Billing & Coding

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Learning Objectives

After interacting with these materials, the learner should be able to:

1. Describe the importance of billing and coding for primary care practice

2. Identify when to use:
   - New vs. Established patient codes
   - Preventive vs. Office visit codes
   - Consultation codes
   - Procedure codes
   - Modifiers

3. Determine when the preceptor might need to see a patient for coding purposes, in addition to clinical supervision
Introduction

• Billing and coding is the responsibility of the attending

• When you graduate from residency, you will be an attending (or fellow) and you will be responsible

• Our goal is to make you as prepared as possible for practice or fellowship

• While a resident, we expect you to make your best coding determination on all encounters

* Editor Note: responsibilities are outlined for trainees at Children’s Hospital of Pittsburgh of UPMC. Check requirements at your own training site.
General Rules*

• Interns and Residents *should* preferably complete notes before the end of the clinic session

• Interns/Residents *must* complete notes within 24 hours of encounter

• Timely coding/billing is a requirement by the institution and by payors

*Editor Note: Rules and responsibilities are outlined for trainees at Children’s Hospital of Pittsburgh of UPMC. Check requirements at your own training site.*
Definitions

• **Billing** – Submitting a charge to the insurer or the patient (if uninsured) for the service

• **Coding** – The process of **assigning**
  - a numeric value for the service rendered (Evaluation and Management (E and M) Code) and
  - a diagnosis for the problem addressed (International Statistical Classification of Diseases and Related Health Problems (ICD) code)
Billing and Coding Importance

Why are billing and coding important?

For what purposes are the data used?
Billing and Coding Importance

E and M codes are used to bill for services (more on E and M later).

Goal is to:

Bill accurately...

• Allows pediatricians to make a living
• Enhances quality of care – how?

And not over bill:

• Can result in denied claims or an audit from insurance company and/or Medicare
Billing – a dirty word?

Acknowledgement: Talking about reimbursement in health care, especially in pediatrics, may be distasteful for some.

But good financial practice management makes for happier partners, more nurses and office staff, better equipment and resources, etc. that can translate to better quality of care.
Billing and Coding Importance

Diagnosis codes can potentially be used for

• **Research** (e.g., retrospectively determining how often antibiotics are used for the common cold or otitis media)

• **Monitoring population health trends and metrics** (e.g., determining the proportion of pts in a clinic with persistent asthma who have active prescriptions for inhaled corticosteroids)

• **Monitoring clinic processes** (e.g., evaluating appropriate rapid strep testing practices for patients presenting with pharyngitis)

• **Other ideas?**
Evaluation and Management (E and M) Codes

• Codes for E and M are a subset of the Current Procedural Terminology (CPT) codes (other subsets are anesthesia, surgical, radiology, pathology and other medical codes)

• Determined each year by American Medical Association

• CPT defines, by code, services rendered by each medical specialty

• Each CPT code has a Relative Value Unit (RVU) attached to it
RVUs

• RVUs are determined within and among specialties based on relative time, technical skill, mental effort, psychological stress etc. required to perform each clinical service

• Look at handout 1* to determine the relative values of the common outpatient services we perform (Note: Handout may open in background: if so, close or shrink the PPT presentation to access handout)

• Follow the NF (non-facility) RVUs and the 100% Medicare NF columns to determine physician fee reimbursements (note: well child check ~ $100)

RVUs for Common Pediatric Services

- Infant well child visits (prev med) = outpatient services visits at 99214 level, but increase by age
- New patients >> established
- Consultation visits >> outpatient services visits
- Reimbursement increases for each level significantly (e.g., 99213 vs 99214)

Check with your training site to confirm all coding practices
Reimbursement Covers...

- Your salary
- Your staff salaries
- Equipment and supplies
- Rent and electricity
- Malpractice insurance
- Other costs...
Can you define a “new” versus an “established” patient?
New vs. Established Patients

- **New:** A patient who has not been seen by you or another member of your billing group/specialty in the past 3 years
  
  New patient visits render significantly higher reimbursement

- **Established:** A patient seen by you or your group in the past 3 years
  
  - a newborn seen by the CHP-GAP Magee Newborn service follows up in GAP Primary Care Center (PCC) is “Established” to PCC because she was seen by one of the GAP faculty in the hospital
  
  - CHP of UPMC GAP PCCs (Oakland and Turtle Creek) and Newborn service at Magee Women’s Hospital are all part of the same billing group

- Your practice site may also be a part of a larger billing group.
Outpatient Svcs vs Prev Med: 4 basic E and M categories

- Outpatient Services visits are acute or followup
  - New pts (codes 99201-5)
  - Established (codes 99211-5)

- Preventative Medicine visits are well child checks
  - New (99381-5)
  - Established (99391-5)

Check with your training site to confirm all coding practices
What determines the coding level within each E and M category?

• Age for well child checks
• Documentation for acute or f/u visits – we will discuss these first
Documentation

It’s not what you did, it’s what you wrote that you did!

• Your documentation must support what you code (and what you did)

• Code must be supported by 3 components:
  ▪ history
  ▪ physical exam
  ▪ medical decision making (assessment & plan)

• Document referrals, labs, procedures (e.g. nebs, fluoride varnish, cerumen removal, cath UAs) by ordering them and noting them in the “Plan” section of your progress note
E and M categorization is complicated

• Becoming skilled in this area is an evolution that takes a lot of time

• Briefly review the following slides for a broad overview

• Follow along with handout 2* (Print out if you have not yet done so) (Note: may open in background: you may need to close or shrink the PPT presentation to access handout)

• These will be followed by some case examples
History

3 elements of history:

• HPI
  – Status of chronic conditions OR
  – Multiple elements of acute condition

• ROS
  – Can either select systems reviewed OR
  – Mention a couple AND that “all others negative”

• PFSH
Examination

2 criteria for scoring
- Body areas OR
- Organ systems

4 x 4 Rule:
Need 4 body areas or systems with 4 elements in each to meet criteria for Detailed Exam
Medical Decision Making (MDM)

3 elements with a “final result for complexity”

• Number of dx or tx options (point system)
• Amount/complexity of data (point system)
• Risk of complications and/or morbidity/mortality (whichever is highest)
  – Presenting problem
  – Diagnostic procedures ordered
  – Management options
MDM – Final Result for Complexity

• Use the 3 elements of MDM to score
• Need 2 of 3 in column to determine level
• See handout 2
Final Step

• Select appropriate level in chart for each of 3 components (Hx, exam and MDM)
  – New patient or Consultation (more later)
    • Need 3 of 3 in column or to the left
  – Established patient
    • Need 2 of 3 in column or to the left

• Note: A simple problem (e.g., ringworm or diaper rash) is a max of 99213 no matter how thorough your hx and PE is. Payor will deny a higher claim.
Outpatient Services Visit Codes
Established

• **99211:**
  – Nurse only visit
  – MD does not go into room
    • Physician must be present in office suite to bill this code.
  – These are used when patients come in to see the nurse only for shots, blood draws, etc.
  – They do generate revenue in addition to the procedures done at the visit

*Check with your training site to confirm all coding practices*
Outpatient Services Visit Codes
Established

• **99212**
  – Very, very little documentation is required to meet this.
  – These should be used rarely
  – To meet the criteria for this, you only need 2 of 3:
    • Document 1 HPI element
    • Examine 1 organ system
    • And have a very simple plan (e.g. “reassurance”)
  – It’s actually hard to have such a simple note

Check with your training site to confirm all coding practices
Outpatient Services Visit Codes
Established

• 99213
  – *The most common code* used
  – Almost always meet criteria using EPICARE “ped acute – simple problem” template
  – Should be default code for residents
  – Need 2 of 3 of the following
    • Chief complaint, \( \geq 1 \) HPI elements, \( \geq 1 \) ROS
    • Limited exam (6 elements total) of \( \geq 2 \) body areas or systems
    • Limited Dx or Mgmt options

Check with your training site to confirm all coding practices
Outpatient Services Visit Codes

Established

• 99214
   – Preceptor MUST go in the room and see the patient to bill at this level (Note: in community practices, preceptors must *always* see the patient, regardless of level)
   – Requires 2 of 3
     • HPI contains ≥ 4 elements (or ≥ 3 chronic conditions), ROS ≥ 2, PFSH ≥ 1
     • Extended exam (12 elements total) of ≥ 2 body areas/systems
     • Multiple dx or Mgmt options. Moderate amt/complexity of data. Moderate overall risk.

Check with your training site to confirm all coding practices
Outpatient Services Visit Codes Established

- **99215** (less common, might occur with pt getting admitted or transferred to ED)
  - Preceptor must go in
  - Requires 2 of 3
    - History: HPI ≥ 4 elements OR ≥ 3 chronic conditions, ROS ≥ 10, PFSH ≥ 2
    - Exam: ≥ 2 elements from ≥ 9 systems/body areas
    - MDM: High complexity

Check with your training site to confirm all coding practices
Cases

- Go through the following cases and assign E and M codes
- Use *handout 2* to score
- *Case 1*
- *Case 2*
- *Case 3*
Click here for Case 1  (If you have not yet done so)  Note: Case may open in background: you may need to close or shrink the PPT presentation to access handout)

Indicate levels of:

- History
- Exam
- MDM
- Overall code?

Check with your training site to confirm all coding practices
Case 1 - Answers

• History – Exp. Prob. Focused (EPF) only 1 chronic prob, not 4 elements of symptoms
• Exam – EPF
• MDM – Low complexity (new prob to examiner but not to practice group, prescription drug mgmt)
• Overall Code - 99213
Case 2

- **Click here for Case 2** (If you have not yet done so) (Note: Case may open in background: you may need to close or shrink the PPT presentation to access handout)

- Indicate levels of:
  - History
  - Exam
  - MDM
  - Overall code?
Case 2 - Answers

- History - Detailed
- Exam - Comprehensive
- MDM – Moderately complex
- Overall Code – 99214

Note – limited by lack of complete ROS. Can do several systems and mention remainder were assessed and neg. In this example, documentation was “pertinent items noted in HPI”
Case 3

• **Click here for Case 3** (If you have not yet done so) (Note: Case may open in background: you may need to close or shrink the PPT presentation to access handout)

• **Indicate levels of:**
  – History
  – Exam
  – MDM
  – Overall code?
Case 3 - Answers

• History – EPF (limited by small ROS)
• Exam – EPF vs D (could debate. “4 x 4 Rule” requires 4 systems or body areas with at least 4 elements. Vitals, eyes, heart make it but skin is borderline)
• MDM – Low complex (est. prob to practice but worsening (2), no data, prescription drug mgmt (mod))
• Overall Code – 99213 or 4 depending on exam
Outpatient Services Codes

New Patients (same for Consults)

- Coding level **requirements are** one **higher** for History and Exam but exactly the same for medical decision-making

- *All three* key components must be met

- For a 99203
  - Detailed hx (4 elements of HPI, 2 ROS, 1 PMH)
  - Detailed exam (extended exam of > 2 body areas)
  - Low complexity MDM (Limited dx or mgmt)

Check with your training site to confirm all coding practices
Confused? Don’t worry!

- E and M coding for outpatient services is complex and confusing.
- Don’t memorize it yet but begin to familiarize yourself with the components.
- Refer to charts and tables if in doubt.
- For residents, default to 99213, unless attending sees pt.
- This is a learning process over three years.
Using TIME for Outpatient Services Visits

- Time alone can be used to E and M coding level and *trumps* any other documentation
- Time must be time spent by *attending physician*
- Counseling/education must be *greater than 50% of total visit time*
- Amount of time must be documented in note
- “I spent 20 of 25 mins counseling about ADHD medication indications and side effects...”
- Total visit time: 15 min (level 3), 25 min (level 4), 40 min (level 5)

Check with your training site to confirm all coding practices
Consultation

- Consult codes are to be used for Pre-op exams
- Pick Primary Care Preop Exam smartset (EPIC)
- Example: surgeon asks you to perform a pre-operative evaluation before elective surgery or dental surgery

**Preceptor needs to see ALL CONSULTS**
- regardless of year of residency

- Consult codes are higher RVUs for same level (Automatically defaults if Epicare smartset is used)

Check with your training site to confirm all coding practices
Consult Code Requirements

Three Rs required to code for consultation visit

• **Request** in writing from referring physician, clinical service or dentist (mention this in your note)

• **Render** the service requested.

• **Report** back to the referring provider. A copy or record of the note that was sent.
  
  – Examples:
    • Letter
    • H&P (with record that it was sent)
    • Something else that proves that we corresponded to the referring doctor (fax number)

Also check with your unique practice site to see how consults are managed
Preventive Medicine Visits

• Used for WCC visits

• Same rule for “New” & “Established” patients as with office (sick) visits – 3yr

• If using Epicare (CHP of UPMC electronic health record) smartsets, code is automatically chosen that corresponds to patient’s age

Check with your training site to confirm all coding practices
Preventive Medicine Visits

• If the child is too sick for a complete WCC, do not use a Preventive Code. Use an outpatient services visit code – need to change it in the LOS section of Navigator in Epicare – if not using Epicare, check with your practice.

• If you do a complete WCC but spend a lot of time addressing asthma, code for the WCC.

• RVUs for WCC, after including procedures associated with EPSDT visits (vision, hearing, lead, hgb, dental varnish, etc.), almost always exceed a level 4 outpatient services visit

Check with your training site to confirm all coding practices
Case 4

• **Click here for Case 4** (If you have not yet done so) (Note: Case may open in background: you may need to close or shrink the PPT presentation to access handout)

• What code would you use?
Case 4 Answer

- 99392 (Preventive Med Established (1-4 yrs)
- Might be tempted to code for the bronchiolitis using the outpatient codes (99213 or 4)
- As long as well child services were performed, generally better to code for Prev Med visit for a number of reasons (usually more RVUs, shows compliance with EPSDT)
Diagnosis Codes
ICD-10-CM

• International Classification of Diseases: 10th Edition for Clinical Modification

• **All Visits** require an E/M code **AND** a Diagnosis Code

• Epicare will not let you close the note without a diagnosis

• Reimbursement not based on diagnosis codes

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Check with your training site to confirm all coding practices
Diagnosis Codes

• Code all diagnoses that were discussed & documented. *Place them in the problem list if active.*

• If you are dealing with multiple diagnoses, Epicare will require you to select the primary diagnosis

• If you work in a practice setting that does not use Epicare, please check on the procedures at your training site.
Diagnosis Codes

• Don’t use “r/o” as a diagnosis. Instead use symptom
  – Example: Not “r/o UTI.” Use “dysuria” instead

• Don’t use “follow up” as a diagnosis. Use the original diagnosis (even if it’s resolved)
  – Example: you are seeing a child to recheck an AOM. The patient no longer has symptoms or signs of AOM. Select AOM and you can then display it as “AOM-resolved” by editing the diagnosis after it populates.
Diagnosis Codes

• Only use the diagnoses that are documented in your note
  – Example: Don’t code asthma if the child has a history of asthma but you didn’t discuss it

• Don’t use “worried well.” Use the presenting symptom as the Dx.

Check with your training site to confirm all coding practices
EPSDT

- Early Periodic Screening, Diagnosis, and Treatment
- The child health component of Medicaid
- Required in every state
- Program designed to improve health of low-income children
- You will see this designation as a BestPractice Advisory reminder in Epicare

Check with your training site to confirm all coding practices
EPSDT

• Select the SMARTSET with Vaccines For Children (VFC) to ensure
  – Proper vaccine products are given
  – Billing occurs properly

• Certain procedures are bundled under EPSDT that are charged separately under private insurance.

• The state tracks screening compliance through billing data

Check with your training site to confirm all coding practices
Immunizations

• If use EPICARE, use SMARTSETS to order
  – Via WCC smartset which includes them
  – Or type “Ped Imm” in the smartset search field and select the immunizations needed

• This will associate the order with the proper diagnosis, procedure and counseling charges

• Pay attention to insurance type (MA vs commercial). Immunization products and billing are affected by insurance.

Check with your training site to confirm all coding practices
Procedures

• Most procedures are automatically billed in EPIC
• But you must **order** the procedure, even those that you do yourself (cerumen removal, bladder cath)
• Clinic coders may double check and correct procedure codes (occurs for Oakland)
• Remember neb or MDI treatments (called inhalation therapy in EPIC)

Check with your training site to confirm all coding practices
GC/GE Modifiers

• One of these MUST be marked for every patient seen by a resident
• GC – used if the preceptor sees ("Cs") the patient
• GE – used if the preceptor does not go in the room
• Payors use these data to track GME involvement

Check with your training site to confirm all coding practices
Which patients must the preceptor see?

• Interns in *CHP Primary Care Practices*: Every patient for the 1<sup>st</sup> 6 months of residency training*
  – Every patient billed above a “level 3”
    i.e. 99214, 99215, 99204, & 99205
  – Outpatient Consults

* Residents in *Community Practices*: Preceptors must see every patient regardless of resident training year.

Check with your training site to confirm all coding practices
Remember

• Update allergies
• Reconcile meds
• Update PMH
• Update problem lists
• Print after-visit summaries (AVSs)
• New MU (Meaningful Use) tab shows which required elements have been completed
• These should be done at every visit

Check with your training site to confirm all coding practices
Summary

• Your Documentation must support the codes

• All patient encounters get a E and M code AND a Diagnosis code

• Don’t forget to order procedures/services that are provided

• Remember when your preceptor needs to go in the room (in community settings, preceptors must always see patients)

Check with your training site to confirm all coding practices
Acknowledgements

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Resources

  July 24, 2013.

• American Academy of Pediatrics. “2016 RBRVS: What is it and how does it affect
  pediatrics?” https://www.aap.org/en-us/Documents/Coding_2016_RBRVS.pdf,

• e-MedTools. E and M Service Coding and Audit Worksheet. https://e-
For those interested in more see the following slides

(Determining Physician Reimbursement)
How is physician reimbursement determined?
How is physician reimbursement determined?

- Relative Value Units (RVUs) – calculated based on the type and level of service that is coded in an encounter. RVUs are “relative” to all the other services done by other specialties.

- RVUs are set by Centers for Medicare and Medicaid Services (CMS) and periodically updated with input from a committee comprised of 23 different physician specialties and representatives of major physician organizations like the AMA.
How are RVUs calculated – what are the factors?

• Obviously, doing a total hip replacement is worth more than a well child exam...but why?
How are RVUs calculated – what are the factors?

Three major components

– **Physician work** (time, technical skill, mental effort, psychological stress) – 52% of total RVU/service

– **Practice expense** (cost of maintaining office) – 44% of total RVU/service
  - Non-facility – refers to outpatient office practices
  - Facility – refers to inpatient or same day surg centers

– **Professional liability** insurance (malpractice) – 4% of total RVU/service
How are RVUs calculated – what are the factors?

Modified further by the Geographic Practice Cost Index (GPCI) adjustment

– Cost of living (affects the physician work component)
– Practice cost (affects practice expense component)
– Professional liability insurance

Western PA GPCI adjustment is: 1.00, .913, and 1.123, respectively (close to average)
Final Step

Medicare Conversion Factor (CF)

• Nationally determined, updated annually. Political hot-button issue every year.

• Results in payment to physicians

• Affects pediatrics even though we think of Medicare being associated with older patients because payer may base their own reimbursement CF on the Medicare version.

• 2015 CF is $35.75/RVU
Well 2-month exam
Established patient – example*

- E and M code – 99391
- Work RVU: 1.37
- Non-facility RVU: 1.36
- PLI RVU: 0.09
- Total RVUs 2.82
- CF calculation: $2.82 \times $35.75 = $100.82†

* Note that we did not do the geographic adjustment in this example
† This revenue is used to pay the physicians, nurses, MAs, schedulers, expenses of the facility, liability, equipment, etc.