Our Objectives

• Establish foundational knowledge of where codes exist and how to use manuals (i.e. navigate descriptions of the codes)
• Understand the importance of good compliant coding and documentation
• Take a deep dive into codes for services typically performed by Public Health
• Gain insight into codes for preventive health and the ACA
• Discuss predictive modeling
• Discuss Provider contracting

Understanding Coding – Starting Point

• Physicians and other qualified staff perform services, procedures, provide medications, supplies, and utilize equipment during patient encounters.
• Determine diagnoses and treatments.
• Services are captured in medical record
• Provider assigns codes based on services rendered and diagnosis of patient
• Staff or billing vendor enter the assigned codes, (each with specific definitions on which payment is based) into a billing system to bill the appropriate insurance carrier or patient.
Understanding Coding – Codes

  - Approximately 7,800 codes
  - Codes for visits, injections, procedures, anesthesia, diagnostic testing
  - Basic modifiers
- International Classification of Diseases 9th Revision Clinical Modification (ICD9-CM)
  - Approximately 17,000 codes
  - Guidelines on using and sequencing diseases, illness and injuries
  - Volumes I and II are diagnoses for outpatient coding Volume III - inpatient
- Healthcare Common Procedure Coding System (HCPCS)
  - Medicare specific codes
  - Ambulance, drugs, supplies, and DME
  - More specific modifiers

CPT Manual

- Read the introductions for each section
- Understand the underlying premise to the group of codes
- Good understanding → maximize reimbursement
- Poor understanding → loss of revenue, refunds and possible penalties
  - Not billing at appropriate level (under or over-coding)
  - Not billing for provided services because you are unaware of existence of separate code

This is a great example of detail information provided in the section guidelines that precede the actual codes.
CPT – Common errors

- Urinalysis:
  - 81000 – Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
  - 81001 – automated, with microscopy
  - 81002 – non-automated without microscopy
  - 81003 – automated, without microscopy

- Lab Panels:
  - You must perform EVERY lab listed within a panel
  - Even if only one test is missing you must break out the codes and bill separately
  - If a code is not listed (additional), don’t forget to bill that code along with the panel

CPT – Pricing Structure Overview

- Each CPT code is assigned a relative value unit (RVU) through the Resource Based Relative Value System (RBRVS)
  - Places a value on the providers work to complete the service (skill, training, and intensity)
  - Practice expense – cost of ancillary staff, supplies and overhead
  - Malpractice
  - Considers geographical location (GPI)

- RVUs are multiplied by the current conversion factor (CF) to translate into fees

- RVU values also take into consideration facility vs. non-facility

ICD9-CM Manual

- Read the chapter guidelines
  - At the beginning of the manual
  - Provide specific coding guidelines to code assignment and proper sequencing

- Understand the punctuation and symbols used throughout the book
  - [ ] Brackets - lists synonyms and alternative wording. Used in the index to identify manifestation codes (slanted)
  - ( ) Parentheses – supplementary words; non-essential modifiers
  - : Colon – incomplete term needs modifying words that follow to help identify use of code
HCPCS
- Make sure you read each code description
  - For example Depo-Provera changed in 2013
    - Moved from J1051 (Medroxyprogesterone acetate, 50mg)
    - To J1050 (Medroxyprogesterone acetate, 1mg)
- Review Appendix I – Table of Drugs and Biologics
  - Quick reference with alphabetic listing of drugs
  - Lists both generic and brand names

Mapping
- Refers to assigning appropriate ICD-9 with CPT or HCPCS codes.
  - A code may or may not have a corresponding “payable” diagnosis code mapping.
  - Even some of the Medicare Preventive Medicine Procedures list corresponding diagnosis direction as “no specific code required”
- Found mostly on LCDs and NCDs then review commercial carrier
  - Example WPS – LCD L30145 Vitamin B12 injections
  - There are only 11 “payable” codes
  - Providers should map in EHR and/or encounter forms

Why is coding appropriately important
Why do we care??
- Tell the patient’s story (what’s wrong and needs treatment)
- Documentation (not documented, not done)
- Reimbursement (stay in business for your patients)
- Medical Liability (every visit is a risk for the provider)
- Risk of Medicaid Review/Audit (enough said)
- Provider Profiling (Predictive modeling)
- Epidemiological Tracking (clinical documentation of outcomes)
- Internal Tracking (preventive/disease maintenance)
### New patient vs. Established patient

- A “new” patient is one who has not received any professional service from the physician or other qualified health care provider, or another physician or other qualified health care provider of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
- An “established” patient is one who has received a service, according to the above definition, within the past three years.

### “Nurses visit” – 99211

- 99211 – Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
  - Should not be billed for: (ok….this is not cut and dry)
    - Phone calls to patients
    - Drawing blood for lab tests
    - Administration of medications

### “Nurses visit” – 99211 (continued)

- When it can be billed:
  - Patient comes in for complaints of urinary burning and frequency.
  - Blood Pressure check at the request of the physician, NP or PA
    - If BP check prompted by patient, depends on clinical indications
  - Nurse suture removal (when sutures placed by different practice)
  - Assessing a wound for dressing change (not post operative care of practice)
  - When there is documentation to establish a need for clinical evaluation and management.
Common Coding Guidelines

“Nurses visit” – 99211 (continued)
What CMS and other carriers have found and published as errors:

- PT/INR results in chart only
- Blood draw only
- Prescription refill noted
- BP only listed in the chart
- Injection given with BP noted

Common Coding Guidelines

“Nurses visit” – 99211 (continued)
What should you see in the chart:

- Brief history
- Minor clinical intervention (BP, dressing change reading a TB test)
- Providing education, refilling a prescription (provider sign off), notation of conversation with physician, NP or PA with treatment plan.

Common Coding Guidelines

“Nurses visit” – 99211 (continued)
Example: BP check

- Record blood pressure and other vital signs
- Document clinical reason for checking blood pressure (i.e. F/U to previously abnormal results or new symptoms on medication)
- Indication of provider’s evaluation of the clinical information obtain and management recommendation
- Identity and credentials of each provider involved in care
CPT/HCPCS/ICD9 codes

Common services for Public Health Departments: Our deep dive into the most important codes for you!

- TB testing
- PAP Collection
- Preventive Codes (including preventive counseling)
- Vaccinations, administration and counseling
- Preventive services for PPACA/Medicare
- Evaluation and management (aka E&M codes)

TB Testing – CPT 86580 / ICD9 V74.1

- Since the test is an inoculation screening test, rather than a vaccination, the test includes administering the skin test and you should not code separately for the administration.
- The Resource Based Relative Value System (RBRVS) does not include costs for a reading.
- Patients who do not show a response to the test may never return for a reading so this nurse “reading” cost is not included in the RVUs for 86580.
- If the patient does return for a reading, you may code 99211 for the nurse reading. Make sure to document appropriately and……

PAP Smear – HCPCS code Q0091

The controversial pap collection- To bill or not to bill!!

- This is a Medicare created code
- According to ACOG, its included in the preventive codes (99381-99397)

Medicare intended use: (annual pap, breast and pelvic)
99387 – 52 (non-covered portion)
G0101 (breast and pelvic)
Q0091 (pap collection)

Let me explain…….
Preventive Code Choices:

Preventive physical exams:
- 99381/99391 - infant (age younger than 1 year)
- 99382/99392 - early childhood (age 1 through 4 years)
- 99383/99393 - late childhood (age 5 through 11 years)
- 99384/99394 - adolescent (age 12 through 17 years)
- 99385/99395 - 18-39 years
- 99386/99396 - 40-64 years
- 99387/99397 - 65+

What's in the chart?
- Let's look at the definition of the codes:
  - Comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures.
  - The "comprehensive" nature of the Preventive Medicine Services codes 99381-99397 reflects an age and gender appropriate history/exam and is not synonymous with the "comprehensive" examination required in Evaluation and Management codes 99201-99350.

Preventive Code Choices:

Preventive Counseling
- 99401 - approximately 15 minutes
- 99402 - approximately 30 minutes
- 99403 - approximately 45 minutes
- 99404 - approximately 60 minutes
- New or Established Patient Counseling and/or Risk Factor Reduction Intervention Services Preventive Medicine, Individual Counseling Services. Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
- Typically not covered by commercial carriers
Vaccinations

- The administration confusion:
  - Vaccine administration can be broken down to three categories
    - Vaccines without counseling (90471-90474)
    - Vaccines with "physician" counseling (90460-90461)
    - Vaccines for Medicare (G0008, G0009, G0010)
  - Route of administration:
    - Most are given as injections (90471 and 90472)
    - Some are oral and/or intranasal (90473 and 90474)

**ICD-9 codes fall between – V03-V06.9**

Vaccinations

- Initial vs. Subsequent vaccines at same encounter:
  - Initial:
    - Only one initial administration code should be listed per encounter for example:
    - Both an injectable and intranasal vaccines performed during the same visit. Report 90471 as initial administration. (90471 has a slightly higher reimbursement rate than intranasal)
  - Subsequent:
    - An additional administration fee is required to document the second or third vaccine administration these are "add-on" codes (+)
      - 90461, 90472, 90474 – Never reported alone

Vaccinations

Vaccines without counseling (90471-90474)

- When 3 or more vaccines are performed during the same encounter:
  - 5 injectable vaccines
    - 90471 x1 (initial)
    - 90472 x4 (subsequent)
  - 4 injectable vaccines, 1 oral
    - 90471 x1 (initial)
    - 90472 x3 (subsequent)
  - 1 intranasal, 2 oral vaccines
    - 90471 x1 (initial)
    - 90472 x2 (subsequent)
Vaccinations

Vaccines with Counseling:
- CPT definition for reporting includes both physician and other qualified health care providers (NP or PA)
- Code assignment is based on the number of components within a vaccine, rather than the total number of vaccines given.

Examples:
- 90707 Measles, mumps and rubella virus vaccine (MMR) subQ
  - Administration is reported 90460 and 90461 x2
- 90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hep B, and poliovirus vaccine (DtaP-HepB-IPV)
  - Administration is reported 90460 and 90461 x4

Examples of Multi-Component Vaccines with Administration Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Initial Administration</th>
<th>Subsequent Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>90636</td>
<td>HepA-HepB</td>
<td>90460</td>
<td>90461</td>
</tr>
<tr>
<td>90644</td>
<td>Hib-MenCY</td>
<td>90460</td>
<td>90461 x3</td>
</tr>
<tr>
<td>90666</td>
<td>DtaP-Hib-IPV</td>
<td>90460</td>
<td>90461 x4</td>
</tr>
<tr>
<td>90707</td>
<td>Mumps and Rubella</td>
<td>90460</td>
<td>90461</td>
</tr>
<tr>
<td>90720</td>
<td>DTP-Hib</td>
<td>90460</td>
<td>90461 x3</td>
</tr>
<tr>
<td>90748</td>
<td>HepB-HPV</td>
<td>90460</td>
<td>90461</td>
</tr>
</tbody>
</table>

Let’s put it all together in coding scenario

- Patient presents for routine physical exam and vaccinations for:
  - Tetanus and diphtheria toxoids (Td) IM (90714)
  - Hepatitis A and Hepatitis B, (HepA-HepB) IM (90636)
  - Human Papilloma virus (HPV) IM (90649)
  - Influenza virus vaccine, intranasal (90660)

How do you report the correct administration codes with counseling:
Let’s put it all together in coding scenario

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>90714</td>
<td>90460 and 90461</td>
</tr>
<tr>
<td>90636</td>
<td>90460 and 90461</td>
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<tr>
<td>90649</td>
<td>90460</td>
</tr>
<tr>
<td>90660</td>
<td>90460</td>
</tr>
</tbody>
</table>

Let’s put it all together in coding scenario

- Tetanus and diphtheria toxoids (Td) IM (90714)
- Hepatitis A and Hepatitis B, (HepA-HepB) IM (90636)
- Human Papilloma virus (HPV) IM (90649)
- Influenza virus vaccine, intranasal (90660)

Report the correct administration codes *without counseling*

Let’s put it all together in coding scenario

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>90714</td>
<td>90471</td>
</tr>
<tr>
<td>90636</td>
<td>90742</td>
</tr>
<tr>
<td>90649</td>
<td>90472</td>
</tr>
<tr>
<td>90660</td>
<td>90474</td>
</tr>
</tbody>
</table>
Medicare Vaccination/Administration

- Different for influenza, pneumonia or Hepatitis B
  - Rules for reporting initial or subsequent vaccines do not apply
  - Some codes have a one-to-one relationship and are always pared together
    - G0008 – Influenza (Q2034-Q2039)
    - G0009 – Pneumonia (90732)
    - G0010 – Hepatitis B (90746)
  - When other vaccines are combined with the above the standard CPT administration codes will be used to track the remaining vaccines.

Medicare vs. Non-Medicare

Vaccines administered: Flu (90658 or Q2036) Tetanus (90703) MMR (90707) and HPV (90649)

<table>
<thead>
<tr>
<th>Non-Medicare claim:</th>
<th>Medicare claim:</th>
</tr>
</thead>
<tbody>
<tr>
<td>90658</td>
<td>Q2036</td>
</tr>
<tr>
<td>90471</td>
<td>G0008</td>
</tr>
<tr>
<td>90703</td>
<td>90703</td>
</tr>
<tr>
<td>90707</td>
<td>90471</td>
</tr>
<tr>
<td>90649</td>
<td>90707</td>
</tr>
<tr>
<td>90472 x3</td>
<td>90649</td>
</tr>
<tr>
<td></td>
<td>90472 x2</td>
</tr>
</tbody>
</table>

Administration of Screening Tests

CPT code 99420
Basic definition is: Administration and interpretation of health risk assessment instrument (i.e. health hazard appraisal)

Example case #1
Initial office visit for a 18-year old male who presents with recurring episodes of fatigue and anxiety over the past four months. In the course of a detailed history and examination, m3 screen is administered and interpreted. Medical decision making is of low complexity; approximately 30 minutes are spent face-to-face with the patient. Patient is requested to return in 30 days for a follow-up visit.
Administration of Screening Tests

Example case #1 Answer:
First line of claim 99203-25 with 309.28
Second line of claim 99420 with V79.0
99203-25 New patient level 3 office visit (appended with -25 modifier to indicate completely separate from HRA)
99420 – Administration and interpretation of HRA (M3)

Administration of Screening Tests

Case #2 – Follow up office visit for a 27 year old female diagnosed with postpartum depression on initial visit. A problem focused exam is completed on a resolving left leg pain issue. A follow up depression screening to compare to the previous screening is performed and interpreted. Approximately 10 minutes is spent face-to-face with the patient.

Administration of Screening Tests

Case #2 Answer –
First line of claim 99212-25 with 309.28; 729.5
Second line of claim 99420 with V79.0
99212-25 – Established patient level 2 office visit (appended with -25 modifier to indicate completely separate from HRA)
99420 - Administration and interpretation of HRA
Preventive Medicine’s New Era

- Insurance companies have to waive co-pays, co-insurance & deductibles for these services
  - Neither the patient nor provider get the benefit of preventive care coverage unless the documentation, coding & billing are aligned
- Screening is trolling:
  - No symptoms
  - No abnormal findings
  - No personal diagnosis
  - Family history may be a screening criteria but is not a personal diagnosis or “history of”

### Sample of Reimbursed Preventive Medicine Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Preventive Physical Exam (IPPE)</td>
<td>G0402</td>
</tr>
<tr>
<td>Bone Mass Measurements</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular Screening Blood Tests (V81.0, V81.1, V81.2)</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening (V76.41; V76.51)</td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td>V76.64</td>
</tr>
<tr>
<td>Seasonal Flu (V04.81)</td>
<td></td>
</tr>
<tr>
<td>Pneumonia (V03.82)</td>
<td></td>
</tr>
<tr>
<td>Hep B Vaccine (V05.3)</td>
<td></td>
</tr>
<tr>
<td>Glaucoma Screening (V80.1)</td>
<td></td>
</tr>
<tr>
<td>Annual Wellness Visits</td>
<td>G0438 or G0439</td>
</tr>
<tr>
<td>Osteoporosis Screening (V82.81)</td>
<td></td>
</tr>
</tbody>
</table>

### Medicare Preventive Medicine Benefits

- Initial Preventive Physical Examination (IPPE)-G0402
  - Screening EKG optional (must be result of IPPE) G0403-5
  - No specific DX code
- Annual Wellness Visit (AWV)—G0438 or G0439
  - Every 12 months/must be after the first 12 months of start of coverage
  - No specific DX code
- Ultrasound Screening for AAA
  - Once in a lifetime
  - Must result from IPPE
**Medicare Preventive Medicine Benefits**

- Cardiovascular Screening Blood Tests
  - Every 5 years
  - Documentation must show asymptomatic/12 hour fast
- Flu, Pneumococcal & Hepatitis B Vaccinations
  - Specific CPT codes, administration G codes, DX codes
- Screening Mammography
  - 35-39 one baseline / 40 and over annually
- Screening Pap Tests
  - Every 24 months / unless high risk
- Screening Pelvic Examination

**Medicare Preventive Medicine Benefits**

- Prostate Cancer Screening
  - DRE and PSA lab Male 50 and over - annually
- Human Immunodeficiency Virus (HIV) Screening
  - High risk beneficiaries - annually
  - Different for pregnant patient
- Bone Mass Measurements
  - Only certain beneficiaries – list of criteria (i.e. estrogen deficient)
- Tobacco-Use Cessation Counseling Services
  - G codes Medicare/CPT codes Private payer
  - Specific DX codes J05.1 or V15.82

**Documentation of Preventative Medicine**

- Remember the importance of documentation in the medical record for all of these services.
- CMS clearly outlines what the expectations are for each preventative service
- The work must be represented in the documentation to bill the preventative codes.
- For example: IPPE requires 7 components to be documented. Without the necessary documentation the service cannot be billed.
Elements/Documentation of IPPE

The IPPE must include all of the following seven components:

• Review of the beneficiary’s medical and social history with attention to modifiable risk factors for disease detection.
• Review of the beneficiary’s potential risk factors for depression or other mood disorders.
• An examination to include the beneficiary’s height, weight, body mass index measurement, blood pressure measurement, visual acuity screen, and other factors as deemed appropriate by the physician or qualified non-physician practitioner.
• End-of-life planning upon the beneficiary’s consent.
• Education, counseling, and referral based on the results of the previous five components.
• A brief written plan such as a checklist for obtaining other appropriate covered preventive services and screenings.

Example Audit of IPPE

USPSTF Preventive Medicine Benefits

The following is a list of preventive services that have a rating of A or B from the U.S. Preventive Services Task Force (USPSTF) that patients are entitled to without deductible, co-pay or coinsurance:

• Tobacco use counseling and intervention: (preg or non-preg adults) The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products: 99406/99407 – 305.1 V15.82
• Alcohol misuse counseling: The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. 99408/99409 (G0396/G0397) V79.1
USPSTF Preventive Medicine Benefits

• Anemia screening: pregnant women. The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women. V78.0

• Breast Cancer Screening: The USPSTF recommends screened mammography for women with or without clinical breast exam, every 1 to 2 years for women age 40 years and older. V76.10, V76.11, V76.12, V76.19

• Cervical Cancer Screening: The USPSTF recommends screening for cervical cancer in women age 21 – 65 years with cytology (PAP) every 3 years or, for women ages 30 – 65 years who want to lengthen the screening interval, screening with a combination of cytology and HPV testing every 5 years. Q0091 V76.2

USPSTF Preventive Medicine Benefits

• Depression screening: adolescents. The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up

• Depression screening: adults. The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. V79.0 – Depression Screening

USPSTF Preventive Medicine Benefits

• Understanding the “rating process”

A = Strongly Recommended
B = Recommended

<table>
<thead>
<tr>
<th>Code</th>
<th>Statement</th>
<th>Suggestion for Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
<td>The provider provide this service.</td>
</tr>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is moderate certainty that the net benefit is substantial.</td>
<td>The provider provide this service.</td>
</tr>
<tr>
<td>C</td>
<td>The USPSTF recommends the service. There is moderate certainty that the net benefit is small.</td>
<td>The provider provide this service for selected patients depending on individual circumstances.</td>
</tr>
<tr>
<td>D</td>
<td>The USPSTF recommends the service. There is moderate certainty that the net benefit is small.</td>
<td>Disregard the use of this service.</td>
</tr>
<tr>
<td>E</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is small.</td>
<td>Disregard the use of this service.</td>
</tr>
</tbody>
</table>

http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm
Example of Billing for USPSTF A/B
Case #1 - 53 y/o female, s/p TVH, BSO five years ago
• The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older – Grade B
• Physician sees the patient in the office for breast exam (no pap) & orders screening mammography

Question: The patient should not pay co-insurance for this service. How do you bill?

Answer:
CPT: 99212 (level 2 E&M – problem-focused exam)
Modifier: -33 (preventive medicine service)
ICD-9: V76.19 (screening breast exam)

Modifier -33 will tell the insurance company that this is preventive medicine service – not subject to co-insurance responsibility by the patient

E&M Coding
LOTS of helpful guidelines found right in the CPT book!!
• Key Contributing factors to selecting the appropriate code:
  – Place of service
  – Type of service
  – Patient status
• Key Components
  – There are seven total components
  – Three are KEY in selecting the right level
  – Four are considered more contributory to the selection of the level
E&M Coding

- Three key components:
  - **History** - relative to the patient's clinical picture
  - **Examination** - relative to present and concurrent problems
  - Physician’s **medical decision-making** process in managing the patient

- Four contributory elements:
  - Counseling with the patient and/or family
  - Coordination of care with other health care professionals or facilities
  - Nature of the patient’s presenting problem
  - Time

More than likely you will utilize the following codes:

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>99211</td>
</tr>
<tr>
<td>99202</td>
<td>99212</td>
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<tr>
<td>99203</td>
<td>99213</td>
</tr>
<tr>
<td>99204</td>
<td>99214</td>
</tr>
<tr>
<td>99205</td>
<td>99215</td>
</tr>
</tbody>
</table>

E&M Coding – Key Component History

- **History** Includes
  - Chief complaint
  - History of present illness
  - Review of systems
  - Past, family, and/or social history

- Chief complaint: a concise statement in the patient’s own words that describes the problem, symptom, condition, diagnosis, or other factor that is the reason for the encounter.
E&M Coding – Key Component History

History of present illness

- Description of the patient’s present illness from the first sign and/or symptom to the present
- Includes elements such as
  - Location
  - Duration
  - Quality
  - Severity
  - Timing
  - Context
  - Modifying factors
  - Associated signs and symptoms

---

E&M Coding – Key Component History

- Review of Systems (ROS)
  - ROS is a series of questions that provider and/or ancillary staff ask the patient based upon the history of the present illness or complaint.
    - Constitutional (e.g., fever, weight loss)
    - Eyes
    - Ears, nose, mouth, throat
    - Cardiovascular
    - Gastrointestinal
    - Genitourinary
    - Musculoskeletal
    - Integumentary (skin and/or breast)
    - Neurological
    - Psychiatric (e.g., mood swings)
    - Hematologic/Lymphatic
    - Endocrine
    - Allergic/immunologic

---

E&M Coding – Key Component History

<table>
<thead>
<tr>
<th>Past Medical</th>
<th>Family History</th>
<th>Social History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Illness</td>
<td>Family illness</td>
<td>Smoking</td>
</tr>
<tr>
<td>Past surgeries</td>
<td>Hereditary diseases</td>
<td>Drug use</td>
</tr>
<tr>
<td>Allergies</td>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Current Meds</td>
<td>Living arrangements</td>
<td></td>
</tr>
<tr>
<td>Past hospitalizations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
E&M Coding — Key Component History

<table>
<thead>
<tr>
<th>Type of History</th>
<th>Chief Complaint</th>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past Medical, Family, and Social History (PMFH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused E&amp;M</td>
<td>Required</td>
<td>Brief (1-3)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused E&amp;M</td>
<td>Required</td>
<td>Brief (1-3)</td>
<td>Problem (Detailed)</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed E&amp;M</td>
<td>Required</td>
<td>Extended</td>
<td>Extended (2-9)</td>
<td>Complete</td>
</tr>
<tr>
<td>Comprehensive E&amp;M</td>
<td>Required</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
</tr>
</tbody>
</table>

E&M Coding — Key Component Exam

- Area of documentation that is easily converted to a template
- There are two versions of documentation requirements:
  - 1995 (body areas or organ systems)
  - 1997 Bulleted

Exam Component 1995

**Body Areas:**
- Head
- Neck
- Chest
- Abdomen
- Back/Spine
- Genitals/Groin/Buttocks
- Left upper extremity
- Right upper extremity
- Right lower extremity
- Left Lower extremity

**Organ Systems:**
- Constitutional
- Eyes
- Ears, Nose, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Integumentary
- Musculoskeletal
- Neurological
- Psychiatric
- Hematologic/Lymphatic/Immunologic
E&M Coding – Key Component Exam

1995

- **Problem Focused** – limited exam of affected body area OR organ system
- **Expanded Problem Focused** – limited exam of the affected body area OR organ system and other symptomatic or related organ system(s)
- **Detailed** – an extended exam of the affected body area(s) and other symptomatic or related organ system(s)
- **Comprehensive** – a general multi-system exam or complete exam of a single organ system

E&M Coding – Key Component Exam

1997 guidelines:

- **Problem focused exam** – one to five bullets in one or more organ systems or body areas
- **Expanded problem focused exam** – at least six elements identified as a bullet in one or more organ systems or body areas
- **Detailed exam** – at least six organ systems or body areas of at least 2 elements each or documentation of at least twelve elements identified by a bullet in two or more organ systems
- **Comprehensive** – at least nine organ systems for each system all elements identified by a bullet

The difference between straightforward and high level decision making at its best!!

Three areas of documentation for MDM

- **Diagnosis** – number and status of diagnoses treated
- **Complexity of data** – tests and procedures performed or ordered
- **Risk** – level of risk assigned to diagnoses treated
  * Probably the most difficult for non-clinical coders

- **Diagnosis**
  - Is this new or established to the provider?
  - Is it improving, worsening, or stable?
  - Does it require additional workup?

- **Complexity of data**
  - Diagnostic Testing
    - Credit is given for number of tests performed, ordered, or reviewed.
    - The type of testing lends more toward complexity rather than number of testing.
E&M Coding – Key Component MDM

Risk
- Takes the categories already looked at within the decision making into consideration for level of risk determination
- Three components:
  - Presenting Problem
  - Diagnostic procedure(s) ordered
  - Management Options
- The risk of significant complications is based on all the risks associated with the presenting problem(s) the diagnostic procedure(s) and the management options
What about coding by time

- 50% or more of the time must be spent in counseling or coordination of care with the patient
- Documentation of the total face-to-face time with the patient
- Select appropriate level based on “closest” time.

Predictive Modeling

- Concept has been around in the credit card industry for many years
- Generally based on claims data, which historically offered only information about diagnoses and limited patient demographic and treatment information
- HHS Secretary has testified before the Senate Appropriations Subcommittee on Labor, Health and Human Services, indicating the need to implement predictive modeling software as a method to combat fraud
Predictive Modeling

- HHS has begun pooling its claims data with information from other government agencies to help improve fraud detection.
- The agency received $110 million in their budget for a two-year IT initiative that would build "predictive modeling" capabilities into Medicare's payment systems.

Predictive Modeling

- Moving from a "pay-and-chase" payment model to one where payments are suspended when potential fraud is suspected (PPACA).
- The nation's largest private health insurer, United Healthcare, saved $125 million over two years by using an analytics system similar to the one that CMS will use.
- Kaiser Permanente has also used predictive modeling software to identify suspect providers – after using the technology for three months, Kaiser identified 21 providers that sat outside of established billing norms and, therefore, fit the model of potential fraud. Further claims review determined that 18 of these providers warranted further review.

Predictive Modeling

Potential effect on providers:
- Delays in payment – departure from "pay-and-chase" era
- Increased effort to examine internal claims practices and determine the risks for audits triggered by the predictive modeling
- The need for education on compliance activities and increased efforts to audit and monitor billing procedures
Negotiating Contracts - few simple facts

- Most third party payor contracts have standard language
- Don’t just sign, read the fine print (may have something to do with reimbursement)
- Negotiating rates/fee schedules – what’s the bottom line?

Much to do about copays and deductibles..

- Is it illegal to waive copays and deductibles?
- How do you find out the amount of a patient’s deductible and copay?
- Can you collect deductibles, copays, or coinsurance up front prior to the adjudication of a claim?
- Can a patient refuse to pay a copay?

The End......or is it??