Outpatient Coding and Billing Compliance

Peter Cronholm, MD MSCE
Department of Family Medicine and Community Health

Coding - Objectives

- Understand documentation requirements for preventive, disease and procedure-based billing compliance
- Differentiate between level 3 and level 4 established patients
- Differentiate disease-based from preventive services billing

Types of Billing Encountered Most Frequently

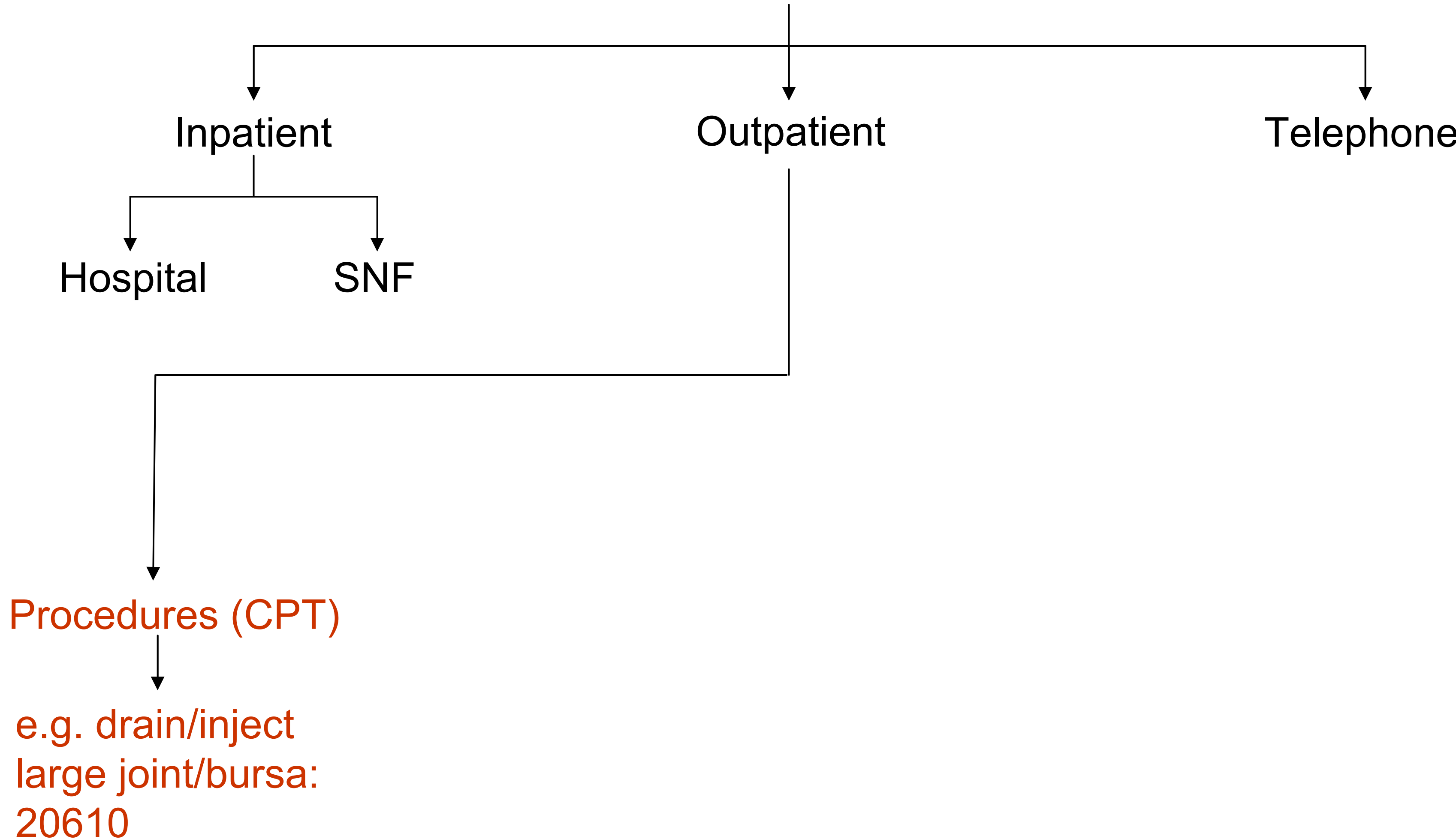
- Evaluation and Management
- Preventive Care
- Obstetrics
- Procedures
- Consultations

- Billing compliance ≠ quality medical care

- “Guidelines" for coding and documentation are actually a morass of rules that seem to encourage down-coding by making the rules vague and the penalties harsh

- Coding is a mixture of rote memorization and gut instinct – Level 3 vs. Level 4: most doctors have a sense of what one feels like

- Capitation matters (~65%)
  - Keystone East
  - U.S. Healthcare
  - Health Partners
  - Keystone Mercy
  - Health Partners


Patient Encounter
Inpatient
Outpatient
Telephone
Hospital
SNF
Procedures (CPT)
e.g. drain/inject
large joint/bursa:
20610

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Desktop Action Patient Care Reports Tools Admin Help

Forward Home Schedule In Basket Chart Encounter Tel Encounter Patient Lists Secure UPHS Web Link Epic Upgrade 2005 Print Log Out

Home | Test,A

Test, A

Age	Sex	DOB	MRN	Allergies	Type	PCP	Alerts	INS
40 y.o.	F	6/6/1966	197953	Penicillins, Codeine, Su *	(None)*	(None)	HM	No billing inforn*

SnapShot
Chart Review
Results Review
Flowsheets
Problem List
History
Letters
Demographics
Graphs
Growth Chart
MedView
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SmartForms
Enter/Edit Results
Health Maintenance
Telephone Encounter

Hotkey List
Exit Workspace

Order Entry (Encounter Date: 08/09/2006) - Weight: (Not entered for this visit) Height: (Not entered for this visit)

Association Pref List Interactions Pharmacy Providers Open Orders Pend Orders Sign Orders Financial Routing SmartSets

Order: DRAIN/INJECT LARGE JOINT/BURSA Priority: Routine Class: Back Office Qty: 1 Assoc. dx:

Status: Normal Mods:

Full Detail (F4)

Take	Req			F/S		Order	Dx	Detail
						DRAIN/INJECT LARGE JOINT/BURSA [20610]		Back Office, Routine

New Order Status Modifiers Cancel/Delete Select All Med Class Benefit CC Results Show placed orders F7 - Prev order F8 - Next order

Association: Selected Grid All Auto Clear Replace LOS: OFFICE/OUTPT VISIT,EST,LEVL III [99213

Diagnosis:

	P	Encounter Diagnoses (right-click dx for more options)
1		MIXED HYPERLIPIDEMIA [272.2]
2		BENIGN HYPERTENSION [401.1]
3		DIABETES MELLITUS TYPE II-UNCOMPL [250.00]
4		JOINT EFFUSION-L/LEG [719.06]

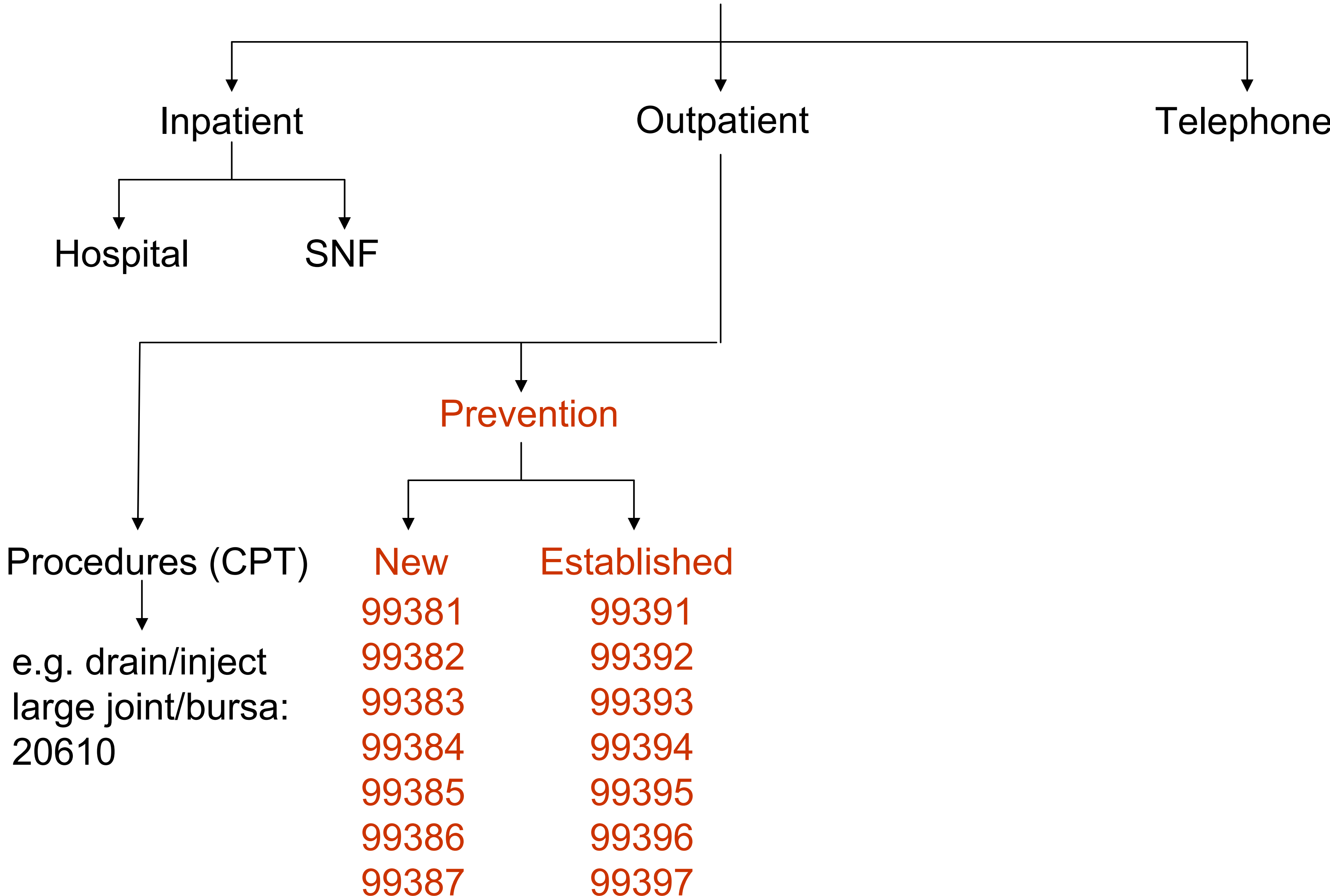
Add
Add

Link	Problem List (right-click problem for more options)	Status
+	BENIGN HYPERTENSION [401.1]	Active,
+	DIABETES MELLITUS TYPE II-UNCOMPL [250.00]	Active,
+	MIXED HYPERLIPIDEMIA [272.2]	Active,

New Dx Delete Dx Annotate/Edit Dx Primary Dx New Problem Edit Problem Resolve Now Show resolved

Auth Prov: CRONHOLM MD, PETER [5177] Pharmacy: <none selected> 1 order

PETER CRONHOLM MD Results, Staff Message, Patient Call, Open Orders, Canceled Ord, Chart Cosign, My Open Encounters, Addendum 1:43 PM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99395
99396
99397

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Exit Workspace

Level of Service

than 50% of appointment time.

> 15 > 25 > 40

etailed | Comprehensive

etailed | Comprehensive

te Complexity | High Complexity

LOS Code Lookup

Code	Description
99394	PREVENTIVE VISIT,EST,12-17
99395	PREVENTIVE VISIT,EST,18-39
99396	PREVENTIVE VISIT,EST,40-64
99397	PREVENTIVE VISIT,EST,65 & OVER
99392	PREVENTIVE VISIT,EST,AGE 1-4
99393	PREVENTIVE VISIT,EST,AGE5-11
99391	PREVENTIVE VISIT,EST,INFANT
99384	PREVENTIVE VISIT,NEW,12-17
99385	PREVENTIVE VISIT,NEW,18-39
99386	PREVENTIVE VISIT,NEW,40-64
99387	PREVENTIVE VISIT,NEW,65 & OVER
99382	PREVENTIVE VISIT,NEW,AGE 1-4
99383	PREVENTIVE VISIT,NEW,AGE5-11
99381	PREVENTIVE VISIT,NEW,INFANT

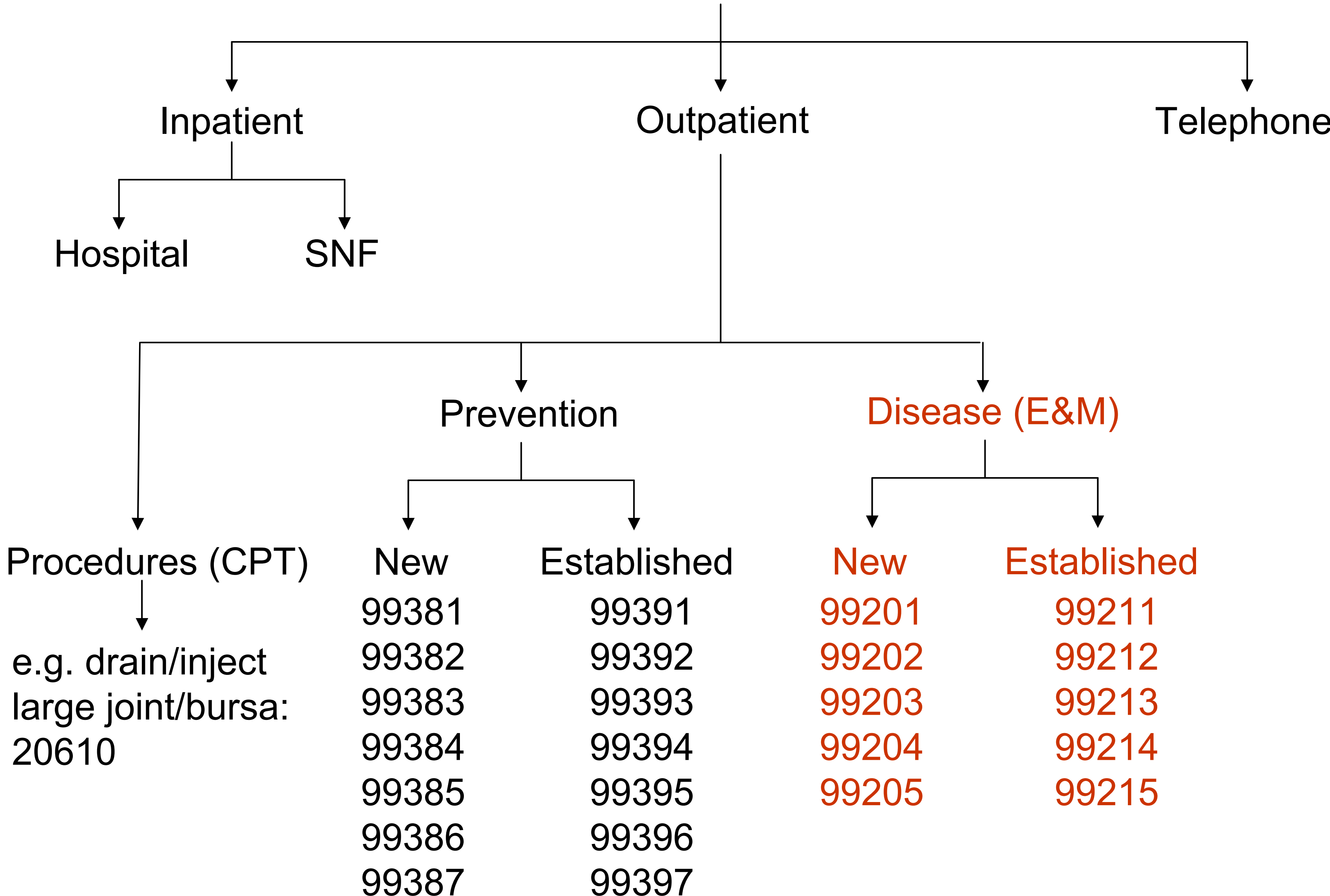
Accept | Cancel

Modifiers
1.
2.
3.
4.

LOS Code
prev | Calculate
Auth Provider: CRONHOLM MD, PETER [5177]

Analyzer | Restore

PETER CRONHOLM MD | Results, Staff Message, Patient Call, Open Orders, Canceled Ord, Chart Cosign, My Open Encounters, Addendum | 11:40 AM



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99395
99396
99397
New
99201
99202
99203
99204
99205
Established
99211
99212
99213
99214
99215

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Level of Service

Service: OFFICE/OUTPATIENT [8]

- New Patient
- Established Patient

Counseling more than 50% of appointment time.

Visit Length (Min): > 5, > 10, > 15, > 25, > 40

History
Problem Focused | Expanded Problem Focused | Detailed | Comprehensive

Exam
Problem Focused | Expanded Problem Focused | Detailed | Comprehensive

MDM
Straightforward | Low Complexity | Moderate Complexity | High Complexity

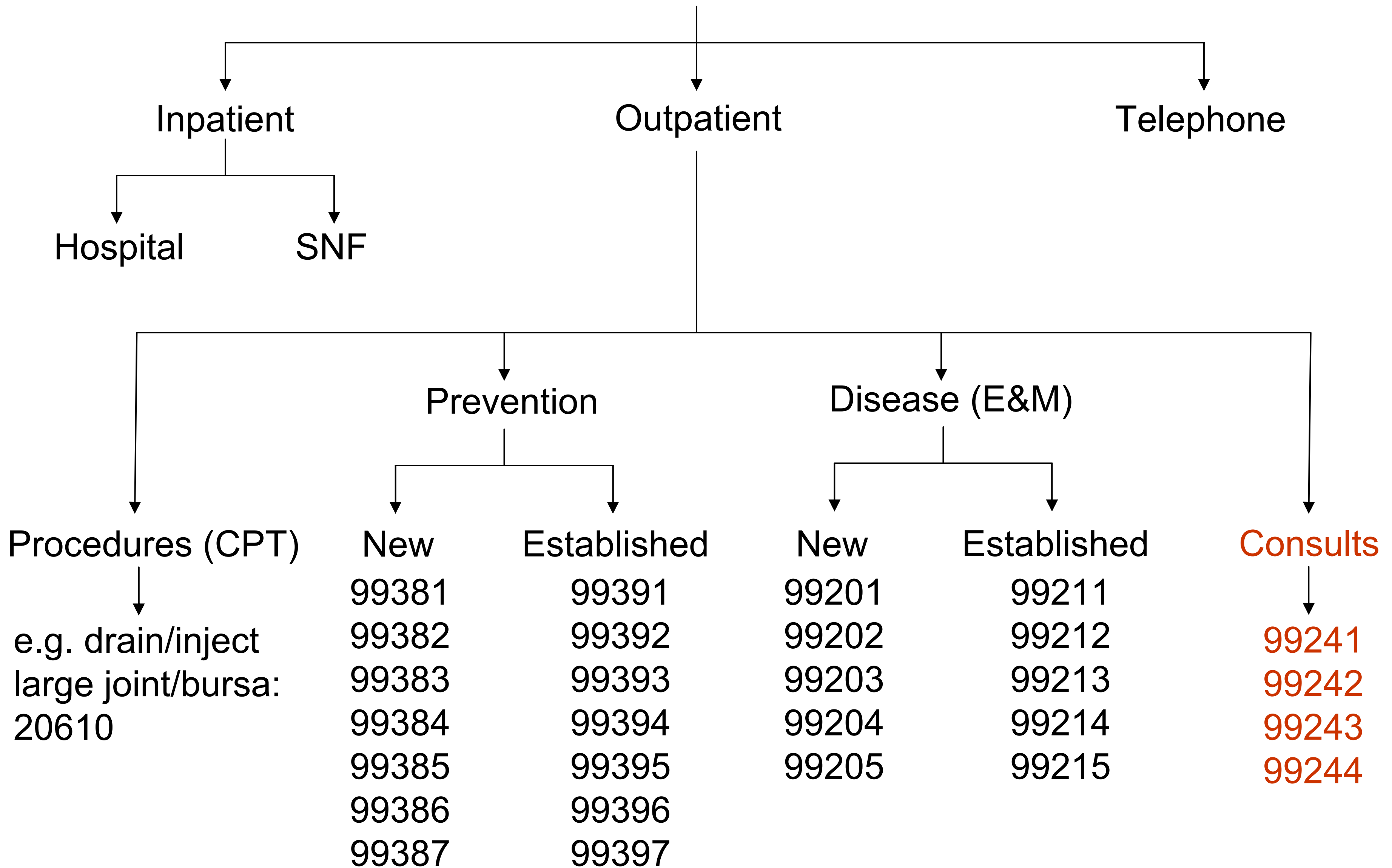
Modifiers
1.
2.
3.
4.

LOS Code: OFFICE/OUTPT VISIT,EST,LEVL III [99213] Calculate

Auth Provider: CRONHOLM MD, PETER [5177]

Analyzer Restore

PETER CRONHOLM MD Results, Staff Message, Patient Call, Open Orders, Canceled Ord, Chart Cosign, My Open Encounters, Addendum 11:45 AM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Level of Service

Service: OFFICE/OUTPATIENT [8]

New Patient
Established Patient

Counseling more than 50% of appointment time.

Visit Length (Min): > 5 | > 10 | > 15 | > 25 | > 40

History
Problem Focuse... | ...nprehensive

Exam
Problem Focuse... | ...nprehensive

MDM
Straightforward | ...n Complexity

LOS Code Lookup

Code	Description
99241	OFFICE CONSULTATION,LEVEL I
99242	OFFICE CONSULTATION,LEVEL II
99243	OFFICE CONSULTATION,LEVEL III
99244	OFFICE CONSULTATION,LEVEL IV
99245	OFFICE CONSULTATION,LEVEL V

Accept | Cancel

Modifiers
1.
2.
3.
4.

LOS Code: consult | Calculate

Auth Provider: CRONHOLM MD, PETER [5177]

Analyzer | Restore

PETER CRONHOLM MD | Results, Staff Message, Patient Call, Open Orders, Canceled Ord, Chart Cosign, My Open Encounters, Addendum | 11:43 AM

Billing Guides

Disease-based Billing

New Patient*				
Code	**History**	**Exam**	**DM**	**Time (min)**
99201	PF	PF	S	10
99202	EPF	EPF	S	20
99203	D	D	LC	30
99204	C	C	MC	45
99205	C	C	HC	60
*Note: 3 of 3 at the billing level are required				

Established Patient*				
Code	**History**	**Exam**	**DM**	**Time (min)**
99211	-	-	-	5
99212	PF	PF	S	10
99213	EPF	EPF	LC	15
99214	D	D	MC	25
99215	C	C	HC	40
*Note: 2 of 3 at the billing level are required				

How do I start?

…Decision Making

Decision Making

	Decision*	Dx	Risk	Data
	S	1	Min	1
3	LC	2	Low	2
4	MC	3	Mod	3
	HC	4	High	4

*Note: 2 out of 3 at the billing level are required

Decision Making - Dx

Problem	Points	Comments
Self-limited, minor	1	Max of 2
Established Dx	1	+1 for uncontrolled or worsening
New, no work-up	3	Max of 3
New, work-up	4	

3 points = level 4

Decision Making: Risk

	Risk Level	Examples
	Minimal	Problems: **One self-limited/minor** Dx Procedures: Venipuncture; CXR; EKG; UA; US; echo; KOH prep Mx Options: Rest, gargles, bandages
3	Low	Problems: > 1 self-limited/minor; **1 stable chronic**; acute uncomplicated Dx Procedures: PFTs; BE; FNA; arterial puncture; skin biopsy Mx Options: **OTCs**; minor surgery; PT; OT; IVFs
4	Moderate	Problems: 1+ chronic with mild effects; **>1 chronic**; new prob - no Dx; acute illness with systemic effects; acute complicated injury Dx Procedures: Cardiac stress testing; fetal contraction stress test; endoscopy; deep needle or incisional biopsy; arteriogram; LP; thoracentesis Mx Options: Minor surgery with risk factors; **Rx drugs**; IVFs; closed fracture
	High	Problems: 1+ chronic with severe effects; **life-threatening**; abrupt neuro changes Dx Procedures: Endoscopy with risk factors Mx Options: Parental controlled substances; Rx - intensive monitoring; DNR decision

Decision Making: Data

Data	Points
Labs*	1
Radiology*	1
Medical Studies*	1
Second opinion	2
Discussion of results	1
Old records	1
Summary of old records	2
*Note: Requested or reviewed	

3 points = level 4

3 or 4?

- Most of the time…Yes!
- It is probably NOT a 2
- It may be a 5

Think 99214 if the patient has…

- a new complaint with a potential for significant morbidity if untreated or misdiagnosed;
- a new problem that requires a prescription;
- three stable problems that require medication refills; or
- one stable problem and one inadequately controlled problem that requires medication refills or adjustments

What needs to be in a history?

	History	HPI	ROS	SHx / FHx
	PF	1+	0	0
3	EPF	1+	1	0
4	D	3+	2+	1
	C	3+	9+	2* or 3**

*Established or **New patients

History Components

- History of Present Illness:
  - location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms OR status of chronic diseases

- Review of Systems:
  - Constitutional, Eyes, ENT/mouth, Cardiovascular, Respiratory, GI, GU, MSK, Skin/Breasts, Neurologic, Psychiatric, Endocrine, Hem/lymph, and Allergy/immune
  - Sufficient documentation: At least one complete system + "Remainder of ROS is negative in detail"

- Past Family, Social History:
  - Sufficient documentation: "PFSHx: Non-Contributory"

What needs to be in the exam?

	Exam	Systems	Bullets
	PF	1+	1+
3	EPF	1+	6+
4	D	2+	12+
	C	9+	18+

General Multi-system Exam

System	Bullets
Constitutional	Any 3 vital signs; AND general appearance
Eyes	Conjunctivae and lids; pupils and irises; AND optic discs and posterior segments
Ears, nose, mouth and throat	External ears and nose; external auditory canal; hearing; nasal mucosa, septum and turbinates; lips, teeth and gums; AND oropharynx, oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	Neck; AND thyroid
Respiratory	Respiratory effort; percussion of chest; palpation of chest; AND auscultation of lungs
Cardiovascular	Palpation of heart; auscultation of heart noting abnormal heart sounds and murmurs; carotid arteries; abdominal aorta; femoral arteries; pedal pulses; AND edema and/or varicosities
Chest (breast)	Inspection of breasts; AND palpation of breasts and axillae
Gastrointestinal (abdomen)	Exam of abdomen noting masses or tenderness; liver and spleen; hernia; anus, perineum and rectum noting sphincter tone, hemorrhoids or rectal masses; AND stool for occult blood testing
Genitourinary	(FEMALE) external genitalia and vagina; urethra noting masses, tenderness, or scaring; bladder; cervix; uterus; AND adnexa / parametria (MALE) scrotal contents; penis; AND DRE or prostate
Lymphatic	Neck; axillae; groin; AND other
Musculoskeletal	Gait and ; digits and nails; joints, bones and muscles of the 1) head and neck; 2) spine, ribs and pelvis; 3) RUE; 4) LUE; 5) RLE; 6) LLE noting malalignment, asymmetry, crepitation, defects, tenderness masses or effusions; ROM noting pain, crepitation or contracture; muscle strength and tone noting atrophy or abnormal movements
Skin	Inspection AND palpation of skin and subcutaneous tissues
Neurologic	CNs noting deficits; DTRs noting pathological reflexes; AND sensation
Psychiatric	Judgment and insight; orientation to time, place and person; recent and remote memory; AND mood and affect

Example Physical

.physical

OBJECTIVE (EPF=1/6; D=2/12; C=9/18):

Constitutional (2): .vs

General: {appearance:50}

HEENT (10): Anicteric with normal conjunctivae and lids. PERRLA. EOMI. Normal external nares and pinnae. Normal external canals. Grossly normal hearing. Normal nasal septum and turbinates with normal mucosa. Normal dentition. Moist mucus membranes with normal palate, tongue, and posterior pharynx. Neck is supple without evidence of thyromegaly or nodules.

Cardiovascular (2): Normal palpation of the heart. Regular rate and rhythm; no murmurs, rubs or gallops.

Respiratory (4): Normal respiratory effort with normal percussion and palpation of the chest. Clear to auscultation bilaterally without crackles or wheezes***

Gastrointestinal (3): Normal bowel sounds. Soft and non-tender without hepatosplenomegaly or evidence of hernia

Musculoskeletal (5): Normal gait. No effusions in upper or lower extremities bilaterally. No instability noted on exam and normal range of motion. Normal muscle tone and bulk.

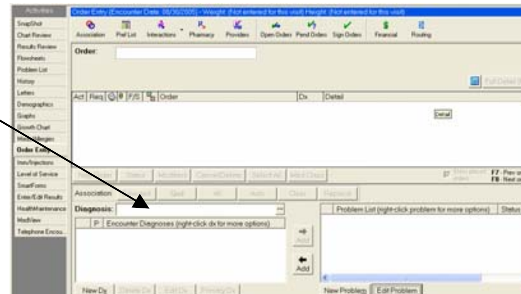
Lymphatic (1):no neck adenopathy

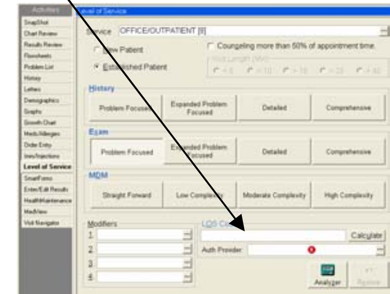
Skin (2): No lesions noted or palpated.

Neurologic (3): Cranial nerves 2-12 intact bilaterally. Sensation intact to light tough. 2+ DTRs bilaterally.

Preventive Medicine

- Comprehensive history, ROS and exam
- Counseling (anticipatory guidance / risk reduction intervention):
  - **.Ag00to02** Discussed car seats, feeding, normal growth and development, immunizations, and home safety issues.
  - **.Ag03to10** Discussed car seats, feeding, normal growth and development, immunizations, helmets, seatbelts, passive smoke exposure, regular exercise, and home safety issues.
  - **.Ag19to49** Discussed seat belts, cholesterol screening, exercise, tobacco, alcohol, substance abuse, and sexually transmitted disease exposures.
  - **.Ag50to64** Discussed seat belts, cholesterol screening, exercise, tobacco, alcohol, substance abuse, fecal occult blood testing, as well as flexible sigmoidoscopy vs. colonoscopy for colon cancer screening.
  - **.Ag65andover** Discussed seat belts, exercise, tobacco, alcohol, substance abuse, and documented height.
- V-Codes where diagnoses are entered = Preventive billing (well adult {V70.0}, child {V20.2}, etc.)
- Caution when using





From Peter Cronholm, MD.
Sent Jul 27, 2006 3:22 PM
To Charo Harvey
Subject RE: VISIT
Patient [redacted]
Phone Entered [redacted] Pt Work [redacted] Pt Home [redacted]

Message I changed his billing to a level 4 established.

Peter Cronholm, MD
7/27/2006 3:22 PM
----- Message -----
From: Charo Harvey
Sent: Jul 24, 2006 4:16 PM
To: Peter Cronholm, MD.
Subject: VISIT

Pt saw you on 06/23/06 which was coded as a preventative visit (99396). His insurance is personal choice which is sending him a bill for the visit. Can you please review your notes to see if possible if you change the level of service to get this visit paid? Personal choice states that they only pay for one preventative visit per year. His first one was 07/15/05 and then the next was 06/23/06 which was to early for a preventative visit.

Thanks

Note!

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Chart Review - filtered (records loaded: 3 (all records loaded), records satisfying filter: 3) Last refresh: 02:37 PM

Filters | Clear All Filters | Hide Add'l Visits | Text Search | Show/hide the text search window in Review | Review | Master Report | Flowsheet-Ltd

Encounters | Laboratory | Imaging | Procedures | ECG | Other Orders | Medications | Episodes | Letters | Notes/Trans | Misc Reports

Date	Type	Department	Provider	Description
06/23/2006	Office Visit	PFC7MU	Cronholm, Peter, MD.	Routine Medical Exam; Impotence, Organic Origin; Screening Mal Neop-Prostate; Screening-Diabetes Mellitus; Joint Pain-L/Leg;
12/29/2005	Consult Ltr	PFC7MU	Cronholm, Peter, MD.	UPHS dept. of med. gastroenterology 12/13/2005
07/15/2005	Office Visit	PFC7MU	Cronholm, Peter, MD.	Routine Medical Exam (Primary Dx); Impotence, Organic Origin

Applied Filters: Hide Add'l Visits(default) | Refresh

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Billing based on time

- New: 10, 20, 30, 45, and 60 minutes
- Established: 5, 10, 15, 25, 40 minutes

New Patient*				
Code	History	Exam	DM	Time (min)
99201	PF	PF	S	10
99202	EPF	EPF	S	20
99203	D	D	LC	30
99204	C	C	MC	45
99205	C	C	HC	60

Established Patient*				
Code	History	Exam	DM	Time (min)
99211	-	-	-	5
99212	PF	PF	S	10
99213	EPF	EPF	LC	15
99214	D	D	MC	25
99215	C	C	HC	40

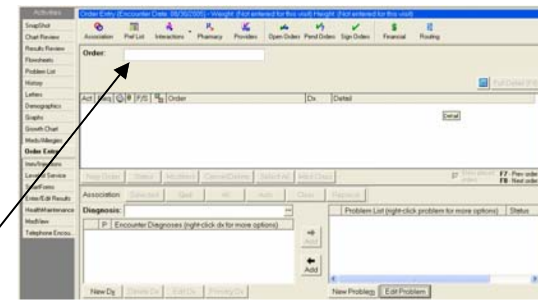
- Only required documentation

.Counseling

Discussed with the patient: diagnostic results***, prognosis***, risk and benefits of management options***, instruction for management***, compliance***.

The total time for the visit was *** minutes. More than 50% of this time was spent counseling the patient.

- Caveats (resident time = nada; documentation is important)

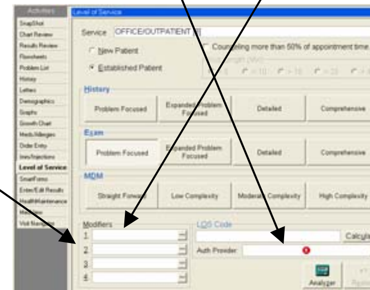


Procedures

- Usually no level of service or low level of service if only reason for visit is procedure
- Remember to bill for medications used and for the procedure itself in CPT section
- Must be "supervised" by attending (note: GC modifier)

  …the attending must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure

- Document the procedure separate from other issues
- Must have a 25 modifier



Consultations

- Documentation of the request from an outside provider
- Documentation of the assessment
- Documentation of having sent information to requesting provider
- Attending must see patient while in office (GC)
- Levels of consultation billing in LOS-section

The primary care exception

- First 6-months or until cleared by residency: all visits must be GC-precepted
- After this period: any visit can be GC-precepted, but only level 4 visits need be (otherwise GE modifier)

Notes

- **Evaluation and Management Documentation Provided by Students:** Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

- **Inpatient Billing:** In this situation, a resident may or may not have performed an independent service.
  - In the absence of a note by the resident, the teaching physician must document on the same basis he or she would document an E/M service in a non-teaching setting.
  - Where a resident has written notes, the teaching physician's documentation may refer to the resident's note and provide summary comments that establish, revise, or confirm the resident's findings and the appropriate level of service required by the patient. For example, the teaching physician would not have to restate the review of systems and family social history in the case of an initial hospital service. However, the teaching physician must document that he or she performed the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity and the level of the service billed by the teaching physician.

The following is an example of minimally acceptable documentation:

Admitting Note: "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

Follow-up Visit: "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."

Follow-up Visit: "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."

Billing Information

- 215-349-5423 (info)
- 215-349-5422 (reporting)
- http://www.hgsa.com/professionals/bguides/teach.shtml

Cases