New Physicians and Residents:
Billing and Coding

Danielle Cooley, DO
ACOFP FULL DISCLOSURE FOR CME ACTIVITIES

Please check where applicable and sign below. Provide additional pages as necessary.

Name of CME Activity: 2017 ACOFP Annual Convention & Scientific Seminars
Dates and Location of CME Activity: March 16 - 19, 2017, Gaylord Palms Resort and Convention Center, Kissimmee, FL, United

Name of Faculty/Moderator: Danielle L. Cooley, DO

DISCLOSURE OF FINANCIAL RELATIONSHIPS WITHIN 12 MONTHS OF DATE OF THIS FORM

X

A. Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services.

B. I have, or an immediate family member has, a financial relationship or interest with a proprietary entity producing health care goods or services. Please check the relationship(s) that applies.

- [ ] Research Grants
- [ ] Speakers' Bureaus*
- [ ] Ownership
- [ ] Consultant for Fee
- [ ] Stock/Bond Holdings (excluding mutual funds)
- [ ] Employment
- [ ] Partnership
- [ ] Others, please list:

Please indicate the name(s) of the organization(s) with which you have a financial relationship or interest, and the specific clinical area(s) that correspond to the relationship(s). If more than four relationships, please list on separate piece of paper:

<table>
<thead>
<tr>
<th>Organization With Which Relationship Exists</th>
<th>Clinical Area Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
</tr>
</tbody>
</table>

*If you checked “Speakers’ Bureaus” in item B, please continue:

- Did you participate in company-provided speaker training related to your proposed topic? Yes: No:
- Did you travel to participate in this training? Yes: No:
- Did the company provide you with slides of the presentation in which you were trained as a speaker? Yes: No:
- Did the company pay the travel/lodging/other expenses? Yes: No:
- Did you receive an honorarium or consulting fee for participating in this training? Yes: No:
- Have you received any other type of compensation from the company? Please specify: Yes: No:
- When serving as faculty for ACOFP, will you use slides provided by a proprietary entity for your presentation and/or lecture handout materials? Yes: No:
- Will your topic involve information or data obtained from commercial speaker training? Yes: No:

DISCLOSURE OF UNLABELED/INVESTIGATIONAL USES OF PRODUCTS

X

A. The content of my material(s)/presentation(s) in this CME activity will not include discussion of unapproved or investigational uses of products or devices.

B. The content of my material(s)/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated below:

I have read the ACOFP policy on full disclosure. If I have indicated a financial relationship or interest, I understand that this information will be reviewed to determine whether a conflict of interest may exist, and I may be asked to provide additional information. I understand that failure or refusal to disclose, false disclosure, or inability to resolve conflicts will require the ACOFP to identify a replacement.

Signature: Danielle L. Cooley, DO
Date: 2.3.17

Please email this form to joank@acofp.org as soon as possible
Deadline: Friday, February 10, 2017
Billing & Coding – What you need to Know

Danielle Cooley, DO
Associate Professor
RowanSOM
Family Medicine & Osteosciences

Learning Objectives

• Differentiate between E/M levels of service
• Identify when the -25 Modifier is necessary
• Recognize the appropriate codes to use for Medicare Wellness Visits, Wellness visits, and TCM visits
• Describe proper billing strategies for OMT procedures
• Recall necessary components for reimbursement of counseling and coordination of care services in the office setting
• Discuss proper billing components for immunizations given in the office
Overview

- CPT Coding
- Preventive Service Coding
- Medicare Wellness Coding
- Preoperative Visit Coding
- Transition of Care Management Visit Coding (TCM)
- Evaluation/Management Coding
- OMT Billing
- Modifiers
- Additional Billable Services
- Proper Billing of Immunizations

CURRENT PROCEDURAL TERMINOLOGY (CPT)
Current Procedural Technology - CPT

List of descriptive terms and identifying codes for reporting medical services and procedures

Provides a universal language

• Describes medical, surgical, diagnostic services
• Reliable nationwide communication

Main Types in Family Medicine

• E/M
• Preventative
• Procedures

Healthcare Common Procedure Coding System (HCPCS)

Known as “hicks picks”

Developed by CMS

Describes many different parts of healthcare

Level 1: CPT Codes

Level 2: Devices and Supplies
PREVENTATIVE SERVICES CODING

CPT Codes- Preventive Codes

“Health Maintenance Assessments”, “Physicals”, “Wellness Visits”

Based patient age and New/Established status

Note: Medicare does not cover these- there are separate HCPCS Codes for these
CPT- Preventive Services

**New Patients**
- 99381 < 12 months
- 99382 1-4 years
- 99383 5-11 years
- 99384 12-17 years
- 99385 18-39 years
- 99386 40-64 years
- 99387 65+ years

**Established Patients**
- 99391 <12 months
- 99392 1-4 years
- 99393 5-11 years
- 99394 12-17 years
- 99395 18-39 years
- 99396 40-64 years
- 99397 65+ years

---

Medicare Wellness Visits

- Medicare has separate Preventive Service HCPCS codes (similar to a CPT)
- New since The Affordable Care Act in 2011
- Coverage of certain preventive services
  - Annual Wellness Visit
  - USPSTF Grade A/B
  - Recommendations
    - ACIP Recommendations
      Some in Medicare Part B, Some Medicare Part D
Medicare Wellness Visits- HCPCS Codes

- G0402 - Initial Preventive Physical Exam (Welcome to Medicare)
- G0438 - Initial Annual Wellness Visit
- G0439 - Subsequent Annual Wellness Visit

Differences in timing of visits and how long the patient has been with Medicare

Pre-operative Visits

- Complete history and physical
- Documentation of the procedure and date of service
- E/M Codes - 99213, 99214, 99215
Preoperative Visits - Diagnosis Codes

1. Pre-operative Risk
   - Z01.810 - Cardiac Pre-op exam
   - Z01.811 - Respiratory Pre-op Exam
   - Z01.818 - General Pre-Op Exam

2. Diagnosis that is requiring the patient to have surgery

3. Diagnosis that is putting the patient at risk

Preoperative Visit - Example

1. Z01.810 - Cardiac Exam

2. K80.20 Gallstones

3. I50.42 Chronic Combined CHF
Transition of Care Management Visits

Interactive Patient Contact
- Must be within 48 hours (2 business days) of discharge, except holidays
- Documentation of 2 attempted calls also counts

Medication Reconciliation
- Must be completed no later than the day of face-to-face appointment

Face to Face Encounter
- 99495 - 7-14 days of discharge with moderate complexity MDM
- 99496 - 7 days of discharge with high complexity MDM

EVALUATION/MANAGEMENT (E/M CODING)
Evaluation & Management Services

New Patient Visits - Problem Based
- 99201
- 99202
- 99203
- 99204
- 99205

Established Patient Visits - Problem Based
- 99211 * No Physician Necessary*
- 99212
- 99213
- 99214
- 99215

CPT - Hospital Visits

Based on Complexity of History/Exam/Medical Decision Making

Initial Hospital Visit
- 99221
- 99222
- 99223

Hospital Follow Up
- 99231
- 99232
- 99233
CPT- Hospital- Observation Status

Patients are not admitted to the hospital – Observation Based on History/Exam/Medical Decision Making

99234
99235
99236

Picking the Correct Code

3 Key Components
Counseling & Coordination of Care/Time

History
Examination
Medical Decision Making
Picking the Correct Code

3 Key Components

- History
- Examination
- Medical Decision Making

Counseling & Coordination of Care/Time
3 Key Components - History

Level of Service Based on:

- HPI
- Review of Systems
- Past Medical/Family/Social History

<table>
<thead>
<tr>
<th>Component</th>
<th>Problem Focused (99212)</th>
<th>Expanded Problem Focus (99213)</th>
<th>Detailed (99214)</th>
<th>Comprehensive (99215)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI- Chronic Conditions</td>
<td>1-2 Chronic Conditions (Status)</td>
<td></td>
<td>3 Chronic Conditions (Status)</td>
<td></td>
</tr>
<tr>
<td>HPI-Acute*</td>
<td>Brief (1-3 elements)</td>
<td></td>
<td>Extended (4+ elements)</td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Pertinent 1 System</td>
<td>Extended (2-9 systems)</td>
<td></td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>Pertinent (1 area)</td>
<td>Complete (2 or 3 areas)</td>
<td></td>
</tr>
</tbody>
</table>
3 Key Components- History

**HPI Acute Elements:** Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated signs/symptoms

**New Patient:** Level Determined by 3 out of 3 components (lowest common)

**Established Patient:** Level Determined by 2 out of 3 components (lowest common)

3 Key Components- History Example

Patient visit included:

- HPI- discussed and documents 2 chronic conditions
- ROS- general, cardiac, pulmo, gastro
- Past Family history reviewed and documented
### 3 Key Components - History Example

<table>
<thead>
<tr>
<th>Component</th>
<th>Problem Focused (99202/99212)</th>
<th>Expanded Problem Focus (99203/99213)</th>
<th>Detailed (99204/99214)</th>
<th>Comprehensive (99205/99215)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI- Chronic Conditions</td>
<td>1-2 Chronic Conditions (Status)</td>
<td></td>
<td>3 Chronic Conditions (Status)</td>
<td></td>
</tr>
<tr>
<td>HPI-Acute*</td>
<td>Brief (1-3 elements)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Pertinent 1 System</td>
<td>Extended (2-9 systems)</td>
<td>Complete (10+ systems)</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>Pertinent (1 area)</td>
<td></td>
<td>Complete (2 or 3 areas)</td>
</tr>
</tbody>
</table>

### 3 Key Components - History Example

<table>
<thead>
<tr>
<th>Component</th>
<th>Problem Focused (99202/99212)</th>
<th>Expanded Problem Focus (99203/99213)</th>
<th>Detailed (99204/99214)</th>
<th>Comprehensive (99205/99215)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI- Chronic Conditions</td>
<td>1-2 Chronic Conditions (Status)</td>
<td></td>
<td>3 Chronic Conditions (Status)</td>
<td></td>
</tr>
<tr>
<td>HPI-Acute*</td>
<td>Brief (1-3 elements)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Pertinent 1 System</td>
<td>Extended (2-9 systems)</td>
<td>Complete (10+ systems)</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>Pertinent (1 area)</td>
<td></td>
<td>Complete (2 or 3 areas)</td>
</tr>
</tbody>
</table>
3 Key Components - Exam

Criteria based on Body areas or Organ Systems

Cannot be a combination of above

Body areas- should have 4 elements examined and documented

- Ex- Pulm- CTA B/L, no rales, no rhonchi, no wheezing
### 3 Key Components - Exam

<table>
<thead>
<tr>
<th>Component</th>
<th>Problem Focused (99202/99212)</th>
<th>Expanded Problem Focus (99203/99213)</th>
<th>Detailed (99204/99214)</th>
<th>Comprehensive (99205/99215)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body Areas:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Head, including face</td>
<td>- Each Extremity</td>
<td>1 body area</td>
<td>Up to 7 areas</td>
<td>Up to 7 areas</td>
</tr>
<tr>
<td>- Chest, including breast/axilla</td>
<td>- Neck</td>
<td></td>
<td>Up to 7 areas</td>
<td>8 or more areas</td>
</tr>
<tr>
<td>- Abdomen</td>
<td>- Genitalia-groin, buttock</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Back, including spine</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organ System:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Const</td>
<td>- GU</td>
<td>1 body system</td>
<td>Up to 7 Systems</td>
<td>8 or more systems</td>
</tr>
<tr>
<td>- Eyes</td>
<td>- Musc</td>
<td></td>
<td>Up to 7 Systems</td>
<td></td>
</tr>
<tr>
<td>- ENT</td>
<td>- Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cardio</td>
<td>- Neuro</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pulm</td>
<td>- Psych</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- GI</td>
<td>- Heme/Lymph</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Picking the Correct Code**

- **History**
- **Examination**
- **3 Key Components**
- **Counseling & Coordination of Care/Time**
- **Medical Decision Making**
3 Key Components - Medical Decision Making

Complexity of Diagnosis and Management

Three Elements:

- Number of possible diagnoses and/or number of management options (Box A)
- Amount and/or complexity of medical recorders, diagnostic tests, and/or other information that must be obtained (Box B)
- Risk of complications, morbidity, and/or mortality as well as co-morbidities associated with the problems, diagnostic procedures and the possible management options (Box C)

Medical Decision Making – Box A

<table>
<thead>
<tr>
<th>Problem Status</th>
<th>Number</th>
<th>Points</th>
<th>Result (# x Pts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited/Minor</td>
<td>Max = 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established Problem (to Examiner) stable, improved</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established Problem (to Examiner) worsening</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New Problem (to examiner) No additional work up</td>
<td>Max= 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New Problem- Additional work up</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Medical Decision Making - Box B

### Box B - Amount and/or Complexity of Data Reviewed

<table>
<thead>
<tr>
<th>Data Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or Lab Test</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or Order Radiology</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or Order Medicine Test</td>
<td>1</td>
</tr>
<tr>
<td>Discuss Results with Performing Physician</td>
<td>1</td>
</tr>
<tr>
<td><strong>Decision</strong> to obtain old records and/or obtain history from someone other than the patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than the patient and/or discussion of the case with another healthcare provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent Visualization of Image, Tracing, or Specimen itself (not report)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Box C - Risk of Complications/Morbidity/Mortality

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedures Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One Self-limited/minor</td>
<td>-Labs; CXR; EKG; U/A; Ultrasound; KOH prep</td>
<td>Rest/Gargles/ superficial dressings/ bandages</td>
</tr>
<tr>
<td>Low</td>
<td>-Two+ self limited/minor</td>
<td>-Physiologic Tests (non-stress)</td>
<td>-OTC Meds</td>
</tr>
<tr>
<td></td>
<td>-One stable chronic</td>
<td>-Non-cardio imaging studies with contrast</td>
<td>-Minor Surgery</td>
</tr>
<tr>
<td></td>
<td>-Acute uncomplicated illness/injury</td>
<td>-Superficial needle biopsies</td>
<td>-PT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Arterial Punctures</td>
<td>-OT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Skin Biopsies</td>
<td>-IV fluids</td>
</tr>
<tr>
<td>Moderate</td>
<td>-1+ chronic condition with mild exacerbation/progression/side effect of treatment</td>
<td>-Stress Tests (cardiac and fetal)</td>
<td>-Minor surgery with risk</td>
</tr>
<tr>
<td></td>
<td>-2+ stable chronic</td>
<td>-Endoscopy</td>
<td>-Elective major surgery without risk</td>
</tr>
<tr>
<td></td>
<td>-Undiagnosed new problem with uncertain prognosis</td>
<td>-Deep needle bx</td>
<td>-Rx Meds</td>
</tr>
<tr>
<td></td>
<td>-Acute illness with systemic symptoms</td>
<td>-cardiovascular imaging with contrast</td>
<td>-Therapeutic nuclear med</td>
</tr>
<tr>
<td></td>
<td>-Acute complicated injury</td>
<td>-obtain fluid from body cavity</td>
<td>-IV fluid with additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-closed treatment of fracture/dislocation without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>-1+ chronic illness with severe exacerbation/progression/side effect</td>
<td>-cardiovascular imaging with risk factors</td>
<td>-Elective major surgery with risk</td>
</tr>
<tr>
<td></td>
<td>-acute/chronic condition posing threat to life/bodily function</td>
<td>-cardiac EP studies</td>
<td>-Emergency major surgery</td>
</tr>
<tr>
<td></td>
<td>-abrupt change in neurologic status</td>
<td>-endoscopy with risk factors</td>
<td>-Parenteral CDS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-discography</td>
<td>-Drug therapy with intensive monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Decision for DNR or to de-escalate care d/t poor prognosis</td>
</tr>
</tbody>
</table>
## Medical Decision Making - Components

### Final Results for Medical Decision Making Complexity

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Complexity of Data</th>
<th>Highest Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>≤1 minimal</td>
<td>Minimal</td>
</tr>
<tr>
<td></td>
<td>2 limited</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>≥4 extensive</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>3 multiple</td>
<td>High</td>
</tr>
</tbody>
</table>

### Selecting the Right E/M Level

#### NEW PATIENT - OUTPATIENT

<table>
<thead>
<tr>
<th>Requirements</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>TIME (min)</th>
<th>LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires 3 components at minimum level</td>
<td>Prob Focused</td>
<td>Expan Prob Focused</td>
<td>Prob Focused</td>
<td>Self-limited</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>30</td>
<td>45</td>
<td>60</td>
<td>99201</td>
</tr>
<tr>
<td></td>
<td>99202</td>
<td>99203</td>
<td>99204</td>
<td>99205</td>
<td></td>
</tr>
</tbody>
</table>

#### ESTABLISHED PATIENT - OUTPATIENT

<table>
<thead>
<tr>
<th>Requirements</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>TIME (min)</th>
<th>LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires 2 components at minimum level</td>
<td>Minimal Problem</td>
<td>Prob Focused</td>
<td>Expan Prob Focused</td>
<td>Self-limited</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>15</td>
<td>25</td>
<td>40</td>
<td>99211</td>
</tr>
<tr>
<td></td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
<td></td>
</tr>
</tbody>
</table>
Counseling & Coordination of Care

This goes hand in hand with your time based coding

Documentation must reflect – If you didn’t write it down, it didn’t happen!!!

Cannot count time spent by the resident or Fellow in the absence of a teaching physician
Counseling & Coordination of Care

- Diagnostic results, impression, and recommended procedures
- Risk Factor reduction
- Prognosis
- Patient education
- Risks and benefits of treatment options
- Follow up

Time - Using Time to Code

Document Total Face-To-Face Time with Patient/Family

- Start and stop time or X/Y minutes
- Example: 20/25 minutes spent counseling on behavioral modifications
- Example: Physician Start: 8:30, Physician Stop: 8:59

> 50% of time spent counseling patient

Discussed Coordination of Care

- Treatment Options
- Medication Adjustments
- Risks/Benefits discussed

Need all 3 to Use time to select the level of service
PUTTING IT ALL TOGETHER: CASE

Putting it All Together: Case

- 64 y/o female presents to office for evaluation of cough x 2 weeks.
  - HPI: Cough has been present for 2 weeks, worsening in that time, now moderate in intensity. Productive of yellow mucus. Worse at night. Has hx of COPD but this is worse than baseline. Robitussin did help some, but cough returned. Pt has also noted fevers (Tmax 102.1 yesterday), and worsening shortness of breath, particularly at night. Using inhaler several times per day. (Last use 1 hour ago)
  - ROS: +fevers, -chills, -rigors; +dyspnea, +productive cough, -chest pain, -palpitations, -abd pain, -nausea/vomitting
  - PMFSH:
    - PMHx: COPD, HTN, Vitamin D Deficiency
      - Meds: Albuterol HFA PRN, Enalapril 5mg daily, HCTZ 25mg daily, Ca/Vitamin D OTC
    - SocHx: +1/2ppd smoker x 30 years, no EtOH, no illicit drugs
    - FamHx: mother with HTN, father with kidney disease, both deceased
Putting it All Together: Case

• 64 y/o female established patient presents to office for evaluation of cough x 2 weeks.
  – HPI: 4+ elements
  – ROS: 4 systems
  – PMFSH: 3 elements

<table>
<thead>
<tr>
<th>Component</th>
<th>Problem Focused</th>
<th>Expanded Problem Focus</th>
<th>Detailed Focus</th>
<th>Comprehensive Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI-Chronic Conditions</td>
<td>1-2 Chronic Conditions (Status)</td>
<td></td>
<td>3 Chronic Conditions (Status)</td>
<td></td>
</tr>
<tr>
<td>HPI-Acute*</td>
<td>Brief (1-3 elements)</td>
<td></td>
<td>Extended (4+ elements)</td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td>Pertinent 1 System</td>
<td>Extended (2-9 systems)</td>
<td>Complete (10+ systems)</td>
<td></td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>Pertinent 1 System</td>
<td>Complete (2 or 3 areas)</td>
<td></td>
</tr>
</tbody>
</table>

Putting it All Together: Case

Exam -
• Vitals: T 100.8F, BP 160/108, RR 22, HR 90, Pox 96%
• Gen: well groomed, no acute distress
• ENT: Throat non-injected, no exudates; TM intact b/l with no bulging, retraction or erythema; normal nasal turbinates
• Cardio: regular, +s1/+s2, no murmurs, no palpable thrill
• Resp: Good effort, +expiratory wheezing b/l with decreased breath sounds LLL. No egophony or fremitus noted.
Putting it All Together: Case

Exam-
- Vitals: T 100.8F, BP 160/108, RR 22, HR 90, Pox 96%
- Gen: well groomed, no acute distress
- ENT: Throat non-injected, no exudates; TM intact b/l with no bulging, retraction or erythema; normal nasal turbinates
- Cardio: regular, +s1/+s2, no murmurs, no palpable thrill
- Resp: Good effort, +expiratory wheezing b/l with decreased breath sounds LLL. +rhonchi in the LLL. No egophony or fremitus noted.

<table>
<thead>
<tr>
<th>Body Areas</th>
<th>Problem Focused</th>
<th>Expanded Problem Focus</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 body area</td>
<td>Up to 7 areas</td>
<td>Up to 7 areas</td>
<td>8 or more areas</td>
</tr>
</tbody>
</table>

Putting it All Together: Case

Assessment/Plan-
- 1. Community Acquired Pneumonia
  - Empiric treatment with antibiotics
  - Rx nebulizer q6hrs PRN
  - T/C Steroids if no improvement with above
  - Check CXR abnormal lung exam
- 2. HTN (deteriorated)
  - Increase enalapril to 10mg daily
Medical Decision Making

Box A - Number of Diagnoses or Treatment Options

<table>
<thead>
<tr>
<th>Problem Status</th>
<th>Number</th>
<th>Pts</th>
<th>Result (#xPts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited/Minor</td>
<td>Max = 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established Problem (to Examiner) stable, improved</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Established Problem (to Examiner) worsening</td>
<td>Max = 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New Problem (to examiner) No additional work up</td>
<td>Max = 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New Problem - Additional work up</td>
<td>Max = 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Box B - Amount and/or Complexity of Data Reviewed

<table>
<thead>
<tr>
<th>Data Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or Lab Test</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or Order Radiology</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or Order Medicine Test</td>
<td>1</td>
</tr>
<tr>
<td>Discuss Results with Performing Physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than the patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than the patient and/or discussion of the case with another healthcare provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent Visualization of Image, Tracing, or Specimen itself (not report)</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
</tr>
</tbody>
</table>

Box C - Risk of Complications/Morbidity/Mortality

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedures Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One Self-limited/minor</td>
<td>-Labs; CXR; EKG; U/A; Ultrasound; KOH prep</td>
<td>-Rest/Gargles/ superficial dressings/bandages</td>
</tr>
<tr>
<td>Low</td>
<td>-Two+ self limited/minor -One stable chronic -Acute uncomplicated illness/injury</td>
<td>-Physiology tests (non-stress) -Non-cardio imaging studies with contrast -Superficial needle biopsies -Arterial Punctures -Skin Biopsies</td>
<td>-OTC Meds -Minor Surgery -PT -OT -IV fluids</td>
</tr>
<tr>
<td>High</td>
<td>-1+ chronic condition with severe exacerbation/progression/side effect -acute/chronic condition posing threat to life/bodily function -abrupt change in neurologic status</td>
<td>-cardiovascular imaging with risk factors -cardiac EP studies -endoscopy with risk factors -discography</td>
<td>-Elective major surgery with risk -Emergency major surgery -Parenteral CDS -Drug therapy with intensive monitoring -Decision for DNR or to de-escalate care d/t poor prognosis</td>
</tr>
</tbody>
</table>
Medical Decision Making - Components

### Final Results for Medical Decision Making Complexity

<table>
<thead>
<tr>
<th>A</th>
<th>Number of diagnoses</th>
<th>≤1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>≥4 extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Complexity of Data</td>
<td>≤1 minimal</td>
<td>2 limited</td>
<td>3 multiple</td>
<td>≥4 extensive</td>
</tr>
<tr>
<td>C</td>
<td>Highest Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

#### Type of Decision Making
- Straight-Forward
- Low Complexity
- Moderate Complexity
- High Complexity

### Putting It All Together - Case

#### History

<table>
<thead>
<tr>
<th>Component</th>
<th>Prob Foc</th>
<th>Expanded Problem Focus</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI-Chronic Conditions</td>
<td>1-2 Chronic Conditions (Status)</td>
<td>3 Chronic Conditions (Status)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPI-Acute*</td>
<td>Brief (1-3 elements)</td>
<td>Extended (4+ elements)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Pertinent 1 System</td>
<td>Complete (10+ systems)</td>
<td></td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>Pertinent (1 area)</td>
<td>Complete (2 or 3 areas)</td>
<td></td>
</tr>
</tbody>
</table>

#### Exam

<table>
<thead>
<tr>
<th>Body Areas</th>
<th>Problem Focused</th>
<th>Expanded Problem Focus</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 body area</td>
<td>Up to 7 areas</td>
<td>Up to 7 areas</td>
<td>8 or more areas</td>
<td></td>
</tr>
</tbody>
</table>

### Medical Decision Making

<table>
<thead>
<tr>
<th>A</th>
<th>Number of diagnoses</th>
<th>≤1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>≥4 extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Complexity of Data</td>
<td>≤1 minimal</td>
<td>2 limited</td>
<td>3 multiple</td>
<td>≥4 extensive</td>
</tr>
<tr>
<td>C</td>
<td>Highest Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

#### Type of Decision Making
- Straight-Forward
- Low Complexity
- Moderate Complexity
- High Complexity

#### CODED AS A 99214 LEVEL VISIT

<table>
<thead>
<tr>
<th>ESTABLISHED PATIENT- OUTPATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
</tr>
<tr>
<td>Prob Focused</td>
</tr>
<tr>
<td>Exam</td>
</tr>
<tr>
<td>Prob Focused</td>
</tr>
<tr>
<td>MDM</td>
</tr>
<tr>
<td>Self-limited</td>
</tr>
<tr>
<td>TIME (min)</td>
</tr>
<tr>
<td>LEVEL</td>
</tr>
</tbody>
</table>
Documentation

All Billable Services must be supported by documentation in the chart note.

Diagnosis codes should be as specific as possible.

Include acuity if diagnosis (new, stable, deteriorated, improved).

Use signs and symptoms if unable to make a definitive diagnosis during encounter.

- Cannot code diagnosis described as “rule out,...probable,...possible,...questionable”


- Example: ESRD impacts antibiotic choices

Include conditions being managed by specialist that you need to consider when making medical decisions.

- Example: Steroids will affect DM control
OMT BILLING AND CODING

Billing for OMT

OMT is billed as a CPT code (procedure)

**Needs to be a separate and distinct procedure**

- The E/M service may be causes or prompted by the same symptoms or condition for which the OMT service was provided

Need to link the diagnosis codes to the procedure codes
Billing for OMT

In order to bill for OMT and E/M service on the same day:

- Patient must have presented for another reason and OMT was decided upon by the physician as medical decision making
- Patient cannot have CC of “I’m here for OMT”
- Procedure note must be documented

OMT is a procedure in the CMS PCE

- Attending must be present for key and critical components

CPT Codes for OMT

Office-Based or Hospital Based OMT

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>98925</td>
<td>1-2 regions</td>
</tr>
<tr>
<td>98926</td>
<td>3-4 regions</td>
</tr>
<tr>
<td>98927</td>
<td>5-6 regions</td>
</tr>
<tr>
<td>98928</td>
<td>7-8 regions</td>
</tr>
<tr>
<td>98929</td>
<td>9-10 regions</td>
</tr>
</tbody>
</table>

Body Regions= head, cervical, thoracic, lumbar, sacrum, pelvis, LE, UE, rib, abdomen/other
ICD 10 Codes for OMT

<table>
<thead>
<tr>
<th>Code</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>M99.00</td>
<td>Head</td>
</tr>
<tr>
<td>M99.01</td>
<td>Cervical</td>
</tr>
<tr>
<td>M99.02</td>
<td>Thoracic</td>
</tr>
<tr>
<td>M99.03</td>
<td>Lumbar</td>
</tr>
<tr>
<td>M99.04</td>
<td>Sacrum</td>
</tr>
<tr>
<td>M99.05</td>
<td>Pelvis</td>
</tr>
<tr>
<td>M99.06</td>
<td>UE</td>
</tr>
<tr>
<td>M99.07</td>
<td>LE</td>
</tr>
<tr>
<td>M99.08</td>
<td>Rib</td>
</tr>
<tr>
<td>M99.09</td>
<td>Abdomen/Other</td>
</tr>
</tbody>
</table>

Reimbursement for OMT CPTs

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Non-Facility Charge</th>
<th>Facility Charge (Inpatient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>98925</td>
<td>1-2 regions</td>
<td>$34.55</td>
<td>$26.30</td>
</tr>
<tr>
<td>98926</td>
<td>3-4 regions</td>
<td>$50.25</td>
<td>$39.65</td>
</tr>
<tr>
<td>98927</td>
<td>5-6 regions</td>
<td>$65.56</td>
<td>$52.60</td>
</tr>
<tr>
<td>98928</td>
<td>7-8 regions</td>
<td>$80.48</td>
<td>$66.34</td>
</tr>
<tr>
<td>98929</td>
<td>9-10 regions</td>
<td>$96.18</td>
<td>$79.69</td>
</tr>
</tbody>
</table>

- OMT CPT Codes contain reimbursement for the history and PE components related to the OMT service
- A separate E/M code can only be billed if there is identifiable, separate components from the OMT in the visit and documentation supports
Modifiers

Ways to indicate another service was performed in addition to the primary service

Most commonly used modifier is the -25

Only used on E/M codes

Not used on Preventive Service Codes
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>-21</td>
<td>Prolonged E/M Service</td>
</tr>
<tr>
<td>-22</td>
<td>Unusual Procedural Service</td>
</tr>
<tr>
<td>-23</td>
<td>Unusual Anesthesia</td>
</tr>
<tr>
<td>-24</td>
<td>Unrelated E/M by same physician during post-op period</td>
</tr>
<tr>
<td>-25</td>
<td>Significant, separately identifiable E/M service by the same physician on the same day</td>
</tr>
<tr>
<td>-26</td>
<td>Professional Component</td>
</tr>
<tr>
<td>-27</td>
<td>Multiple outpatient hospital E/M on the same date</td>
</tr>
<tr>
<td>-32</td>
<td>Mandated Services</td>
</tr>
<tr>
<td>-47</td>
<td>Anesthesia by Surgeon</td>
</tr>
<tr>
<td>-50</td>
<td>Bilateral Procedure</td>
</tr>
<tr>
<td>-51</td>
<td>Multiple Procedures</td>
</tr>
<tr>
<td>-59</td>
<td>Two non-E/M services on same day</td>
</tr>
</tbody>
</table>

Modifiers

- **-25**: used for OMT, trigger point injections, cryotherapy, cerumen removal, etc
  - Anything that is a separately identifiable service

- **-59**: Used to report Distinct Procedure or Service was distinct or independent from the other non E/M service
  - Ex: OMT and cerumen removal
  - Ex: Separate biopsies at two site
Modifiers - Documentation

Scissor Test

All elements of procedure must be documented separately from the other service

- History/Exam/Procedure Note/Post-Procedure Plan
- Separate the E/M documentation with a procedure heading
- Not used for diagnostic tests (strep, Urine dipstick)

Procedure Heading

- Name: (Patient Name) Ex. John Doe
- DOB: (Patient DOB) Ex. 10-20-65
- Diagnosis: (Patient Diagnosis) Ex- Somatic Dysfunction of Multiple Regions
- Procedure: (Procedure) Ex. Osteopathic Manipulative Treatment
Billing for Procedures with Modifiers

Documentation Language is important

Example: “Patient was seen and examined and it was decided at that time to proceed with X to improve the patient’s symptoms. Risks/benefits were explained to the patient and the patient consented to the treatment”

Use of the -25 Modifier

Requirements:

Patient’s condition required a significant, separately identifiable E&M service above and beyond the other service provided

E&M Service may be prompted by the symptoms or condition for which the procedure was provided (or vice versa)

• Different diagnoses are NOT required for reporting the E&M services on the same date
Example of -25 Modifier

**Appropriate Use**
- Patient presents with complaint of L sided hearing loss
- History & Exam reveals significant cerumen impaction on the left
- Requires significant separately identifiable service
- E/M Service (99213, etc) Dx: hearing loss
- Cerumen Removal (69210) Dx: Cerumen impaction on the left
- Billing for E/M with -25 modifier (99213 -25, 69210)

**Inappropriate Use**
- Patient presents complaining of excess ear wax wishing cerumen removal
- Patient is requesting the service- a separate E/C code cannot be billed

Example of -25 Modifier- EKGs

**Appropriate Use**
- Patient presents with complaint of chest pain
- History & Exam reveals chest pain and normal/abnormal cardiac exam
- Requires significant separately identifiable service
- E/M Service (99213, etc) Dx: chest pain-EKG(93000) Dx: chest pain
- Billing for E/M with -25 modifier (99213 -25, 93000)

**Inappropriate Use**
- Patient presents for pre operative EKG (not pre op exam)
- Patient is requesting the service- a separate E/C code cannot be billed-only bill for the EKG
ADDITIONAL BILLABLE SERVICES

Alcohol Misuse Screening/Counseling

**CMS**
- G0442- Alcohol Misuse Screenings (15 mins)- Annual
- G0443- Brief Face-to-Face behavioral counseling (15 min)- 4 times per year for those who screen +
- No Copay/deductible

**Other**
- 99408- Structured Screening (AUDIT/DAST, etc) with brief intervention; 15-30 mins
- 99409- > 30 minutes
Depression Screening

**CMS**
- G0444 - Annual screening (15 min)
- Need to have depression care supports available in office to utilize
- Copay/Deductible waived

**Other**
- 99420 – Administration and Interpretation of Health Risk Assessment

Diabetes Self Management Training

**CMS**
- G0108 - DSMT - individual - per 30 mins
- G0109 - DSMT - group (2+) per 30 mins
- Must be provider treating DM. Must be physician or NPP (PA/NP)
- Frequency – up to 10 hours in 12 months in first year, 2 hours of follow up each subsequent year
- Copay/Deductible applies

**Other**
- 98960 - 30 min individual DSMT by CDE/RD/RN
- 98961 - 2-4 patients
- 98962 - 5-8 patients
**Intensive Behavioral Therapy (IBT) for Obesity**

**CMS**
- G0447: Face-to-Face, 15 mins
- G0473: Face-to-Face, group (2-10), 30 mins
- Covered: obese patients

**Other**
- 99401: 15 minutes
- 99402: 30 minutes
- 99403: 45 minutes
- 99404: 60 minutes

Frequency:
- 1st month: weekly
- 2-6th month: QOW
- 7-12th month: monthly, to get past 6 months, pts must have lost 3 kgs (6.6 lb)

Copay/Deductible waived

---

**Counseling to Prevent Tobacco Use**

**CMS**
- G0436: Asymptomatic patient, 3-10 mins
- G0437: Asymptomatic patient, >10 mins

Frequency: 2 cessation attempts per year
- Max 4 sessions per attempt

Copay/Deductible waived

**Other**
- 99406: intermediate 3-10 minutes
- 99407: intermediate >10 minutes
IBT for Cardiovascular Disease

CMS

- G0446: Annual F2F behavioral therapy for CV disease - 15 mins
- Frequency: Annually
- Copay/Deductible waived

Other

- 99401: 15 minutes
- 99402: 30 minutes
- 99403: 45 minutes
- 99404: 60 minutes

IMMUNIZATIONS
Key Points to Immunizations

Reimbursement for two components:
- The act of injecting
- The substance injected

An immunization is an injection, but has a specific administration code
- Different than other injections (B12, depomedrol, etc)

Difference between Medicare vs. Other

Immunizations - Medicare

Medicare covers immunizations recommended by the Advisory Council on Immunization Practices (ACIP)
- Some as Part B
- Some as Part D

Influenza vaccine, pneumococcal vaccine and hepatitis B (where indicated) are covered as Part B benefit

Others as part D (Zoster, Tdap, etc)
Immunizations- Medicare

Administration Codes
- G0008- Influenza Vaccine Administration
- G0009- Pneumococcal Vaccine Administration
- G0010- Hepatitis B Vaccine Administration

Code for Vaccine Serum
• Different for each vaccine formulation

Diagnosis Code- ICD-10
• Z23- on code for ALL vaccines
Immunizations- Non-Medicare

**Administration Codes**

**Age-based**

Two different admin codes per age group depending on how many vaccines are administered

---

**Immunization- Non-Medicare**

**Pediatric Patients** Age 1-18 (Counseling needed)

- 90460: administration with counseling first vaccine/toxoid component
- 90461: each additional vaccine/toxoid component

**Adult Patients** (Age 19+) (no counseling needed)

- 90471: Immunization Administration, on vaccine (IM/SQ)
- 90472: Immunization Administration, each add’l (IM/SQ)
- 90473: Immunization by intranasal or oral route, one vaccine
- 90474: Immunization Administration by intranasal or oral route, each add’l
Immunization- Vaccine Counseling

Provided face to face by physician or other appropriate healthcare provider

Can include

- VIS statement
- Evaluating for contraindications
- Answering parent/patient questions

Summary

- Understand accurate billing and coding for successful practice
- Demonstrate appropriate documentation to support billing and coding
- Utilize modifiers appropriately
- Summarize appropriate use of additional billable services
- Identify preventive service visits requirements
- Describe necessary documentation for OMT procedure codes
QUESTIONS????

References


• https://www.cms.gov/apps/physician-fee-schedule/search