<td>Straightforward</td>
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<tr>
<td></td>
<td></td>
<td>CC 1 HPI 1 ROS</td>
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<tr>
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<td>Risk – Minimal</td>
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<tr>
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</tr>
<tr>
<td></td>
<td></td>
<td>CC 4 HPI or status of 3 chronic conditions 2 ROS Medical or Family or Social History</td>
<td>1995 – (4-7 – need 4x4) 1997 – (12 checks)</td>
<td>Diagnosis – Limited</td>
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<td></td>
<td></td>
<td>Data – Limited</td>
</tr>
<tr>
<td>99253</td>
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<td>Risk – Low</td>
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<tr>
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<td>Moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CC 4 HPI or status of 3 chronic conditions 10 ROS Medical, Family, Social History</td>
<td>1992 – (8) 1997 – (2 checks from 9 areas); or 1997(all checks in border &amp; 1 check in others)</td>
<td>Diagnosis – Multiple</td>
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<td></td>
<td>Risk – Moderate</td>
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<td>99205</td>
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<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CC 4 HPI or status of 3 chronic conditions 10 ROS Medical, Family, Social History</td>
<td>1995 – (8) 1997 – (2 checks from 9 areas); or 1997(all checks in border &amp; 1 check in others)</td>
<td>Diagnosis – Extensive</td>
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<tr>
<td>99245</td>
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<td></td>
<td></td>
<td>Data – Extensive</td>
</tr>
<tr>
<td>99255</td>
<td>110</td>
<td></td>
<td></td>
<td>Risk – High</td>
</tr>
</tbody>
</table>
Importance of History

• **Medical necessity** of an Evaluation and Management (E/M) encounter is often visualized only when **viewed through the prism of its characteristics captured in specific History of Present Illness (HPI) elements.**

• Staff can do the past medical history, family history, social history but **we expect the provider to do the chief complaint in the history of present illness.**
Normal and Negative

For the examine and the review of system(s) related to the presenting problem - do not describe as "normal" or "negative."
1. **Const**: Vital signs listed above. Well developed, well nourished and in no acute distress. Alert and oriented X’s 3. No mood disorders noted, calm affect.

2. **Eyes**: Sclera white, conjunctiva clear, lids are without lag. PERRLA. Pupils and irises are equal and round without defect.

3. **ENT**: TMs intact and clear, normal canals, grossly normal hearing. Oropharanx clear and moist without erythema. Gums pink, good dentition.

4. **Lymph/Neck**: No masses, thyromegaly, or abnormal cervical notes. No bruit. Tracheal midline.

5. **Cardio**: RRR, Normal S1, S2 w/o murmurs, rubs or gallops. Skin warm and dry. No peripheral edema.

6. **Respiratory**: Chest symmetrical, respirations non-labored. No dullness or flatness. Clear bilaterally to auscultation, non-tender to palpitation.

7. **Musculo**: No deformity or scoliosis noted. No frank gait disturbance noted. No cyanosis or edema. Pulses normal in all 4 extremities. No atrophy or abnormal movements. Appropriate muscle strength bilaterally.

8. **Neurologic**: No focal deficits, cranial nerves II-XII grossly intact with normal sensation, reflexes, coordination, muscle strength and tone.

9. **GI/Abdomen**: Soft, non tender, non distended, no hepatosplemomegaly, normal bowel sounds, no masses noted.
Expanded vs. Extended

• The difference is not the number of systems examined. Two to seven systems are required for both examinations.
• The difference is the **detail** in which the examined systems are described.
1995 – Detailed 4-7 (4x4)

1. **Const:** Vital signs listed above. Well developed, well nourished and in no acute distress. Alert and oriented X’s 3. No mood disorders noted, calm affect.

2. **Eyes:** Sclera white, conjunctiva clear, lids are without lag. PERRLA. Pupils and irises are equal and round without defect.

3. **ENT:** TMs intact and clear, normal canals, grossly normal hearing. Oropharanx clear and moist without erythema. Gums pink, good dentition.

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1997 “Bullet Guidelines”

• Allow you to document systems and areas, however you have to be very specific about what you document about those systems and areas.

• Most EMRs are based on the 1997 guidelines but are not compliant
<table>
<thead>
<tr>
<th>Multi-System</th>
</tr>
</thead>
</table>

**Const:**
- Well developed, well nourished, no acute distress.

**Eyes:**
- Sclera white, conjunctiva clear. Lids are without lag. PERRLA. Discs flat, no hemorrhages or exudates noted.

**Ears:**
- No scars, lesions, or masses;
- Tympanic membranes translucent, non-bulging and mobile. Canal walls pink, without discharge.
- Hearing non-impaired.

**Nose:**
- Mucosa and turbinates pink, septum midline.

**Mouth:**
- Lips pink and symmetrical, gums pink, good dentition.

**Throat:**

**Neck:**
- Full ROM, midline tracheal position.
- No thyromegaly.

**Resp.:**
- Respiration non-laborated.
- Lung fields. No flatness, dullness or hyperresonance.
- Tactile fremitus not diminished.
- Clear to auscultation bilaterally.

**Documentation Guidelines are in Blue Type**

- General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
- Inspection of conjunctivae and lids
- Examination of pupils and irises (eg, reaction to light and accommodation, size and symmetry)
- Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
- External inspection of ears and nose (eg, overall appearance, scars, lesions, masses)
- Otoscopic examination of external auditory canals and tympanic membranes
- Assessment of hearing (eg, whispered voice, finger rub, tuning fork)
- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
- Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of thyroid (eg, enlargement, tenderness, mass)
- Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Percussion of chest (eg, dullness, flatness, hyperresonance)
- Palpation of chest (eg, tactile fremitus)
- Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
## Single System

<table>
<thead>
<tr>
<th>ENT:</th>
<th>Palate and gums pink, good dentition.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mucosa moist, no pallor or cyanosis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NECK:</th>
<th>No JVD.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No thyromegaly or tenderness.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESP:</th>
<th>Respiration non-labor.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clear to auscultation bilaterally.</td>
</tr>
</tbody>
</table>

| CARD: | No lifts, heaves, or thrills felt on palpation. S1 and S2; |
|      | RRR, no murmurs-rubs-gallops. |
|      | No Bruits throughout: |
|      | Carotic arteries, |
|      | Abdominal aorta, |
|      | Femoral arteries. |
|      | Pedal pulses +2 throughout. |
|      | No edema, no varicosities. |

| Inspection of teeth, gums and palate |
| Inspection of oral mucosa with notation of presence of pallor or cyanosis |

| Examination of Jugular veins (eg, distension; a, v or cannon a waves) |
| Examination of thyroid (eg, enlargement, tenderness, mass) |

| Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) |
| Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs) |

| Palpation of heart (eg, location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) |
| Auscultation of heart including sounds, abnormal sounds and murmurs |

### Examination of:
- Carotic arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay)
- Abdominal aorta (eg, size, bruits)
- Femoral arteries (eg, pulse amplitude, bruits)
- Pedal pulses (eg, pulse amplitude)
- Extremities for peripheral edema and/or varicosities

<table>
<thead>
<tr>
<th>ABDOMEN:</th>
<th>No palpable masses, no tenderness.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Liver and spleen non-tender.</td>
</tr>
<tr>
<td></td>
<td>Hemocult negative.</td>
</tr>
</tbody>
</table>

| Examination of abdomen with notation of presence of masses or tenderness |
| Examination of liver and spleen |
| Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy |

<table>
<thead>
<tr>
<th>MUSCULO:</th>
<th>Erect, without scoliosis, or kyphosis.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gait smooth and balanced. Able to undergo tests involving exercise.</td>
</tr>
<tr>
<td></td>
<td>No atrophy or weakness.</td>
</tr>
</tbody>
</table>

| Examination of the back with notation of kyphosis or scoliosis |
| Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs |
| Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements |
1997 Guidelines – Not Correct

• **EYES:** [ ] Sclera white, [ ] conjunctive clear. Lids are without lag. [ ] PERRLA.

• **ENT:** [ ] Tympanic membranes translucent, non-bulging and mobile. [ ] Canal walls pink, without discharge. [ ] Mucosa and turbinates pink, septum midline. [ ] Lips pink [ ] Lips symmetric.

• This would be 8 bullets and not compliant
1997 Guidelines - Correct

- **EYES:** [ ] Sclera white, conjunctive clear. Lids are without lag. [ ] PERRLA.

- **ENT:** [ ] Tympanic membranes translucent, non-bulging and mobile. Canal walls pink, without discharge. [ ] Mucosa and turbinates pink, septum midline. [ ] Lips pink / symmetric.

- This would be 5 bullets and compliant
What To Do

• I’ll have a copy of those guidelines posted on my web site and I’ll give you a link on medicalofficeblog.com

• Make sure that you are only getting credit for what the government says you get credit for documenting.

• THIS IS A CRITICAL COMPONENT OF YOUR EMR COMPLIANCE
## Codes That Are High MDM

<table>
<thead>
<tr>
<th>Codes</th>
<th>Cardiovascular imaging studies with contrast with identified risk factors</th>
<th>Elective major surgery (open, percutaneous or endoscopic) with identified risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 or more chronic illnesses w/ severe exacerbation, progression, side effects of treatment</td>
<td>Cardiac electrophysiological tests</td>
<td>Emergency major surgery (open, percutaneous or endoscopic)</td>
</tr>
<tr>
<td>Acute or chronic illnesses or injuries that pose a threat to life or bodily function (eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/ potential threat to self or others, peritonitis, acute renal failure)</td>
<td>Diagnostic endoscopies with identified risk factors</td>
<td>Parenteral controlled substances</td>
</tr>
<tr>
<td>Abrupt change in neurologic status (eg, seizure, TIA, weakness, or sensory loss)</td>
<td>Discography</td>
<td>Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>

## Remember High Risk & 4 Points

**OR**

4 Data and 4 Dx Points
# Codes That Are High MDM

## Calculation of Data Points

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review and/or order of clinical lab tests</td>
<td>(80000)</td>
</tr>
<tr>
<td>1</td>
<td>Review and/or order tests in radiology section of CPT</td>
<td>(70000)</td>
</tr>
<tr>
<td>1</td>
<td>Review and/or order tests in medicine section of CPT</td>
<td>(90000)</td>
</tr>
<tr>
<td>1</td>
<td>Discussion of tests results w/performing physician</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Independent review of image, tracing or specimen</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Decision to obtain old records/history from someone other than patient</td>
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</tr>
<tr>
<td>2</td>
<td>Relevant findings from review of old records</td>
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</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
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## Calculation of Diagnosis Points

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<th>Description</th>
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<tr>
<td>1</td>
<td>Self-limited – Max of 2</td>
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</tr>
<tr>
<td>1</td>
<td>Established Stable</td>
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</tr>
<tr>
<td>2</td>
<td>Established Worsening</td>
<td></td>
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<tr>
<td>3</td>
<td>New - No Workup – Max of 1</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>New - With Workup</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
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</table>
New Patients – Think:

- **99202** – No treatment
- **99203** – Short term meds, OTC, minor surgery
- **99204** – Long term meds, major surgery
- **99205** – Sick enough to admit / major surgery with risks / extensive data

Also check grid to make sure you document correct history and examination!!
Established Patients

I’m inbred!
Outpatient Visit

Established Patient

99211 - 99215

“Requires Two of Three Key Elements”
• When selecting an EM code based on time counseling, (in the office) - which element is not required in your documentation?

A. Your total face-to-face time  
B. Staff face-to-face time  
C. That greater than 50% was counseling  
D. Detail on topics you discussed

Answer: B
Established Patients – Think:

- **99212** – One stable condition
- **99213** – Two stable or one unstable problem
- **99214**:  
  - 3 chronic stable on meds  
  - 2 unstable on meds  
  - 1 stable and one unstable on meds
- **99215** – Sick enough to admit/extensive dx with risk or data

Also check grid to make sure you document correct history and examination or counseling time!!
Established Visits

Established Outpatient

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<td>43%</td>
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<td>99214</td>
<td>41%</td>
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<td>Visit Type</td>
<td>Duration</td>
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<tr>
<td>------------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99212</td>
<td>Problem Focused</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>Exp. Problem Focused</td>
<td>15</td>
</tr>
<tr>
<td>99214</td>
<td>Detailed</td>
<td>25</td>
</tr>
<tr>
<td>99215</td>
<td>Comprehensive</td>
<td>40</td>
</tr>
</tbody>
</table>
Counseling Dominated

3 standard criteria for time:

1. Total Face-to-Face time of provider
2. That more than 50% was counseling
3. Topics you discussed

“If the level of care is being based on time spent with the patient for counseling/coordination of care documentation should support the time for the visit and the documentation must support in sufficient detail the nature of the counseling”
Established Patients – Think:

- **99212** – One stable condition
- **99213** – Two stable or one unstable problem
- **99214**:  
  - 3 chronic stable on meds  
  - 2 unstable on meds  
  - 1 stable and one unstable on meds
- **99215** – Sick enough to admit/extensive dx with risk or data

Also check grid to make sure you document correct history and examination or counseling time!!
Diagnosis Codes
Use of Accident Dx Codes

ICD-9
Any ICD-9 Code starting with an 8 or a 9 requires the following:
• Date of Injury
• Place of Injury

ICD-10
Any ICD-10 starting with an S or T will require:
• Date of Injury
• Cause
• Place
• Activity
• External Employment Statue
Modifiers
Global Period

- **0-10 days** = minor (-25 on E&M)
- **90 days** = major actually 92 days (-57 on E&M)
- **MMM** = maternity codes
- **XXX** = global concept doesn’t apply (x-ray/lab)
- **YYY** = up to carrier (unlisted codes)
- **ZZZ** = always included in global of another service (add on codes)
E&M Only Modifiers

- 24 – Unrelated E&M
- 25 – E&M and minor surgery same day
- 57 – E&M day before or day of major surgery

Use of the 25 modifier means the procedure note is separate from the E&M note
Surgery Only Modifiers

- 58 – Anticipated at time of initial procedure
- 78 – Related to initial procedure
- 79 – Unrelated to initial procedure

Use of the 78 modifier means the second procedure will be reduced
E&M and Minor Surgery

78 y/o woman presents to physicians office to have her HTN and DM addressed. She also complains of having several skin tags on her neck. The physician addresses the HTN and DM and removes 5 skin tags from the right side of her neck. During her exam, the provider notices that her DM is uncontrolled and the patient is scheduled for a follow-up appointment the following week:

A. 99214-25, 11200
B. 11200
C. 99214, 11200-25
D. 99214-57, 11200-25
E&M in Global

One week later the patient returns for follow-up visit for his elevated BP and to have the skin tag sites examined. During the visit the patient asks to have a brown lesion on their right arm examined. The physician documents the exam and changes the BP medicine and then destroys a pre-malignant lesion on the patient’s right forearm. Code for the second visit:

A. 99213-24-25, 17000
B. 99213-24,25, 17000-79
C. 17000
D. 99213-25, 17000-51
Preventive

Z00.01  
Well Exam with abnormal findings

I13.2  
HTN Heart with Heart Failure & CKD Stage 5

I50.9  
Heart Failure

N18.5  
CKD Stage 5

Z72.0  
Current Smoker
IPPE- Welcome to Medicare

1. Review Medical and Social History.
2. Review Risk Factors for Depression and Mood Disorders.
4. Height, Weight, BP, VA, BMI.
5. End-of-life Planning If Needed
6. Education, Counseling and Referrals Based on Above
7. Education, Counseling, and Referrals for Other Listed Services
1. Health Risk Assessment
2. Establishment of an individual's medical and family history.
3. Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.
4. Measurement of an individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the individual's medical and family history.
5. Detection of any cognitive impairment that the individual may have.
6. Review of the individual's potential (risk factors) for depression, Review of the individual's functional ability and level of safety, based on direct observation.
7. Review of the individual's functional ability and level of safety, based on direct observation
8. Establishment of the following:
   ++ A written screening schedule, such as a checklist, for the next 5 to 10 years
   ++ A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended.
9. Furnishing of personalized health advice to the individual and a referral, as appropriate.
10. Any other element determined appropriate through the National Coverage Determination process.
1. Health Risk Assessment
2. An update of the individual's medical and family history.
3. An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing personalized prevention plan services.
4. Measurement of an individual's weight (or waist circumference), blood pressure, and other routine measurements as deemed appropriate, based on the individual's medical and family history.
5. Detection of any cognitive impairment, as that term is defined in this section, that the individual may have.
6. An update to both of the following:
   ++ The written screening schedule for the individual as that schedule was developed at the first AWV providing personalized prevention plan services. CMS-1503-FC 761
   ++ The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual as that list was developed at the first AWV providing personalized prevention plan services.
7. Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs as that advice and related services are defined in paragraph (a) of this section.
8. Any other element determined through the NCD process.
Breast / Pelvic Exam

The HCPCS Code:
• G0101 – Pelvic and Breast Exam

The Diagnosis Codes
V72.31
Routine gynecological exam
V76.47
Screening for neoplasm of the vagina
V76.49
Screening of woman without a cervix
V76.2
Screening for neoplasm of cervix
V15.89* - Every Year
Presenting health hazards
Four Questions

CERVICAL CANCER HIGH RISK SURVEY

Was your first sexual activity prior to the age of 16?  □ Yes  □ No

Have you had more than 5 sexual partners?  □ Yes  □ No

Do you have a history of sexually transmitted disease (including HIV) infection?  □ Yes  □ No

Have you had fewer than 3 negative pap smears within the previous seven years?  □ Yes  □ No
Exam Required

Female G/U: (7 of the following 11)

☐ Breasts symmetrical. No masses, lumps, tenderness, dimpling or nipple discharge.

☐ Rectal exam exhibits even sphincter tone, no hemorrhoids or masses.

Pelvic

☐ No external lesions. Normal hair distribution.

☐ Urethral meatus pink, no lesions or discharge.

☐ Urethra intact, no tenderness, masses, inflammation or discharge.

☐ Bladder without tenderness or masses, no incontinence.

☐ Vaginal mucosa moist and pink, without lesions or discharge.

☐ Cervix pink, no lesions, odor, or discharge.

☐ Uterus midline, non-tender, firm and smooth.

☐ No adnexal masses, nodules or tenderness.

☐ Anus and perineum intact. ___ No lesions, rashes, fissures, fistulas or external hemorrhoids.

Wet Prep __________________________ Hemoccult Pos. Neg.
Obtain Pap Smear

The HCPCS Code:
• Q0091 - Obtaining screen pap smear

The Diagnosis Codes
V72.31
Routine gynecological exam
V76.47
Screening for neoplasm of the vagina
V76.49
Screening of woman without a cervix
V76.2
Screening for neoplasm of cervix
V15.89* - Every Year
Presenting health hazards
What Say You?

• G0438 (Tobacco cessation counseling) is billable in what place of service (8 times per year, per patient)?

A. Office  
B. Hospital  
C. Nursing Home  
D. All above  

Answer: D
Tobacco Cessation Codes

The CPT Codes:

- **99406**: Smoking and tobacco cessation counseling; intermediate, greater than 3 minutes, up to 10 minutes,
- **99407**: Smoking and tobacco cessation counseling; intensive, greater than 10 minutes,

The Diagnosis Codes

- Medical dx of the patient at the time of the visit the tobacco is affecting
- If used with E/M, don’t forget modifier 25
New Tobacco Cessation Codes

The HCPCS Codes:

• **G0436**: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes,

• **G0437**: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes,

The Diagnosis Codes

• ICD-9 code 305.1 (non-dependent tobacco use disorder), or
• ICD-9 code V15.82 (history of tobacco use).
TCM

• **99495 Transitional Care Management Services with the following required elements:**
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
  - Medical decision making of at least moderate complexity during the service period.
  - Face-to-face visit, within 14 calendar days of discharge.

• **99496 Transitional Care Management Services with the following required elements:**
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
  - Medical decision making of high complexity during the service period.
  - Face-to-face visit, within 7 calendar days of discharge.
CCM

• 99460 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month requiring he following:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - A comprehensive care plan established, implemented, revised, or monitored
CCM will include:

1. Communication with patient, family, community services
2. Collection of outcomes data
3. Education
4. Assessment and Support
5. Facilitating access to care
6. Development of Comprehensive Plan of Care
7. Ongoing review of patient’s status
8. Development, communication and maintenance of a comprehensive care plan
CCM will be provided by an office that has:

9. 24/7 access to providers
10. Continuity of care and appointments
11. Timely follow-up from ER or hospital discharge – TCM Services
12. Utilizes an EMR
13. Identify, thru EMR who is eligible
14. have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner.
15. Use a form and format in the medical record that is standardized within the practice
16. Patient has to agree to receive CCM services
A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It’s a comprehensive plan of care for all health problems. It normally includes:

1. Problem list
2. Expected outcome and prognosis
3. Measurable treatment goals
4. Symptom management
5. Planned interventions
6. Medication management
7. Community/social services ordered
8. How the services of agencies will be connected to the patient
9. Identification of who is responsible for what issues
Discussion Points

• **E and M Coding for:**
  - Office Visits
    • New Patient Visits
    • Established Patient Visits

• **Modifiers**
  - E/M Only
    • 24 unrelated in global
    • 25 minor surgery
    • 57 major surgery

• **Preventive Services (CMS and Commercial)**
  • IPPE
  • AWV
Any Questions

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Questions?

One, two, three, BREATHE

He’s dead, Jim