Coding: What You Need to Know

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Disclosures

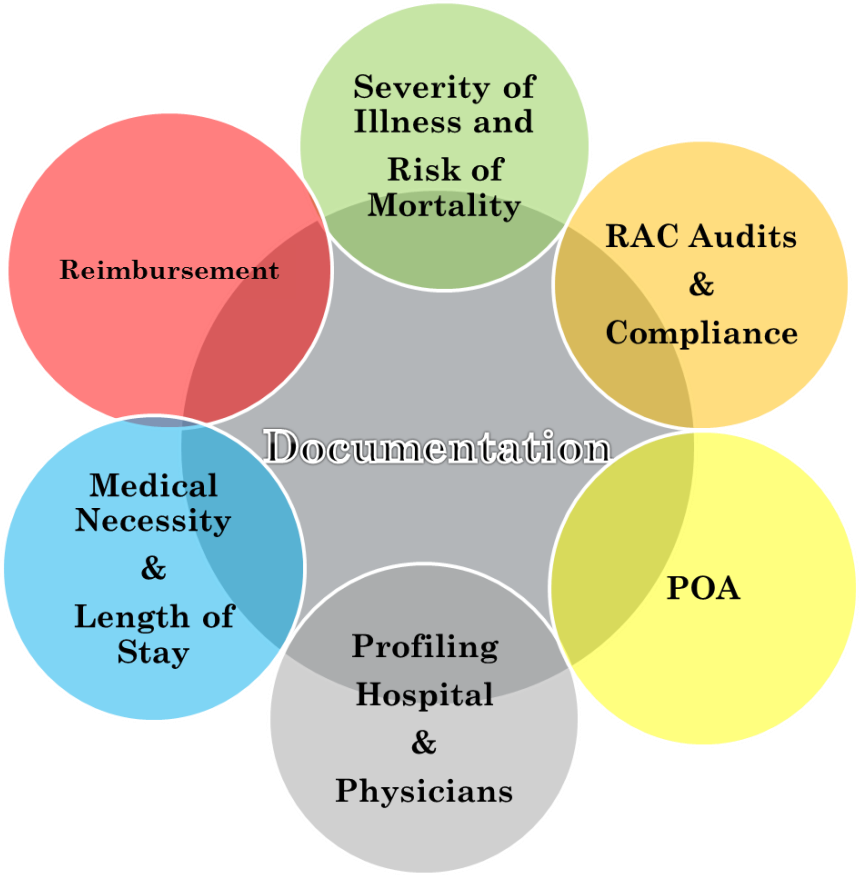
None

Outline

- What is documentation used for?
- Why does documentation matter?
- What documentation counts and where does it come from?
- What are the components required to select appropriate level of E/M services?
- MEAT of a diagnosis
- Points to remember when documenting
- Inpatient
- Office Visits, established and new
- Preventative care visits
- RVUs
- Modifier 25 Facts***

What is documentation used for?

- **Documentation demonstrates the severity of illness and risk of mortality, medical necessity of admission, accurate data and statistics for hospital and provider, and regulatory compliance.**



Why Does Provider Documentation matter?

- **Presents accurate picture of a patients status**

- **Provider documentation is converted into medical codes that are used to:**
  - **Compare actual mortality with expected mortality**
  - **Compare actual length of stay to expected length of stay**
  - **Compare physician and facility performance to peers- "benchmarking" Health Grades, Physician Compare, Leapfrog**
  - **Reimbursement**

What Documentation Counts? Where does it come from?

- **Documentation comes from:**
  - **All narrative documentation by treating providers**
    - **(H&P, progress notes, op-notes & discharge summary)**
  - **Coding staff cannot make clinical assumptions**
  - **Coding staff cannot code from reports written by non-treating MD (such as radiologist or pathologist).**

Components required to select appropriate level of E/M services?

History- includes some or all of the following

- ❑ Chief complaint (CC)
- ❑ History of present illness (HPI)
- ❑ Review of systems (ROS) and
- ❑ Past, family, and/or social history (PFSH)

Examination is based on four types

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

Medical Decision Making; 4 types

1. **Straight forward**
2. **Low complexity**
3. **Moderate complexity**
4. **High complexity**

Components required to select appropriate level of E/M services?

History

The History of Presenting Illness, HPI, is a chronological description of the development of the patient's presenting illness or problem from the first sign and/or symptom or from the previous encounter to the present.

HPI elements are:

Location (eg. diffuse, localized, unilateral, bilateral fixed, body area)
Quality (eg. sharp, dull, throbbing, chronic, aching, burning, radiating)
Severity (eg. on a scale of 1-10, more or less)
Duration (eg. started 3 days ago, since last visit)
Timing (eg. constant, comes and goes)
Context(eg. lifted an object)
Modifying factors (eg. better when heat applied)
Associated signs and symptoms (eg. hurts to swallow)

Components required to select appropriate level of E/M services?

History

Example of an Extended HPI using the 1995 E/M guidelines capturing 4 or more elements**:** Ben's sugars have been extremely high for over a week and are worse in the afternoon. It makes him dizzy and nauseous when this happens. Once he takes his insulin they drop back to normal.

Example of an Extended HPI for the 1997 E/M guidelines capturing the STATUS of 3 Chronic or inactive conditions:
Ben is here for follow up of his type 2 Diabetes which is currently uncontrolled. He continues to struggle with hypertension however, his hyperlipidemia is currently controlled well with exercise and medication.

Aim for 4 or more HPI elements or 3 chronic conditions

Components required to select appropriate level of E/M services?

History

Include complete ROS-an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

Positive and pertinent negative responses in **at least 10 systems**, including the one directly related to the problem identified in the HPI. Systems with positive or pertinent negative responses must be documented individually. For the remaining system, a notation indicating that all other systems are negative is permissible.

Constitutional (e.g. fever, weight loss)	Eyes
Ears, Nose Mouth, and Throat	Cardiovascular
Genitourinary	Respiratory
Gastrointestinal	Neurological
Psychiatric	Endocrine
Musculoskeletal	Hematologic/Lymphatic
Integumentary (skin and/or breast)	Allergic / immunologic

Components required to select appropriate level of E/M services?

HPI Elements				**Calculation**			
☐ Location ☐ Quality	☐ Severity ☐ Duration	☐ Timing ☐ Context	☐ Modifying factors ☐ Associated signs and symptoms	☐ **Brief** (1–3)	☐ **Brief** (1–3)	☐ **Extended (4 or more)**	☐ **Extended (4 or more)**
HPI: Status of Chronic Conditions ☐ 3 conditions				☐ **N/A**	☐ **N/A**	☐ **Status of 3 chronic conditions**	☐ **Status of 3 chronic conditions**
ROS: (Review of Systems)				☐ **None**	☐ **Pertinent to Problem** (1 system)	☐ **Extended** (2–9)	☐ **Complete** **Complete ROS**: Ten or more systems, or some systems with statement "all others negative."
☐ Constitutional (weight loss, etc.) ☐ Eyes	☐ Ears, nose, mouth, and throat ☐ Card/Vascular ☐ Respiratory	☐ GI ☐ GU ☐ Musc\Skeletal ☐ Integumentary *(Skin, breast)*	☐ Neuro ☐ Psych ☐ Endo ☐ Hem Lymph ☐ All/immuno ☐ All others negative				
PFSH (past medical, family, social history) areas ☐ Past history *(patient's past experiences with illnesses, operations, injuries and treatments)* ☐ Family history *(a review of medical events in the patient's family, including diseases which may be hereditary or place the patient is at risk)* ☐ Social history *(an age-appropriate review of past and current activities)* **Note**: For subsequent hospital and nursing facility E/M services, only an interval history is necessary. It is not necessary to record information about the PFSH.				☐ **None**	☐ **None**	☐ **Pertinent to problem** (1 history area)	☐ **Complete (2 or 3 history area)** Complete PFSH **Two history areas**: a) Established patients – office (outpatient) care; b) Emergency dept. **Three history areas**: a) New patients – office (outpatient) care, domiciliary care, home care; b) Initial hospital care; c) Hospital observation; d) Initial nursing facility care.
			Final Results	**Problem Focused**	**Expanded Problem Focused**	**Detailed**	**Comprehensive**

Components required to select appropriate level of E/M services?

Examination is based on four types

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

Components required to select appropriate level of E/M services?

Examination

Physical Exam: Includes Vital Signs & Lab results

Body Areas recognized (1995)
Head/including face
Neck
Chest/including breasts and axilla
Abdomen
Genitalia/groin and buttocks
Back
Each extremity

Document by Body area (1995) or Organ systems (1997) do not combine

Organ systems recognized (1997):
Constitutional
Eyes
Ears, nose, mouth, throat
Cardiovascular
Respiratory
Gastrointestinal
Genitourinary
Musculoskeletal
Skin
Neurologic
Psychiatric
Hematologic/Lymphatic/Immunologic

Components required to select appropriate level of E/M services?

Examination	Calculation – Choose either 1995 or 1997 rules to calculate result			
	1995			
Body areas: ☐ Head, including face ☐ Chest, including breast and axillae ☐ Abdomen ☐ Neck ☐ Back, including spine ☐ Genitalia, groin, buttocks ☐ Each extremity	☐ One body area or system	☐ 2–5 areas or systems (Minimal detail for areas and/or systems examined; check list type documentation without any expansion of documentation of findings)	☐ 6–7 areas or systems (Expanded documentation of the areas and/or systems examined; requires more than checklists; needs to have normal/abnormal findings expanded upon)	☐ 8 or more *systems only*
	1997			
Organ systems: ☐ Constitutional (e.g., vitals, gen app) ☐ Ears, nose. mouth, throat ☐ Respiratory ☐ GI ☐ GU ☐ Cardiovascular ☐ Musculoskeletal ☐ Skin ☐ Neuro ☐ Psych ☐ Hem/lymph/imm ☐ Eyes	☐ 1–5 bullets (1 or more body areas or system)	☐ 6 bullets (1 or more body areas or system)	☐ 12 bullets in 2 or more body areas/systems or 2 bullets in 6 or more body areas/ systems (except eye and psych exams, which are 9 bullets)	☐ 2 bullets in 9 or more body areas or systems; or complete single organ system
Final Results	**Problem Focused**	**Expanded Problem Focused**	**Detailed**	**Comprehensive**

Components required to select appropriate level of E/M services?

Medical Decision Making

The complexity of establishing a diagnosis and/or selecting a management option as measured by:

- ❑ the number of possible diagnoses and/or the number of management options that must be considered
- ❑ the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- ❑ the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options

Components required to select appropriate level of E/M services?

Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There is a maximum number in two categories.)

Table 3A

A—Problem(s) Status	B—Number	C—Points	D—Results
Self-limited or minor (stable, improved, or worsening)	Max = 2	1	
Est. problem (to patient); stable, improved		1	
Est. problem (to patient); worsening		2	
New problem (to patient); no additional workup planned	Max = 1	3	
New problem (to patient); add workup planned		4	
		Total	

Multiply the number in columns B—Number and C—Points and put the product in column D—Results. Enter a total for column D, then **bring total to line A in the "Final Result for Complexity" table below.**

Amount and/or Complexity of Data Reviewed

For each category or reviewed data identified, circle the number in the **Points** column. Total the points.

Table 3B

Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider.	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
Total	

Bring total to line C in final "Result for Complexity" table below.

Risk of Complications and/or Morbidity or Mortality

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. **Enter the level of risk identified in "Final Result for Complexity" table below.**

Table 3C

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, e.g., cold insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest X-rays • EKG/ EEG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension or • noninsulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function tests • Noncardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-Counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illness with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac catheter • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic with no identified risk factors) • Prescription drug management (continuation & new prescription) • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic with identified risk factors) • Emergency major surgery (open, percutaneous or endoscopic) • Parental controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Final Result for Complexity

Table 3D

A	**Number diagnoses or treatment options**	**≤ 1 Minimal**	**2 Limited**	**3 Multiple**	**≥ 4 Extensive**
B	**Amount and Complexity of Data**	**≤ 1 Minimal**	**2 Limited**	**3 Moderate**	**≥ 4 Extensive**
C	**Highest Risk**	**Minimal**	**Low**	**Moderate**	**High**
	Type of decision making	**Straight Forward**	**Low Complexity**	**Moderate Complexity**	**High Complexity**

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the second circle from the left. After completing this table, circle the type of decision making within the appropriate grid in Section 5.

Components required to select appropriate level of E/M services?

If the physician documents total time *and* indicates that counseling or coordinating care dominates (more than 50%) the encounter, time **may determine level of service**. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction and/or discussion with another health care provider

Question	Answer	
Does documentation reveal total time?	☐ Yes	☐ No
Does documentation describe the content of counseling or coordinating care?	☐ Yes	☐ No
Does documentation reveal that more than half of the time was counseling or coordinating care?	☐ Yes	☐ No

If all answers are "yes," you may select level based on time.

Inpatient

	Initial Hospital/Observation—Requires three components within shaded area			**Subsequent Hospital**—Requires two components within shaded area		
History	D/C	C	C	PF interval	EPF interval	D interval
Examination	D/C	C	C	PF	EPF	D
Complexity of medical decision	SF/L	M	H	SF/L	M	H
Average time (minutes) (Initial observation care has no average time)	30 Init hosp (99221) Observation care (99218)	50 Init hosp (99222) Observation care (99219)	70 Init hosp (99223) Observation care (99220)	15 Subsequent (99231) Observation (99224)	25 Subsequent (99232) Observation (99225)	35 Subsequent (99233) Observation (99226)
Level	I	II	III	I	II	III

Nursing Facility Care

	Initial Nursing Facility—Requires three components within shaded areas			**Subsequent Nursing Facility**—Requires two components within shaded areas				**Other Nursing Facility** (Annual Assessment)—Requires three components within shaded areas
History	D/C	C	C	PF interval	EPF interval	D interval	C interval	D interval
Examination	D/C	C	C	PF	EFP	D	C	C
Complexity of medical decision	SF/L	M	H	SF	L	M	H	L/M
Average time (minutes) (Initial observation care has no average time)	25 (99304)	35 (99305)	45 (99306)	10 (99307)	15 (99308)	25 (99309)	35 (99310)	30 (99318)
Level	I	II	III	I	II	III	IV	

PF = Problem Focused | EPF = Expanded Problem Focused | D = Detailed | C = Comprehensive | SF = Straightforward | L = LowM = Moderate H = High

Components required to select appropriate level of E/M services?

If the physician documents total time *and* indicates that counseling or coordinating care dominates (more than 50%) the encounter, time **may determine level of service**. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction and/or discussion with another health care provider

Question	Answer	
Does documentation reveal total time?	☐ Yes	☐ No
Does documentation describe the content of counseling or coordinating care?	☐ Yes	☐ No
Does documentation reveal that more than half of the time was counseling or coordinating care?	☐ Yes	☐ No

If all answers are "yes," you may select level based on time.

Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care and Home Care

	New—Requires 3 components within shaded area					**Established**—Requires 2 components within the shaded area			
History	PF	EPF	D	C	C	PF interval	EPF interval	D interval	C interval
Examination	PF	EPF	D	C	C	PF	EPF	D	C
Complexity of medical decision	SF	L	M	M	H	SF	L	M	M/H
Average time (minutes)	20 Domiciliary (99324) Home Care (99341)	30 Domiciliary (99325) Home Care (99342)	45 Domiciliary (99326) Home Care (99343)	60 Domiciliary (99327) Home Care (99344)	75 Domiciliary (99328) Home Care (99345)	15 Domiciliary (99334) Home Care (99347)	25 Domiciliary (99335) Home Care (99348)	40 Domiciliary (99336) Home Care (99349)	60 Domiciliary (99337) Home Care (99350)
Level	I	II	III	IV	V	I	II	III	IV

PF = Problem Focused | EPF = Expanded Problem Focused | D = Detailed | C = Comprehensive | SF = Straightforward | L = LowM = Moderate H = High

Outpatient and Emergency Room (ER)

	New Office/ER—Requires three components within shaded area					**Established Office**—Requires two components within shaded area				
History	PF ER: PF	EPF ER: EPF	D ER: EPF	C ER: D	C ER: C	Minimal problem that may not require presence of physician	PF	EPF	D	C
Examination	PF ER: PF	EPF ER: EPF	D ER: EPF	C ER: D	C ER: C		PF	EPF	D	C
Complexity of medical decision	SF ER: SF	SF ER: L	L ER: M	M ER: M	H ER: H		SF	L	M	H
Average time (minutes) (ER has no average time)	10 New (99201) ER (99281)	20 New (99202) ER (99282)	30 New (99203) ER (99283)	45 New (99204) ER (99284)	60 New (99205) ER (99285)	5 (99211)	10 (99212)	15 (99213)	25 (99214)	40 (99215)
Level	I	II	III	IV	V	I	II	III	IV	V

What is MEAT?

For each diagnosis:

Monitor: Signs, Symptoms, disease progression, and disease regression

Evaluate: Test results, medication effectiveness, and response to treatment

Assess/Address: Ordering tests, discussion, review records, counseling

Treatment: Medications, therapies, other modalities

Points to Remember When Documenting

- **Acuity** and **consistency** matters
- Document all co-morbidities that are monitored/evaluated /treated. Note if Present on Admission
- Avoid sign/symptom dx followed by differential dx in the D/C summary
- Link all symptoms to a probable cause. Use the key terms: **Due To & Caused by**

Example:

AMS ⇨ **UTI** **(AMS due to UTI)**

Sepsis ⇨ **PNA** **(Sepsis due to PNA)**

Progress Notes

1. **For History:** 4 or more HPI elements or 3 chronic conditions

2. **For ROS:** Responses for 2-9 systems

3. For Examination: An extended examination of at least 2 elements from 6 areas/systems or 12 elements in 2 or more affected body area (s) and other symptomatic or related organ system(s).

4. Assessment: A comprehensive and succinct assessment of why the patient is here and what is going on with the patient that is updated **DAILY.**

****** Copy and Paste is an ongoing problem for EVERYONE. Please be very mindful and make sure things are updated on a DAILY basis. *****

Progress Notes

- A progress note must be written daily in sufficient detail to allow formulation of a reasonable picture of the patient's clinical status.

- The daily progress note should contain <u>enough information and detail to justify patient's inpatient stay each day.</u>
- Daily progress notes should provide new information daily and <u>not</u> be copy & pasted day to day

Progress Note

Subjective

Subjective:
Symptoms: Stable. No shortness of breath, cough or chest pain.
Diet: No nausea.

Objective

Objective:
General Appearance: Comfortable, well-appearing, in no acute distress and not in pain.
Vital signs: (most recent): Blood pressure 151/78, pulse 78, temperature 97.9 °F (36.6 °C), temperature source Oral, resp. rate 18, height 6' 4" (1.93 m), weight 195 lb (88.451 kg), SpO2 99 %.
Lungs: Normal respiratory rate and normal effort. Breath sounds clear to auscultation.
Heart: Normal rate. Regular rhythm. S1 normal and S2 normal.
Neurological: Patient is alert and oriented to person, place and time.
Abdomen: Abdomen is soft. There is no abdominal tenderness tenderness.

Labs:
CBC:
Lab Results

Component	Value	Date
WBC	4.8	6/9/2015
RBC	4.33	6/9/2015
HGB	11.7*	6/9/2015
HCT	35.7*	6/9/2015
MCV	82.4	6/9/2015
RDW	13.0	6/9/2015
PLT	244	6/9/2015

, BMP
Lab Results

Component	Value	Date
NA	137	6/9/2015
K	3.8	6/9/2015
CL	100	6/9/2015
CO2	29	6/9/2015
BUN	12	6/9/2015
CREATININE	0.90	6/9/2015

Labs:
CBC:
Lab Results

Component	Value	Date
WBC	4.8	6/9/2015
RBC	4.33	6/9/2015
HGB	11.7*	6/9/2015
HCT	35.7*	6/9/2015
MCV	82.4	6/9/2015
RDW	13.0	6/9/2015
PLT	244	6/9/2015

, BMP
Lab Results

Component	Value	Date
NA	137	6/9/2015
K	3.8	6/9/2015
CL	100	6/9/2015
CO2	29	6/9/2015
BUN	12	6/9/2015
CREATININE	0.90	6/9/2015
GLUCOSE	155*	6/9/2015
CALCIUM	8.9	6/9/2015

Assessment

Assessment:
(1. Cellulitis/gangrene right second toe
2. PVD
3. DM
4. HTN).

Plan:
(1. On IV abx, management as per ID and podiatry
2. Vascular surgery tomorrow pending cardiac clearance. Seen by Dr. Cho and underwent stress test today. Reports are pending
3. On insulin
4. BP elevated, on BP meds).

Discharge Summary

Reason for hospitalization: Chief complaint, including a description of the initial diagnostic evaluation.

Significant findings: Admission and discharge diagnoses (as well as those conditions resolved during hospitalization).

Procedures and treatment provided: Consults, procedure findings, surgical findings, test results, all diagnoses treated or evaluated during stay.

Patient's discharge condition: How the patient is doing at time of discharge.

- ✓ ***The discharge summary should not introduce new information, nor should it conflict with previous documentation substantiated in the record.***
- ✓ ***List all possible and probable diagnoses in the discharge summary***
- ✓ ***Studies have demonstrated a trend toward a decreased risk of readmission when the DC summary arrives before the outpatient follow- up visit takes place.***

CPT Codes- Office Visit

CPT	Established Office Visit
99212	Second lowest level of care for an established patient being seen in the office Usually the presenting problems are **self-limited or minor**. Documentation requires **TWO** out of **THREE** of the following: 1) Problem Focused History 2) Problem Focused Exam 3) Straightforward Medical Decision-Making Or 10 minutes spent face-to-face with the patient if coding based on time. The appropriate documentation must be included.
99213	Usually the presenting problems are of **low to moderate severity**. 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.

CPT Codes- Office Visit

CPT	Established Office Visit
99214	Usually the presenting problems are of **moderate to high severity.** 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
99215	The 99215 represents the highest level of care for established patients being seen in the office. Usually the problems are of **moderate to high severity**. The documentation for this encounter requires **TWO** out of **THREE** of the following : 1) Comprehensive History 2) Comprehensive Exam 3) High Complexity Medical Decision-Making Or 40 minutes spent face-to-face with the patient if coding based on time. The appropriate documentation must be included.

CPT Codes- Office Visit

CPT	New Office Visit
99202	2nd Lowest level of care for a new patient in the office. Usually the presenting problems are of low to moderate severity. Documentation for this encounter requires **THREE** out of **THREE** of the following : 1) Expanded Problem Focused History 2) Expanded Problem Focused Exam 3) Straightforward Medical Decision-Making Or 10 minutes spent face-to-face with the patient if coding based on time. The appropriate documentation must be included.
99203	Usually the presenting problems are of **mild to moderate severity**. Documentation for this encounter requires **THREE** out of **THREE** of the following: 1) Detailed History 2) Detailed Exam 3) Low Complexity Medical Decision-Making Or 30 minutes spent face-to-face with the patient if coding based on time. The appropriate documentation must be included.

CPT Codes- Office Visit

CPT	New Office Visit
99204	Usually the presenting problems are of **moderate to high severity**. Documentation for this encounter requires **THREE** out of **THREE** of the following: 1) Comprehensive History 2) Comprehensive Exam 3) Moderate Complexity Medical Decision-Making Or 45 minutes spent face-to-face with the patient if coding based on time. The appropriate documentation must be included
99205	The highest level of care for new patients seen in the office. Usually the problems are of **moderate to high severity.** Documentation for this encounter requires **THREE** out of **THREE** of the following : 1) Comprehensive History 2) Comprehensive Exam 3) High Complexity Medical Decision-Making Or 60 minutes spent face-to-face with the patient if coding based on time.The appropriate documentation must be included.

CPT Codes- Preventative Medicine

Service Codes (annual exam/ Physical exam)

CPT	New Patient	CPT	Established Patient
99385	Initial 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, new patient; 18-39 years	99395	Periodic comprehensive preventive medicine reevaluation 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, established patient; 18-39 years
99386	Same as above, new patient; 40-64 years	99396	Same as above, established patient; 40-64 years
99387	Same as above, new patient; 65 years and older	99397	Same as above, established patient; 65 years and older

Relative Value Units

RVUs can change

Not meant to provide adjustments for risks associated with case complexity or prognosis
Are not a measure or representation of "collections" / "real money" coming into a practice/hospital.
No relationship account billing/office issues.

Relative Value Unit:
wRVU ~ 50-53% of total RVU
peRVU ~ (practice expense) ~ 45% of total RVU
mpRVU (mal practice) ~ 5% of total RVU
Payment for service based on RVU (combining resources and cost attributed to physician service)

CMS Proposed Changes

MGMA benchmarks

RVU calculator

99212	*0.48*
99213	*0.97*
99214	*1.50*
99215	*2.11*
99202	*0.93*
99203	*1.42*
99204	*2.43*
99205	*3.17*
99385	*1.92*
99386	*2.33*
99387	*2.50*
99395	*1.75*
99396	*1.90*
99397	*2.00*

Any Questions?

Modifier 25

Definition: Significant, separately identifiable evaluation and management (E/M) service by the **same physician*** on the day of a procedure

> ***Same physician** - Medicare regulation states: *"Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician."*

Appropriate Usage

- ❑ Modifier 25 indicates that on the day of a procedure, the patient's condition required a significant, separately identifiable E/M service, above and beyond the usual pre and post-operative care associated with the procedure or service performed.
- ❑ Use Modifier 25 with the appropriate level of E/M service.
- ❑ The procedure performed has a global period listed on the Medicare Fee Schedule Relative Value File. This global period could be 000, 010, or 090 days.
- ❑ An E/M service may occur on the same day as a procedure and within the post-operative period of a previous procedure. Medicare allows payment when the documentation supports the 25 modifier and the 24 modifier (unrelated E/M during a post-operative period.)
- ❑ Use Modifier 25 in the rare circumstance of an E/M service the day before a major surgery that is not the decision for surgery and represents a significant, separately identifiable service.

Modifier 25

Inappropriate Usage

- ❑ A physician other than the physician* performing the procedure.
- ❑ Documentation shows the amount of work performed is consistent with that normally performed with the procedure.

The following statements are false

- ❑ I can always use this modifier when I did not plan the procedure.
- ❑ I can always use this modifier when the diagnoses are different.
- ❑ I can never use this modifier when the diagnoses are the same.

Modifier 25

Example: The physician sees the patient for a condition requiring a significant and separately identifiable E/M service prior to removing a wart.

The physician appended modifier 25 to the wrong code.