“Breaking the Code: ICD, CPT, HCPCS, DSM, E&M, EPF, SF, EI-MH”

NCSCHA 2010 Annual Conference

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Session Objectives

- Demonstrate, through interactive coding exercises, the ability to select appropriate ICD-9 and CPT Codes for preventive and primary care services offered in a school health center setting.

- Define the acronyms in our workshop title and state the purpose of various diagnostic and procedural coding systems currently in use.

- State at least 4 of 7 reasons why accurate coding is important to School Health Center practice.

- Demonstrate ability to select ICD-9 and CPT Evaluation and Management Codes as demonstrated through interactive Coding Exercises.

- Demonstrate knowledge of other physical health procedure codes commonly used in school health center settings.
Coding Background and Terminology
Types of Coding

- International Classification of Diseases (ICD-9 Clinical Modification - CM)
- Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR)
Coding Translates Words into Numbers

- Procedure codes indicate what was done. (e.g. CPT; HCPCS)
- Diagnosis codes justify why it was done. (e.g. ICD-9-CM)
Over-coding and Under-coding

• CPT and ICD-9 codes must always relate

• The first ICD-9 code you use drives the relationship to the CPT code
School Health Center Coding

• There is no difference between coding in a SHC and any other setting – the coding assumptions are the same.

• You provide the same level of care regardless of the location.
Why is it important for providers to code appropriately?

- Tell your story
- Documentation
- Reimbursement
- Medical Liability
- Risk of Medicaid Review/Audit
- Provider Profiling
- Patient Labeling
- Epidemiological Tracking
- Internal Tracking
When a provider is under-coding they tell the wrong story

The wrong story is:

✅ SHC providers are seeing very few patients with multiple problems.

✅ SHC providers should see more patients since they are not seeing complicated patients.

✅ The SHC should decrease the number of physicians and add more mid-level providers.
Fraud

**Intentional** deception or misrepresentation

- Deliberately billing for services not performed
- Unbundling of services
- Intentionally submitting duplicate claims
Abuse

Improper billing practices

- Billing for non-covered services
- Misusing codes on a claim form
Errors

- Accept it; you will make them.
- Your best defense is having a plan for your coding and being able to explain it.
Coding Does Not Equal Good Medicine
But - Coding Requires Good Documentation to Justify the Code Selected
General Coding Principles

- Coding gets you paid for your services

- Coding can be used to justify the need for services to your funders
ICD-9-CM Diagnosis Coding
ICD-9-CM Coding

- Used by all insurers
- Codes are made up of 3, 4, or 5 digits (numeric or alphanumeric)
- Codes are updated annually
- Source documents should support the diagnosis code(s) selected
- Failure to code properly can result in fines, sanctions or decreased revenue
ICD-9-CM Code Book

- **Volume 1: Disease Tabular Index**
  Notes all exclusive terms and 5th-digit instructions

- **Volume 2: Alphabetic Index of Diseases**
  Does not contain detail; do not code from this volume

- **Volume 3: ICD-9-CM Procedure Codes**
  Only used by hospitals to report inpatient procedures
ICD-9-CM Codes

Range from 001.0 to V89.09

They identify:

- Diagnoses
- Symptoms
- Conditions
- Problems
- Complaints
- Other reason for the procedure, service, or supply provided
ICD-9-CM Coding Examples

Streptococcal Pharyngitis 034.0
Tobacco Abuse 305.1
Acute Bacterial Pneumonia 482.9
Dysmenorrhea 625.3
Asthma 493.90
Dermatitis due to sunburn 692.71
Obesity 278.00
ICD-9-CM Coding Examples

Generalized Abd. Pain 789.07

Heart Murmur 785.2

Nausea & Vomiting 787.01

Positive TB Skin Test 795.5

Headache 784.0
V-Codes

- Used when patient is not currently sick
  - To classify factors influencing health status.
    (e.g. Pregnancy; Family/Personal Health History)
  - To classify type of contact with health services.
    (e.g. Well Child Check-up; Sports Physical)

- Alphanumeric Code

- V-Codes can be problem-oriented, service oriented or factual
“V” Codes

Can be used as a:

- Solo Code
- Principal Code
- Secondary Code
Coding Tip!

When locating a V-Code in the Alphabetic Index, use the reason for the visit as the main term.

Common terms in alphabetic index where V-codes are found include:

- Aftercare
- Checking
- Checkup
- Examination
- Follow-up
- History (of)
- Observation (for)
- Problem (with)
- Screening (for)
- Vaccination
V-Codes

V-Codes are used for:

- Routine examinations
- Aftercare
- Follow-up examinations
- Pre-op examinations
- Counseling
- Screening
ICD-9-CM Coding Examples

MMR Vaccination V06.4
Well Child Checkup V20.2
Sports Physical Exam V70.3
Suspected Pregnancy V72.40
ICD-9-CM Coding

E Codes
(External Causes of Injury or Poisoning)
Always a 2ndary diagnosis.
Optional Codes-Use with caution.

- How an accident occurred
- What caused an injury
- Whether a drug overdose was accidental
- An adverse drug reaction
- Location of occurrence
Coding Tip!

✓ Whenever possible, avoid ICD-9-CM Codes that are labeled:
  – NEC - not elsewhere classified OR
  – NOS - not otherwise specified

✓ Always code to the highest level of specificity (5th digit) if possible.
Coding Tip!

Do not code diagnoses documented as “probable”, “suspected” or “rule out” as if the diagnosis is established.

- In these instances code the symptoms, signs, abnormal test results or other reason for the visit.

- If no condition or problem is documented at the end of the visit, code the documented chief complaint or symptom.
Coding Tip!

- First diagnosis code should describe the chief reason for the service.
- Link procedures with justifying diagnosis.
Coding Outpatient Physical Health Visits and Services
Types of Outpatient Visits and Services to Be Discussed

- Nurse-Only Visits
- Preventive Medicine Service Codes
- Screening/Counseling Codes
- Immunization Codes
- Nutrition Codes
- Surgical Codes
- Pulmonary/Respiratory Codes
- Other Codes (HCPCS; Supply Codes)
- State / Local Use Codes
A “new” patient is one who has not received any professional service from the health care provider, or another provider of the same specialty 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 latter definition, within the past three years.
Determining Medical Necessity

- Services or procedures that are justified as reasonable and necessary for the diagnosis and treatment of an illness or injury.

- All payors define medical necessity differently.

- The clinical rationale for performing the services or procedures must be documented through coding and in the medical record.
Nurse-Only Visits

- CPT 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.

- LU241 – Triage – Non-billable RN contact (report only). Statewide local use code for HD’s and SHCs funded by DPH.

- Clarify which visits are billable versus non-billable.
Best Practice Roundtable
Recommendations

- Use a proactive approach to address the needs of “frequent flyers”.
  - Offer a comprehensive (e.g. Bright Futures/GAPS/HEADSSS-type) risk assessment and a comprehensive physical to “frequent flyers” who repeatedly present with complaints.
  - Schedule a visit with the social worker to get to the heart of issues that bring the student repeatedly into the Center.
  - Consider use of a “Care Contract” to encourage more appropriate use of the Center.
Best Practice Roundtable Recommendations

- Set fees in a way that makes sense for the way the Center is providing services.
  - Set the nurse visit (CPT 99211) fee at a level that will balance obtaining reimbursement for the cost of the service and yet is reasonable enough that staff are encouraged to bill for the service when appropriate. [Note: Be mindful of Medicaid fee schedule allowances, if applicable].
  - Ensure all staff are comfortable with the process of implementing the sliding fee scale to discourage down-coding or inappropriate labeling of a billable service as non-billable.
Best Practice Roundtable Recommendations

- Use staff appropriately based on their level of training and skill.
  - Assign RN/LPN responsibilities that include triaging acute visits to determine who should see the student (RN/LPN; NP/PA; SW; RD).
  - Determine feasibility of hiring CMA/LPN at front desk to handle administrative assistant, triaging and related responsibilities to prepare patients for RN and/or NP/PA.
  - Do not use non-clinical front desk staff for the initial triaging function as this constitutes inappropriate delegation of a medical task.
Do we have triage form for concern?

Must meet all 3 criteria:
1. Less than 15 minutes
2. Triage form used with minimal additional data collection
3. Self limiting condition

Must meet at least two criteria:
1. More than 15 minutes
2. Additional data documented on triage form
3. Requires consultation
4. Additional procedures performed

Student comes in for an acute care walk-in visit

Secretary gives triage form to student to complete first section

Secretary puts triage form, service slip and chart in nurses door

Nurse completes triage visit

Billable?

Nursing Billable Visits Flow

Complete per standing order and if minor, do not bill

Schedule with NP

Is it a nurse visit?

Yes

No

Billable?

Not billable

Use nonbillable visit procedure code to document (LU241)

Keep documentation limited to triage form only.

Yes

No

Billable

Contact the parent by telephone to discuss billable visit and document

Code as a 99211 with the ICD-9 that addresses the symptoms associated with the visit

If initial visit for student, must refer to NP. Nurse cannot bill 99211 for new patients.
Preventive Medicine Service Codes  
(CPT 99381-99397)

- Code choice based on age & new vs. established.

- Includes age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures.

- Immunizations (admin fees & vaccines), certain screening services and any diagnostic tests should be coded separately. Some of these will be considered “add-on” codes for billing purposes. [Note: See slide #11-13 for examples of “add-on” codes].

- The term “comprehensive” in a preventive service examination is not synonymous with a “comprehensive” E/M exam.

- If a limited physical is performed in order for the student to participate in sports, use statewide local use code LU208.
Preventive Medicine Service CPT Codes
[Used with ICD-9 Diagnosis Code V20.2 “Routine infant or child health check”]

<table>
<thead>
<tr>
<th>Age</th>
<th>New</th>
<th>Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>99381</td>
<td>99391</td>
</tr>
<tr>
<td>1-4</td>
<td>99382</td>
<td>99392</td>
</tr>
<tr>
<td>5-11</td>
<td>99383</td>
<td>99393</td>
</tr>
<tr>
<td>12-17</td>
<td>99384</td>
<td>99394</td>
</tr>
<tr>
<td>18-39</td>
<td>99385</td>
<td>99395</td>
</tr>
</tbody>
</table>
Acute Problems within a Comprehensive Physical

- When doing a preventive health visit (V20.2) and there is a separate acute health problem – you can list both the preventive health visit code (first) and the acute visit code (second).

- The provider must list ICD-9 codes that justify both.

- The billing department must add a modifier (-25) – “Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service”

- For NC Medicaid, the policy is as follows:
  “A Health Check screening assessment and an office visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.”
Screening / Counseling Codes
(Preventive Medicine Service “Add On” Codes)

- CPT 92551 – Hearing screening test
- CPT 99173 – Screening test of visual acuity, quantitative, bilateral
- Laboratory tests related to Dyslipidemia, STDs, Pregnancy; Pap Smear; Wet Prep; etc.
- CPT 96150-96151 - Health and Behavioral Assessment Codes – Performed by Qualified Behavioral/Mental Health Provider; must provide medical (not behavioral health) ICD-9-CM Code (e.g. Diabetes; Asthma; etc.)
- CPT 99406-99407 – Smoking & Tobacco Use Cessation Counseling
- CPT 99408-99409 – Alcohol &/or Substance (other than tobacco) Structured Screening and Brief Intervention
- CPT 99420 – Admin. & Interpretation of Health Risk Assessment Instrument:
  - Health Risk Appraisals: Bright Futures, GAPS, HEADSSS, or Modified Tool
  - Evidence-Based Mental Health Screening Tools (e.g. PSC, SDQ, PHQ-9, BDI-PC)
Immunization Codes

- Immunization Administration Codes

  For Injections:
  - CPT 90471 (Initial Vaccine)
  - CPT 90472 (Each Additional Vaccine)

  For Intranasal or Oral Vaccines
  - CPT 90473 (Initial Vaccine)
  - CPT 90474 (Each Additional Vaccine)

- Vaccine Codes (CPT 90476 - 90749)
# Adolescent Vaccine Codes

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>CPT Code</th>
<th>ICD-9 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>90633</td>
<td>V05.3</td>
</tr>
<tr>
<td>Hepatitis A-Hepatitis B</td>
<td>90636</td>
<td>V05.3</td>
</tr>
<tr>
<td>Human Papilloma Virus</td>
<td>90649</td>
<td>V04.89</td>
</tr>
<tr>
<td>Influenza, Split Virus, Preservative Free</td>
<td>90656</td>
<td>V04.81</td>
</tr>
<tr>
<td>Influenza, Split Virus</td>
<td>90658</td>
<td>V04.81</td>
</tr>
<tr>
<td>Influenza, Live, Intranasal</td>
<td>90660</td>
<td>V04.81</td>
</tr>
<tr>
<td>Measles, Mumps &amp; Rubella [MMR]*</td>
<td>90707*</td>
<td>V06.4</td>
</tr>
<tr>
<td>Polio, Inactivated [IPV]*</td>
<td>90713*</td>
<td>V04.0</td>
</tr>
<tr>
<td>Tetanus &amp; Diptheria Toxoids [Td]</td>
<td>90714</td>
<td>V06.5</td>
</tr>
<tr>
<td>Tetanus, Diptheria Toxoids &amp; Acellular Pertussis [Tdap]*</td>
<td>90715*</td>
<td>V06.1</td>
</tr>
<tr>
<td>Varicella*</td>
<td>90716*</td>
<td>V05.4</td>
</tr>
<tr>
<td>Pneumococcal Polysaccharide, 23-Valent [PPV23]</td>
<td>90732</td>
<td>V03.82</td>
</tr>
<tr>
<td>Meningococcal, Serogroups A,C,Y,W-135 (tetravalent)[MCV4]</td>
<td>90734</td>
<td>V03.89</td>
</tr>
<tr>
<td>Hepatitis B*</td>
<td>90744*</td>
<td>V05.3</td>
</tr>
</tbody>
</table>

* Vaccines required by NC law for school entry.
Nutrition Codes

- **Medical Nutrition Therapy Codes**
  - CPT 97802 – Initial Assessment & Intervention, each 15 minutes
  - CPT 97803 – Re-Assessment and Intervention, each 15 minutes
  - CPT 97804 – Group MNT (2 or more youth), each 30 minutes

- **Non-Billable Nutritionist Contact**
  - LU239
  - [Used by DPH-funded centers as a statewide local use code to capture data on non-billable nutrition contacts].
Surgical Codes [CPT 10021-69979]

Most commonly used surgical codes in SHCs:

- CPT 10060 - Incision and Drainage of Abscess, Single
- CPT 10061 – Incision and Drainage of Abscess, Multiple
- CPT 11975 – Insertion, Implantable Contraceptive Capsules
- CPT 11976 – Removal, Implantable Contraceptive Capsules
- CPT 11981 – Insertion, Non-Biodegradable Drug Delivery Implant
- CPT 11982 – Removal, Non-Biodegradable Drug Delivery Implant
- CPT 17000 – Destruction of Lesion or Wart, Single
- CPT 17003 – Destruction of Lesion or Wart, 2+
- CPT 29130 – Application of Finger Splint
- CPT 36415 – Collection of Venous Blood by Venipuncture
- CPT 69210 – Removal of Impacted Cerumen
Pulmonary / Respiratory
(CPT 94010-94799)

- If a significant, separately identifiable service is performed unrelated to the technical performance of the pulmonary function test, an evaluation and management service may be reported. Attach -25 modifier to the E/M code.

- Over time, there has been differing guidance with regard to how to code “peak flow”. The current recommendation is to code CPT 99211.
Other Codes

❖ HCPCS
  ▪ A Codes – Medical and Surgical Supplies
  ▪ J Codes – Drugs Administered Other Than Oral Method

❖ Supply Codes
  ▪ Code only supplies and materials provided over and above those usually included with the office visit or other services rendered.
  ▪ HCPCS (A Codes) or CPT 99070 – Depending on the carrier.
State Local Use Codes

- Created out of a desire to consistently report on a statewide basis a few services for which there is no nationally recognized code.

- LU025 - Medication Administration (Report Only)
- LU208 – Limited Sports Physical (Report Only)
- LU237 – Non-Billable Social Work Contact (Report Only)
- LU238 – Non-Billable Health Education Contact (Report Only)
- LU239 – Non-Billable Nutrition Contact (Report Only)
- LU241 – Triage – Non Billable RN Contact (Report Only)
Local Use Codes

- Codes developed by local organizations to capture data on services for which there are no legitimate, nationally-recognized codes.

- It is important not to use a nationally-recognized code illegitimately for a different purpose than the code definition. Could result in accidental billing and an audit finding. To be safe, avoid using local use codes that resemble a CPT or HCPCS Code.
Office Visit Coding for School Health Centers
CMS Coding Guidelines
1995 vs. 1997

- Both 1995 and 1997 guidelines are approved for use by CMS.

- Agencies should specify use of 1995 or 1997 guidelines in their administrative policies.

- This lecture is based on the 1995 guidelines because they are 15 pages long vs. 57 pages of the 1997 version.

Evaluation & Management (Office Visit) Coding

- Evaluation/Management (E/M) services refer to visits and consultations furnished by health care providers.

- New Patient vs. Established Patient
  
  - New Patient (CPT 99201-99205): one who has not received any professional service from the health care provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.
  
  - Established Patient (CPT 99211-99215): one who has received a service, according to the latter definition, within the past three years.
Coding choices are made based on the building blocks that define the level of E&M Office Visit Service that has been provided, as illustrated in the next several slides.
Three Key Components Used to Select the Level of E/M Service

- **History** (Subjective Findings)
- **Examination** (Objective Findings)
- **Medical Decision Making** (Assessment & Plan)

**Notes:**

- *New patient codes (CPT 99201-99205) require that all three key components be satisfied. Established patient codes (CPT 99212-99215) require that two of three components be satisfied. [Explanation follows].*

- *For visits where time doing counseling or coordination of care represents > 50% of the provider / patient visit, time may be considered the key or controlling factor to qualify for a particular level of E/M services. [See PPT Slides 23-24].*
Evaluation/Management (Office Visit) Services

- There are 5 different levels of service. CPT code numbers for “new” vs. “established” visits do not match for the 5 levels of service.
- The history & exam are classified as Problem Focused (PF); Expanded Problem-Focused (EPF); Detailed (D) and Comprehensive (C).
- The level of medical decision making is ranked as Straightforward (SF); Low Complexity (LC); Moderate Complexity (MC) and High Complexity (HC).
- The levels of service for “new” vs. “established” visits are defined below.

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Level 1: 99211 – Minimal</td>
</tr>
<tr>
<td>Level 1: 99201 – PF; PF; SF</td>
<td>Level 2: 99212 – PF; PF; SF</td>
</tr>
<tr>
<td>Level 2: 99202 – EPF; EPF; SF</td>
<td>Level 3: 99213 – EPF; EPF; LC</td>
</tr>
<tr>
<td>Level 3: 99203 – D; D; LC</td>
<td>Level 4: 99214 – D; D; MC</td>
</tr>
<tr>
<td>Level 4: 99204 – C; C; MC</td>
<td>Level 5: 99215 – C; C; HC</td>
</tr>
<tr>
<td>Level 5: 99205 – C; C; HC</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Selecting the Correct Office Visit Level for a “New” Patient

* Requires 3 components in one column be met or exceeded to select that CPT code level.

<table>
<thead>
<tr>
<th>History</th>
<th>PF</th>
<th>EPF</th>
<th>D</th>
<th>C</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Complexity of Medical Decision-Making</td>
<td>SF</td>
<td>SF</td>
<td>L</td>
<td>M</td>
<td>H</td>
</tr>
<tr>
<td>Average Time (Minutes)</td>
<td>10”</td>
<td>20”</td>
<td>30”</td>
<td>45”</td>
<td>60”</td>
</tr>
<tr>
<td>Level</td>
<td>1 CPT 99201</td>
<td>2 CPT 99202</td>
<td>3 CPT 99203</td>
<td>4 CPT 99204</td>
<td>5 CPT 99205</td>
</tr>
</tbody>
</table>
Selecting the Correct Office Visit Level for an “Established” Patient

* Requires 2 components in one column be met or exceeded to select that CPT code level.

<table>
<thead>
<tr>
<th>History</th>
<th>Minimal problem that may not require presence of medical provider.</th>
<th>PF</th>
<th>EPF</th>
<th>D</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td></td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
</tr>
<tr>
<td>Complexity of Medical Decision-Making</td>
<td>SF</td>
<td>L</td>
<td>M</td>
<td>H</td>
<td></td>
</tr>
<tr>
<td>Average Time (Minutes)</td>
<td>5”</td>
<td>10”</td>
<td>15”</td>
<td>25”</td>
<td>40”</td>
</tr>
<tr>
<td>Level</td>
<td>1 CPT 99211</td>
<td>2 CPT 99212</td>
<td>3 CPT 99213</td>
<td>4 CPT 99214</td>
<td>5 CPT 99215</td>
</tr>
</tbody>
</table>
CPT 99211 – Minimal Service for an Established Patient

- **CPT 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.

- Service is provided under “physician supervision.” (e.g. RN visit under “standing medical protocols” is the most common use of CPT 99211 in a School Health Center setting).

- If this code is used, it states that the expertise of a medical provider is not necessary. **This code is not required to meet the three key components (history, exam and medical decision-making) in order to be used for coding / billing purposes.**
Key Elements for History Component

- **Chief Complaint (CC)**
  - Must be identifiable for EVERY patient encounter

- **History of Present Illness (HPI)**
  - A description of the development of the patient’s present illness/symptoms since last clinic encounter

- **Review of Systems (ROS)**
  - A review/inventory of associated symptoms within each of the fourteen body systems

- **Past, Family, and/or Social History (PFSH)**
  - A review of patient’s past medical/surgical history as well as familial and social history
**History of Present Illness (HPI)**

HPI includes the following elements.*

<table>
<thead>
<tr>
<th>Location:</th>
<th>Timing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where is the sign or symptom occurring?</td>
<td>When and how frequently does the sign or symptom occur?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality:</th>
<th>Context:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the character of the sign or symptom?</td>
<td>Are there any activities/situations associated with symptoms?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severity:</th>
<th>Modifying Factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How hard is it to endure? Pain scale useful.</td>
<td>What makes the symptoms worse or better?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration:</th>
<th>Associated Signs / Symptoms:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long has patient suffered with this symptom?</td>
<td>Are there any other bodily complaints associated with problem?</td>
</tr>
</tbody>
</table>

* Each element counts as one. Maximum score 8.
Review of Systems (ROS)

- A review/inventory of associated symptoms within each of the fourteen body systems.
- The **fourteen systems** are:
  - Constitutional symptoms
  - Eyes
  - Ears, Nose, Throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genito-urinary
  - Musculoskeletal
  - Integumentary
  - Neurological
  - Hematologic/Lymphatic
  - Endocrine
  - Psychiatric
  - Allergic/Immunologic

* Each system counts as one. Maximum score is 14.
Past, Family, and/or Social History* (PFSH)

- **Past Medical/Surgical History:**
  A review of previous medical/surgical problems/treatments; medications; allergies (medication, food, etc); immunization status.

- **Family History:**
  A review of medical events in the patient’s family which may be hereditary or place the patient at risk.

- **Social History:**
  A review of patient’s past/present living conditions (school performance, school/community activities, relationships with family /friends, alcohol/drug/ tobacco use, sexual history, employment, etc)

* Each type of history counts as one. Maximum score is 3.
History Component Scoring Tool
(Number of elements for HPI, ROS & PFSH required for each level*)

<table>
<thead>
<tr>
<th></th>
<th>PROBLEM-FOCUSED</th>
<th>EXPANDED PROBLEM-FOCUS</th>
<th>DETAIL</th>
<th>COMPREHENSIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CC</strong></td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>HPI</strong></td>
<td>Brief (1-3 elements)</td>
<td>Brief (1-3 elements)</td>
<td>Extended (≥4 elements)</td>
<td>Extended (≥4 elements)</td>
</tr>
<tr>
<td><strong>ROS</strong></td>
<td>None</td>
<td>Pertinent to Problem (1 system)</td>
<td>Extended (2-9 systems)</td>
<td>Complete (≥ 10 systems) Can count “all others negative”.</td>
</tr>
<tr>
<td><strong>PFSH</strong></td>
<td>None</td>
<td>None</td>
<td>Pertinent (New=2 hx areas) (Est. = 1 hx area)</td>
<td>Complete (New = 3 hx areas) (Est. = 2 hx areas)</td>
</tr>
</tbody>
</table>

* Overall history level is determined by the column marked furthest to the left.
Key Elements for Examination Component

Involves the examination of one or more of 7 body areas or 14 organ systems (based on 1995 General Multi-System Exam Guidelines)*:

Body Areas:
- Head/face
- Neck
- Chest/breasts/axillae
- Abdomen
- Genitalia/groin/buttocks
- Back/spine
- Each extremity

Organ Systems:
- Constitutional
  (Vital Signs; Wgt Loss; Gen Appearance)
- Eyes
- Ears/Nose/Mouth/Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (Skin)
- Neurological
- Psychiatric
- Hematologic/Lymphatic
- Endocrine
- Allergic/Immunologic

* Each body area / organ system counts as one.
# Examination Component Scoring Tool

<table>
<thead>
<tr>
<th>Examination</th>
<th>PROBLEM-FOCUSED</th>
<th>EXPANDED PROBLEM-FOCUSED</th>
<th>DETAILED</th>
<th>COMPREHENSIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 body area / organ system</td>
<td>2-7 body areas/organ systems</td>
<td>2-7 body areas/organ systems</td>
<td>8 or more body areas/organ systems</td>
</tr>
</tbody>
</table>
Key Elements for Medical Decision-Making Component

- Takes into account the complexity of establishing a diagnosis and/or selecting a management option.

- Considers the following elements in assessing level of complexity of decision-making:
  
  A. Number of possible diagnoses/management options that must be considered.
  
  B. Risk of complications, morbidity and/or mortality as well as co-morbidities associated with patient’s presenting problem(s)
  
  C. Amount/complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.

- Data & diagnoses/treatment options are assigned points. Medical decision making is scored based on those points.
## Medical Decision-Making

### A. Number of Diagnoses or Treatment Options

<table>
<thead>
<tr>
<th>Problems to Examining Provider</th>
<th>Number X Points = Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited/minor (stable, improved, worsening)</td>
<td>1 Max=2</td>
</tr>
<tr>
<td>Est. problem (to examiner); stable, improved</td>
<td>1</td>
</tr>
<tr>
<td>Est. problem (to examiner); worsening</td>
<td>2</td>
</tr>
<tr>
<td>New problem (to examiner); no added work-up planned.</td>
<td>3 Max=3</td>
</tr>
<tr>
<td>New problem (to examiner); added work-up planned.</td>
<td>4</td>
</tr>
</tbody>
</table>

Bring Total from A - Number of Diagnoses/Tx Options into Final Scoring for Medical Decision Making (PPT slide 75).

**TOTAL**
Medical Decision Making

B. Risk of Complications +/- Morbidity or Mortality
[Four PPT slides describe level of risk: minimal, low, moderate, high].

*Final score is the highest component marked.*

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
|         | • 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 |
## Medical Decision Making

### B. Risk of Complications +/- or Morbidity or Mortality

<table>
<thead>
<tr>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two or more self-limited or minor problems</td>
<td>Physiologic tests not under stress, e.g. pulmonary function tests</td>
<td>Over the counter drugs</td>
</tr>
<tr>
<td>One stable chronic illness, e.g. well controlled hypertension, non-insulin dependent diabetes, cataract, benign prostatic hyperplasia</td>
<td>Non-cardiovascular imaging studies with contrast, e.g. barium enema</td>
<td>Minor surgery with no identified risk factors</td>
</tr>
<tr>
<td>Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain</td>
<td>Superficial needle biopsies</td>
<td>Physical therapy</td>
</tr>
<tr>
<td></td>
<td>Clinical laboratory tests requiring arterial puncture</td>
<td>Occupational therapy</td>
</tr>
<tr>
<td></td>
<td>Skin biopsies</td>
<td>IV fluids without additives</td>
</tr>
</tbody>
</table>
# Medical Decision Making

## B. Risk of Complications +/- or Morbidity or Mortality

<table>
<thead>
<tr>
<th>MODERATE</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| • One or more chronic illnesses 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 | • Minor surgery with identified risk factors  
  • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors  
  • Prescription drug management  
  • IV fluids with additives  
  • Closed treatment of fracture or dislocation without manipulation |
# Medical Decision Making

## B. Risk of Complications +/- Morbidity or Mortality

<table>
<thead>
<tr>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIGH</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • One or more chronic illnesses with severe exacerbation, progression, or side effects of tx  
  • 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, sent to ER, eminent delivery) | • Cardiovascular imaging studies with contrast with identified risk factors  
  • Diagnostic endoscopies with identified risk factors  
  • Discography | • Elective major surgery (open, percutaneous or endoscopic) with identified risk factors  
  • Emergency major surgery  
  • Parenteral controlled substances  
  • Drug therapy requiring intensive monitoring for toxicity |

*Final score is the highest component marked.*

Bring the Risk Level from “B - Risk of Complications +/- Morbidity or Mortality” into final scoring for Medical Decision Making (see PPT slide 75).
# Medical Decision-Making

## C. Amount +/- or Complexity of Data to be Reviewed

<table>
<thead>
<tr>
<th>Data to be Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review +/- or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review +/- or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review +/- or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing provider</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records +/- or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review + summarization of old records +/- or obtaining history from someone other than patient +/- or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
</tbody>
</table>

Bring Total from C - Amount +/- or Complexity of Data to be Reviewed into Final Scoring for Medical Decision Making (see PPT slide 75).  

TOTAL
## Medical Decision Making Scoring Tool

<table>
<thead>
<tr>
<th>Level of Decision Making</th>
<th>Straight-forward</th>
<th>Low Complexity</th>
<th>Moderate Complexity</th>
<th>High Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Number of diagnoses or treatment options</td>
<td>Minimal ((\leq 1))</td>
<td>Limited ((2))</td>
<td>Multiple ((3))</td>
<td>Extensive ((\geq 4))</td>
</tr>
<tr>
<td>B: Risk for Complications +/- or Morbidity or Mortality</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>C: Amount +/- or Complexity of Data</td>
<td>Minimal or Low ((\leq 1))</td>
<td>Limited ((2))</td>
<td>Moderate ((3))</td>
<td>Extensive ((\geq 4))</td>
</tr>
</tbody>
</table>

*To score medical decision making, two of the three elements in the table above must be met or exceeded.*
Other Factors for Consideration

• Time/Counseling/Coordination of Care

  – CPT states, “When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting), then (and only then) may time be considered the key or controlling factor to qualify for a particular level of E/M services.”

  – Counseling may include: discussion of test results, diagnostic/treatment recommendations, prognosis, risk/benefits of management options, instructions, education, compliance or risk-factor reduction.
Evaluation & Management Visits with > 50% of Time Spent in Education/Counseling

<table>
<thead>
<tr>
<th>Outpatient -- NEW</th>
<th>Codes</th>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td>Times (min)</td>
<td>10”</td>
<td>20”</td>
<td>30”</td>
<td>45”</td>
<td>60”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient - ESTABLISHED</th>
<th>Codes</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>Times (min)</td>
<td>5”</td>
<td>10”</td>
<td>15”</td>
<td>25”</td>
<td>40”</td>
<td></td>
</tr>
</tbody>
</table>

Documentation should reflect:

- The actual time spent in face-to-face contact with the patient
- >50% of the encounter involved counseling or coordination of care
- The nature of the counseling/coordination of care activities (e.g.: counseled patient regarding smoking cessation)
Selecting the Correct Office Visit Level for a “New” Patient

* Requires 3 components in one column be met or exceeded to select that CPT code level.

<table>
<thead>
<tr>
<th>History</th>
<th>PF</th>
<th>EPF</th>
<th>D</th>
<th>C</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Complexity of Medical Decision-Making</td>
<td>SF</td>
<td>SF</td>
<td>L</td>
<td>M</td>
<td>H</td>
</tr>
<tr>
<td>Average Time (Minutes)</td>
<td>10”</td>
<td>20”</td>
<td>30”</td>
<td>45”</td>
<td>60”</td>
</tr>
<tr>
<td>Level</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>CPT 99201</td>
<td>CPT 99202</td>
<td>CPT 99203</td>
<td>CPT 99204</td>
<td>CPT 99205</td>
<td></td>
</tr>
</tbody>
</table>
Selecting the Correct Office Visit Level for an “Established” Patient

* Requires 2 components in one column be met or exceeded to select that CPT code level.

<table>
<thead>
<tr>
<th>History</th>
<th>Minimal problem that may not require presence of medical provider.</th>
<th>PF</th>
<th>EPF</th>
<th>D</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td></td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
</tr>
<tr>
<td>Complexity of Medical Decision-Making</td>
<td>SF</td>
<td>L</td>
<td>M</td>
<td>H</td>
<td></td>
</tr>
<tr>
<td>Average Time (Minutes)</td>
<td>5”</td>
<td>10”</td>
<td>15”</td>
<td>25”</td>
<td>40”</td>
</tr>
<tr>
<td>Level</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>CPT 99211</td>
<td>CPT 99212</td>
<td>CPT 99213</td>
<td>CPT 99214</td>
<td>CPT 99215</td>
<td></td>
</tr>
</tbody>
</table>
Coding Exercises
Supplemental Codes

• **Unusual time or location** use E/M or procedure code plus special services code (99050-99058).

• **Critical Care Services** (99291-99292) unstable critically ill or unstable critically injured requiring constant attendance of the provider provided in any location.

• **Prolonged Services Codes** (99354-99359) coded with E/M codes – subtract amount of time associated with the E/M Code
Coding Tips

- Link procedures with justifying diagnosis to establish “medical necessity”

- Avoid “clustering” (i.e. using one or two middle level service codes assuming that it will all even out in the end).
Documentation

- If it isn’t documented, it wasn’t done – from an audit perspective.
- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
  - Date of encounter
  - Reason for encounter (chief complaint) and relevant history
  - Physical examination findings and screening/diagnostic test results
  - An assessment, clinical impression or diagnosis
  - A plan of care
  - Signature and credential of clinician
  - S-O-A-P notes help assure complete documentation
- Document the elements that justify the level of E/M key components.
- The rationale for ordering diagnostic and other ancillary services should be documented or easily inferred.
Documentation (continued)

- Health risk factors should be identified and addressed.

- The patient’s progress, response to / changes in treatment, and revision of diagnosis should be documented.

- Document to whom referrals are made and outcomes from previous referrals.

- Include orders for lab work, x-rays or tests; returned reports should be initialed / dated; document review of reports in progress note.

- CPT and ICD-9-CM codes reported on the health insurance claim form or patient billing statement should be supported by the documentation in the billing record.
Questions?