Financing the Medical Home
A Coding Update for Primary Care
2010

Friday July 30, 2010
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Conflict of Interest

- I have no conflicts of interest to declare related to this program.
- The content of this seminar reflects correct coding principles. The examples and recommendations are my own and do not represent the policy or recommendations of any company or organization.

Stay Awake- Otherwise You Might Slide Right Out of Your Seat!
The Agenda

Coding Update 2010
Basics of Medical Home Reimbursement
Coding to Finance the Medical Home

The Good Ol’ Days of Medicine

- Oh give me a home where fee for service still roams, and the skies are not cloudy all day. Where seldom is heard a low payment word, and denials are all held at bay......
HOW Birds SEE the WORLD.......
So Who Is the “Big Bird’
The OIG

1. 1996- HIPAA establishes the “Program”- Health Care Fraud and Abuse Control Program”
2. Through the Office of Inspector General
3. Coordinates Federal, state, and local efforts to find and prosecute those who commit health care fraud.

So Who Is the “Big Bird’
The OIG

2009 Results- Success is.....

1. $1.63 Billion in judgements and settlements
2. $2.53 Billion transferred back to the Medicare budget
3. $441 million back to the Federal Medicaid program
Our Agenda

1. Resources and Rules
2. 2010 Coding/Reimbursement Update
3. E/M Coding Opportunities
4. Immunization Coding

Translational Coding
From the Book to the Exam Room to the Bank

1. Identify the Key Services You Want to Provide for Your Patients
2. Know enough coding to make the business case for implementing or continuing these service
Coding Resources

- AMA – Current Procedural Terminology
- Tn Chapter of the AAP
- Tn Chapter of the AAFM
- American College of Physicians
- Center for Medicare and Medicaid Services (CMS)

VACCINES RESOURCES

1. CDC - www.cdc.gov/nip
2. AAP - www.aap.org MOC-Practice Management Online (PMO)
3. Immunization Action Coalition - www.immunize.org
MEDICAL HOME RESOURCES

Patient Centered Medical Home (PCMH)

AAP- Website and Implementation Tool Kit
http://www.pediatricmedhome.org/
http://www.medicalhomeinfo.org/tools/providerindex.html#Howto

NCQA

Some Background

Learn Some Basic Rules!

• Physician Payment “Rules”
• Basic CPT and ICD Coding Rules
The Coding System

Physicians Report Services Provided to Patients to Payers Using Numeric Codes

HIPAA Requires Certain Code Sets for Electronic Transactions

CPT and ICD are the Core Code Sets Used by All Physicians (and Payers)

CPT - American Medical Association

ICD - CDC, AHA, CMS


• Copyrighted publication by the AMA
• Used as the standard Medicare code set since 1990’s
• Tell payers what service was performed by a physician on a given patient on a given date
• Provides common definitions for physician work based on
  • Nature and amount of work
  • Place and type of service
Current Procedural Terminology Code Categories

- **Category I** - usual billing for payment for patients services
- **Category II** - Performance Improvement or Tracking Codes - pay for performance measures
- **Category III** - New procedures and technology - can be used for payment


- Revised Yearly
- Manual published in the fall (October)
- New/revised codes are effective on the following 1 Jan.
- Cat III codes and vaccine codes –early release- on the AMA website every 1 July/1 Jan- become effective 6 months later if before 1 October


- Category I
  - Evaluation and Management 99201-99499
  - Anesthesiology 00100-01999, 99100-99140
  - Surgery 10021-69990
  - Radiology (Including Nuclear Medicine and Diagnostic Ultrasound) 70010-79999
  - Pathology and Laboratory 80047-89356
- Category II 0001F-7025F
- Category III 0016T-0207T


- **Reporting**- “billing” CPT codes to a payer for services rendered so they can be paid or tracked (entered into a database)
- **Licensure**- a state act allowing the provider to perform a service under a “scope of practice” law, act, or regulation
- **Credentialing**- certification by a public or private payer- defines services for which the provider will be paid
Who can Report CPT codes?

- It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group.
- Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician or other qualified health care professional.

Who can Provide the Service?

- Medical services can be provided to patient in accord with the applicable state licensing boards and scope of practice acts
- Providers must be licensed to provide the service
Who can get paid for the Service?

- Physician or other qualified health care professionals are paid by fee schedules found in provider contracts.
- These professionals are typically **credentialed** to be paid for specific services by payers or health plans.

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The Revenue Cycle

- **SERVICE ➔ CODE**
- ➔ **VALUE ➔ RBRVS**
- ➔ **FEE SCHEDULE**
- ➔ **CONTRACT ➔ $**
So-If You Don't Get Paid.......Where Is The Problem?

Code- CPT/ICD (system or individual)
RBRVS- RUC or CMS
Payment Policy of Payer-
Patient- Covered Benefit-
Your Contract- Find Leverage (size, importance etc)

HOW TO IMPROVE

• Measure Your Coding Profiles
• Participate in a Practice-Based Coding Education program with regular self auditing of medical records (compliance program)
• Always Focus on Correctly Coding - Dollars Will Follow and You Will Win Audits or Attempts at Recoveries
Top 10 Rules of CPT Coding

1. **MD** selects the code-at point of care

2. Documentation- necessary for good care *and* compliance

3. Use different code levels that match your work- not all visits are 99213’s!

4. Learn to use modifiers, procedure, and add-on codes

5. Set different fees for different codes - one fee for each code - learn about and use the RBRVS

10 Rules of CPT Coding

6. Set fees independent of reimbursements- avoid (accelerating) the downward spiral

7. Know fee schedules and payment policies of payers- use in contracting

8. Watch your EOB’s!- Denial management-profile by type and triage- Appeal! Appeal!

9. Review CPT and ICD codes yearly- Begin in October- revise superbills and fee schedule.

10. Design a superbill with 90% of CPT / ICD codes used by practice. Consider an outpatient and inpatient superbill.
DIAGNOSIS (ICD 9) CODES

- ESTABLISH MEDICAL NECESITY
- EACH CPT CODE IS LINKED TO 1 OR > DIAGNOSIS CODE(S)
- DESCRIBE
  - Patient, (not the service) or
  - Condition (Sign, Symptom, DX)
  - Reason for Encounter
  - Usually 5 digits
- New codes- released July in Federal Register- Active 1 Oct. per HIPAA

DIAGNOSIS (ICD9) CODES

- NUMERIC CODES
  - 0-999, by organ systems
  - Primary codes 493.00 asthma

- V CODES
  - Primary code for well visits (V20.2), Vaccines
  - Secondary codes- V15.03 Allergy to eggs

- E CODES-injuries, adverse events
  - Only secondary codes-E906.0 dog bite
1. Select diagnosis codes to identify Diagnoses, Symptoms, Problems, Complaints, or other reason for the encounter
2. Code to the highest degree of specificity.
   - Assign the 4th or 5th digit whenever available - new source of denials

3. Diagnoses coded as probable, suspected or “rule out” should not be coded as if the diagnosis is confirmed
4. List the ICD code that is the main reason for the encounter first in the record.
   - Next list co-existing conditions if those conditions affect the treatment and/or management of the patient
**BASIC ICD CODING GUIDELINES**

- 5. Do not code for conditions that were previously treated and no longer exist at the time of the visit.
  - Can use V67.9 -- follow-up exam
  - Or..V67.59-follow up after rx
  - Some insurance plans allow one visit to recheck with same prior diagnosis code used. Best to use both numeric and V code.

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**Update - Medical Home**

The National Business Group on Health (NBGH) – Fortune 500 companies and other large public sector employers- 50 million covered lives

Issue brief Strengthening Health Care for Children: Primary Care and the Medical Home which can be accessed at: [http://www.businessgrouphealth.org/pdfs/Medical%20home%20proof%20FINAL.pdf](http://www.businessgrouphealth.org/pdfs/Medical%20home%20proof%20FINAL.pdf)

Pages 11-13 list recommendations for employers to support the medical home model, including payment for care coordination and non-face to face care.
AAP - Medical Home Definition

- Primary care
- Family-centered partnership
- Community-based, interdisciplinary, team-based approach to care
- Care that is: accessible, family-centered, coordinated, compassionate, continuous, and culturally effective.
- Preventive, acute and chronic care
- Quality improvement

Joint Principles of the Patient-Centered Medical Home

- American Academy of Pediatrics
- American Academy of Family Physicians
- American College of Physicians
- American Osteopathic Association
  
  March 2007
Medical Home Joint Principles: Pediatric Preamble

- Family-centered care
- Community-based system of care
- Transitions
- Value

Medical Home Joint Principles

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety are hallmarks of a medical home
- Enhanced access to care
- Payment appropriately recognizes the added value
A Better Payment Structure

• Fee for Service
  • Visits and Procedures
  • Current system
• Prospective Payment
  • Covers care coordination
• Retrospective - Pay for Performance
  • Quality Indicators
  • Patient experience

Linkage of PCMH to Reimbursement

One Model

Fee Schedule for Visits/Procedures

Pay for Performance
Quality, Resource Use and Patient Experience

Payment per Patient for Qualified Medical Homes
(services not normally reimbursed)

Future Payment Structure
An “Enhanced” Fee Schedule

• Fee for Service
  • Visits and Procedures
  • Current system
  • Usual Fee schedule
  • **Goal**- adequate coverage for non face to face care management, 24 hour access, and vaccine delivery
  • CMS fee schedule resource based-

Linkage of PCMH to Reimbursement

One Model

Fee Schedule for Visits/Procedures

Pay for Performance
Quality, Resource Use and Patient Experience

Payment per Patient for Qualified Medical Homes
(services not normally reimbursed)
P4P-Refined for More Meaningful Quality/Efficiency Measures

Retrospective - Pay for Performance
- Quality Indicators
  - HEDIS measures
  - Local- EPSDT
- Patient experience
  - Pt. satisfaction
- Utilization Measures
  - ER visits
  - Inpatient Admissions
  - Episodes of care

Linkage of PCMH to Reimbursement
One Model

Pay for Performance
Quality, Resource Use and Patient Experience

Fee Schedule for Visits/Procedures

Payment per Patient for Qualified Medical Homes
(services not normally reimbursed)

Proposed Payment Structure
Pay IT Forward!

Prospective Payment
- A per member per month payment
- Pays for increased practice care management/coordination
- Pays for infrastructure- EI-, eRX
- May be for all patients or those with special needs

Linkage of PCMH to Reimbursement
One Model

Pay for Performance
Quality, Resource Use and Patient Experience

Fee Schedule for Visits/Procedures

Payment per Patient for Qualified Medical Homes
(services not normally reimbursed)
The Key Services for the Medical Home
Fee for Service

New Codes for New Services
2010 Update

Why a Key Service for the Medical Home?

1. Allows new and existing services to be paid

2. New codes may replace existing ones
   - New codes may not be covered or may be considered “bundled and non allowed”- until physicians bill/contract aggressively
   - Some new codes are harder than others to get paid (non face to face, non physician)
Case

You are following the AAP-BF preventive medicine guidelines and see a 4 day old breast feeding baby in follow up from the NBN - he is jaundiced and has lost 7% of his birth weight. You were the attending while in the NBN.

Case

What is the best CPT code for reporting the service?

A. 99391
B. 99381
C. 99214
D. 99391-99213-25
Case

What is the best CPT code for reporting the service?

A. 99391
B. 99381
C. 99214
D. 99391-99213-25

Case

What is the best ICD (diagnosis) code for reporting the service?

A. V-20.2
B. V-20.32
C. V-20.31
Case

What is the best ICD (diagnosis) code for reporting the service?

A. V-20.2
B. V-20.32
C. V-20.31

New CPT for 2010
effective January 1

New /Revised Cat I Codes

• These codes are to be announced in late September or early October 2009

• See NCE website for latest list once updated
What’s New for 2009
Did You Miss Any?

- **CPT**

**Evaluation and management services**
- Renumbered codes newborn and neonatal/pediatric critical care
- New introductory language prolonged services, preventive medicine services

**Medicine Code Changes**
- Special Otorkinolaryngologic Services
- Vestibular Function Tests Without Electrical Recording
- Audioligic Function Tests With Medical Diagnostic Evaluation
- Allergy Testing
- Health and Behavior Assessment and Intervention
- Renumbered codes hydration, injections, infusions

What’s New for 2010
Going Live 1 Jan 2010

- **CPT**

**Evaluation and management services**
- Revisions only
  - Consultation Codes- Define transfer of care
  - New language for filing separate reports
  - Prolonged Services Without Direct (Face-to-Face) Patient Contact (99358 and 99359)

**Medicine Code Changes**
- Vaccines
- Pediatric Pulmonary Function Testing
- Immune Globulin
Special Reports

- Most CPT code families has a code for an “unlisted” service- best to file a paper claim and a report
- A service that is rarely provided, unusual, variable, or new may require a special report.

Consultations, Concurrent Care, and Transfers

- A consultation is a type of evaluation and management service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. At the request of another physician or appropriate source to either recommend care for a specific condition/problem or to determine whether to accept responsibility for ongoing management of the patient’s entire care or for the care of a specific condition/problem.
Consultations, Concurrent Care, and Transfers

- **Concurrent care** is the provision of similar services (e.g., hospital visits) to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required.

- **Transfer of care** is the process whereby a physician who is providing management for some/all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility, and who from the initial encounter is not providing consultative services. The physician transferring care is then no longer providing care for these problems, though may continue providing care for other conditions when appropriate.

Consultations, Concurrent Care, and Transfers-NEW

- **CMS for 2010** - will NOT paying for consultations

  - Federal Register Oct 2010

  - RVU’s are being added to office and inpatient services
E/M Changes in 2010

**Prolonged Services Without Direct (Non-Face-to-Face) Patient Contact (99358 and 99359)**

- 99358 Prolonged E/M service before and/or after direct (face-to-face) patient care; first hour
- +▲ 99359 each additional 30 minutes (List separately in addition to code for prolonged physician service.)

(Use 99359 in conjunction with code 99358.)

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E/M Changes in 2010

**Prolonged Services Without Direct (Face-to-Face) Patient Contact (99358 and 99359)**

- Codes 99358 and 99359 are used when a physician provides prolonged service not involving direct (face-to-face) care that is beyond the usual non-face-to-face component of physician service time.
- This service is to be reported in relation addition to another physician service, including E/M services at any level. This prolonged service may be reported on a different date than the primary service to which it is related.
- For example, extensive record review may relate to a previous E/M service performed earlier and commences on receipt of past records. However, it must relate to a service or patient where direct (face-to-face) patient care has occurred or will occur and relate to ongoing patient management. A typical time for the primary service need not be established in CPT.
Vaccines and Globulins 2010

- Code 90669 has been revised and a new vaccine product code for a pending 13 valent pneumococcal conjugate vaccine has been added. Note that code 90670 is awaiting US Food and Drug Administration approval.
- ▲90669 Pneumococcal conjugate vaccine, polyvalent 7 valent, when administered to children younger than 5 years, for intramuscular use
- ☑90670 Pneumococcal conjugate vaccine, 13 valent, for intramuscular use

Vaccines and Globulins 2010

- 90644 Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza b vaccine, tetanus toxoid conjugate (Hib-MenCY-TT), 4-dose schedule, when administered to children 2-15 months of age, for intramuscular use
Immune Globulins 2010

- The descriptor for code 90378 is revised in CPT 2010, and code 90379 has been deleted as the product is no longer manufactured or available.
- ▲ 90378 Respiratory syncytial virus immune globulin (RSV-IgIM), monoclonal antibody, recombinant, for intramuscular use, 50 mg, each
- DELETED- 90379 Respiratory syncytial virus immune globulin (RSV-IgV), human, for intravenous use

Medicine - Pulmonary

New codes have been established to report pulmonary function testing in a sedated infant or child through 2 years of age.

- 94011 Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age
- 94012 Bronchodilation (before and after bronchodilator) measurement of spirometric forced expiratory flows before and after bronchodilator in an infant or child through 2 years of age
- 94013 Measurement of lung volumes (ie, functional residual capacity, forced vital capacity, and expiratory reserve volume) in an infant or child through 2 years of age
New ICD-9 codes for 2011

• Released June 2010

• These new codes are effective (and must be accepted by third-party payers) on October 1, 2010. In accordance with the Health Insurance Portability and Accountability Act of 1996, CMS is no longer allowing payers a grace period to implement the new and revised codes.

New ICD-9 codes for 2011

237.73 Schwannomatosis
237.79* Other neurofibromatosis
275.01 Hereditary hemochromatosis
275.02 Hemochromatosis due to repeated red blood cell transfusions
275.03 Other hemochromatosis
275.09 Other disorders of iron metabolism
276.61 Transfusion associated circulatory overload
276.69 Other fluid overload
278.03 Obesity hypoventilation syndrome
287.41 Posttransfusion purpura
287.49 Other secondary thrombocytopenia
315.35* Childhood onset fluency disorder
447.70 Aortic ectasia, unspecified site
447.71 Thoracic aortic ectasia
447.72 Abdominal aortic ectasia
447.73 Thoracoabdominal aortic ectasia
### New ICD-9 codes for 2011

#### Influenza

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>237.73</td>
<td>Influenza due to identified avian influenza virus with pneumonia</td>
</tr>
<tr>
<td>488.01*</td>
<td>Influenza due to identified avian influenza virus with other respiratory manifestations</td>
</tr>
<tr>
<td>488.02*</td>
<td>Influenza due to identified avian influenza virus with other respiratory manifestations</td>
</tr>
<tr>
<td>488.09*</td>
<td>Influenza due to identified avian influenza virus with other respiratory manifestations</td>
</tr>
<tr>
<td>488.11*</td>
<td>Influenza due to identified novel H1N1 influenza virus with pneumonia</td>
</tr>
<tr>
<td>488.12*</td>
<td>Influenza due to identified novel H1N1 influenza virus with other respiratory manifestations</td>
</tr>
<tr>
<td>488.19*</td>
<td>Influenza due to identified novel H1N1 influenza virus with other respiratory manifestations</td>
</tr>
</tbody>
</table>

### New ICD-9 codes for 2011

#### Influenza

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>560.32</td>
<td>Fecal impaction</td>
</tr>
<tr>
<td>724.03</td>
<td>Spinal stenosis, lumbar region, with neurogenic claudication</td>
</tr>
<tr>
<td>752.31</td>
<td>Agenesis of uterus</td>
</tr>
<tr>
<td>752.32</td>
<td>Hypoplasia of uterus</td>
</tr>
<tr>
<td>752.33</td>
<td>Unicorneate uterus</td>
</tr>
<tr>
<td>752.34</td>
<td>Bicornuate uterus</td>
</tr>
<tr>
<td>752.35</td>
<td>Septate uterus</td>
</tr>
<tr>
<td>752.36</td>
<td>Arcuate uterus</td>
</tr>
<tr>
<td>752.39</td>
<td>Other anomalies of uterus</td>
</tr>
<tr>
<td>752.43</td>
<td>Cervical agenesis</td>
</tr>
<tr>
<td>752.44</td>
<td>Cervical duplication</td>
</tr>
<tr>
<td>752.45</td>
<td>Vaginal agenesis</td>
</tr>
<tr>
<td>752.46</td>
<td>Transverse vaginal septum</td>
</tr>
<tr>
<td>752.47</td>
<td>Longitudinal vaginal septum</td>
</tr>
<tr>
<td>780.33</td>
<td>Post traumatic seizures</td>
</tr>
<tr>
<td>780.66</td>
<td>Febrile nonhemolytic transfusion reaction</td>
</tr>
</tbody>
</table>
New ICD-9 codes for 2011

**Influenza**

- 784.52* Fluency disorder in conditions classified elsewhere
- 784.92 Jaw pain
- 786.30 Hemoptysis, unspecified
- 786.31 Acute idiopathic pulmonary hemorrhage in infants [AIPH] 
- 786.39 Other hemoptysis
- 787.60 Full incontinence of feces
- 787.61 Incomplete defecation
- 787.62 Fecal smearing
- 787.63 Fecal urgency
- 799.51 Attention or concentration deficit
- 799.52 Cognitive communication deficit
- 799.53 Visuospatial deficit
- 799.54 Psychomotor deficit
- 799.55 Frontal lobe and executive function deficit
- 799.59 Other signs and symptoms involving cognition
- 970.81 Poisoning by cocaine
- 970.89 Poisoning by other central nervous system stimulants

New ICD-9 codes for 2010

- Health supervision for the newborn younger than 8 days
- Health supervision for newborn 8 to 28 days old
- Failure to thrive in the newborn
- Apparent life-threatening event in an infant
- Infantile colic
- Torus fracture of the ulna
- Nursemaid elbow
- Family disruption
- Counseling for parent-biological child problem
- Counseling for parent-adopted child problem
- Counseling for parent (guardian)-foster child problem
- Omphalocele and gastroschisis
- Expansion of poisoning codes
- Expansion of hypoxic-ischemic encephalopathy codes
- Expansion of codes related to family history
- New codes for neurologic screening
- New codes to show inhaled and systemic steroid use
- New codes to report external causes of injuries, poisonings, and adverse effects.
## New ICD-9 codes for 2010

### ABO Incompatibility

- **999.60** ABO incompatibility reaction, unspecified
- **999.61** ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
- **999.62** ABO incompatibility with acute hemolytic transfusion reaction
- **999.63** ABO incompatibility with delayed hemolytic transfusion reaction
- **999.69** Other ABO incompatibility reaction
- **999.70** Rh incompatibility reaction, unspecified
- **999.71** Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed
- **999.72** Rh incompatibility with acute hemolytic transfusion reaction
- **999.73** Rh incompatibility with delayed hemolytic transfusion reaction
- **999.74** Other Rh incompatibility reaction
- **999.75** Non-ABO incompatibility reaction, unspecified
- **999.76** Non-ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
- **999.77** Non-ABO incompatibility with acute hemolytic transfusion reaction
- **999.78** Non-ABO incompatibility with delayed hemolytic transfusion reaction
- **999.79** Other non-ABO incompatibility reaction
- **999.80** Transfusion reaction, unspecified
- **999.81** Hemolytic transfusion reaction, incompatibility unspecified
- **999.82** Acute hemolytic transfusion reaction, incompatibility unspecified
- **999.85** Delayed hemolytic transfusion reaction, incompatibility unspecified

### Personal History

- **V13.62** Personal history of other (corrected) congenital malformations of genitourinary system
- **V13.63** Personal history of (corrected) congenital malformations of nervous system
- **V13.64** Personal history of (corrected) congenital malformations of eye, ear, face and neck
- **V13.65** Personal history of (corrected) congenital malformations of heart and circulatory system
- **V13.66** Personal history of (corrected) congenital malformations of respiratory system
- **V13.67** Personal history of (corrected) congenital malformations of digestive system
- **V13.68** Personal history of (corrected) congenital malformations of integument, limbs, and musculoskeletal systems
- **V15.53** Personal history of retained foreign body fully removed
- **V25.11** Encounter for insertion of intrauterine contraceptive device
- **V25.12** Encounter for removal of intrauterine contraceptive device
- **V25.13** Encounter for removal and reinsertion of intrauterine contraceptive device
- **V49.86** Do not resuscitate status
- **V49.87** Physical restraints status
- **V62.85** Homicidal ideation
- **V85.41** Body Mass Index 40.0-44.9, adult
- **V85.42** Body Mass Index 45.0-49.9, adult
- **V85.43** Body Mass Index 50.0-59.9, adult
- **V85.44** Body Mass Index 60.0-69.9, adult
- **V85.45** Body Mass Index 70 and over, adult
### New ICD-9 codes for 2010

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V88.11</td>
<td>Acquired total absence of pancreas</td>
</tr>
<tr>
<td>V88.12</td>
<td>Acquired partial absence of pancreas</td>
</tr>
<tr>
<td>V90.01</td>
<td>Retained depleted uranium fragments</td>
</tr>
<tr>
<td>V90.09</td>
<td>Other retained radioactive fragments</td>
</tr>
<tr>
<td>V90.10</td>
<td>Retained metal fragments, unspecified</td>
</tr>
<tr>
<td>V90.11</td>
<td>Retained magnetic metal fragments</td>
</tr>
<tr>
<td>V90.12</td>
<td>Retained nonmagnetic metal fragments</td>
</tr>
<tr>
<td>V90.2</td>
<td>Retained plastic fragments</td>
</tr>
<tr>
<td>V90.31</td>
<td>Retained animal quills or spines</td>
</tr>
<tr>
<td>V90.32</td>
<td>Retained tooth</td>
</tr>
<tr>
<td>V90.33</td>
<td>Retained wood fragments</td>
</tr>
<tr>
<td>V90.39</td>
<td>Other retained organic fragments</td>
</tr>
<tr>
<td>V90.81</td>
<td>Retained glass fragments</td>
</tr>
<tr>
<td>V90.83</td>
<td>Retained stone or crystalline fragments</td>
</tr>
<tr>
<td>V90.89</td>
<td>Other specified retained foreign body</td>
</tr>
<tr>
<td>V90.9</td>
<td>Retained foreign body, unspecified material</td>
</tr>
<tr>
<td>V91.00</td>
<td>Twin gestation, unspecified number of placenta, unspecified number of amniotic sacs</td>
</tr>
<tr>
<td>V91.01</td>
<td>Twin gestation, monochorionic/monoamniotic (one placenta, one amniotic sac)</td>
</tr>
<tr>
<td>V91.02</td>
<td>Twin gestation, monochorionic/diamniotic (one placenta, two amniotic sacs)</td>
</tr>
<tr>
<td>V91.03</td>
<td>Twin gestation, dichorionic/diamniotic (two placentae, two amniotic sacs)</td>
</tr>
<tr>
<td>V91.09</td>
<td>Twin gestation, unable to determine number of placenta and number of amniotic sacs</td>
</tr>
<tr>
<td>V91.10</td>
<td>Triplet gestation, unspecified number of placenta and unspecified number of amniotic sacs</td>
</tr>
<tr>
<td>V91.11</td>
<td>Triplet gestation, with two or more monochorionic fetuses</td>
</tr>
<tr>
<td>V91.12</td>
<td>Triplet gestation, with two or more monoamniotic fetuses</td>
</tr>
<tr>
<td>V91.19</td>
<td>Triplet gestation, unable to determine number of placenta and number of amniotic sacs</td>
</tr>
<tr>
<td>V91.20</td>
<td>Quadruplet gestation, unspecified number of placenta and unspecified number of amniotic sacs</td>
</tr>
<tr>
<td>V91.21</td>
<td>Quadruplet gestation, with two or more monochorionic fetuses</td>
</tr>
<tr>
<td>V91.22</td>
<td>Quadruplet gestation, with two or more monoamniotic fetuses</td>
</tr>
<tr>
<td>V91.29</td>
<td>Quadruplet gestation, unable to determine number of placenta and number of amniotic sacs</td>
</tr>
<tr>
<td>V91.90</td>
<td>Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs</td>
</tr>
<tr>
<td>V91.91</td>
<td>Other specified multiple gestation, with two or more monochorionic fetuses</td>
</tr>
<tr>
<td>V91.92</td>
<td>Other specified multiple gestation, with two or more monoamniotic fetuses</td>
</tr>
<tr>
<td>V91.99</td>
<td>Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs</td>
</tr>
</tbody>
</table>
New ICD-9 codes for 2010
Preventive Medicine Visits - health supervision

- Old- V20.2 for birth until through age 18 years

NEW
- newborn
  - under 8 days old V20.31
  - 8 to 28 days old V20.32
- infant or child
  - over 28 days old, routine V20.2

New ICD-9 codes for 2010
Counseling

NEW Pediatric
- pre-adoption visit for adoptive parent(s) V65.11
- pre-birth visit for expectant parent(s) V65.11
New ICD-9 codes for 2010

Influenza

• **488.0** Influenza due to identified avian influenza virus
  - Avian influenza
  - Bird flu
  - Influenza A/H5N1

• **488.1** 2009 H1N1 [swine] influenza virus
  - Novel 2009 influenza H1N1
  - Novel H1N1 influenza
  - Novel influenza A/H1N1
  - Swine flu

2010 ICD-Others

• **372.06** Acute chemical conjunctivitis
• **569.87** Vomiting of fecal matter
• **756.72** Omphalocele
• **756.73** Gastrochisis
• **768.70** Hypoxic-ischemic encephalopathy, unspecified
  • **768.71** Mild hypoxic-ischemic
  • **768.72** Moderate hypoxic-ischemic
  • **768.73** Severe hypoxic-ischemic
2010 ICD-Others

- 779.31 Feeding problems in newborn
- 779.32 Bilious vomiting in newborn
- 779.33 Other vomiting in newborn
- 779.34 Failure to thrive in newborn
- 784.42 Dysphonia
- 784.43 Hypernasality
- 784.44 Hyponasality
- 784.51 Dysarthria
- 784.59 Other speech disturbance
- 787.04 Bilious emesis
- 789.7 Colic

2010 ICD-Others

- 799.21 Nervousness
- 799.22 Irritability
- 799.23 Impulsiveness
- 799.24 Emotional lability
- 799.25 Demoralization and apathy
- 799.29 Other signs and symptoms involving emotional state
- 799.82 Apparent life-threatening event in infant
- 813.46 Torus fracture of ulna (alone)
- 813.47 Torus fracture of radius and ulna
- 832.2 Nursemaid elbow
2010 ICD-Others

- 969.00 Poisoning by antidepressant, unspecified
- 969.01 Poisoning by monoamine oxidase inhibitors
- 969.02 Poisoning by selective serotonin and norepinephrine reuptake inhibitors
- 969.03 Poisoning by selective serotonin reuptake inhibitors
- 969.04 Poisoning by tetracyclic antidepressants
- 969.05 Poisoning by tricyclic antidepressants
- 969.09 Poisoning by other antidepressants
- 969.70 Poisoning by psychostimulant, unspecified
- 969.71 Poisoning by caffeine (etiology-coding seminar)
- 969.72 Poisoning by amphetamines
- 969.73 Poisoning by methylphenidate
- 969.79 Poisoning by other psychostimulants

2010 ICD-Others

- V10.90 Personal history of unspecified type of malignant neoplasm
- V10.91 Personal history of malignant neuroendocrine tumor
- V15.52 Personal history of traumatic brain injury
- V15.83 Personal history of underimmunization status
- V20.31 Health supervision for newborn under 8 days
- V20.32 Health supervision for newborn 8 to 28 days old
- V60.81 Foster care (status)
- V60.89 Other specified housing or economic circumstances
- V61.07 Family disruption due to death of family member
- V61.08 Family disruption due to other extended absence of family member
- V61.23 Counseling for parent-biological child problem
- V61.24 Counseling for parent-adopted child problem
- V61.25 Counseling for parent (guardian)-foster child
**2010 ICD-Others**

- V72.60 Laboratory examination, unspecified
- V72.61 Antibody response examination
- V72.62 Laboratory examination ordered as part of a routine general medical examination
- V72.63 Pre-procedural laboratory examination
- V72.69 Other laboratory examination
- V80.01 Special screening for traumatic brain injury
- V80.09 Special screening for other neurological conditions
- V87.32 Contact with and (suspected) exposure to algae bloom
- V87.44 Personal history of inhaled steroid therapy
- V87.45 Personal history of systemic steroid therapy
- V87.46 Personal history of immunosuppressive therapy

**2010 ICD- E Codes**

- E001.0 Activities involving walking, marching, and hiking
- E002.1 Activities involving springboard and platform diving
- E002.2 Activities involving water polo
- E003.0 Activities involving ice skating
- E004.3 Activities involving climbing and bungee jumping
- E004.9 Other activity involving climbing, rappelling, and jumping off
- E005.2 Activities involving gymnastics
- E005.4 Activities involving cheerleading
- E006.0 Activities involving roller skating (inline) and skateboarding
- E006.4 Activities involving bike riding
2010 ICD- E Codes

- E006.5 Activities involving jump rope
- E007.1 Activities involving American flag or touch football
- E007.8 Activities involving physical games generally associated with school recess, summer camp, and children
- E008.3 Activities involving Frisbee
- E009.2 Activity involving aerobic and step exercise
- E010.2 Activity involving free weights
- E011.0 Activities involving computer keyboarding
- E011.1 Activities involving handheld interactive electronic device
- E012.9 Activity involving other arts and handcrafts
- E029.2 Roughhousing and horseplay

RBRVS 2010
the Medicare Fee Schedule

- Fees are calculated by multiplying the rvu for a CPT code (service) times the conversion factor (cf)
- The cf is determined by the “SGR” formula - keeps the Medicare budget neutral
- For 2010 it was to be $28.41 - a 21.2% reduction, but.....
- On June 25, 2010- $36.87 - “Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010” increased the 2010 Medicare conversion factor by 2.2% retroactive to June 1, 2010 through November 30, 2010.
CASE

An established 6 mo old is seen for “tremors”. Your hx/pe are detailed and mdm is moderate, and lasts 21 minutes. You think this might be a 99213 or 99214, but have to decide if going to “look it up is worth the time”. If your payments average 130% of Medicare, the difference in a 99213 and 99214 is about-

A. $10  
B. $20  
C. $30  
D. $40
The Key Services for the Medical Home

Evaluation and Management Services - Outpatient Office Visits

Why a Key Service for the Medical Home?

1. Highest Volume Service
2. Allows increasing the level to match the work of long visits
3. Critical for payment and compliance

Reimbursement Keys

1. These codes are paid!
2. Biggest hurdles to reimbursement
   • Undercoding and learning the coding guidelines
   • Contracting for fair rates
HOW TO IMPROVE

• Measure Your Coding Profile
• Participate in a Practice-Based Coding Education program
• Focus on Correctly Coding Your Work-The Dollars Will Follow

CASE-9921X

Chief Complaint - resp. infection

6 mo. Female- established. Hx- cough. 4 days wheezes, feeds well, worsening. No fever. No meds. NKA. In day care. All Other ROS neg.

PE- T-99 P-90 R-50 wt- 9 kg

Impression-1. URI 2. BOM 3. heat rash
Plan- Supportive Care. Amoxicillin 250mg tid. (time-13 minutes)
CASE- 9921X

A. 99212
B. 99213
C. 99214
D. 99215

CASE- 9921X

A. 99212
B. 99213
C. 99214
D. 99215......BUT..........

7/28/2010
EM DG  
Medicare Guidance

- Provides Guidance on Selecting Levels of E/M Codes
- Hx and PE documented should be medically necessary to manage the problem for the encounter
- Documented extraneous information should not be used to upcode E/M Levels

?Appropriate Coding-the “Bell Curve”-Not Evidence Based!

[Graph showing distribution of coding levels with categories for Under coding and Over coding]
AAP 2001 REPORT
Are You Here??

- E/M CODE - EST. PT.
  FREQUENCY - PER MD
  99211-146
  99212-1000
  **99213-5224**
  99214-425
  99215-37

- Like most veterinary students, Doreen breezes through chapter 9
THE NEW BELL CURVE 99214

• Margie Andrea- UM- MGMA Connexion January 2005 > 40%
• Rob Walker MD- SC- >34%
• CMS- 2006 Medicare Data- 29%

Distribution of CPT E&M established patient visit codes before and after correcting for errors in code assignment

<table>
<thead>
<tr>
<th>Code</th>
<th>Uncorrected claims</th>
<th>Corrected claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>0.55</td>
<td>0.56</td>
</tr>
<tr>
<td>99212</td>
<td>7.86</td>
<td>2.59</td>
</tr>
<tr>
<td>99213</td>
<td>79.82</td>
<td>46.76</td>
</tr>
<tr>
<td>99214</td>
<td>10.34</td>
<td>47.18</td>
</tr>
<tr>
<td>99215</td>
<td>0.13</td>
<td>2.91</td>
</tr>
</tbody>
</table>
SOAPM Abstract NCE 2004

Five Years of Coding Education in Pediatric Practice: The Financial Impact

Robert D. Walker, MD, FAAP, CPE
Columbia, S.C.
Results

• Charges for 99213 and 99214 in 2004 totaled $4,229,185
• The same number of visits coded at 1998 percentages would have resulted in charges of $3,205,772
• The difference based simply on improved coding is $1,023,413

THE CODING 2 STEP

1. First select the code based on the Feel-Example, “ART”

2. Then validate your code using a E/M tool, “SCIENCE”
THE “ART” OF CODING

• THE “FEEL”
• FROM EXPERIENCE
• BY EXAMPLE

THE “FEEL”

• 99211- nurse visit
• 99212- easy, brief problems
• 99213- average, usual problems
• 99214- “oh no”
• 99215- post visit “just ran a marathon” feeling

YOU should select the EM code level, not your office staff- you have felt the pain
99212
TYPICAL PRESENTING PROBLEMS
1. Diaper rash
2. OM recheck-resolved
3. Otitis Externa
4. Thrush

99213
TYPICAL PRESENTING PROBLEMS
1. Fever and pharyngitis
2. UTI- cystitis
3. URI and Otitis
4. Mild LRI’s
5. Moderate injury

Most Acute Uncomplicated Illness/Problems
99214

TYPICAL PRESENTING PROBLEMS
1. Chronic or Multiple Problems
   - Headaches, Abdominal Pain
   - Fatigue, Anorexia
   - Asthma, Diabetes
2. School, Behavioral Problems
   - ADD - return visits
3. Acute Complicated Illnesses
   - Fever without focus
   - Influenza

99215

TYPICAL PRESENTING PROBLEMS
1. Diabetes complicated by influenza
2. Headaches with vomiting
3. Abdominal pain, disabling
4. Fatigue, anorexia in teen
5. Fever without focus - <60 days
6. School, behavioral problems
7. ADD - initial evaluation
THE "SCIENCE" OF CODING
CMS EM Documentation Guidelines

• Two Versions-
  • 1995 and 1997- can use either
• Used by all Federal and most private Payers
• www.cms.gov (search EMDG)

Selecting The Correct E/M Code

• Three Key Criteria
  • History
  • Physical Examination
  • Medical Decision Making
• For New Patients- Must Have Three of Three Criteria at Same Level
• For Established Patients- Only Two of Three Criteria at Level
### Elements of The History

<table>
<thead>
<tr>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family, Social History (PFSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location, quality, severity, duration, timing, context, modifying factors, associated signs &amp; symptoms</td>
<td>Constitutional; eyes; ears, nose, mouth &amp; throat; cardiovascular; respiratory; GI; GU; musculoskeletal; integumentary (including breast); neurological; psychiatric; endocrine; hematologic/lymphatic; &amp; allergic/immunologic</td>
<td>Past-experience with illnesses, operations injuries &amp; treatments;ag allergy hx, medications taken prior to the visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family - medical history, including diseases that may be hereditary or place patient at risk;current illness in the family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social - age appropriate review of patient’s past and current activities including marital status, employment, drug &amp; alcohol abuse, education and sexual history, day care status</td>
</tr>
</tbody>
</table>

### Levels of History

<table>
<thead>
<tr>
<th>Level of History</th>
<th>Chief Complaint (CC)</th>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family, Social History (PFSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CPT</td>
<td>Medicare</td>
<td>CPT</td>
<td>Medicare</td>
</tr>
<tr>
<td>Problem Focused</td>
<td>Required</td>
<td>Brief</td>
<td>1-3 elements</td>
<td>Not Required</td>
</tr>
<tr>
<td>Expanding Problem Focused</td>
<td>Required</td>
<td>Brief</td>
<td>1-3 elements</td>
<td>Problem- Pertinent</td>
</tr>
<tr>
<td>Detailed</td>
<td>Required</td>
<td>Extended</td>
<td>4+ elements OR 3+ chronic or inactive conditions</td>
<td>Extended 2-9 systems</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Required</td>
<td>Extended</td>
<td>4+ elements OR 3+ chronic or inactive conditions</td>
<td>Complete 10 systems</td>
</tr>
</tbody>
</table>

|                  | Medicare                         |                                  | Medicare                             |                                  |
|                  |                                  |                                  | Not Required                          |                                  |
|                  |                                  |                                  | 1 element                             |                                  |
|                  |                                  |                                  | 2 or 3 elements                      |                                  |
## Body Areas/organ Systems in the Physical Exam

<table>
<thead>
<tr>
<th>CPT Definitions</th>
<th>Medicare Documentation Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1995 Guidelines</strong></td>
<td><strong>1997 Guidelines</strong></td>
</tr>
<tr>
<td><strong>Body Areas:</strong> abdomen; back, including spine; chest, including breast &amp; axillae; genitalia/groin/ buttoks; head, including face, each extremity; and neck</td>
<td><strong>Body Areas:</strong> abdomen; back, including spine; chest, including breast &amp; axillae; genitalia/groin/ buttoks; head, including face, each extremity; and neck</td>
</tr>
<tr>
<td><strong>Organ Systems:</strong> cardiovascular; ears/nose/mouth/throat/eyes; GI; GU; hematologic/lymphatic/immunologic; musculoskeletal; neurologic; psychiatric; respiratory; and skin</td>
<td><strong>Organ Systems:</strong> cardiovascular; ears/nose/mouth/throat/eyes; GI; GU; hematologic/lymphatic/immunologic; musculoskeletal; neurologic; psychiatric; respiratory; and skin</td>
</tr>
</tbody>
</table>

### Levels of Physical Examination

“Bullets” are specific items examined within a system or area.

<table>
<thead>
<tr>
<th>Level of Physical Exam</th>
<th>CPT Definitions</th>
<th>Medicare Documentation Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem-Focused</strong></td>
<td>Limited exam of affected body area</td>
<td>1 body area or organ system</td>
</tr>
<tr>
<td></td>
<td>1-5 bullets in one or more organ systems/body areas</td>
<td></td>
</tr>
<tr>
<td><strong>Expanded Problem- Focused</strong></td>
<td>Limited exam of affected body area + other symptomatic or related organ systems</td>
<td>2-4 body areas/organ systems including affected area</td>
</tr>
<tr>
<td></td>
<td>6-11 bullets in one or more organ systems/body areas</td>
<td></td>
</tr>
<tr>
<td><strong>Detailed</strong></td>
<td>Extended exam of affected body area + other symptomatic or related organ systems</td>
<td>5-7 body areas/organ systems including affected area</td>
</tr>
<tr>
<td></td>
<td>12 or more bullets in two or more organ systems/body areas</td>
<td></td>
</tr>
<tr>
<td><strong>Comprehensive</strong></td>
<td>General multi-system exam or complete examination of single organ system</td>
<td>8 or more organ systems</td>
</tr>
<tr>
<td></td>
<td>General multi-system exam: 2 bullets from 9 different body areas/organ systems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Genitourinary single system exam: Specific number of bullets from 3 body areas/organ systems + any 1 element from 6 other body areas/organ systems</td>
<td></td>
</tr>
</tbody>
</table>
### Medical Decision Making

Elements Included in Medical Decision Making Component - Select level with two of three

<table>
<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of DATA to be reviewed</th>
<th>Risk of complications and/or morbidity or mortality</th>
<th>Type of Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

### Medical Decision-Making

**select level of highest one element**

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problems</th>
<th>Diagnostic Procedures</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>1 self-limited</td>
<td>Lab test: Venipuncture</td>
<td>Bandages/rest/drug</td>
</tr>
<tr>
<td>Low</td>
<td>2 or more self-limited 1 stable chronic illness</td>
<td>Superficial needle bx Lab test: Arterial puncture Single x-ray Physiologic tests</td>
<td>OTC drugs Minor surgery OT</td>
</tr>
<tr>
<td></td>
<td>Acute uncomplicated illness or injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>1 or more chronic illness with mild exacerbation</td>
<td>Multiple x-rays Deep-needle bx LP, joint aspiration CT, MRI Cardiography</td>
<td>Minor surgery with risks Elective major surgery Prescription drugs Closed fx of fx</td>
</tr>
<tr>
<td></td>
<td>2 or more stable acute illnesses with systemic symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>Acute complicated injury Undiagnosed new problem; with uncertain prognosis</td>
<td>Discography Myelography Arteriogram</td>
<td>Elective major surgery with risks/ER major surgery Parenteral controlled substance/drug therapy with intensive monitoring DNR</td>
</tr>
<tr>
<td></td>
<td>1 or more chronic illness with severe exacerbation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute illness with threat to life/limb Abrupt change in neurologic status</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 'POINT' method to determine type of medical decision making

<table>
<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Points</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (max = 2)</td>
<td>1</td>
<td>Review and/or order clinical lab tests, radiology tests or tests in CPT medicine section (max = 3)</td>
<td>1 each class of test</td>
</tr>
<tr>
<td>Established problem to examiner, stable/improved</td>
<td>1</td>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Established problem to examiner, worsening</td>
<td>2</td>
<td>Decision to obtain old record and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>New problem to examiner, no additional workup planned (max = 1)</td>
<td>3</td>
<td>Review, summarize old records and/or obtain history from someone other than the patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>New problem to examiner, additional workup planned</td>
<td>4</td>
<td>Independent visualization of image, tracing or specimen (not report review)</td>
<td>2</td>
</tr>
</tbody>
</table>

- Number of diagnoses or management options points ≤1 (minimal) 2 (limited) 3 (multiple) ≥4 (extensive)
- Amount and/or complexity of data to be reviewed points ≤1 (minimal/none) 2 (limited) 3 (multiple) ≥4 (extensive)
- Risk of complications and/or morbidity or mortality Minimal Low Moderate High
- Type of decision making Straightforward Low complexity Moderate complexity High complexity

### Office or Other Outpatient Services - New Patient

Document either all 3 key components (history, exam & medical decision making) OR time spent counseling the patient

<table>
<thead>
<tr>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of History CC</td>
<td>Problem-Focused</td>
<td>Expanded Problem-Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>HPI Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>1-3 elements</td>
<td>1-3 elements</td>
<td>4 + elements OR 3 + chronic or inactive conditions</td>
<td>4 + elements OR 3 + chronic or inactive conditions</td>
<td>4 + elements OR 3 + chronic or inactive conditions</td>
</tr>
<tr>
<td>ROS Not Required</td>
<td>1 system</td>
<td>2-9 systems</td>
<td>10-14 systems</td>
<td>10-14 systems</td>
</tr>
<tr>
<td>PFSH Not Required</td>
<td>Not Required</td>
<td>1 of 3 elements</td>
<td>3 of 3 elements</td>
<td>3 of 3 elements</td>
</tr>
</tbody>
</table>

| **Physical Examination** | | | | |
| Level of Exam | Problem-Focused | Expanded Problem-Focused | Detailed | Comprehensive | Comprehensive |
| 1995 1 system | 2-4 system | 5-7 systems | 8 or > systems | 8 or > systems |
| 1997 1-5 elements | 6-11 elements | 12 elements in 2 systems | 18 elements -2 in each of 9 systems | 18 elements-2 in each of 9 systems |

| **Medical Decision Making** | | | | |
| Level of MDM | Straightforward | Straightforward | Low | Moderate | High |

| **Face-To-Face Time** | | | | |
| Typical Times | 10 minutes | 20 minutes | 30 minutes | 45 minutes | 60 minutes |

| Relative value units/ 2004 Medicare payment Conversion Factor=$37.34 |
| Total Rvu $ | 0.97/316.22 | 1.73/64.60 | 2.57/95.96 | 3.63/135.54 | 4.61/172.13 |
### Office or Other Outpatient Services - Established Patient

Document either 2 or 3 key components (history, examination, & medical decision making) OR time spent counseling the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Physical Examination</th>
<th>Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>No required</td>
<td>Not Required</td>
<td>Not Required</td>
</tr>
<tr>
<td>99212</td>
<td>Problem-Focused</td>
<td>1 system</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99213</td>
<td>Detailed</td>
<td>2-9 systems</td>
<td>Low</td>
</tr>
<tr>
<td>99214</td>
<td>Comprehensive</td>
<td>10-14 systems</td>
<td>Moderate</td>
</tr>
<tr>
<td>99215</td>
<td>Required</td>
<td>18 elements in 2 systems</td>
<td>High</td>
</tr>
</tbody>
</table>

#### Level of History

- **CC**: Not required
- **HPI**: 1-3 elements
- **ROS**: Not Required
- **PFSH**: Not Required

#### Level of Exam

- **1995**: Not Required
- **1997**: Not Required

#### Level of MDM

- **1999**: Required
- **2010**: Required

#### Face-To-Face Time

- Typical Times: 5 minutes supervision,
- 10 minutes, 15 minutes, 25 minutes, 40 minutes

#### Relative value units/ 2009 Medicare payment Conversion Factor= $37.34

| Rate | 0.52/$18.75 | 1.03/$37.15 | 1.70/$61.31 | 2.56/$92.33 | 3.46/$124.79 |

**Physician must be in the office during the E/M service**

### 99214 - KEY ELEMENTS

**HISTORY**

- **detailed**
- **CC**
- **HPI-ext=4 or >**
- **ROS- 2-9**
- **PFSH- 1/3**

**PHYSICAL EXAM**

- **detailed**
- **5-7 systems (95)**
- **12 elements (97)**

**MDM**

- **moderate**

**Time 25 min**
Time

- An explicit factor to assist in selecting the most appropriate level of E/M services
- When counseling and/or coordination of care are more than 50% of the face to face encounter, time is the key controlling factor.
- Documentation of time in the medical record is a must in this situation
- Counseling - discussion with a patient and/or family concerning:
  - Diagnostic studies or results
  - Prognosis
  - Risks and benefits of management options
  - Importance of compliance
  - Patient and family education

Typical Times for Outpatient Services

- 99211  5 min.
- 99212  10 min.
- 99213  15 min.
- 99214  25 min.
- 99215  40 min.
- 99201  10 min.
- 99202  20 min.
- 99203  30 min.
- 99204  45 min.
- 99205  60 min.
99215 and TIME

**BEST WAY TO A "5"**

- IF TOTAL VISIT > 40 MINUTES (FACE TO FACE)
- RULE- IF OVER 50% COUNSELING OR COORDINATION OF CARE
- DOCUMENT COUNSELING/TOTAL TIME
  
  (21/40 MIN.)

---

**Prolonged Services**

<table>
<thead>
<tr>
<th>Type of Patient Care</th>
<th>Outpatient</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face to Face</td>
<td>99354 first hour &gt; 30 min</td>
<td>99356 first hour &gt; 30 min</td>
</tr>
<tr>
<td></td>
<td>99355 each add 30 min &gt; 75 min</td>
<td>99357 each add 30 min &gt; 75 min</td>
</tr>
<tr>
<td>Before or after Face to Face</td>
<td>99358 first hour &gt; 30 min</td>
<td>99358 first hour &gt; 30 min</td>
</tr>
<tr>
<td></td>
<td>99359 each add 30 min &gt; 75 min</td>
<td>99359 each add 30 min &gt; 75 min</td>
</tr>
</tbody>
</table>
The RAC (Recovery Audit Contractor) Audits - Coming to a theater near you

They are invited to audit your claims by the employer CMS by Congressional mandate was first - good roi of 3:1

They audit using software that spots overcoding with a high likelihood of accuracy

RAC sends letters asking for a recoupment

The Tennessee Medical Society challenged legally and the RAC stopped its efforts
The RAC (Recovery Audit Contractor) Audits - Coming to a theater near you

Federal Programs - SCHIP, Medicaid, and likely commercial are or will be using these programs

Based on the strict application of the Correct Coding Initiative (CMS) or CCI

Edits to deny code pairs for services that should not be billed together

CCI Edits by CMS

USE Certain modifiers to "break the edits"

Two key modifiers -25, and -59

Review on the CMS web site

www.CMS.gov - search "CCI"
Key Services for the Medical Home

Be A Consultant!

Why a Key Service for the Medical Home?

1. Allows increased payment for consulting can consult your partner
2. Areas of expertise can be found in many clinics without subspecialty referral/wait
3. Pt. satisfier
Reimbursement Keys

1. These codes are paid
2. Biggest hurdle to reimbursement is learning the coding guidelines

OPPORTUNITIES
OUTPATIENT CONSULTATION CODES

- RVU’S ARE USUALLY HIGHER THAN E/M OFFICE VISIT CODES
- CAN DO WITHIN THE SAME GROUP
- DON’T FORGET THE ED!
Consultations

Consultation is a service provided by a physician whose opinion or advice is requested by another physician or other appropriate source.

Consultant may initiate diagnostic and/or therapeutic services.

Consultation Codes

- Consult
  - A service provided at the documented request of another physician for a specific purpose
  - Written report of findings must be provided to the referring physician
- Codes
  - Office - 99241-99245
  - Hospital -99251-99255
- FOR 2006 Confirmatory and Inpatient Follow up Consult Codes Deleted
Consultations
The “FOUR” R’s

Consultant must document:

- **Request** for consultation (written or verbal)
- **Reason** for consultation
- **Rendering**—Opinion and services ordered and performed
- **Report** or communication in writing back to the referring source

---

**RVU’S CONSULT vs. OFFICE VISIT**

<table>
<thead>
<tr>
<th></th>
<th>EST OV-99214</th>
<th>NEW OV-99204</th>
<th>CONSULT-99244</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVU</td>
<td>2.18</td>
<td>3.61</td>
<td>4.54</td>
</tr>
<tr>
<td>PAYMENT RBRVS $</td>
<td>78.91</td>
<td>130.68</td>
<td>164.34</td>
</tr>
</tbody>
</table>
### Office or Outpatient Consultations-new/est.

<table>
<thead>
<tr>
<th>Codes</th>
<th>99241</th>
<th>99242</th>
<th>99243</th>
<th>99244</th>
<th>99245</th>
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<tbody>
<tr>
<td>History</td>
<td>Problem Focused</td>
<td>Expand. Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Exam</td>
<td>Problem Focused</td>
<td>Expand. Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Decision Making</td>
<td>Straight forward</td>
<td>Straight forward</td>
<td>Low complex</td>
<td>Moderate complex</td>
<td>High complex</td>
</tr>
<tr>
<td>Time</td>
<td>15</td>
<td>30</td>
<td>40</td>
<td>60</td>
<td>80</td>
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<td>Key #</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
</tr>
</tbody>
</table>

### Hospital or Inpatient Consultations-new/est.

<table>
<thead>
<tr>
<th>Codes</th>
<th>99251</th>
<th>99252</th>
<th>99253</th>
<th>99254</th>
<th>99255</th>
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</thead>
<tbody>
<tr>
<td>History</td>
<td>Problem Focused</td>
<td>Expand. Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Exam</td>
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</tr>
<tr>
<td>Time</td>
<td>20</td>
<td>40</td>
<td>55</td>
<td>80</td>
<td>110</td>
</tr>
<tr>
<td>Key #</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
</tr>
</tbody>
</table>
Key Services for the Medical Home

Preventive Care Services

Why a Key Service for the Medical Home?

1. Preventive care is the cornerstone of prevention
   • Early detection-obesity, development
   • Anticipatory guidance-violence, substance use

2. Critical for payment and compliance
Reimbursement Keys

1. These codes are paid if a covered benefit
2. Must learn to use the -25 modifier

Preventive Medicine Services

- E/M services are typically performed in the absence of a significant problem/abnormality
- Extent and focus depends on the patient’s age
- Includes counseling/anticipatory guidance/risk factor reduction
Preventive Medicine Services

• Use -25 modifier for significant-separate abnormality
• “Comprehensive Nature” not same as other E/M codes
• Code separately for labs, immunizations, screening tests with their own codes! (EPSDT)

Preventive Medicine Services

New Patient

Initial E/M of a new patient requiring a comprehensive history, comprehensive exam, identification of risk factors, ordering of appropriate tests, and counseling

99381  Age < 1 year
99382  Ages 1 - 4 years
99383  Ages 5 - 11 years
99384  Ages 12 - 17 years
99385  Ages 18 - 39 years
Preventive Medicine Services

Established Patient

Periodic reevaluation and management requiring a comprehensive history, comprehensive exam, identification of risk factors, and ordering of studies

99391 Age < 1 year
99392 Ages 1 - 4 years
99393 Ages 5 - 11 years
99394 Ages 12 - 17 years
99395 Ages 18 - 39 years

Code for Preventive Medicine Ancillary Services (know your contracts)

Screening

Hearing screen, pure tone air  99551
Developmental screening  96110
Vision screening  99173

Lab

Hemoglobin  85108
Urine  81002
Venipuncture/finger stick  36415

Injectables

Immunization administration  90471–90472
Injection/antibiotic  90788
Injection/other  90782
Understanding Modifier - 25

• Most common modifier used
• failure to use is a common cause for a DENIED when CCI edits are applied
• Used to report two services performed on the same day by the same physician for the same patient

The Coding Pearls
The Preventive Medicine Code

“If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported.

Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.”
The Coding Pearls
The Modifier -25

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

The Coding Pearls
The Modifier -25

- A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service).

- The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.
The Coding Pearls

The Modifier -25

- The modifier ALWAYS goes on the E/M code
- When a Prev. Medicine code and an E/M office visit for a problem are billed together, ALWAYS put the -25 on the non-prev. E/M code
- Never attach the -25 to a non-E/M code

The Coding Pearls

The Modifier -25

- When a separate problem is evaluated and reported with a NEW preventive medicine service-
  - Use the NEW OV/Outpatient codes 99201-99205
The Coding Pearls
The Modifier -25
Sick + Well

What is Significant?

• A separate visit would have been required to take care of the problem
• A problem requires an RX to treat

What is Separate?

• Additional documentation is needed
• Separate documentation helps you select the correct E/M code level
  • Addit. Hx, pe, mdm
• Separate documentation also helps you with an audit-keeps auditors happier-just like legible writing
The Coding Pearls
The Modifier -25
Sick + Well

Which services performed with an E/M code trigger the need for a Modifier -25?

Services that have physician work- other E/M codes and procedures

- Labs, X-rays do not
- Vaccines usually do not
- Vaccine administration fees - carrier specific

The Key Services for the Medical Home

Procedures
Why a Key Service for the Medical Home?

1. Greatly expand the scope of care provided in the Medical Home
2. Parents find value in avoiding the ED

Reimbursement Keys

1. These codes pay well and are typically covered
2. They are “free” of the E&M documentation guidelines

WHY USE PROCEDURE CODES!

- All the world is not E/M
- There are over 8000 non E/M codes in CPT - Try some!
  - Most pediatricians perform several procedures
  - Reimbursement - the RVU’s/$$ are usually higher/time for procedures
  - Compliance - the procedure codes usually most accurately describe the service
  - The documentation criteria for procedures is defined by the physician -not CMS
Common Pediatric Procedures

- Minor Surgery
  - Circumcision
  - Wart, granuloma removal
  - ID Abscess
- Laceration Repair
- Removal of Foreign Bodies
- Sprain and Simple Fracture Care
- Obtaining Specimens
  - Phlebotomy, LP, bladder Cath
- IV Access
- Testing Procedures

Procedures Have “Bundled” Services and “Globals”

- Payment for the procedure includes
  - pre-procedure evaluation
  - actual procedure and local anesthesia
  - post-procedure care up to a set number of days
    - “global period”
- Global period can last for 0, 10 or 90 days
  - starts when decision to perform the procedure is made
  - all procedure related services during the global period are included in the payment calculation
Procedures-E/M Rule

“When the procedure is carried out at the time of an initial or established patient visit involving significant identifiable E/M services, the appropriate visit is listed with the modifier '-25' appended to the E&M code in addition to reporting the procedure.”

Procedures-Their Value

- The procedures that are done in the inpatient hospital setting have a "facility " rvu/$
  - Outpatient (office ) has a "non-facility" rvu/$

Example- Newborn Circumcision

  outpt.- 3.56/$128.11
  inpt.-  3.15/$113.35
New CPT 2007

New CPT 2007
effective January 1

“NEW” Circumcision Code

▲54150 Circumcision, using clamp or other device, with regional dorsal penile or ring block
outpt. -3.56/$128.11
inpt.-3.15/$113.35

(Report 54150 with modifier 52 when performed without dorsal penile or ring block)

(54152 has been deleted. To report, use 54150)

New CPT 2007
effective January 1

Our New “All Warts” Codes

17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; up to 14 lesions
-2.38/$90.20
17111 15 or more lesions
-2.82/$106.87

99213 = 1.66/$62.91
New CPT 2007

effective January 1

One Hour Continuous Nebulizer Rx

94644 Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour
(For services of less than 1 hour, use 94640)

0.94/$35.62

94645 each additional hour (List separately in addition to code for primary procedure)
(Use 94645 in conjunction with 94644)

0.36/$13.64

Minor Surgery Procedures

Laceration Repair

• Use same codes for sutures as for glue
  • Medicare has a G code for glue repair-private payers do not use

• When more than one repair in the same body area, add up the individual lengths of all the lacerations and submit one code
Laceration Repair

12001  Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
  Outpt. 3.79/$143.63  Inpt.- 2.63/$99.67

12002  2.6 cm to 7.5 cm
  Outpt. 4.03/$152.23  Inpt. 2.94/$111.42

12011  Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
  Outpt. 4.01/$151.97  Inpt. 2.72/$103.08

12013  2.6 cm to 5.0 cm
  Outpt. 4.41/$197.45  Inpt. 3.11/$142.12

Minor Surgery Procedures
Removal of Foreign Bodies

10120 - removal of foreign body skin-
  - Outpt. 3.47/$131.50  Inpt. 2.32/487.92

69200 - removal foreign body-ear
  - Outpt. 3.12/$118.24  Inpt. 1.39/$52.68

30300- removal foreign body- nose
  - Outpt. 5.65/$214.12  Inpt. 3.02/$114.45

Incision and Drainage
Abscesses/Hematomas

10060-drainage of skin abscess-
  Outpt. 2.60/$98.53
  Inpt. 2.28/$86.41

11740 - subungual hematoma
  Outpt 1.02/$38.66
  Inpt. 2.14/$81.10
FRACTURE CARE

E/M visits vs Fracture care Codes

- FX Care CPT Codes are billed once per fracture - RVU's are good
- most have a 90 day global period - one payment covers all professional services performed during that 90 days for that fracture
- Always report X-rays, subsequent cast/splints in addition

GLOBAL CARE - RBRVS

25600 fx distal radius

<table>
<thead>
<tr>
<th>Type Billing</th>
<th>Global 25600</th>
<th>E/M 4 visits-99213 -1 99212-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pro service</td>
<td>$275</td>
<td>$146</td>
</tr>
<tr>
<td>Xrays -3</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td>Splinting-29125</td>
<td>$0</td>
<td>$73</td>
</tr>
<tr>
<td>Supplies-A4590</td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$365</td>
<td>$309</td>
</tr>
</tbody>
</table>
TEACHING POINT

Considerations in using the Global code-

1. Parent shocked at initial charge- EXPLAIN!
2. Partners may provide follow up care at no professional revenue
3. Partners may forget and bill subsequent visits as E/M (fraud)
4. Sometimes other service (E/M) provided during the global are denied- if so appeal using the -24 modifier.

Fracture Codes

24640 Nursemaid’s Elbow
Facility (hospital)
- Total = 2.12
- $80.35

Non-facility (office)
- Work = 1.20
- Total = 3.17
- $120.14

23500 - Closed treatment clavicle fracture
Facility
- Total = 4.91
- $186.09

Non-facility
- Total = 5.26
- $199.35
Pulmonary Procedure Codes

- **94010** Spirometry
  - $0.89 / $33.73
- **94060** – Spirometry pre- and post bronchodilator
  - $1.51 / $57.23
- **94070**- pre-post cold air/exercise
  - $1.59 / $60.21
- **94644**- Teaching/instruction mdi or nebulizer
  - $0.37 / $14.02
- **94640** - Inhalation therapy-neb or mdi - if>1, use -76 modifier or units  0.34 / $12.89
- **94760** - Pulse oximetry
  - $0.07/$2.65

Key Services for the Medical Home

Non-Face-To-Face Services
Why a Key Service for the Medical Home?

1. About one third of care in a pediatric medical home is delivered by telephone.
2. Maintaining an excellent telephone system is resource intensive—both your and your nurse’s time—thus a need for payment.

Reimbursement Keys

1. These are new codes—payment will be dependent on billing volume, educating payers at multiple levels, and contracting.
**Telephone Care—Use Until 1 Jan 08**

Telephone call to a patient, or for consultation or for medical management with other health care professionals—made by the physician—

- **99371** Simple or brief
  - Report on tests, clarify instructions, adjust therapy

- **99372** Intermediate
  - Advice on a new problem, initiate therapy,
  - Discuss tests in detail

- **99373** Complex or lengthy
  - Lengthy counseling session, Detailed or prolonged discussions regarding serious illness

(Only infrequently paid by insurers)

**TELEPHONE CARE Finding Value**

USE FOR—

1. Telephone provides an *alternative setting for an episode of care*
2. *Management* of chronic disease
TELEPHONE CARE

Finding Value

DO NOT USE FOR CALLS -

• Leading to an appointment
• Less than five minutes
• For one week following up to a visit or procedure

Telephone Care Codes

*NEW for 2008

Three New Codes for Telephone EM Care and Three Parallel Codes in Medicine Section for Non-Physicians

Level Defined by Length of Call

Will Have a "Global" Period of 7 days

CMS Will Need to Publish RVU's

Section On Telephone Care- Telephone Reimbursement Tool Kit-MOC

*Pending Final Approved By AMA CPT-for use 1 Jan 2008
Telephone Services 2008

- **99441** Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- **99442** 11-20 minutes of medical discussion
- **99443** 21-30 minutes of medical discussion

Changes for 2008: RBRVS

- **Highlights - 2009 RBRVS**

  Telephone services

  - **99441** - 0.33/$12.57
  - **99442** - 0.63/$23.99
  - **99443** - 0.95/$36.18

  - One rvu = $34.06 2008 proposed
Telephone Services 2008
The Reporting Rules

1. Telephone services are non-face-to-face evaluation and management (E/M) services provided by a physician to a patient using the telephone.

2. These codes are used to report episodes of care by the physician initiated by an established patient or guardian of an established patient.

3. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is NOT reported; rather the encounter is considered part of the pre-service work of the subsequent E/M service, procedure, and visit.

4. Likewise if the telephone call refers to an E/M service performed and reported by the physician within the previous seven days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure.

5. Do NOT report 99441-99443 if reporting 99441-99444 performed in the previous seven days.

6. For telephone services provided by a qualified non-physician health care professional, see 98966-98968.
Telephone Services 2008
Non-Physician Providers

• A “parallel” universe for non-physicians
• 3 codes in a new section: Non-Face-to-Face Non-physician Services, Telephone Services
  • Found in the Medicine Chapter with other non-E/M codes
• Who will use? PT, OT, Psychology, ???RN

Telephone Services 2008
Non-Physician Providers

• Telephone services are non-face-to-face assessment and management services provided by a qualified health care professional to a patient using the telephone.
• Remainder of code language matches physician codes
• *Who can use will depend on state scope of practice acts and who gets paid depends on payer policy*
Telephone Services 2008
Non-Physician Providers

• **98966** Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

• **98967** 11-20 minutes of medical discussion

• **98968** 21-30 minutes of medical discussion

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Changes for 2008: RBRVS

**Highlights - 2008 RBRVS**

**Telephone services**

**Other Qualified Health Care Personnel**

- **98966** - 0.35/$13.33
- **98967** - 0.66/$25.14
- **98969** - 0.98/$37.33

- *One RVU = $34.06 2008 proposed*
Other Non-Face-to-Face Services: E/M Services by E-mail-2007

- **0074T** Online evaluation and management service, per encounter, provided by a physician, using the Internet or similar electronic communications network, in response to a patient's request, established patient
  - (Category III CPT Code for new technologies)

Online Services

New Category I Code for 2008

- **99444** Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network
  - Report once per seven day period
Changes for 2008: RBRVS

- Highlights - 2008 RBRVS

  Team Conference
  - 99366-  1.08 rvu
  - 99367-  1.40 rvu
  - 99368-  0.91 rvu

  One rvu = $34.06 2008 proposed

Care Plan Oversight
Why a Key Service for the Medical Home?

1. Allows reimbursement for managing chronic illness and behavior
2. Pays for all non face to face time not billed with other nftf codes

Reimbursement Keys

1. These codes are paid at the 30 minute level by most payers
2. Will need a system for tracking/reporting time
CARE PLAN OVERSIGHT

• Care Plan Oversight Services are reported separately from codes for office/outpatient, hospital, home, nursing facilities or domiciliary services.

• The complexity and approximate physician time of the care plan oversight services provided within a 30-day period determine code selection.

CARE PLAN OVERSIGHT

• Can only be reported by one physician (PCP/Medical Home Provider) to reflect that physician’s sole or predominant supervisory role.

• If the work involved is very low intensity or infrequent, supervision service is included in pre- and post-encounter work for home, office/outpatient and nursing facility or domiciliary visit codes.
Care Plan Oversight Activities

- Review of subsequent reports of patient status,
- Review of related laboratory and other studies,
- Communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care,

CPT 2006 E/M Change Care Plan Oversight

\[ \text{Integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month;} \]
**CARE PLAN OVERSIGHT**

**Home Health**
- Physician supervision of a patient under care of home health agency, in home, domiciliary or equivalent environment requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, etc, within a calendar month.
- 99374 15-29 minutes
- 99375 30 minutes or more

**CARE PLAN OVERSIGHT**

**Hospice**
- Physician supervision of a hospice patient requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, etc, within a calendar month.
- 99377 15-29 minutes
- 99378 30 minutes or more
CARE PLAN OVERSIGHT
Nursing Facility

- PHYSICIAN SUPERVISION OF A NURSING FACILITY PATIENT REQUIRING COMPLEX AND MULTIDISCIPLINARY CARE MODALITIES INVOLVING REGULAR PHYSICIAN DEVELOPMENT AND/OR REVISION OF CARE PLANS, ETC, WITHIN A CALENDAR MONTH.
- 99379 15-29 MINUTES
- 99380 30 MINUTES OR MORE

CPT 2006 E/M Change
Care Plan Oversight For Everyone Else!

New Codes Added for Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Plan Oversight Services
Use for Managing the Non Face-to-Face Services of Managing Care Plan
Codes placed by CPT in a Different Location from the Existing CPO Codes
CPT 2006 E/M Change
Care Plan Oversight

- 99339 Individual physician supervision of a patient (patient not present) in HOME, domiciliary or rest home (eg, assisted living facility) 15-29 minutes - Calendar Month

- 99340 30 minutes or more

The Key Services for the Medical Home

Team Care
Non-Physician Services
Why a Key Service for the Medical Home?

1. Allows reimbursement for work your nurse and others do to assess and manage problems
2. Allows expansion of education, testing, and treatment services

Reimbursement Keys

1. Most codes are paid
2. Nurse must document as you do -an E/M service!
3. All but one can only be billed on days with no MD visit
USEFUL Non Physician SERVICES

- NURSE VISITS - 99291
- HEALTH BEHAVIOR ASSESSMENT INTERVENTION CODES 96150-96155
- MEDICAL NUTRITION SERVICES 97802-97804
- PATIENT EDUCATION (new 2006)

99211-Nurse Visit

- Lowest level established patient code
- Use for incident to: technician, medical assistant, LPN, RN with direct supervision
- Does not require face-to-face physician contact - typical time 5 minutes in CPT
- Usually requires a co-pay
- 2009 RBRVS: 0.54/$20.57
99211-Nurse Visit

- Typical Presenting Problems
  Nurse Visit (Provides an E/M Service)
  - BP Check
  - Throat Culture
  - Neonate Weight Check
  - ADHD Medication Refill
  - PPD Check
  - Dressing changes
  - Simple suture removal
  - Immunizations - in addition to administration code (if a separate problem addressed)
- Document!

99211-Nurse Visit

- Must Provide a service under MD protocol
- Direct supervision-MD should be available
- Document the content or time!
- MD should review the completed note and sign.
The Pediatric Care Team
Non-Physician Providers

- NP, PA, Psych, Social Worker, Dietician, OT, PT

- NP’s and PA’s can use the physician codes including E/M (if practicing within their state defined scope of practice). Nurses cannot use E/M codes.

- Practice nurses- RN, LPN, MA or NA

Health and Behavior
Assessment/Intervention

- To identify and address psychological, behavioral, emotional, cognitive, and social factors - prevention, treatment, or management of physical health problems (acute or chronic)

- Not meeting the criteria for psychiatric diagnosis - Psychiatric services not to be reported the same day

- E/M service codes not to be reported the same day

- To be used by non-physicians
Health and Behavior  A/I

- 96150 Assessment each 15 minutes  .69 rvu/$26.51
  face to face initial assessment
- 96151 - Reassessment  .67 rvu/$25.39
- 96152 Intervention each 15 minutes
  individual  .64 rvu/$24.25
- 96153 - Group (2 or more patients)  .15 rvu/$ 5.68
- 96154 - Family (patient present)  .63 rvu/$23.88
- 96155 - Family (w/o patient present)  .63 rvu/$23.90

Health and Behavior  A/I

- Used only by non-physicians -
  - MD,NP,PA use E/M office visit codes
- Cannot be reported with other E/M service
  by MD on same day-typically a stand alone visit
HEALTH BEHAVIOR ASSESSMENT INTERVENTION CODES 96150-96155

Example- 16 year old with worsening asthma visits the nurse for smoking cessation assessment, and returns in one month for intervention beginning a cessation program.

Medical Nutrition Therapy

- 97802  .48 rvu/$18.19
  - Initial assessment and intervention
  - Individual, face to face, each 15 minutes
- 97803  .48 rvu/$18.19
  - Reassessment and intervention
  - Each 15 minutes
- 97804  .19 rvu/$7.20
  - Group (2 or more individuals)
  - Each 30 minutes
Medical Nutrition Therapy

- Medicare Payment Policy - Pays for Licensed Registered Dieticians Only
- Private Plans May Vary
- Could become a component of obesity management

Medical Nutrition Therapy Example

- 8 year old who is overweight visits for dietary counseling
New in CPT 2006
Patient Education Codes

• 98960  Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient

• 98961  2-4 patients

• 98962  5-8 patients

Patient Education Codes
2009 RVU’s

rvu/ $$

• 98960  Individual- 0.59/$22.47

• 98961  2-4 patients 0.29/$11.05

• 98962  5-8 patients 0.21/$8.00
New in CPT 2006
Patient Education Codes

CPT

• The qualifications of the nonphysician healthcare professionals and the content of the educational and training program must be consistent with guidelines or standards established or recognized by a physician society, nonphysician healthcare professional society/association, or other appropriate source.
• Can be reported the same day as a physician visit (dr. sees pt and nurse provides education session-good!)

New in CPT 2006
Patient Education Codes

• **Why** - The code for 'nurse visit' 99211 did not allow reporting of longer/more intense visits
• **Who Will Use?** Many non-physician members of the office care teams who treat a variety of children with chronic illness (CYSHCN). Will support disease management programs.
• **CAUTION-** new codes -no rvu’s yet published- (should be similar to Health Behavior Codes)
Patient Education Codes
Examples-

- Obese 16 yr old visits diabetes nurse for education on exercise and medication management
- Infant and mother visit for breast feeding consultation with you nurse (certified lactation counselor)
- 6 yr old with asthma visits for asthma education by office nurse asthma educator

Key Services for the Medical Home

Immunization Services

- Making The Margin Meet The Mission
Why a Key Service for the Medical Home?

-IS the ultimate preventive service- EBM
- Vaccines can be financially profitable = direct revenue
- Vaccines are a KEY driver of patient volume for other preventive services -well child care = related revenue

Reimbursement Keys
1. Coding is Easy- Payment is Hard
2. Contracting is a key feature
3. Group Purchasing is available throughout the US

FIRST…..BEST PRACTICES IN VACCINE CODING

THE SIX STEPS
1. Select the Correct CPT Code for the Product -be specific! 90476-90748
2. Correctly link an ICD 9 Code (diagnosis) to the CPT code for the Vaccine
3. Always add the appropriate vaccine administration CPT code considering age, MD counseling, and route/order of administration (and link the same Diagnosis code to this CPT code)
4. Add the Code for any E/M services or other services (lab, xray etc)
5. Consider a modifier -25 for outpatient office E/M codes (not needed for preventive care E/M codes 99381-99395)
6. Frequently check your remittance advice (EOB) for payments
NEW VACCINE PRODUCT CODES GET EARLY WEB RELEASE

www.ama-assn.org/ama/pub/category/10902.html

- For new vaccines-first check the CURRENT CPT manual-
- if code not included, go to this website

Coding Pandemic Influenza Vaccine -Option One

- The Vaccine Product
  - 90663 Influenza virus vaccine, pandemic formulation- HINI

- Immunization Administration
  - The usual- 90465-8 or 90471-4

- ICD- vaccination- influenza  V04.81
Coding Pandemic Influenza Vaccine – Option Two
CMS Medicare Method 09

- The Vaccine Product
  G9142  Influenza A (H1N1) vaccine, any route of administration

- Immunization Administration
  G9141  —Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)

- ICD- vaccination- influenza  V04.81

Coding Pandemic Influenza Vaccine – Option Three
NEW- AMA CPT October 09

- The Vaccine Product
  90663  Influenza virus vaccine, pandemic formulation, H1N1

- Immunization Administration
  90470- Administration  Influenza virus vaccine, pandemic formulation, H1N1, IM or Intranasal, including counseling

- ICD- vaccination- influenza  V04.81
**Pediatric Immunization Administration**

90465 Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day

90466 each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)

90467 Immunization administration under age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day

90468 each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)

**Existing Immunization Administration**

90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)

90472 each additional vaccine (single or combination vaccine/toxoid)

90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)

90474 Each additional vaccine (single or combination vaccine/toxoid)
### All IA Codes Now Fully Valued RBRVS since 2007

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Short Description</th>
<th>Total RBRVS 2008</th>
<th>Avg Medicare Allowance</th>
<th>Total RBRVS</th>
<th>Avg Medicare Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>90465</td>
<td>1st Injection with counseling, &lt; age 8 years</td>
<td>.56 / .58</td>
<td>$21.33 / $20.92</td>
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<td></td>
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<tr>
<td>90466</td>
<td>Each Additional Injection with counseling, &lt; age 8 years</td>
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<td>.28 / .29</td>
<td>$10.66 / $10.46</td>
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</tr>
<tr>
<td>90467</td>
<td>1st Intranasal or Oral with counseling, &lt; age 8 years</td>
<td>.35 / .38</td>
<td>$13.33 / $13.71</td>
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<td></td>
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<tr>
<td>90468</td>
<td>Each Additional Intranasal or Oral with counseling, &lt; age 8 years</td>
<td></td>
<td>.27 / .28</td>
<td>$10.28 / $10.10</td>
<td></td>
</tr>
<tr>
<td>90471</td>
<td>First Injection</td>
<td>.56 / .58</td>
<td>$21.33 / $20.92</td>
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<td></td>
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<tr>
<td>90472</td>
<td>Each Additional Injection</td>
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<td>.29 / .29</td>
<td>$11.05 / $10.46</td>
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<td>90473</td>
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<td></td>
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<tr>
<td>90474</td>
<td>Each Additional Intranasal or Oral</td>
<td>.25 / .25</td>
<td>$9.52 / $9.02</td>
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</tbody>
</table>

### H1N1 – 90470

**CMS Relative Value**

- Published November 09
- Total Relative Value = 0.63
- Total payment using the 2009 conversion factor of $36.06 = $22.72

\[(90465 \text{ or } 90471 = $21.33)\]
Starting NEW VACCINES
It’s All About the TIMING!

FDA Approval (licensure) ➔
ACIP Approval/Recommendation ➔
Payer and VFC Coverage Decisions ➔
Payers Load Fee Schedule ➔
CDC publishes in MMWR

*Entire Process May Take 6-9 months

CASE

Your state VFC program is limiting single component HIB vaccine but is substituting the combination DtaP-HIB-IPV. You comply with the change to the combination despite losing two immunization admin. codes for each patient switched from the single component- In order to make up for this you will-
CASE

You would -
A. Request the payer increase payment for the IA code set
B. Request the payer add an additional payment to the CPT code for the vaccine itself
C. Eat it by doing the right thing
D. Report the new immunization administration code for combination vaccines

CASE

You would -
A. Request the payer increase payment for the IA code set
B. Request the payer add an additional payment to the CPT code for the vaccine itself
C. Eat it by doing the right thing
D. Report the new immunization administration code for combination vaccines
Immunization Administration for Combination Vaccines

Problem- lose admin. Fees when the switch is made

New codes coming that will reflect the (work of counseling) number of components

Goal- to capture the value now lost

---

Immunization Administration for Combination Vaccines

Status-(Preliminary) successful work with the AMA at CPT and RUC (relative value)

New codes may be released in Oct 2010 for use Jan 2011

AAP will be involved proactively in private payer advocacy
AAP-Payment Reform
a “hybrid” approach

Includes a blending four types of enhanced reimbursement:

- Traditional fee-for-service payments (FFS)
- Payment for quality or performance (P4P)
- A prospective per member per month payment (PMPM)- care management and for infrastructure changes

Prospective Payment Tied to Medical Home Attributes

Improvements require considerable amounts of time (MD and staff), equipment (EHR, eRX), and other resources

How can these changes be quantified in order to cross walk to a payment?
NCQA PPC-PCMH Tool

- NCQA - National Committee on Quality Assurance
- PPC - Physician Practice Connection
- PCMH - Patient Centered Medical Home

**NCQA:**
Physician Practice Connections/PCMH
9 Standards

1. Access & Communication
2. Patient Tracking & Registry Functions
3. Care Management
4. Patient Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting & Improvement
9. Advanced Electronic Communication
PCMH 9 Standards

Standard 2: Patient Tracking and Registry Functions

- A. Uses data system for basic patient information (mostly non-clinical data)
- B. Has clinical data system with clinical data - searchable data fields
- C. Uses the clinical data system
- D. Uses paper or electronic-based charting tools to organize clinical information**
- E. Uses data to identify important diagnoses and conditions in practice**
- F. Generates lists of patients and reminds patients and clinicians of services needed (population management)
The Prospective Payment

1. Monthly payments come from estimate or analysis of savings from reductions in-
   - unnecessary ER visits
   - inpatient admissions/readmissions
   - use/duplication of expensive tests and specialty services

2. Payments may go to all patients of a given payer, OR to those with complex conditions (CSHCN)
Medicare Medical Home Demo
Care Management Fee

**Per Member per Month Payments**

<table>
<thead>
<tr>
<th>HCC Score</th>
<th>&lt;1.6 HCC</th>
<th>Score &gt;1.6</th>
<th>Blended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>$27.12</td>
<td>$80.25</td>
<td>$40.40</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$35.48</td>
<td>$100.35</td>
<td>$51.70</td>
</tr>
</tbody>
</table>

HCC score indicates disease burden (health condition complexity)
Estimate that 25% of beneficiaries with HCC <1.6 and Medicare costs at least 60% higher than average
First 2% of savings not shared 80% of savings above 2% (minus fees) shared with practices

Change...

- It is not necessary to change...
  Survival is not mandatory

  Edward Deming
  Speaking to a group of Detroit automaker executives
  1970s-

  (there will likely be no “Pediatric” bailout)
Let's Get Down To The Business Agenda

• Define Your Best Practice Care Model—your “clinical plan” to become a better medical home
  • Translate component services into coding language
• Make Your business plan!
  • Contact payers - contract
• Keep informed about new payment opportunities

So—Go
Get ‘Em!