Basic E&M Coding

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Terminology

- **CPT** = Current Procedural Terminology, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other qualified health care professionals.

- It is helpful to have a uniform language for medical education, medical care review, outcomes and quality research, as well as claims processing

- It is updated and published annually by the American Medical Association

CPT Codes

- Evaluation and Management Codes (E/M Codes)
  - Defines the Level of Service (LOS) for the visit
  - Office visit codes
  - Consult codes
  - Medicare specific codes (G codes)
- Procedure codes
  - For each procedure performed
- Modifiers
  - Used to indicate preventive services, separate identifiable services, multiple services

CPT Codes

- Each level of service and procedure is assigned a CPT code
- Some CPT codes include or supercede other codes as certain services are included in the master code.
- For example
  - Repair of a wound includes anesthesia, cleaning, and repair of the wound.
  - Excision of a skin lesion includes anesthesia, collection of specimen to send to pathology, and closure (suturing) of the defect

Relative Value Units

CPT codes are associated with work units that determine the “value” of the services provided.

Relative Value Units (RVUs) are comprised of 3 components:

- Work RVUs – wRVUs account for the physician’s knowledge and expertise in performing the service
- Technical/Facility RVUs – account for the equipment needed, the cost of providing the space, supplies and staff to perform the service
- Malpractice RVUs – account for the liability involved

Diagnosis Codes

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization(WHO).

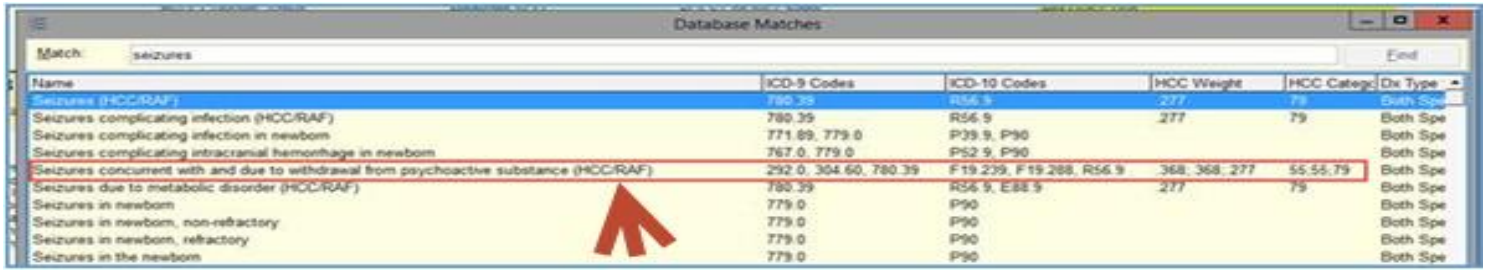
It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

It serves to catalogue health conditions by categories of similar diseases under which more specific conditions are listed.

It remains current until January 1, 2022, when it will be replaced by ICD-11.

The **Importance** of Visit Diagnoses Codes For Every Encounter

- To support and demonstrate medical necessity and to ensure reimbursement from insurance carriers (specifically for procedures)
- To ensure a higher risk adjusted formula (RAF) score, which helps optimize revenue from Medicare products (applies to Evaluation & Management (E/M) codes and procedures)



- Important for all payors – associated with quality outcomes data (identifies how sick the patient is)
- Be sure to document your assessment of the chronic conditions during the encounter and link those conditions to the Evaluation and Management (E/M) Services provided in an outpatient setting.

Billing Document

Complexity of Decision Making

- Time spent (if relevant)
- Labs Reviewed
- EKG Reviewed
- X-ray Reviewed
- Outside source of information – paper records, Care Everywhere, etc.
- Records Reviewed – consultants notes, hospital records

New Patient vs Established Patient

- **New patient**
  - If has not been seen by anyone in the clinic/department within the past 36 months
  - Even if seen elsewhere at UCLA but not in UFHC within 3 years
- **Established patient**
  - If seen by anyone in UFHC, including inpatient care provided by a UFHC physician/provider within the last 36 months

Preventive Services CPT Codes

- Review of medical history (Problems, PMH, PSH, Family Hx, Allergies, Meds)
- Age based physical exam focused on preventive services
- Age based screening:
  - Cancer screening (breast, cervical, colon, prostate)
  - Cardiovascular screening (lipids)
  - Diabetes screening (glucose, hemoglobin A1c)
  - STI screening (HIV, HCV, etc.)
  - Vision screening and audiometry for peds; (also part of Medicare Wellness visit)
- Preventive Services:
  - Immunizations
  - Counseling (obesity, exercise, smoking avoidance, drug/alcohol use, gun exposure, etc.)

Preventive Visit Codes

Age based, New vs Established Patient

Established Patient		New Patient
99391	< 1 year	99381
99392	1 – 4 years	99382
99393	5 – 11 years	99383
99394	12 – 17 years	99384
99395	18 – 39 years	99385
99396	40 – 64 years	99386
99397	65+ years	99387

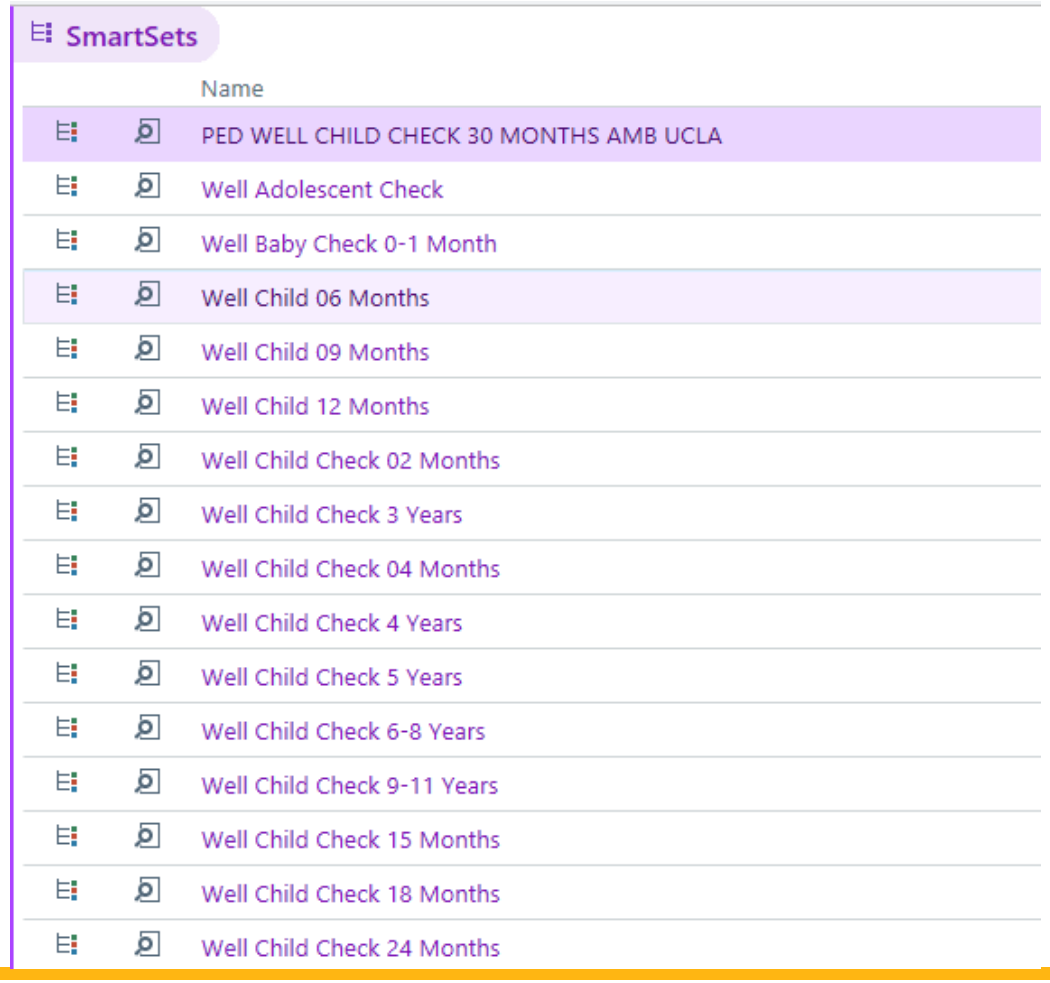
Additional CPT for Preventive Services

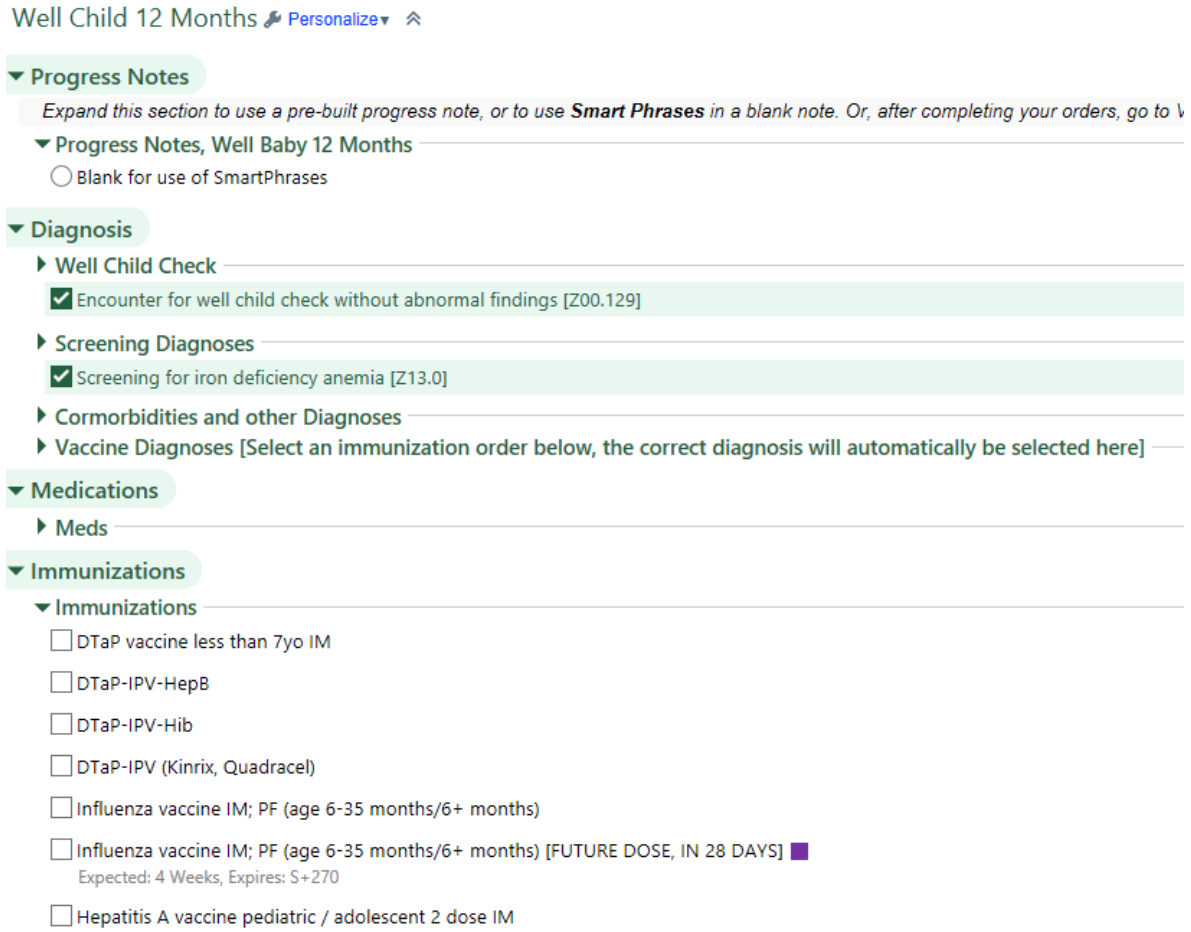
- The Preventive Service CPT code covers the history and physical examination and basic counseling
- In depth counseling may be covered with additional codes (such as smoking cessation counseling)
- Additional CPT codes apply for screening instruments:
  - Visual Acuity
  - Audiometry
  - PHQ-9 – Patient Health Questionnaire - 9
  - GAD-7 - Generalized Anxiety Disorder – 7
  - M-CHAT – Modified Checklist for Autism in Toddlers
  - PSC-Y – Pediatric Symptoms Checklist - Y
  - EPDS - Edinburgh Post-Natal Depression Screen
  - AUDIT-C – Alcohol Use Disorders Identification Test
  - DAST – Drug Screening Questionnaire
- Vaccine Administration and Counseling codes also apply

Preventive Care - Use the SmartSet

- Well Child Visits SmartSet:
  - Includes the additional age-based screening tools/codes
  - Provides after-visit counseling information
  - Includes the age-appropriate vaccines and counseling
  - Includes age appropriate history and physical exam tools
- Adult Male and Female Preventive Visit (CPE) SmartSets:
  - Sex based screening
- Medicare Wellness Visit SmartSet:
  - Includes Medicare specific coding

Well Child SmartSet





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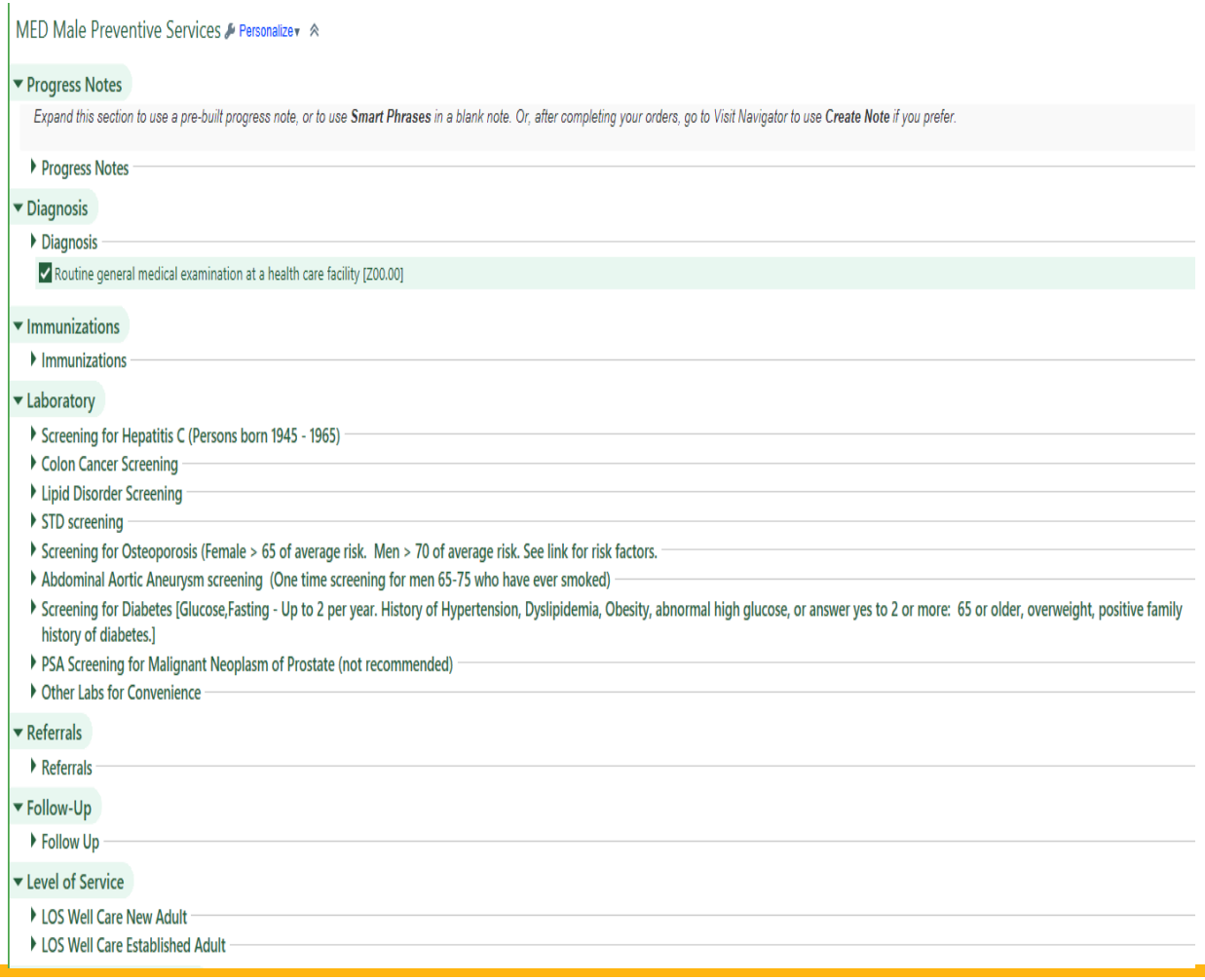
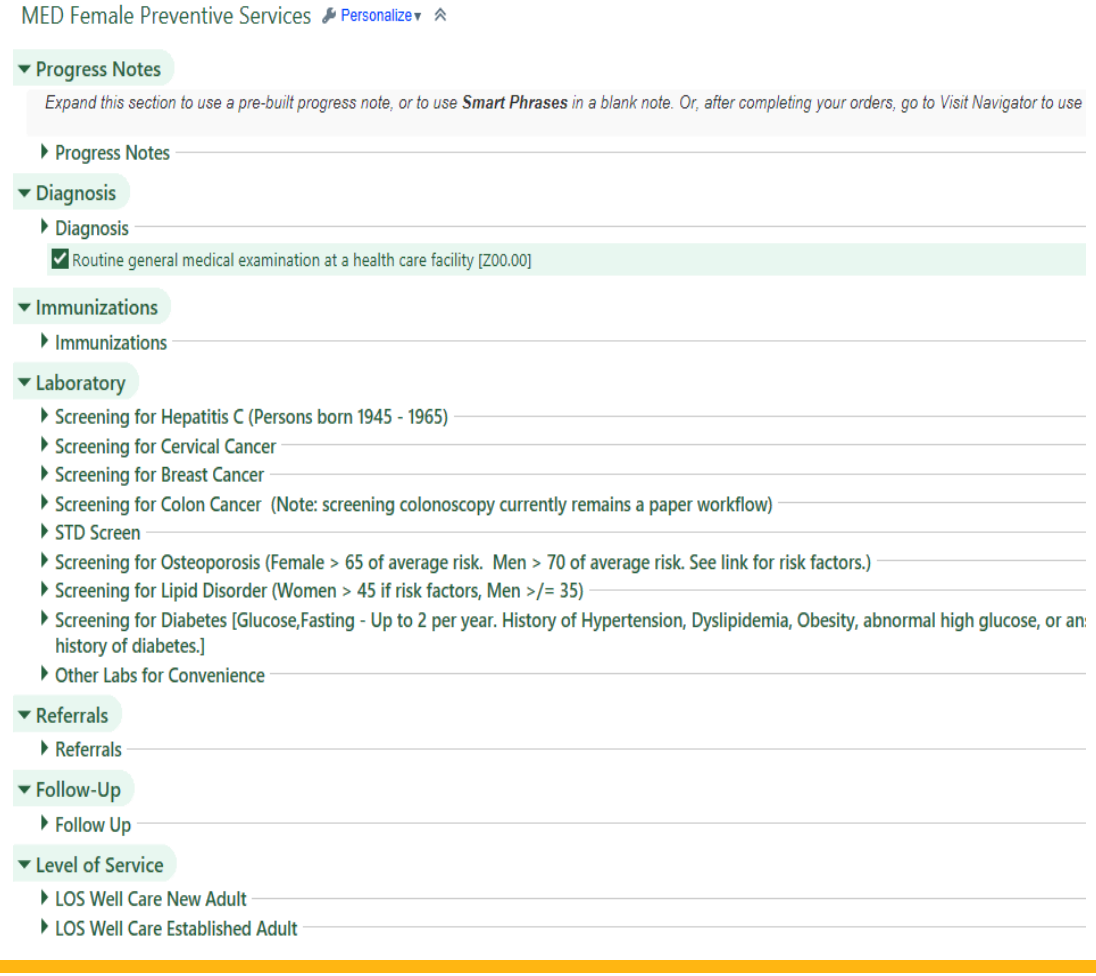
Well Adult Male or Female Preventive Exam (CPE)





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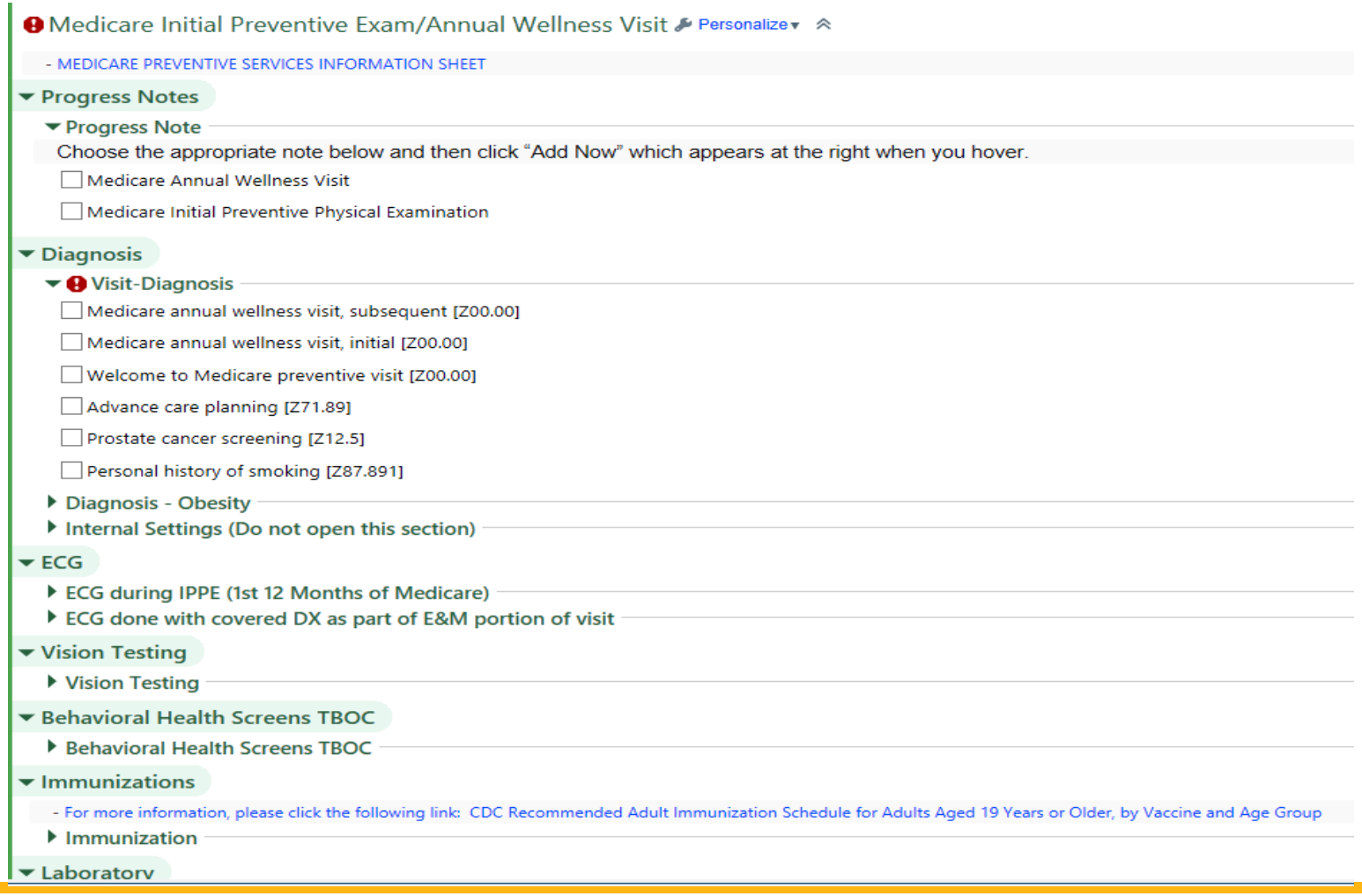
Medicare Wellness Exam/Visits (IPPE, MWVs)



Problem based vs Preventive Care E/M codes

Problem (non-Preventive) Visit Codes

Established Patient	New Patient
99211 – MA/Nurse visit	99201
99212	99202
99213	99203
99214	99204
99215	99205

Determining Level of Service

A. Based on Components of the Visit/Encounter:

- History
- Physical Exam
- Medical Decision Making
  - New Patients require documentation requirements met for all 3 Components
  - Existing Patients only require documentation met for 2 of the 3 Components
    - One of the 3 should be Medical Decision Making

B. Based on Time

- Certain codes are “time based” and the time is specified in the description
- No difference for New or Existing patient

Time Based Codes

- Need to Specify the amount of time in the note
  - Example: Alcohol and/or substance abuse Screening and Brief Intervention:
    - CPT 99408: 15 to 30 minutes
  - Documentation: 25 minutes was spent evaluating the patient and counseling the patient on alcohol cessation
  - May code as long as meet minimum requirements (example – 15 mins.)
- "Mid-point Rule" requires that once you cross the mid-point of the time identified you have met the requirements.
  - CPT Code 99497- **Advance care planning** including the explanation and discussion of advance directives such as standard forms by the physician; **first 30 minutes**, face-to-face with the patient, family member(s), and/or surrogate
    - If **16 minutes** is spent then you have met the requirements to code (**crossed the mid-point**)

Office E / M Codes

- 99201 – New patient with a Simple, Very Limited Problem
  - Rarely used. Someone visiting needs a negative PPD interpreted/read
- 99211 – MA visit only (physician does not interact with patient at visit)
  - Patient follows up for measurement of blood pressure or weight ordered by physician
  - Patient follows up for LVN to instruct on use of home monitoring device (glucometer)
- 99212 – Simple, Limited Problem
  - Healthy young patient with no comorbid conditions with a simple “cold” (URI)
    - No differential diagnosis considerations for sinusitis, pneumonia, bronchitis
  - Patient presenting for a wound check; repair done in ED and is following up w/PCP

99213

The documentation for this encounter requires **TWO** out of **THREE** of the following:

1. Expanded Problem Focused History
2. Expanded Problem Focused Exam
3. Low Complexity Medical Decision Making

Or, 15 minutes spent face-to-face with the patient if coding based on time. The appropriate documentation must be included.

- 1 or 2 stable chronic problems
- 1 acute, uncomplicated, new problem
- 2 minor problems

99214

The documentation for this encounter requires **TWO** out of **THREE** of the following:

1. Detailed History
2. Detailed Exam
3. Moderate Complexity Medical Decision Making

Or, 25 minutes spent face-to-face with the patient if coding based on time. The appropriate documentation must be included.

- 3+ stable chronic problems
- 1 stable and 1 worsening problem *(it is important to indicate that it is worsening or unstable)*
- 1 new problem with a differential diagnosis
- 1 new acute complicated problem (could result in hospitalization)
- Initiation of a new treatment regimen

99214 vs 99215

KEY COMPONENTS (2 OF 3 REQUIRED, PLUS MEDICAL NECESSITY)	***99214***	***99215***	***DIFFERENCE***
History	Detailed: •4+ HPI elements or status of 3 or more chronic diseases •Review of 2 to 9 systems •1 PFSH element	Comprehensive: •4+ HPI elements or status of 3 or more chronic diseases •Review of 10 or more systems •2 PFSH elements	•Review of additional 8 systems •1 additional PFSH element
Exam	Detailed: •12+ exam elements from 2 or more systems	Comprehensive: •18+ exam elements; 2 exam elements from *each* of 9 systems	•6 additional exam elements from *each* of 9 systems
Medical decision-making	Moderate complexity: •Prescription medications •Multiple diagnoses or management options	High complexity: •Parenteral controlled substances •Multiple diagnoses or management options	•1 parenteral controlled substance

Source: FPM Journal Nov-Dec 2014 Issue AAFP.org

Consult Codes

- Patient is “referred” to you for care
- Example – your patient is going to undergo surgery and is referred to you for Pre-operative clearance
- Need to state who referred you in the note
- Need to route a copy of the note to the Referring Provider
- Cannot be used for Medicare (ok for HMO and some PPO plans)

Procedures

- Skin lesions – change for number of lesions treated
  - Pre-Malignant and Malignant Lesions – charge is for each lesion
    - Actinic Keratoses
    - Warts
  - Benign Lesions – charge is for up to 14 lesions
    - Seborrheic Keratoses
- Joint injections
  - Order medication; MA/LVN will “administer” by documenting in the MAR
  - Bill for procedure under Adult Procedures
- Cerumen Removal
  - Lavage – 69209. Order via TBOC and charge drops when staff completes lavage.
    - It is a unilateral procedure; If bilateral add modifier 50 and change quantity to “2”
  - Instrumentation – 69210. Physician (provider) performed.
    - It is a unilateral procedure; if bilateral add modifier 50 and change quantity to “2”
- Modifiers
  - 25 – additional service separate and distinct from office visit or primary procedure
  - 50 – bilateral procedure

Modifiers for separate services

Sometimes a patient has a Preventive Visit but also has a problem oriented issue as well, either acute or chronic. These issues are separate from the Preventive Service visit. This is handled by adding Modifier 25 to the Office Visit (Problem Visit) CPT code.

- **Significant, separately identifiable E/M service by the same physician on the same day of the procedure**
- **E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided**
- **Different diagnosis is not required for reporting of the E/M service, per CPT Guidelines**
- **Documentation must support the E/M level selected.**

Example: 55 year old male presents for CPE. States while at the gym injured his back and is complaining of back pain.

Code 99396 for Preventive (Wellness) Visit. Code 99213-25 for “Back Pain”

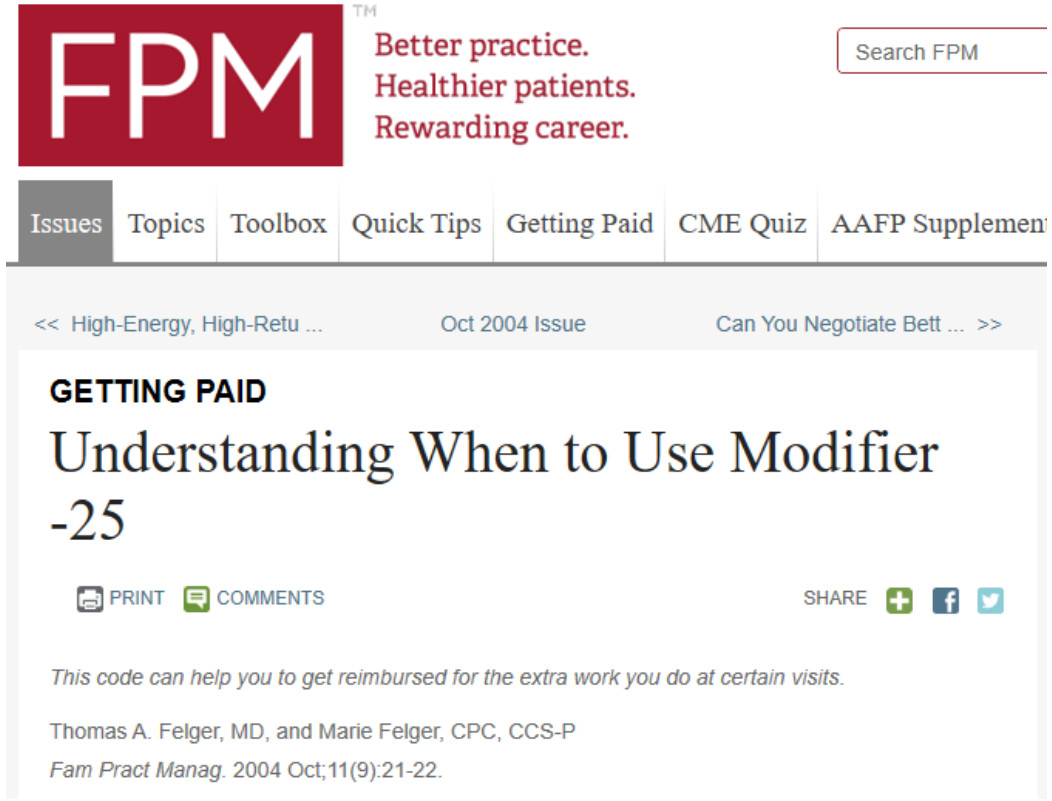
Modifer – 25 for Procedure Visits

- Sometimes a procedure is done during an office visit. If the “office visit” is separate from the procedure, then Modifier 25 is added to the E/M code to indicate that it is a separate service from the procedure
- Example: a patient presents with a fall from a bicycle. He has a 3 cm laceration to the right forearm and a contusion to the left knee. You examine the patient and decide to repair the laceration.
  - You code an office visit (99213-25) for the contusion to the knee
  - You code the laceration repair for right forearm laceration (12002)
  - Modifier 25 goes on the E/M code (99213) to indicate that it is unrelated to the laceration repair. If the patient had only had a laceration then the “evaluation and management” of wound is included in the laceration repair code.

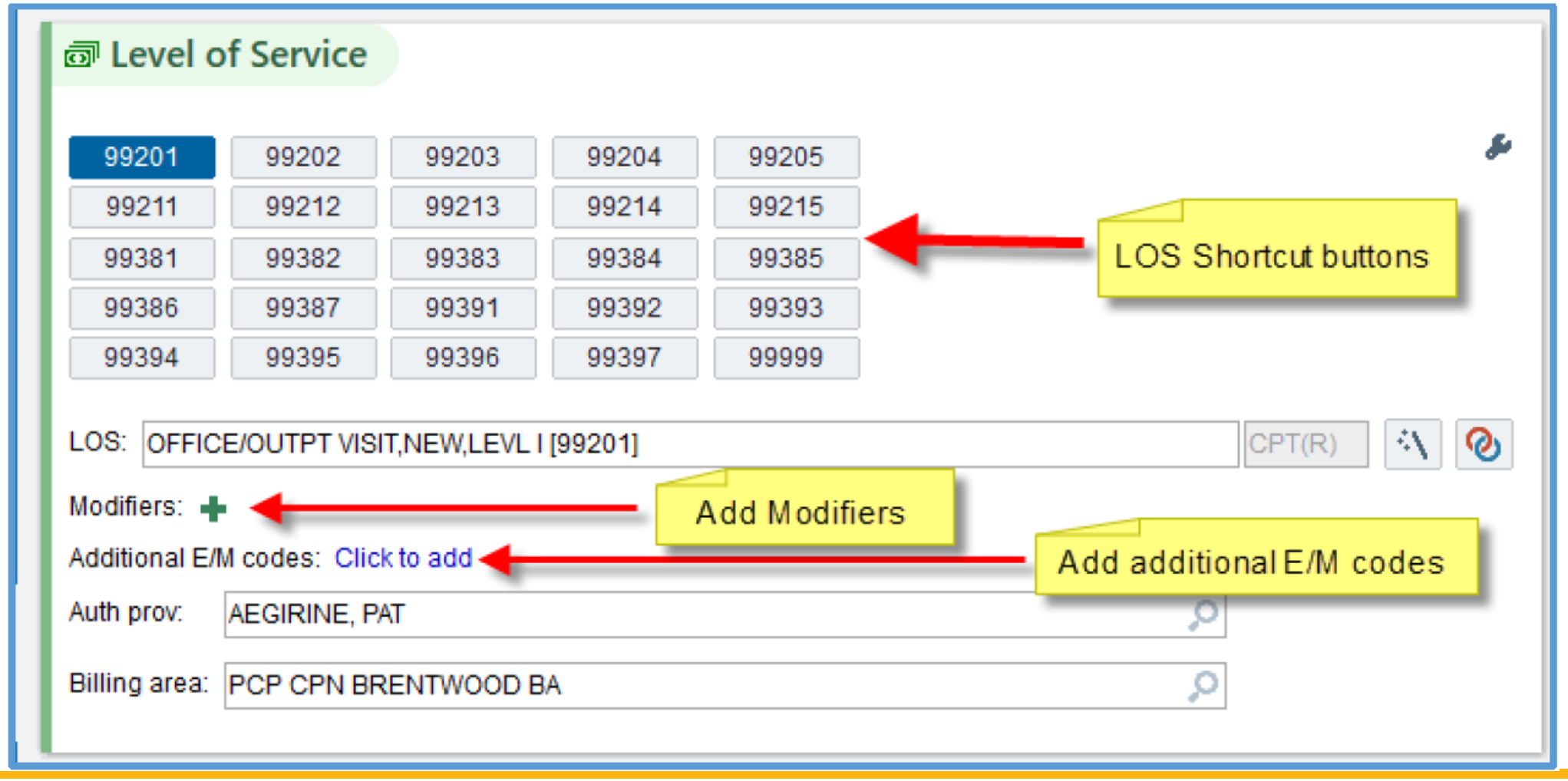
Modifier -25 Explanation

A good explanation of the use of Modifier -25 may be found at:

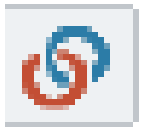
https://www.aafp.org/fpm/2004/1000/p21.html#

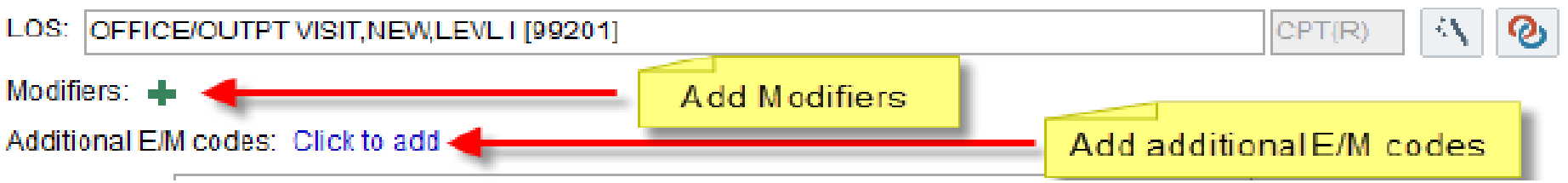


Level of Services (LOS) and Modifiers

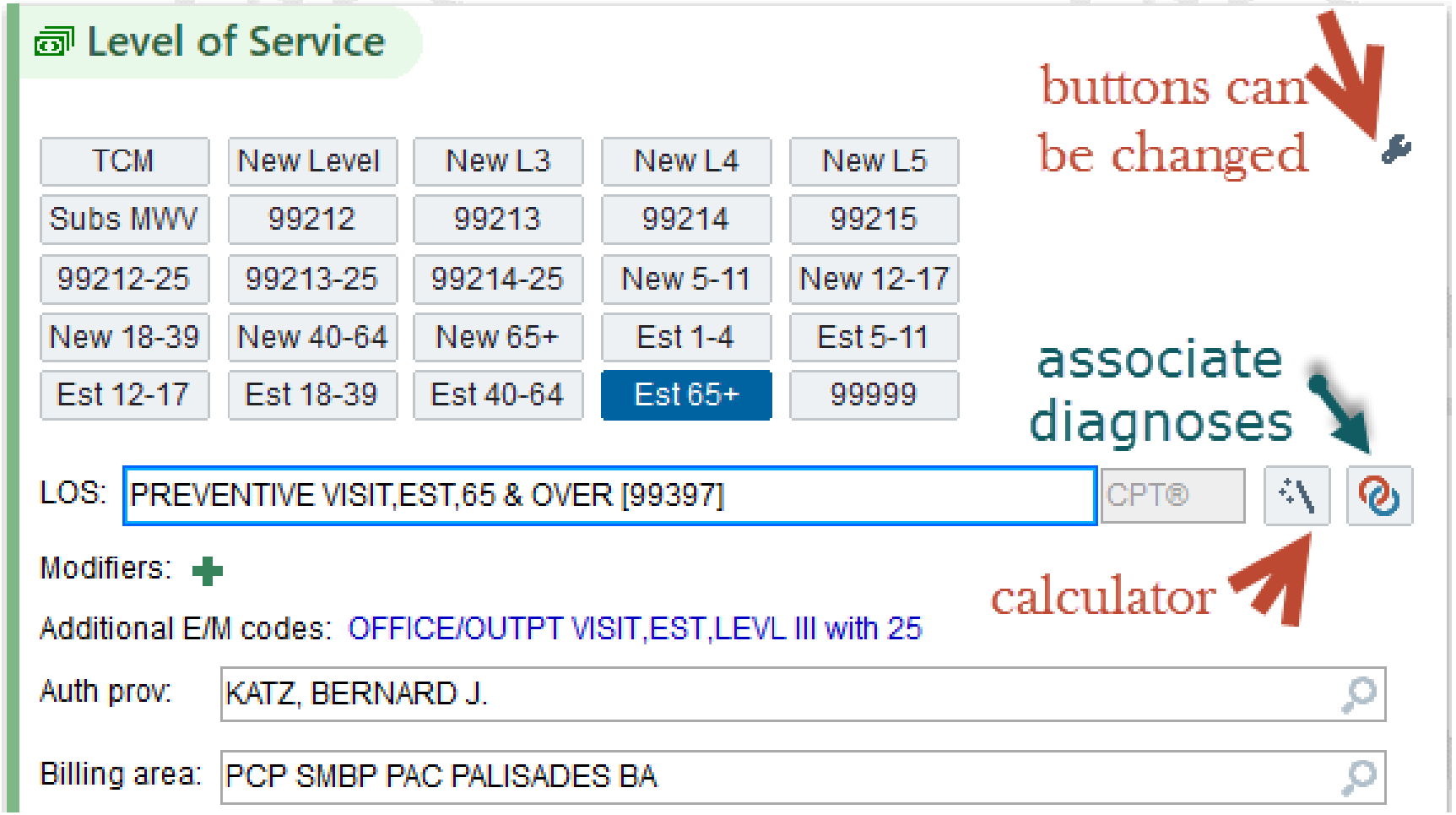


Level of Service Workflow

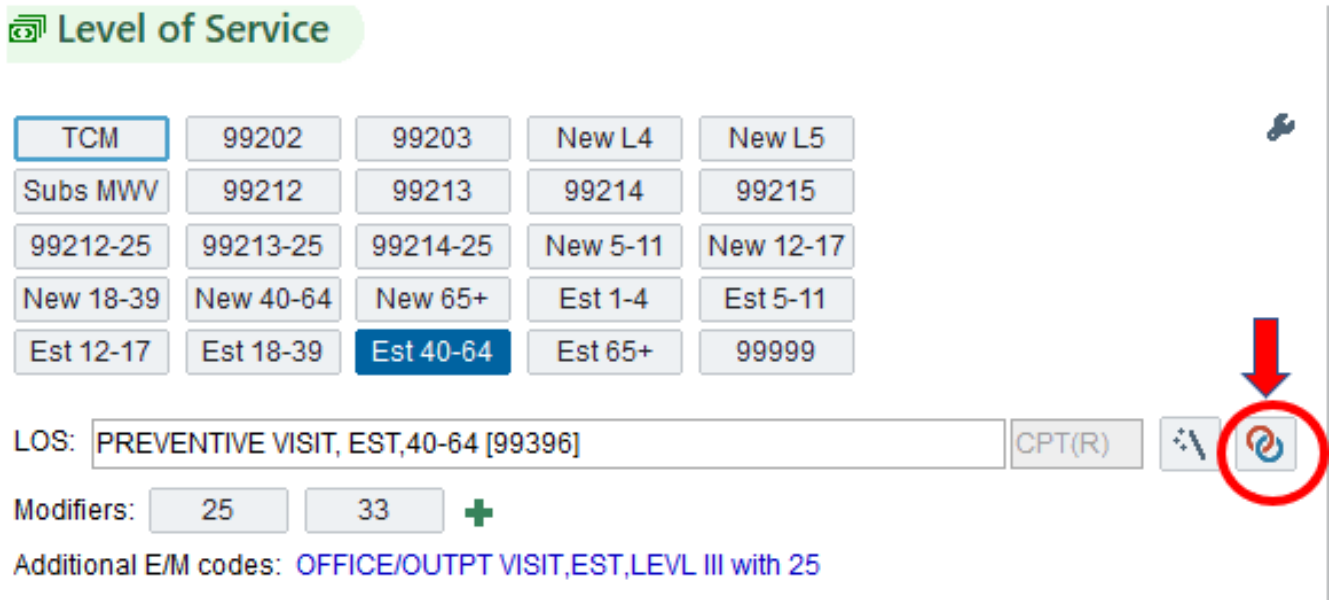
1. If you know the **LOS**, click a speed button
2. If you need to add a modifier, click the ✚ next to Modifiers after selecting LOS code
3. To add a second code, click the “Click to add” hyperlink next to Additional E/M Codes (you need to know the code; it won’t give you a searchable list)
4. If you add more than one LOS code you’ll need to associate the diagnoses with the appropriate CPT codes using the 

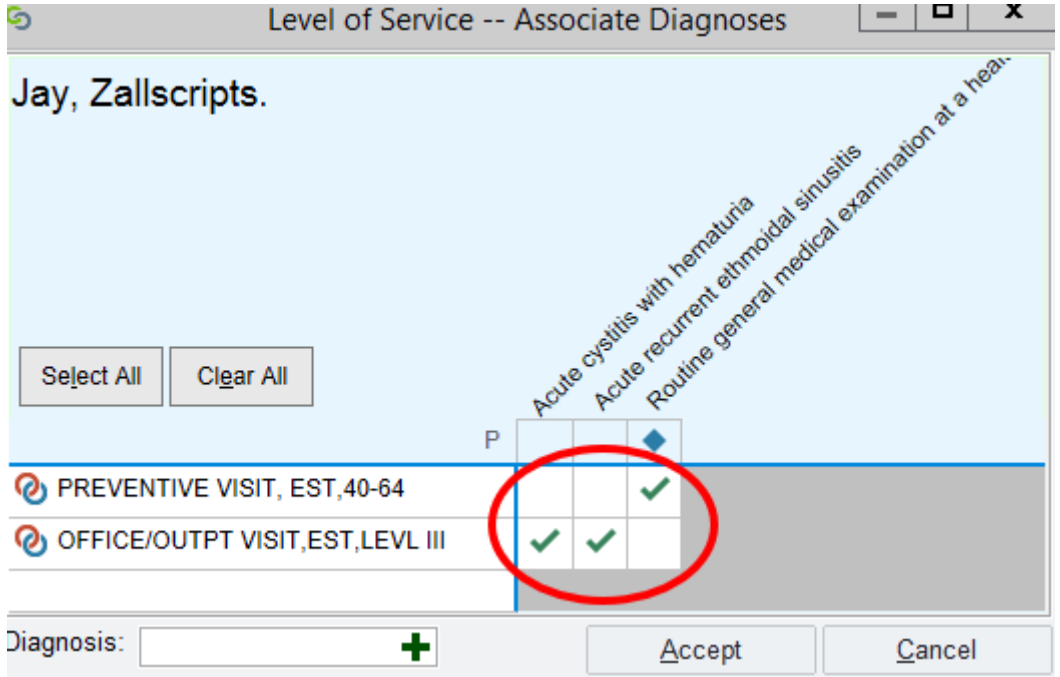


Entering Charges



Need to associate each diagnosis with the correct CPT code by placing check box in the correct place





Personalize codes
(remove 99211 – not used by MD)

99201	**99202**	**99203**	**99204**	**99205**
99999	99212	99213	99214	99215
99381	99382	99383	99384	99385
99386	99387	99391	99392	99393
99394	99395	99396	99397	G0439

New L1	New L2	New L3	New L4	New L5
99999	Est L2	Est L3	Est L4	Est L5
New < 1y	New 1-4	New 5-11	New 12-17	New 18-39
New 40-64	New 65+	Est < 1y	Est 1-4	Est 5-11
Est 12-17	Est 18-39	Est 40-64	Est 65+	Subs MWV