3rd Party Billing:

Capturing the Visit

FAMILY PLANNING - BALTIMORE

APRIL 25, 2014

ANN FINN CONSULTING

Objectives

- At the end of this session, participants will better:
  - ✓Understand how proper documentation and coding support compliant billing practices and efficiencies
  - ✓Understand relevant ICD, CPT and modifier terminology and codes
  - ✓Build strategies to strengthen your overall charge capture practices

Why Should We Bill for Our Services?

- Fiscal sustainability
- Less grants, less funding
- Accountable Care Act (ACA) gives more people insurance who are willing to bill their insurance
- Many still don't have insurance and can't afford to pay for services
- Provide more services…

Who's Paying for Our Services?

- Multiple sources might provide payment for our patients' care:
  - Medicaid Fee for Service, Managed Care / HMO
  - Medicare
  - Private Commercial Insurance (aka Third Party Payers)
  - State and Federal funding
  - Self Pay – Sliding Fee Scale
- Multiple payer sources = multiple requirements making your thorough documentation and coding essential

What Can We Bill?

"Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests."

- ✓Services provided to the patient and documented in the Medical Record
- ✓Services **medically necessary** for the treatment of the patient's illness or condition
- ✓If it isn't documented – it can't be billed

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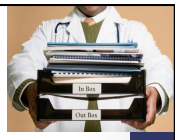
Good Documentation…



- Improves compliance
- Improves patient care
- Improves clinical data for research and education
- Protects the legal interest of the patient, facility and clinician
- Enables proper reimbursement for services performed
- *If it isn't documented – it can't be coded and ultimately billed!*

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Remember…

- In order to bill for our services – we need to:
  - ✓Document services in the Medical Record
  - ✓Capture WHAT services we provide – **CPT / HCPCS**
  - ✓Capture WHY we did the services - **ICD**
  - ✓Document any special circumstances – **Modifiers**
- Invest in up-to-date resources
- Always follow coding guidelines and code only what is in the medical record

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CPT CODING – THE WHAT

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Procedure Codes – "What"

- **CPT**: Level I HCPCS codes are called CPT-4 codes (Current Procedural Terminology©)
  - Every service we provide relates to a CPT code including E/M's, device implants, lesion removals, colpos, lab tests, immunizations etc.
- **HCPCS**: Level II HCPCS codes identify products, supplies, materials and services which are not included in the CPT-4 codes
  - Devices, drugs

CPT: Capture the Procedure

- A patient is having an IUD inserted today. What CPT would be coded for the insertion?
- What if an IUD was removed and a new one inserted?

CPT	Description
57170	Diaphragm, cap fitting
58300	Insert IUD
58301	Remove IUD
11976	Remove contraceptive capsule implant
11981	Insert non-biodegradable drug delivery implant
11982	Remove non-biodegradable drug delivery implant
11983	Removal with reinsertion of non-biodegradable drug delivery implant

HCPCS: Unbilled Device = Lost Revenue

HCPCS	Description
A4266	Diaphragm
A4267	Condoms
J1050	Injection, medroxyprogesterone acetate, 1 mg
J7300	Intrauterine copper contraceptive
J7302	Levonorgestrel-releasing intrauterine contraceptive system
J7303	Contraceptive supply, hormone containing vaginal ring, each
J7304	Contraceptive supply, hormone containing patch, each
J7306	Levonorgestrel implant system (Norplant)
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies
J8499	Oral prescription drug non chemo (Plan B)
S4993	Contraceptive Pills for Birth Control

CPT: Capture the Procedure

- What if instead the patient has a contraceptive implant removed and replaced with a new one?

CPT	Description
57170	Diaphragm, cap fitting
58300	Insert IUD
58301	Remove IUD
11976	Remove contraceptive capsule implant
11981	Insert non-biodegradable drug delivery implant
11982	Remove non-biodegradable drug delivery implant
11983	Removal with reinsertion of non-biodegradable drug delivery implant

HCPCS: The Device

HCPCS	Description
A4266	Diaphragm
A4267	Condoms
J1050	Injection, medroxyprogesterone acetate, 1 mg
J7300	Intrauterine copper contraceptive
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7303	Contraceptive supply, hormone containing vaginal ring, each
J7304	Contraceptive supply, hormone containing patch, each
J7306	Levonorgestrel implant system (Norplant)
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies
J8499	Oral prescription drug non chemo (Plan B)
S4993	Contraceptive Pills for Birth Control

Different Services – Different CPT

- Location and quantity may make a difference
- Examples:

Lesion Removals (Partial Listing)	
CPT	**Description**
17110	Molluscum Destruction 1-14
17111	Molluscum Destruction 15+
46900 / 46924	Anus Simple / Extensive, Chemical
54050 / 54065	Penis Simple / Extensive, Chemical
56501 / 56515	Vulva Simple / Extensive
57061	Vaginal Simple, any method

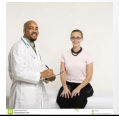
Codes Change - Who Will Update?

- Encounter forms and billing systems need to be compliant:
  - ~~11977 (removal with reinsertion, implantable contraceptive capsules)~~
  - ~~11975 (Insertion, implantable contraceptive capsules)~~
  - ~~J1051 - Injection, medroxyprogesterone acetate, 50 mg~~
  - ~~J1055 - Injection, medroxyprogesterone acetate for contraceptive use, 150 mg~~
  - ~~J1056 - Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg.~~
- Updated Codes
  - 11981 Insertion, non-biodegradable drug delivery implant
  - 11982 Removal, non-biodegradable drug delivery implant
  - 11983 Removal with reinsertion, non-biodegradable drug delivery implant
  - J1050- Injection, medroxyprogesterone acetate, 1 mg.

E/M VISITS

What is an E/M?

- E/M, Medical Visit, Evaluation and Management all stand for "evaluation and management"
  - Provider evaluates a patient's condition and decides on a course of treatment to manage it
- Requires selection of CPT code that best represents:
  - Patient type (New vs. established)
  - Setting of service (Office or OP setting, IP, ED)
  - Level of service

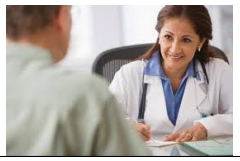


Patient Type

- **Per CPT: New Patient**
  - "One who has NOT received any professional services from the physician, or other qualified healthcare professionals (QHCP) or another physician of the **exact** same specialty and subspecialty who belongs to the same group practice, within the past 3 years"
- **Established Patient**
  - Within 3 years

Types of E/M Visits

- Preventive Medicine Services
- Problem-Focused Visits
- Preventive Medicine Counseling
- Consultations



E/M: Preventive Medicine Services

- E/M codes 99381-99397
- Used for periodic health screening visits (well visits, annual exams, check-ups)
  - Age Specific Codes
  - Can typically be billed 1x per year

E/M: Preventive Medicine Services

- E/M codes 99381-99397 includes:
  - Comprehensive medical history
  - Physical exam, as indicated
  - Anticipatory guidance, risk factor reduction interventions or counseling
  - Immunizations/ labs/ diagnostic procedures
  - Management of insignificant problems
- Not all payers accept these codes

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E/M: Preventive Medicine Services

AGE	NEW	EST.
5-11 years	99383	99393
12-17 years	99384	99394
18-39 years	99385	99395
40-64 years	99386	99396
65 years +	99387	99397

For example: A well-woman check-up exam for a 20 year-old woman returning to the clinic might be reported as 99395

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But Be Careful…

- Not all states or payers recognize the preventive E/M codes 9938x – 9939x for "annual" visits
- Some programs require 992xx / modifier instead
- Read your contracts, check with your payers…

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E/M: Problem-Focused Visits

- Services to evaluate patients with a problem or chief complaint in the OP clinic setting
  - New patients 99201-99205
  - Established patients 99211-99215
- A new patient presenting at your clinic with concerns of an STI that has an exam, lab tests, and counseling might be reported as a 99203

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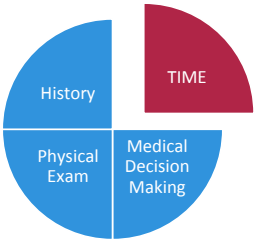
2 Methods to Calculate E/M Level



- Composite of 3 key components (Hx + PE + MDM)

Or

- TIME, when greater than 50% of time is spent in counseling

- 1 method does not fit all visits

1 - Composite of 3 Key Components Method

History
- Chief Complaint
- History of the present illness (HPI)
- Review of body systems (ROS)
- Past, family, social history (PFSH)

Physical Exam
- Single organ system examination
- Multiple organ system examination

Medical Decision Making
- # of diseases and management options
- Amount and complexity of diseases
- Risk of complication

Chief Complaint

- Concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the patient encounter, usually stated in the patient's own words
  - Should be clearly reflected in the medical record
  - Front desk should not be filling this in prior to visit
  - Which is better – is your PDX supported?
    - "23-year old patient seeking contraception and here for annual"
    - "Annual"

2 - Time Based Method

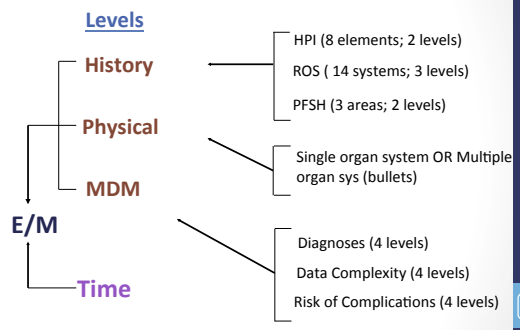
- Time can be used when:
  - ≥ 50% of clinician's total Face-to-Face (FTF) time with patient is spent on counseling / coordination of care
- MUST document in the Medical Record:
  - Total duration of encounter and that over 50% of time is spent counseling
  - Nature and extent of the issues discussed, client questions and physician response, and recommendations or next steps
- UPDATE YOUR ENCOUNTER FORMS!!

Time - Using Midpoints

- 23 minutes FTF of which 18 minutes was spent counseling a new patient
  - 99202
- 20 minutes FTF of which >50% of time was spent counseling an established patient
  - 99213

New	Time (typical)	Established	Time (typical)
99201	< 15 (10)	99211	≤ 7 (5)
99202	16-25 (20)	99212	8-12 (10)
99203	26-37 (30)	99213	13-20 (15)
99204	38-53 (45)	99214	21-33 (25)
99205	> 53 (60)	99215	>33 (40)

Problem Visit E/M Structure



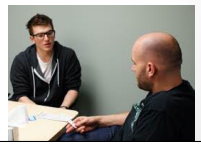
Summary: Problem-Oriented E/M

- ✓Choose E/M based on scores of 3 key elements
  - History, Physical exam, MDM
- ✓Compute counseling time as a percentage of total FTF time
  - If >50%, find E/M based on documented time factor

- ✓Select the E/M code that is greater of 3 key elements or face-to-face time

Preventive Counseling

- Used to report services provided face-to-face (FTC) by a physician or other QHCP for the purpose of promoting health and preventing injury or illness
  - Risk Factor Reduction 99401 – 99404
  - Behavior Change 99406 – 99409 (smoking and alcohol)
- Distinct from E/M
- Document time



E/M: Consultations

- CPT Codes 99241 - 99245
  - "*Opinion* or *advice* regarding evaluation or management of a specific problem is requested by another physician or appropriate source"
  - 3 R's: **Request, referral, report**
- Designate to whom the patient is being sent
  - Specific provider or any provider, Indicate whether request is urgent or routine
- Send the request in writing, including:
  - Purpose of consultation; Relevant history, exam, lab, and imaging studies
  - Preference for treatment recommendations, co-management plan, or specialist to initiate care
- Specify who receives the specialist's report back on your end

Nurse Visits – Are They Billable?

- 99211 may be billed for certain services provided by a Nurse
- Not all payers / states recognize this service
- **Patient must be established**
- **Provider-patient encounter must be face-to-face**
- **An E/M service must be provided**
  - Generally, this means that the patient's history is reviewed, a limited physical assessment is performed or some degree of decision making occurs.
  - If a clinical need cannot be substantiated, 99211 should not be reported. For example, 99211 would not be appropriate when a patient comes into the office just to pick up a routine prescription.
- http://www.aafp.org/fpm/2004/0600/p32.html

Nurse Visits – Often Overbilled

- Since 99211 is an E/M code, there are some minimal documentation requirements in order to meet medical necessity for use of the code
  - There must be a face to face encounter
  - Nature of the presenting problem with a diagnosis from prior MD visit
  - Brief history of the problem
  - Documentation of vital signs (sole reason for visit should not be Blood Pressure check or Blood Draw)
  - Plan of care
  - Date/signature of the nurse or other provider

Injections vs. E/M

- What if a patient is **returning** for an injection only (example: follow up HPV vaccine or DMPA)?
  - Do not automatically bill an E&M with every injection
  - If the E&M is the significant separate service, the E&M and the injection are both reportable
  - Bill the injection code and toxoid as applicable (90471-90474, 96372…)

Nurse Initiates Method

- What if the RN sees a patient to initiate birth control, schedules a subsequent visit with a mid-level for an exam, prescription, etc.?
  - This does not qualify as a 99211 – why?
  - 99211 may only be coded for established patients with a prior face to face with clinician and diagnosis

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Blood Draws vs. E/M

- What if a patient presents to be tested for Syphilis and only has blood drawn?
  - "If another CPT code more accurately describes the service being provided, that code should be reported instead of 99211. For example, if a physician instructs a patient to come to the office to have blood drawn for routine labs, the nurse or lab technician should report CPT code 36415 (routine venipuncture) instead of 99211 since an E/M service was not required.

    Also, just because the nurse or MA takes vitals before doing a venipuncture or giving a shot does not make it an E/M service*"

    99211 requires patient to be established – so a new walk-in for testing would not meet this criteria
- http://www.billing-coding.com/advantage/print.cfm?ArticleID=4707

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Pregnancy Tests and Supply Pickups

- What if a patient comes for a pregnancy test? Is this billed as an E/M?
  - We want to meet with these patients and counsel them – can we get them on a method?
  - Do these patients flow to your NP?
  - Do you use your licensed providers efficiently?
- Supply Pick-up – these are typically not billed as an E/M as there is not a FTF encounter meeting E/M guidelines

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Coding Tips – Pap Smears

- Do not code Q0091
- Obtaining the specimen is considered part of the E/M
- Medicare only code

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ICD CODING – THE WHY

ICD-9-CM Diagnosis Codes – "Why"

- International Classification of Diseases, 9th edition, Clinical Modifications
  - Set of codes defining diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease
  - Supports medical necessity of services/ procedures provided
  - Supported by documentation in patient's medical record
  - Only the licensed provider determines the diagnosis

ICD-9-CM Official Guidelines for Coding and Reporting
http://www.ama-assn.org/resources/doc/cpt/icd9cm_coding_guidelines_08_09_full.pdf

ICD-9 Codes

- Codes 001.0 through V89.09
- Can be three, four, or five digits and are categorized into 2 main groups:
  1) Numeric Codes: Describe diseases, injuries and symptoms
  2) V codes: Describe factors that influence health status or contact with health services – common with sexual / reproductive health
- Always code to the highest level of specificity (5th digit if possible)

Diagnoses Support the Service

Initiating a contraceptive method…	
-- V25.01	General counseling on prescription of oral contraceptives
-- V25.02	General counseling on initiation of other contraceptive measures (barrier methods)
-- V25.03	Encounter for emergency contraceptive counseling and prescription
-- V25.04	Counseling and instruction in natural family planning to avoid pregnancy
-- V25.09	Other general counseling and advice on contraceptive mgmt.
V25.11	Encounter for insertion of IUD
V25.5	Insertion of implantable subdermal contraceptive
V25.9	Unspecified contraceptive management

Surveillance vs. Initiating…

Surveillance of previously prescribed contraceptive methods:

V25.40	Contraceptive surveillance, unspecified
V25.41	Surveillance of contraceptive pill
V25.42	IUD check, removal, or reinsertion
V25.43	Surveillance of implantable subdermal contraceptive
V25.49	Surveillance of other contraceptive method

STI Screening Diagnosis Examples

ICD-9	Description
V01.6	Contact with or exposure to venereal diseases
V65.44	HIV counseling
V65.45	Counseling on other sexually transmitted diseases
V65.5	Person with feared complaint in whom no diagnosis was made (Worried well)
V69.2	High risk sexual behavior
V73.81	Special screening examination for HPV
V73.88	Special screening examination for other specified chlamydial diseases
V73.89	Special screening examination for other specified viral diseases (Ex: herpes)
V74.5	Screening examination for venereal disease

Infection Diagnosis Examples..

ICD-9	Description
054.11	Genital herpes, vulvovaginitis
054.13	Genital herpes, penis
078.11	Condyloma acuminatum
078.19	Other specified viral warts
078.88	Other specified diseases due to chlamydiae
079.98	Unspecified chlamydial infection
098.0	Gonococcal infection (acute) of lower genitourinary tract
112.1	Candidiasis of vulva and vagina
788.1	Dysuria

Primary Diagnosis (PDX)

- Called ***First-listed diagnosis*** in OP setting
- Code assigned to the diagnosis, condition, problem, or other reason shown in the documentation to be *chiefly responsible for services provided*
  - Signs and symptoms may be reported if a diagnosis has not been determined
  - Must be clearly supported in the documentation
  - Is V25 always primary? Only of it is appropriately supported in your documentation!

Secondary Diagnoses (SDX)

- Code all documented conditions that co-exist at the time of the encounter/visit and require or affect patient care, treatment or management
- SDX do not need to be sequenced
- Review official ICD guidelines
  - *Think about the conditions that impact your care and decisions – obesity, diabetes, hypertension…. Do you ever capture these?*

Co-equal Diagnoses

- If 2 + diagnoses are being equally monitored, and treated, and/or evaluated, the diagnoses are considered co-equal and the clinician may select which diagnosis is sequenced first
  - Your "encounter form" / "superbill" should allow space for the clinician to sequence and / or mark diagnoses as co-equal
  - Billing staff can than choose if needed

- *Clearly mark primary, secondary, tertiary codes….*

Coding Tip…

- A code is invalid if it has not been coded to the full number of digits required for that code (5th digit if possible)
- If diagnosis is not established, code the symptom
- Don't code for:
  - "rule-out" diagnoses
  - conditions that were previously treated and no longer exist
  - diagnosis that doesn't apply to the visit

Coding Tip…

Be careful assigning codes – Codes follow the patient long after the visit

- Examples
  - HIV, AIDS
  - GC – other infections
  - HRSB

MODIFIERS

Modifiers – Special Circumstances

- Two digit codes that accompany a CPT code in order to further describe a situation that may impact or modify reporting and reimbursement of services
  - Some modifiers are assigned by the clinician during the visit and some may be added during billing
  - Only certain modifiers impact payment
  - Payers may treat modifiers differently

Examples of Modifiers

Modifier	Description
22	Increased procedural services – used for complex surgery
25	Distinct Service; Same day; Same Physician
33	Preventive Service not subject to cost sharing (New ACA)
51	Multiple Procedures
52	Reduced Service; Services provided were reduced in comparison to the full description of the service
53	Discontinued procedure after induction of anesthesia
59	Two separate procedures performed on the same day by the same physician
91	Repeat laboratory tests or studies performed on the same day on the same patient
FP	Family Planning Encounter or service – check payer

Modifier 25: "Oh By the Way…"

- When a patient presents and has multiple issues treated, two E/M codes may be reported if:
  - Documentation clearly supports separate and distinct services provided
  - Modifier -25 is appended to the problem-oriented E/M visit
  - Provider selects the primary diagnosis for the service chiefly responsible for the services provided
  - Not all payers will reimburse 2 E/M's but good data is needed to advocate for change

E/M and Procedures… (ACOG)

- If clinician and patient discuss a number of contraceptive options, decide on a method, and then an implant or IUD is inserted during the visit, an E/M service may be reported, depending on the documentation.
- If the patient comes into the office and states, "I want an IUD," followed by a brief discussion of the benefits and risks and the insertion, an E/M service is not reported since the E/M services are minimal.
- If the patient comes in for another reason and, during the same visit, a procedure is performed, then both the E/M services code and procedure may be reported.

Modifier 25: "Oh By the Way…"

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OTHER SERVICES

Do Other Services Get Paid?

- **Only if we capture and bill them!**
  - Ancillary Lab Tests / Radiology – In-house vs. Send-out
  - Devices
  - Expanded Hours Access – Nights and Weekends (CPT 99050, 99051)
  - Interpreter Services
  - Smoking Cessation Counseling
  - SBIRT
  - Vaccines / Immunizations

Capturing Lab Tests

- Medical record documentation should include the orders and diagnoses to support medical necessity of tests
- Ask and document exposure (oral, anal, vaginal…)
- Bill all in-house tests provided
- Don't include send-out tests typically
- Check with payers and lab policies

Coding Vaccines

- Code BOTH the toxoid and the administration
- Capture the correct dosage / units / National Drug Code (NDC)
- Include all the required codes for patients who receive multiple vaccinations at a single visit
- Code to payer guidelines if toxoid received through program such as VFC (SL modifier…)

NDC – National Drug Code

- 11-digit number on the package or container from which the medication is administered
- Report units
- Drugs often not paid when NDC not reported on the claim

- Example:
  - GARDASIL is supplied in vials and syringes in the following sizes:
    - Carton of one 0.5-mL single-dose vial, NDC 0006-4045-00
    - Carton of ten 0.5-mL single-dose vials, NDC 0006-4045-41
    - Carton of six 0.5-mL single-dose prefilled Luer Lock syringes with tip caps. NDC 0006-4109-09

Encounter Forms / Superbills

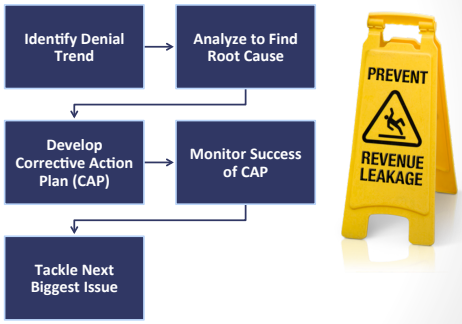
- Communication tool between clinician and biller describing what occurred during the encounter
- Electronic or paper – includes Diagnosis, CPT, modifiers
- Be careful with EMR templates and pre-assigned codes

Is it up-to-date and reflective of all services provided?
Can clinicians sequence and note co-equal diagnosis codes?
Can modifiers be noted?
Reminder - Only the person providing the services should complete the superbill

Common Denials

- ✓Patient not eligible
- ✓No authorization
- ✓Not medically necessary
- ✓Incorrect codes
- ✓Duplicate claim
- ✓Non-covered
- ✓General technical billing errors i.e. Incorrect subscriber ID, missing info on UB format, etc…
- ✓Timely filing
- ✓Additional data is required

Get to the Root of the Problem



Build Success

- ✓Partnership between clinical and billing staff
- ✓Good tools – up-to-date references
- ✓Internal audits
- ✓Evaluate flow / scheduling
- ✓Right licensed clinicians see the right patients
- ✓Know / manage your contracts
- ✓Manage your A/R and denials
- ✓Key reports that matter
- ✓Time and space to do the job well
- ✓Embrace the Changes and Opportunities

QUESTIONS

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Established patient visits: CPT codes and documentation requirements

	E/M CODE				
	99211	**99212**	**99213**	**99214**	**99215**
History					
Chief complaint	Required	Required	Required	Required	Required
History of present illness	NR	1-3 elements	1-3 elements	≥4 elements or ≥3 chronic diseases	≥4 elements or ≥3 chronic diseases
Review of systems	NR	NR	1 system	2-9 systems	≥10 systems
Past history/family history/social history	NR	NR	NR	1 element	≥2 elements
Examination	NR	1 system (1-5 elements)	2 brief systems (6-11 elements)	1 detailed system + 1 brief system (≥12 elements)	8 systems or 1 complete single system (comprehensive)
Medical decision making					
Risk	NR	Minimal	Low	Moderate	High
Diagnosis or treatment options	Minimal	Minimal	Low	Moderate	High
Data	NR	Minimal	Low/Moderate	Moderate	High
Time*	5 minutes	10 minutes	15 minutes	25 minutes	40 minutes
CPT, current procedural terminology; E/M, evaluation and management; HPI, history of present illness; NR, not required.					
*At least one half of total face-to-face time must involve counseling or coordination of care.					
Adapted from: American Medical Association.[4]					

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New patient visits: CPT codes and documentation requirements

	E/M CODE				
	99201	**99202**	**99203**	**99204**	**99205**
History					
Chief complaint	Required	Required	Required	Required	Required
History of present illness	1-3 elements	1-3 elements	≥4 elements or ≥3 chronic diseases	≥4 elements or ≥3 chronic diseases	≥4 elements or ≥3 chronic diseases
Review of systems	NR	1 system	2 systems	≥10 systems	≥10 systems
Past history/family history/social history	NR	NR	1 element	≥3 elements	≥3 elements
Examination	1 system (1-5 elements)	2 brief systems (6-11 elements)	1 detailed system + 1 brief system (≥12 elements)	8 systems or 1 complete single system (comprehensive)	8 systems or 1 complete single system (comprehensive)
Medical decision making					
Risk	Minimal	Minimal	Low	Moderate	High
Diagnosis or treatment options	Minimal	Minimal	Low	Moderate	High
Data	Minimal	Minimal	Low	Moderate	High
Time*	10 minutes	20 minutes	30 minutes	45 minutes	60 minutes
CPT, current procedural terminology; E/M, evaluation and management; HPI, history of present illness; NR, not required.					
*At least one half of total face-to-face time must involve counseling or coordination of care.					
Adapted from: American Medical Association.[4]					

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