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INTRODUCTION

The California Academy of Family Physicians (CAFP) has produced this monograph to assist family physicians with an essential component of your day-to-day existence: coding and billing for the services you provide. Coding appropriately and accurately is essential regardless of practice setting or size. We hope you will find this to be a useful overview and an updated set of guidelines for use in your practice.

Over the years, physicians have learned that coding and billing are inextricably entwined processes. Coding provides the common language through which the physician can communicate – or bill – his or her services to third-party payers, including managed care organizations, the federal Medicare program, and state Medicaid programs.

Getting paid appropriately for services the family physician provides involves more than just coding the service and billing the third-party payer. There are aspects of reimbursement management that occur before the coding is even done and aspects that occur long after the claim has been submitted.

HOW TO USE THIS GUIDE

It is extremely important that everyone in a physician’s office understands that they play a part in effective reimbursement management for the practice. In this guide, we will discuss the steps that should occur throughout the process and how to make sure everything is reported accurately.

This monograph is intended to be a guide for family physicians to illustrate the many benefits of the practice working as a team to optimize reimbursement by coding and billing correctly, and to recover any “lost” (previously un-billed) dollars.

The entire practice staff should review the chapters entitled Tools of the Trade and The Reimbursement Team. Everyone should understand the role that he/she plays with reimbursement and how each member of the team must communicate and work with the other members of the team.

Clinical staff and physicians play an essential role in assuring that all services are documented, and then coded. They should be encouraged to review this monograph as well, paying particular attention to chapter 6 – Don’t Forget to Bill for These Services.

The billing staff should use this monograph as a resource for training as well as a compliance check.

For up-to-date listings of continuing medical education, including coding and billing education, visit Family Medicine Online at www.yourfp.org/cafp.
DISCLAIMER

The material in this manual was written by a practice management consultant and published by the California Academy of Family Physicians. Any advice or information contained in this guide should not be construed as legal advice. When a legal question arises, consult your attorney for appropriate advice.

The information presented in this guide is extracted from official government and industry sources. We make every attempt to assure that information is accurate; however, no warranty or guarantee is given that this information is error-free and neither the author nor CAFP accept responsibility or liability should an error occur.

Current Procedure Terminology (CPT) codes used in this guide are excerpts from the current edition of the CPT book and are intended for instructional purposes only. They are not meant to substitute for up-to-date copies of the CPT that medical practices should keep on hand. CPT is copyrighted property of the American Medical Association.

ACKNOWLEDGEMENT

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ABOUT THE AUTHOR

Mary Jean Sage, CMA-AC has extensive experience in the health care field that spans more than 20 years. She is recognized nationally for her expertise in coding, billing and health care compliance. Her unique blend of administrative and clinical skills has earned her a reputation as an expert in managed care operations and reimbursement management. She was instrumental in developing the Certified Medical Billing Associate program, which credentials medical billers and served as the initial Certification Director for the program. She currently serves as an advisor to a number of billing and coding publications.

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BASIC TOOLS FOR THE BUSINESS OF MEDICINE

Regardless of the type of billing system you are using or whether you are doing your billing in-house or using a service bureau or billing company, you should make sure that your practice has the required tools for billing and coding. These include:

- A thorough understanding of the billing process and billing terminology
- Good forms and documents
- Current reference materials
- Written policies and procedures covering billing
- CPT and Health Care Common Procedure Coding System (HCPCS) procedure coding expertise
- ICD-9-CM diagnosis coding expertise
- A fee schedule based on relative values
- A well-designed patient information form (patient demographics)
- A well-designed superbill or charge document
- A thorough understanding of the insurance claims process
- An understanding of the Health Insurance Portability and Accountability Act (HIPAA) and how it relates to claims processing
- The basics of electronic billing if you choose to go that route

A directory of resources is available in Appendix B.

BASIC STEPS OF MEDICAL BILLING

Reimbursement management starts at the first patient contact and ends only when the account balance is zero. In between, there are a series of important steps, each of which is critical for accurate billing and proper reimbursement. In order to maximize your reimbursement, you must be in control of each step of the reimbursement process:

1. Initial patient contact (usually by telephone, when the patient's insurance status must be ascertained)
2. Patient registration completed or update
3. Waiver signed
4. Copayment collected (if applicable)
5. Charge document initiated
6. Services documented by provider
7. Encounter form reviewed, payment collected
8. Billing system updated
9. Insurance claim prepared
10. Documents filed for review and follow-up
11. Payment received from insurance carrier
12. Inquiry letter received from insurance carrier
13. Denial received from insurance carrier
14. Patient billed
15. Patient pays the bill
16. Review accounts receivable
17. Collection efforts
18. Account closed
As a practicing physician and a business person, you must remember this maxim - your entire practice is the billing department. Billing for the services you, the physician, provide is not just a job for the billing department. Every staff member plays a role in determining how well or how poorly the reimbursement management process works in your practice. There are responsibilities that go along with each of these roles. The schematic below illustrates the various positions in a medical practice and how they all must work together to assure efficient, effective reimbursement management. Let’s discuss some of these positions and what role they play on the Reimbursement Team.

SCHEDULER
↓
RECEPTIONIST
↓
CLINICAL STAFF
↓
PHYSICIAN (and Extenders)
↓
CASHIER
↓
INSURANCE BILLER
↓
COLLECTOR
**SCHEDULER**

The Practice Appointment Scheduler is often the first point of contact for the patient and practice. This is the person who makes those first decisions regarding office collections. He or she sets patient expectations and conveys practice expectations. The Scheduler also communicates to the patient important pieces of information about billing operations and financial policies.

The information that the Scheduler gives to and collects from the patient often has a direct bearing on how successful the practice will be in collecting for the services to be rendered. Here are some areas of responsibility that bear review and monitoring:

- Can we see this patient? Are we a contracted provider for the patient’s health plan? It is crucial that the Appointment Schedulers know the health insurance plans with which the practice contracts.

- Is pre-authorization required for the service the practice is to render? Does the scheduler know which of the services provided by the practice generally require pre-authorization from a third party carrier? If pre-authorization is required, whose responsibility is it to get that pre-authorization?

- Is the patient eligible for coverage, e.g., wellness services or preventive care? Again, who will take responsibility for securing this eligibility information?

- Have you provided financial responsibility information? Does the patient know what he or she will be expected to pay at the time of service?

- Will you mail a new patient information package?

**RECEPTIONIST**

You depend on the Receptionist to gather complete, up-to-date demographic and insurance information—the grist for claims.

- Do you regularly verify patient information sheets? This should occur at least annually, and more often if there are changes in such things as telephone numbers, emergency contacts, or health insurance coverage.

- The position should be a checkpoint for information previously conveyed or gathered by the scheduler: Has eligibility for services been checked/verified? Has a pre-authorization been received and recorded? Have you collected the patient’s co-payment?
CLINICAL STAFF

Yes, the Clinical Staff has responsibilities for billing and collecting too! They must know the insurance plans accepted by the practice and the following things about those contracts:

• Do you know which ancillary services your practice can provide?
• If you do not perform lab/x-ray/physical therapy, where do patients go for these services (who has what contract)?
• Can you provide medical and surgical services on the same day for this plan (and get PAID)?
• Has the clinical staff appropriately recorded any services provided “incident to” a physician’s service on the charge document, e.g., injections and immunizations, diagnostic procedures such as ECG, or spirometry?

PHYSICIAN (AND EXTENDERS)

Yes, you provide the service, and you, too, have some responsibilities to help the billing department operate more smoothly.

• Do you code your own services and code correctly?
• Do you understand the significance of assigning appropriate diagnosis codes to support the medical necessity of the services provided?
• Do you know what services might be “bundled” and/or not paid separately?
• Do you know which of your services may be denied for medical necessity because of diagnosis or frequency of service? Do you inform the patient and secure his or her consent for these services by having an advanced notice of consent and acceptance of financial responsibility signed before you provide the service?

CASHIER

This is often the last stop for the patient before leaving the office. Don’t miss the opportunity to make one last check for accuracy on a number of things:

• Have you collected the right co-pay/co-insurance?
• Have you collected for non-covered services if appropriate?
• Have you checked the superbill/encounter form for completeness? Did you verify the patient had all the services marked on the form, did the patient have any services not marked, and is there a diagnosis available for each service? Now is the time to check with the provider if the form is not complete.
• One last chance — have you verified the patient’s insurance company is current and correct?
Practices differ when it comes to whose responsibility it is to enter charges. Some assign this job to a front office cashier (also known as a check-out clerk), while others batch up encounter forms for the business or billing office to process. No matter whose responsibility it is, there should be a check and balance system in place to verify all charges are captured for all patients.

**INSURANCE BILLER**

Tasks and responsibilities for this position vary. Remember, the claim generation process starts when the charges are posted for a service. However, claims must be reviewed for accuracy and completeness before they are actually generated or sent out.

- Does the person in this position know:
  - ALL the plans for which your practice is a provider?
  - What is considered a “clean claim”?
  - How to appeal for additional payment of denied or underpaid claims?
- Do you mail or transmit insurance claims at least once a week?
- How do you handle the day-to-day correspondence from the insurance plans?

**COLLECTOR**

Sometimes the Collector and the Insurance Biller are one and the same, while other times these duties are divided among several people. No matter the organization of your billing department, someone needs to be responsible for follow-up after claims generation and must bring each patient account to a zero balance. This position must:

- Know how to comply with the rules and regulations of each contracted plan and how to read the remittance advice or explanation of benefits from each.
- Know what the expected payment is for each of your services from each of your insurance plans.
- Know how to determine what is billable to the patient or another third party and what needs to be written off for contractual adjustments.
This position should also have the responsibility for:

- Checking and monitoring your explanation of benefits. You may be losing money due to inaccurate payment processing.

- Improving basic accounts receivable management.
  - Track percentage of accounts receivable in four categories:
    - < 30 days
    - 31-90 days
    - 91-120 days
    - 121+ days
  - Monitor percentage of charges written off to bad debt
  - Calculate days in accounts receivable
  - Implement critical financial management for diverse payer mix of managed care contracts

- Using your computer system/MIS for reimbursement and financial analysis:
  - Reasons for payment denial by major carriers
  - Collection rates by individual payers
  - Payment timing trends
  - Contractual allowances and bad debt levels
  - A/R aging by third party payers
  - Reimbursement by procedure — determine cost effectiveness
  - Reimbursement by payer — determine which are your best and worst contracts

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**SOMETHING FOR ALL**

The number of staff members you have in your billing department will vary according to practice size. As you can see, however, there are many aspects of effective reimbursement management that occur outside the actual billing department. It is important that you build a reimbursement team that not only shares work, but shares information as well.

People who work the accounts receivable need to communicate with the front office staff and charge entry people about what they see on the payment denials and requests for further information that flow through the billing office. A regularly scheduled meeting to discuss A/R and insurance payment issues will encourage this form of communication and sharing of information. Cross-training among the staff members can be advantageous as well.
PUT YOUR BILLING POLICIES AND PROCEDURES ON PAPER

If you lack a manual of billing policies and procedures, there is a much greater likelihood that your office will experience billing dysfunction. Staff will tend to depend on word-of-mouth to explain how things are done. This allows a lot of bad habits to get passed on to new employees. Additionally, it allows individuals to do things their own way, resulting in a number of different ways to do one task, such as work a rejected claim. It also fosters individual standards and timelines for getting things accomplished or resolved. For example, if the standard for entering charges is “as soon as possible,” this could mean two weeks in a poorly run operation, while most experts will agree that no more than 24 hours should go by before a charge is entered.

You can begin to develop this manual by reducing to paper the steps required to get a claim out the door and paid. Follow the process displayed in the Reimbursement Team schematic at the beginning of this chapter and ask yourself what happens from the time the patient calls to make an appointment until the service is provided and the patient’s account is brought to a zero balance.

You may purchase model policies and procedures from the Medical Group Management Association (www.mgma.org). You will want to customize the policies for your specific practice, but the models are a good starting point.

If you need assistance in developing a billing policies and procedures manual, consider utilizing the services of a medical business or practice management consultant. You can access the names of consultants in your area by visiting the Practice Resources page at www.yourfp.org/caf or access the FP Assist Program (a clearinghouse of management consultants) at www.aafp.org/fpassist.

IN-HOUSE vs. OUTSOURCED BILLING

Expect to pay between 8% and 10% of your collections for the associated costs of billing and collecting. It is critical to monitor your billing operations and monitor associated costs accordingly. The pros and cons of in-house versus outsourced billing should also be weighed. While in-house billing gives you better control of your collections operation, it requires dedicated space for activities that do not generate income. For a more in depth discussion on this subject, see the March 1999 issue of Family Practice Management available online at www.aafp.org/fpm.
Medical record documentation is required to record pertinent facts, findings, and observations about an individual’s health history, including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record documents the care of the patient chronologically and is an important element contributing to high quality care. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient’s immediate treatment, and to monitor his/her health care over time.
- Communication and continuity of care among physicians and other health care professionals involved in the patient’s care.
- Accurate and timely claims review and payment.
- Appropriate utilization review and quality of care evaluation.
- Collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the hassles associated with claims processing and should serve as a legal document to verify the care provided, if necessary.

**WHAT PAYERS WANT**

- The site of service.
- The medical necessity and appropriateness of the diagnostic and/or therapeutic service provided.
- Information that the services provided have been accurately reported.
GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:
   a) Reason for encounter and relevant history, physical examination, findings and prior
      diagnostic test results
   b) Assessment, clinical impression of diagnosis
   c) Plan for care
   d) Date and legible identity of the observer

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be
   easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient's progress, response to and changes in treatment, and revision of diagnosis should
   be documented.

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

DOCUMENTING EVALUATION AND MANAGEMENT SERVICES

The documentation of a patient visit should be thorough in describing the medical elements within
the encounter. By following the Evaluation and Management (E/M) component listing, an effective
documentation outline can be developed for documenting E/M services. The key components of
level of service selection are:

• **History:** The patient’s history should be documented as personally taken or reviewed. Past, family
  and social history must be noted for detailed and comprehensive levels of service. Physicians may
  note that the details were reviewed and considered non-contributory.

  1. **Chief Complaint:** A concise statement describing the symptom, problem, condition, diag-
     nosis or other factor that is the reason for the encounter, usually stated in the patient’s words.

  2. **History of Present Illness (HPI):** A chronological description of the development of the
     patient’s present illness from the first sign and/or symptoms to the present. This includes a
     description of location, quality, severity, timing, duration, context, modifying factors and
     associated signs and symptoms significantly related to the presenting problem(s).
        a) Location - Where is the problem located?
        b) Duration - How long have the symptoms been present?
        c) Severity - How bad is the problem, pain, symptoms, such as, “on a scale of 1-10,
           how bad is the pain if 1 is minimal and 10 is extreme?”
d. Quality - Description of the problem in terms such as sharp, throbbing, persistent, dull, etc.
e. Context – What were the circumstances that surrounded the start of the problem?
f. Timing – When does the problem occur?
g. Modifying Factors – Does anything make the problem better or worse, such as, “When I turn on my side, it doesn’t hurt as much”?
h. Associated Signs and Symptoms - Are there any other problems or symptoms associated with this problem?

Review of System (ROS): An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For the purpose of CPT, the following elements of a system review have been identified:

- a) Constitutional symptoms (fever, weight loss, etc.)
- b) Eyes
- c) Ears, Nose, Mouth, Throat
- d) Cardiovascular
- e) Respiratory
- f) Gastrointestinal
- g) Genitourinary
- h) Musculoskeletal
- i) Integumentary (skin and/or breast)
- j) Neurological
- k) Psychiatric
- l) Endocrine
- m) Hematologic/Lymphatic
- n) Allergic/Immunologic

4. Past History: A review of the patient's past experience with illnesses, injuries, and treatments that include significant information about:

- a) Prior major illnesses and injuries
- b) Prior operations
- c) Prior hospitalizations
- d) Current medications
- e) Allergies (e.g., drug, food)
- f) Age appropriate immunization status
- g) Age appropriate feeding/dietary status

5. Family History: A review of medical events in the patient’s family that includes significant information about:

- a) The health status or cause of death of parents, siblings, and children
- b) Specific diseases related to problems identified in the chief complaint
- c) History of the present illness, and/or system review
- d) Diseases of family members which may be hereditary or place the patient at risk

6. Social History: An age appropriate review of past and current activities that includes significant information about:

- a) Marital status and/or living arrangements
- b) Current employment
- c) Occupational history
- d) Use of drugs, alcohol and tobacco
- e) Level of education
- f) Sexual history
- g) Other relevant social factors

• Examination: Details of the physical exam should include complaints, symptoms considered, observations and areas examined.
- **Medical Decision Making:** This critical component should clearly describe the complexity of the process by detailing all diagnoses or presenting problems, elements of data reviewed, patient risk, and treatment options. Data reviewed may be documented by listing laboratory values evaluated or date ranges for review of past complications.

Contributory Factors for selecting levels of service are:

1. **Counseling:** Counseling is a discussion with a patient and/or family concerning one or more of the following areas:
   a) Diagnostic results, impressions, and/or recommended diagnostic studies
   b) Prognosis
   c) Risks and benefits of management (treatment) options
   d) Instructions for management (treatment) and/or follow-up
   e) Importance of compliance with chosen management (treatment) option
   f) Risk factor reduction
   g) Patient and family education

2. **Coordination of Care:** Appropriate for the problems/needs of patient and family

3. **Nature of Presenting Problem:**
   - Minimal – May not require the presence of a physician, but is provided under physician supervision.
   - Self-limited or minor - A problem that runs a definite and prescribed course, is transient, not likely to permanently alter health status or has a good prognosis.
   - Low severity - Risk or morbidity without treatment is low, little to no risk of mortality without treatment, and full recovery without functional impairment is expected.
   - Moderate severity - Risk of morbidity without treatment is moderate, moderate risk of mortality without treatment, uncertain prognosis or increased probability of prolonged functional impairment.
   - High severity - Risk of morbidity without treatment is high, moderate to high risk of mortality without treatment or high probability of severe, prolonged functional impairment.

4. **Time = More Than 50% of the Service** - When counseling or coordination of care equals more than 50% of the physician/patient encounter, then time is one of the key factors in qualifying for a particular level of service. The extent of counseling and/or coordination of care must be documented.

**DOCUMENTING THE DIFFERENT LEVELS OF SERVICE**

The levels of E/M services are based on four types of history, four types of examination and four levels of complexity of medical decision-making. It is the documentation in the medical record that supports these levels of history, exam, and medical decision that are then incorporated into selecting the appropriate overall level of Evaluation and Management Service.
History

The four levels of history are:

1. **Problem Focused** - Chief complaint, brief history of present illness or problem

2. **Expanded Problem Focused** - Chief complaint, brief history of present illness, problem pertinent system review

3. **Detailed** - Chief complaint, extended history of present illness, problem pertinent system review extended to include a review of a limited number of additional systems, and pertinent past, family, and social history directly related to the patient's problems

4. **Comprehensive** - Chief complaint, extended history of present illness, review of systems which is directly related to the problems identified in the history of present illness plus a review of all additional body systems, and complete past, family, and social history.

Each level of history includes some or all of the following elements:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS)
- Past, family and/or social history (PFSH)

A chief complaint is indicated for all levels of service.

The extent of history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

Documentation for history includes the following guidelines:

- The CC, ROS, and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.

- A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. The review and update may be documented by:
  - describing any new ROS and/or PFSH information, noting there has been no change in the information; and,
  - noting the date and location of the earlier ROS and/or PFSH.

- The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient, i.e., health history form. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.
**HPI (history of present illness) elements:**
- Location
- Severity
- Timing
- Modifying factors
- Quality
- Duration
- Context
- Associated signs and symptoms

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<th>Expanded Problem Focused</th>
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<td>Brief (1-3)</td>
<td>Brief (1-3)</td>
<td>Extended (4+ or status of 3+ chronic/inactive conditions)</td>
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**ROS (review of systems):**
- Constitutional (wt loss, etc)
- Ears, nose, mouth, throat
- GI
- Integumentary (skin, breast)
- Endo
- GU
- Hem/lymph
- Eyes
- Cardiovascular
- Musculo
- Neuro
- Allergy, immunologic
- Respiratory
- Psych
- "All others neg."

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**PFSH (past medical, family, social history) areas:**
- Past history (the pt.'s experiences with illnesses, operations, injuries and treatments)
- Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)
- Social history (an age appropriate review of past and current activities)

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Determine a level of history using the table above: a) If a column has 3 elements circled, draw a line up that column to the top row and circle the type or level of history; b) If no column has all of the elements circled, find the circle(s) farthest to the left. Draw a line up that column to the top row and circle the type or level of history.

**Examination**

The levels of examination are:

1. **Problem Focused** - A limited examination of the affected body area or organ system
2. **Expanded Problem Focused** - A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
3. **Detailed** - An extended examination of the affected body areas(s) or organ system(s) and any other symptomatic or related body areas(s) or organ system(s).
4. **Comprehensive** - A general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

For purposes of a multi-system examination, the following organ systems are recognized:

1. Eyes
2. Ears, nose, mouth and throat
3. Cardiovascular
4. Respiratory
5. Gastrointestinal
6. Genitourinary
7. Musculoskeletal
8. Skin
9. Neurologic
10. Psychiatric
11. Hematologic/Lymphatic/Immunologic
12. Constitutional (vital signs, general appearance)
The 1997 Documentation Guidelines developed by the Centers for Medicare and Medicaid Services (CMS, formerly Health Care Financing Administration) also define levels of examination and documentation guidelines for the following single organ system exams:

- Cardiovascular
- Ears, Nose, Mouth and Throat
- Eyes
- Genitourinary (Female)
- Genitourinary (Male)

- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

A general multi-system examination or a single organ system examination may be performed by a physician regardless of specialty. The type (general multi-system or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s).

There are three guidelines for documenting physical examination:

- Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.

- Abnormal or unexpected findings of the examination of any asymptomatic body areas(s) or organ system(s) should be described.

- A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

### 1995 Guidelines

**Body areas:**
- ☐ Head, including face
- ☐ Chest, including breast and axillae
- ☐ Abdomen
- ☐ Back, including spine
- ☐ Neck
- ☐ Genitalia, groin, buttocks
- ☐ Each extremity

**Single Organ system:**
- ☐ Cardiac
- ☐ Ears, nose, mouth, throat
- ☐ Resp
- ☐ Musculo
- ☐ Psych
- ☐ Eyes
- ☐ GI
- ☐ Skin
- ☐ Hem/lymph/imm.
- ☐ Cardiovascular
- ☐ GU
- ☐ Neuro

### 1997 Guidelines

**Multi-System Exam:**
- ☐ Constitutional (e.g. vitals, gen app)
- ☐ Ears, nose, mouth, throat
- ☐ Resp
- ☐ Musculo
- ☐ Psych
- ☐ GI
- ☐ Skin
- ☐ Hem/lymph/imm.
- ☐ Eyes
- ☐ Cardiovascular
- ☐ GU
- ☐ Neuro

**Organ system:**
- ☐ Cardiovascular
- ☐ Ears, Nose, Throat, Mouth
- ☐ Musculoskeletal
- ☐ Skin
- ☐ Eyes
- ☐ Genitourinary (female)
- ☐ Genitourinary (male)
- ☐ Neurological
- ☐ Hematologic/Lymphatic/Immunologic
- ☐ Psychiatric
- ☐ Respiratory
COMPLEXITY OF MEDICAL DECISION MAKING

Medical decision making is made up of three elements and four types. Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by three elements - data, risk and diagnostic and/or management options.

Medical decision making is:

• The number of possible diagnoses and/or management options.

• The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed.

• The risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making “complexity” are recognized:

• Straight-forward

• Low complexity

• Moderate complexity

• High complexity

To qualify for a given type of decision making, two of the three elements must be met or exceeded.

<table>
<thead>
<tr>
<th># of Dx(s) -or- Mgmt. Options</th>
<th>Amount and/or Complexity of Data Reviewed</th>
<th>Risks of Complication, Morbidity or Mortality</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>High</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
</tbody>
</table>

Number of Diagnosis or Treatment Options

Self-limited or minor
Established problem, stable
Established problem, worse
New problem, no further work up
New problem, further work up

Amount and/or Complexity of Data Review

Clinical lab tests
Radiology studies
Medicine studies
Discussion with performing MD
Review old records, discuss with other MD
Independent visualization
Table of Risk  - The highest level of risk in any one category determines the overall risk!

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis</td>
<td>• Laboratory tests requiring venipuncture, chest x-rays, EKG/EEG, urinalysis, ultrasound, KOH prep</td>
<td>• Rest</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Gargles</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Elastic bandages</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>• Two or more self-limited or minor problems</td>
<td>• Physiologic tests not under stress, e.g., pulmonary function tests</td>
<td>• Over-the-counter drugs</td>
</tr>
<tr>
<td></td>
<td>• One stable chronic illness, e.g., well-controlled hypertension or non-insulin dependent diabetes, cataract, BPH</td>
<td>• Non-cardiovascular imaging studies with contrast, e.g., barium enema</td>
<td>• Minor surgery with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>• Superficial needle biopsies</td>
<td>• Physical therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clinical laboratory tests requiring arterial puncture, skin biopsies</td>
<td>• Occupational therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• IV fluids without additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test</td>
<td>• Minor surgery with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Two or more stable chronic illnesses</td>
<td>• Diagnostic endoscopies with no identified risk factors</td>
<td>• Elective major surgery</td>
</tr>
<tr>
<td></td>
<td>• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>• Deep needle or incisional biopsy</td>
<td>(open, percutaneous or endoscopic)</td>
</tr>
<tr>
<td></td>
<td>• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis</td>
<td>• Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization</td>
<td>• Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>• Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>• Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>• Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>• Cardiovascular imaging studies with contrast with identified risk factors, cardiac electrophysiological tests, diagnostic endoscopies with identified risk factors, discography</td>
<td>• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure</td>
<td></td>
<td>• Emergency major surgery (open percutaneous or endoscopic)</td>
</tr>
<tr>
<td></td>
<td>• An abrupt change in neurologic status, e.g., seizure, TIA, weakness, or sensory loss</td>
<td></td>
<td>• Parenteral controlled substances</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Decision not to resuscitate or de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
If the physician documents total time and suggests that counseling or coordinating care dominates the encounter (more than 50%), time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does documentation reveal total time: Face-to-face in outpatient setting, unit/floor in inpatient setting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does documentation describe the content of counseling or coordinating care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does documentation reveal that more than half of time was counseling or coordinating care?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Documenting Surgical or Procedural Services**

When documenting surgical or procedure service, it is preferable always to follow the elements of a good operative report:

a) Site  
b) Size and number of lesions, defects, incisions, etc.  
c) Diagnosis  
d) Complications, if any  
e) Anesthesia, if any, and what type  
f) Disposition of patient

**Summarizing the Need for Documentation**

Approximately 70-80% of all codes used by health care providers are E/M codes. The primary focus of auditors today is the E/M codes — checking the presence of documentation to match or support the level of service reported. Documentation is not subjective with payers. It’s either right or it’s not!

If you under-code or under-report levels of service, you are driving down your current and future levels of reimbursement and utilization. If you up-code or over-report levels of service, you are potentially committing fraud. The solution is to document and code exactly what you did and why you did it, according to the guidelines.

Many health care providers mistakenly do not properly code or submit encounter information for their patients covered under capitated contracts. Many view it as an unnecessary expense for patients for whom they will be paid a fixed capitated amount. Whether or not you are required to submit this information, it is the only way that you will be able to see how your reimbursement compares to other contracts you have. For example if you “bill” all your capitated encounters at Medicare rates, you can compare your reimbursement received versus the work actually done on a monthly basis once your capitation check arrives. This provides critical information when it comes to contract renegotiation and allows you to evaluate whether or not a capitated contract makes sense.
CHAPTER 4

The Evaluation and Management (E/M) Services codes were introduced into CPT nomenclature in 1992. These codes describe services provided by physicians to “evaluate” patients and “manage” their care. The E/M codes replaced “visit” codes that described services generally as a “brief,” “intermediate,” or “comprehensive” visit. These codes are widely used by physicians of all specialties and describe a very large portion of the medical care provided to patients of all ages.

PRIMARY TYPES OF E/M SERVICES

Outpatient - office visits for new and established patients (99201-99205) and (99211 - 99215)

These codes are used to report evaluation and management services provided in the physician’s office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

### NEW PATIENT OFFICE VISIT

3 of 3 components must be met or exceeded

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Physical Exam</th>
<th>Medical Decision</th>
<th>Average (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>P</td>
<td>P</td>
<td>S</td>
<td>10</td>
</tr>
<tr>
<td>99202</td>
<td>E</td>
<td>E</td>
<td>S</td>
<td>20</td>
</tr>
<tr>
<td>99203</td>
<td>D</td>
<td>D</td>
<td>L</td>
<td>30</td>
</tr>
<tr>
<td>99204</td>
<td>C</td>
<td>C</td>
<td>M</td>
<td>45</td>
</tr>
<tr>
<td>99205</td>
<td>C</td>
<td>C</td>
<td>H</td>
<td>60</td>
</tr>
</tbody>
</table>

### ESTABLISHED PATIENT OFFICE VISIT

2 of 3 components must be met or exceeded

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Physical Exam</th>
<th>Medical Decision</th>
<th>Average (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>5</td>
</tr>
<tr>
<td>99212</td>
<td>P</td>
<td>P</td>
<td>S</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>E</td>
<td>E</td>
<td>L</td>
<td>15</td>
</tr>
<tr>
<td>99214</td>
<td>D</td>
<td>D</td>
<td>M</td>
<td>25</td>
</tr>
<tr>
<td>99215</td>
<td>C</td>
<td>C</td>
<td>H</td>
<td>40</td>
</tr>
</tbody>
</table>

Key: History and Physical Exam
- P – Problem focused
- E – Expanded problem focused
- D – Detailed
- C – Comprehensive

Key: Medical Decision Making
- S – Straightforward
- L – Low complexity
- M – Moderate complexity
- H – High complexity

Hospital Observation Service (99218 - 99220)

Hospital observation service codes are used to report evaluation and management services provided to patients admitted as “observation status” into a hospital. It is not necessary that the patient be located in an observation area designated by the hospital.
To report services to a patient designated as "observation status" who is discharged on the same date, use the services codes for Admission and Discharge on the Same Date (99234-99236).

Hospital observation service requires all three key components.

**Observation Care Discharge Service (99217)**

Observation care discharge of a patient from "observation status" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

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**HOSPITAL INPATIENT SERVICES**

**Hospital visits**

According to one study done, based on 125 audits, 80% of hospital visits were miscoded.

A likely reason for this is that the documentation for these visits is not in the doctor's office; it is in the hospital. This makes it hard to code correctly.

*A Critical Tip* – There are only three levels of hospital visit. Remember that if the patient is stable you cannot code higher than a level-one service. A level-two service patient requires that the patient be responding inadequately, or some indication of a need for change in therapy or medication is present. Level-three service should reflect increasing degrees of instability or significant new problems have occurred.

**Initial Hospital Care (99221 - 99223)**

Initial hospital care codes are used to report the first hospital inpatient encounter with the patient by the admitting physician. For initial inpatient encounters by physicians other than the admitting physician, see initial consultation codes or subsequent hospital care codes as appropriate.

When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service, all evaluation and management services provided by that physician in conjunction with that admission, and performed on the same date as the admission, are considered part of the initial hospital care. The inpatient care level of service reported by the admitting physician should include the services related to the admission he or she provided in another site of service as well as in the inpatient setting. Evaluation and management services on the same day provided in sites other than the hospital that are related to the admission should NOT be reported separately.

Initial inpatient hospital care codes require all three key components.
Subsequent Hospital Care (99231 - 99233)

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient’s status since the last assessment by the physician.

Subsequent Hospital Care codes require two of three key components.

Hospital Discharge Services (99238 - 99239)

The hospital discharge management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. These codes include, as appropriate, final examination of the patient and discussion of the hospital stay, even if the time spent by the physician on that date is not continuous. Instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms are also part of this service.

To report services to a patient who is admitted as an inpatient and discharged on the same day, use only the codes for initial hospital inpatient services. To report concurrent care services provided by a physician other than the attending physician, use subsequent hospital care codes on the day of discharge.

CONSULTATION

A consultation is defined as a type of 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.

A consulting physician may initiate diagnostic and/or therapeutic services.

The request for a consultation from the attending physician or other appropriate source and the need for a consultation must be documented on the patient’s medical record. The consultant's opinion and any services that were ordered or rendered must also be documented in the patient's medical record and communicated to the requesting physician or other appropriate source.

A consultation initiated by a patient and/or family, and not requested by a physician, is not reported using the initial consultation codes but may be reported using the codes for confirmatory consultation or office visits, as appropriate. If a confirmatory consultation is required, e.g., by a third party payer, the modifier “32” (mandated services) should also be reported.

Any specifically identifiable procedure, i.e., identified with a specific CPT code, performed on or subsequent to the date of the initial consultation, should be reported separately.

If a consultant subsequently assumes responsibility for the management of a portion of the patient’s condition(s), or the entire condition, the consultation codes should not be used. In the hospital setting, the physician receiving the patient for partial or complete transfer of care should use the appropriate subsequent hospital care codes. In the office setting, the appropriate established patient code should be used.
There are four subcategories of consultations:

1. Office or other outpatient
2. Initial inpatient
3. Follow-up inpatient
4. Confirmatory

See each subcategory for specific reporting instructions.

Family physicians are often asked by surgeons to provide a consultation for surgical clearance on their patients. See our discussion of billing for surgical clearance services in Chapter Six.

**Office or Other Outpatient Consultations (99241 - 99245)**

Office or other outpatient consultation codes are used to report consultations provided in the physician’s office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, custodial care, or emergency department.

The office consultation codes may be used again following the initial consultation if an additional request for an opinion or advice is received regarding the same or a new problem from the attending physician and documented in the medical record. If the patient is only returning as a follow-up at the consulting physician’s request, however, the visit would be coded as an established patient visit.

Office or other outpatient consultation codes require all three key components.

**Pre-operative consultations:** Physicians (primary care or subspecialists) performing pre-operative and post-operative consultations for their established patients at the request of the surgeon may bill the appropriate HCPCS/CPT consultation code as long as all of the following five criteria are met, and the medical record is documented as such.

1. The surgeon must request the consulting physician’s opinion or advice regarding evaluation and/or management of a specific problem.

2. The surgeon’s request for a consultation and the need for consultation must be documented in the patient’s medical record. In an inpatient setting, the request may be documented as part of a plan written in the requesting surgeon’s progress note, an order in a hospital record, or a specific written request for the consultation. In an office or other outpatient setting, the request may be documented by a specific written request for the consultation from the requesting surgeon, or the physician’s records may show a specific reference to the request.

3. The consulting physician’s opinion, and any services ordered or performed, must be documented in the patient’s medical records and must be communicated to the surgeon. The medical record should identify the specific problem that was the reason for the consultation, describe the extent of the history, physical, and medical decision making that supports the level of consultation code billed, and include the consultant’s findings and recommendations to the requesting surgeon.
4. The consulting physician must provide all of the services necessary to meet the description of the level of CPT code billed.

5. If a pre-operative consultation for a given patient was performed by a physician who then provides post-operative services to the same patient, such services must be reported via the appropriate subsequent hospital, office, or E/M procedure code. Post-operative consultations are only considered consultations if the consulting physician did not perform the patient’s pre-operative consultation.

**Initial Inpatient Consultations (99251 - 99255)**

Initial inpatient consultation codes are used to report physician consultations provided to the hospital inpatient, residents of nursing facilities, or patients in a partial hospital setting.

Only one initial consultation per admission should be reported by a consultant.

Initial inpatient consultation codes require all three key components.

**Follow-Up Inpatient Consultations (99261 - 99263)**

Follow-up consultations are visits to complete the initial consultation or subsequent consultative visits requested by the attending physician.

Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient’s status.

If the physician consultant has started treatment at the initial consultation, and participates thereafter in the patient’s management, the codes for subsequent hospital care should be used.

Follow-up consultation codes are used to report the follow-up consultations provided to hospital inpatients or nursing facility residents only.

Follow-up consultation codes require two of three key components.

**Confirmatory Consultations (99271 - 99275)**

Confirmatory Consultations codes are used to report the evaluation and management services provided to patients when the consulting physician is aware of the confirmatory nature of the opinion sought, e.g., when a second/third opinion is requested or required on the necessity or appropriateness of a previously recommended medical treatment or surgical procedure.

Confirmatory consultations may be provided in any setting.

A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice only. Any services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care. If a confirmatory consultation is required, the modifier “32” (mandated services) should also be reported.

Confirmatory consultations require all three key components.
OTHER E/M SERVICES

EMERGENCY DEPARTMENT SERVICES
New and Established Patients 99281 - 99288
• All physicians may use
• Critical care codes should be used if appropriate
• New/established patients coded similarly
  (3/3 components)
• Specialist referral by ER physician not considered consults

PATIENT TRANSPORT SERVICES 99289 - 99288

CRITICAL CARE SERVICES
First 60 minutes 99291
Additional 30 minutes (each) 99292
• Not necessarily “continuous” time
• 15 minutes is the critical “cut-off”
  (1/2 hour - 1 hour, 14 minutes = 99291)
• 99291 used once per day only
• “Status” (diagnosis) not “unit” is deciding factor

NEONATAL INTENSIVE CARE
Initial 99295
Subsequent, unstable 99296
Subsequent, stable 99297
Subsequent, low birth weight 99298

NURSING FACILITY SERVICES (SNF, ICF, LTCF)
Comprehensive assessment 99301 - 99303
Subsequent care 99311 - 99313
Discharge services 99315 - 99316

DOMICILIARY, REST HOME, CUSTODIAL CARE SERVICES
New patient 99321 - 99323
Established patient 99331 - 99333

HOME SERVICES
New patients 99341 - 99345
Established patient 99347 - 99350

PROLONGED SERVICES
Direct patient contact - outpatient
1st hour 99354
Each add’l. 30 minutes 99355
Direct patient contact - inpatient
1st hour 99356
Each add’l. 30 minutes 99357
Without direct patient contact
1st hour 99358
Each add’l. 30 minutes 99359

PHYSICIAN STANDBY SERVICE 99360

CASE MANAGEMENT SERVICES
Team conference 99361 - 99362
Telephone calls 99371 - 99373

CARE PLAN OVERSIGHT SERVICES
(Per 30 day periods)
Patient under home health care agency
15-29 minutes 99374
30 minutes or more 99375
Hospice patient
15-29 minutes 99377
30 minutes or more 99378
Nursing home patient
15-29 minutes 99379
30 minutes or more 99380

Family physicians often provide this type of service.
Please see our discussion of this topic in Chapter Six.
Remember to bill for these services.

PREVENTIVE MEDICINE SERVICES
New patients 99381 - 99387
Established patient 99391 - 99397
Individual counseling 99401 - 99404
Group counseling 99411 - 99412
Others 99420 - 99429

NEWBORN CARE
History and examination; hospital 99431
Other than hospital or birthing center 99432
Subsequent hospital 99433
Admission/discharge; same day 99435
• Normal newborn care
Attendance at delivery 99436
• May be reported in addition to 99431
• May NOT be reported in addition to 99440
Newborn resuscitation 99440

SPECIAL EVALUATION AND MANAGEMENT SERVICES
Basic life and/or disability evaluation 99450
Work related or medical disability evaluation services 99455 - 99456

OTHER E/M SERVICES 99499
INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE

When selecting a level of E/M service, it is important to remember that it is ultimately the responsibility of the physician providing the E/M service to determine the level of service provided. Physician documentation in the patient's medical record is of utmost importance; it must support the level of service reported.

Specific steps must be taken to select the appropriate level of E/M service. These step are:

1. **Identify the category and subcategory of service.**

   Refer to the table of categories and subcategories of E/M services in your CPT manual to identify the appropriate category and subcategory of service provided, e.g., office or other outpatient new patient, established patient, inpatient - initial admission, subsequent care.

2. **Review the reporting instructions for the selected category or subcategory.**

   Most of the categories and many of the subcategories of E/M service have special guidelines or instructions unique to that category or subcategory. It is important to read and be guided by those special instructions.

3. **Review the E/M service code descriptors in the selected category or subcategory.**

   The descriptors for the levels of E/M services recognize seven components (history, exam, medical decision making, counseling, coordination of care, nature of presenting problem, and time). The first six are used in determining the level of service. Review the descriptors in the category or subcategory selected.

4. **Determine the extent of history obtained.**

   The medical history provides essential information for diagnosis and management, and varies based on the clinical judgment of the physician and each individual patient and problem(s). Obtaining the history includes: Chief Complaint, History of Present Illness, Review of Systems, Past, Family and/or Social History. There are four levels (extent) of history: Problem Focused, Expanded Problem Focused, Detailed and Comprehensive. Use the components of history obtained to determine the overall extent (level) of history.

5. **Determine the extent of the examination performed.**

   The extent of the examination performed depends on the clinical judgment of the physician and the nature of the patient's presenting problems. Depending upon the number of systems examined, choose a level (extent) of exam from the following choices: Problem Focused, Expanded Problem Focused, Detailed and Comprehensive.
6. **Determine the complexity of medical decision making.**

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the three elements: data, risk, and diagnostic and/or management options. Two of the three elements must be met or exceeded to select a level of complexity of medical decision making. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

7. **Select the appropriate level of E/M services.**

The selection of the appropriate level of E/M service is based on the key components performed by the physician and the number of key components required for the particular category/subcategory identified.

Some of the categories/subcategories of E/M service require all of the key components to meet or exceed requirements stated in the code descriptor to qualify for a level of E/M services. Other categories/subcategories of E/M service require only two of the three key components to meet or exceed the stated requirements to qualify for a particular level of service.
CHAPTER 5

GETTING PAID FOR WHAT YOU DO

The use of modifiers is an important part of coding and billing for health care services. Modifiers are designed to give insurance carriers, including Medicare, additional information needed to process a claim. This includes HCPCS Level I (CPT) and HCPCS Level II codes. There is a complete list of CPT modifiers in Appendix A of your current year's CPT book. The complete list of HCPCS Level II modifiers can be found in the HCPCS Level II publication. It is often found on the inside of the front and back covers, as well as in an Appendix within the book.

Both sets of modifiers are updated annually and should be checked for accuracy and current validity. Correct modifier use is an important part of avoiding fraud and abuse or noncompliance issues, especially in coding and billing processes involving the federal and state governments. Incorrect modifier usage is identified as one of the top 10 billing errors determined by federal, state, and private payers.

A modifier provides the means by which a physician can indicate or “flag” a service provided to the patient that has been altered by some special circumstance(s), but for which the basic code description itself has not changed. A modifier is used to indicate:

- A service or procedure has both a professional and technical component, but both components are not applicable.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was performed more than once.
- Unusual events occurred during a procedure or service.

Placement of a modifier after either a CPT or HCPCS code does not ensure reimbursement. A special report may be necessary if the service is rarely provided, unusual, variable, or new. The special report should contain pertinent information and an adequate definition or description of the nature, extent, and need for the procedure/service.

Some modifiers are for information only, e.g., -24 and -25, and do not affect the amount of reimbursement. They can, however, determine if the service will be reimbursed or denied.

Other modifiers such as modifier -22 (unusual procedural services) will increase the reimbursement under the protocol for many third-party payers if documentation supports the use of this modifier. Modifier -52 (reduced services) will usually equate to a reduction in payment.

Determining correct modifier assignment can be very frustrating at times. If the medical record document does not support the use of the specific modifier, the physician risks the denial of the claim based on lack of medical necessity. Even worse, there is the potential for fraud and/or abuse penalties should the medical record documentation be reviewed by federal, state, and other third-party payers and found to be insufficient.
A REVIEW OF MODIFIERS COMMONLY USED BY FAMILY PHYSICIANS

**Modifier -21** is used to report prolonged evaluation and management services to a patient when the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category of E/M service.

*Example:* A physician assesses, in the office, an established patient with multiple illnesses (osteoarthritis, emphysema, coronary artery disease and uncontrolled diabetes with a stasis ulcer). After reviewing the history and examining the patient, the family physician counsels the patient and her family, adding time to the visit. The decision making, exam, and history, plus the time spent with the patient (60 minutes), all exceed the highest level of E/M in that category (99215). Since the physician provided all of these services continuously and directly to the patient, and did not leave the patient during the 60-minute visit, the -21 modifier is appended to the code 99215.

In this scenario, the important difference between choosing to use the -21 modifier and not the prolonged physician service with direct (face-to-face) patient contact is that the time spent with the patient is continuous, and the service exceeds the highest level of service in the E/M category. The prolonged physician services with direct (face-to-face) patient contact can be intermittent and reported with any level of E/M service.

**Modifier -22** is used to report an unusual procedural service. The key here is that the service is procedural in nature and not an E/M service. When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier -22 to the usual procedure CPT code. A report may be required by the third-party payer to support the unusual nature of the service.

*Example:* A family physician excises a lesion located in the abdominal folds of a very obese person. The patient’s obesity makes the excision more difficult. The physician indicates the complexity of the removal of the lesion by appending the -22 modifier to the code used to report the removal of the lesion. A copy of the physician’s operative note is attached to the claim when the third-party is billed.

**Modifier -24** is used when a physician provides a surgical service related to one problem and then, during the period of follow-up care for the surgery, provides an evaluation and management service unrelated to the problem. The -24 modifier is appended to the E/M service that follows the surgical service.

*Example:* The family physician repairs a minor laceration on an elderly gentleman who fell on his back stairs and cut his forearm. Five days later, the patient comes back into the office to have his blood pressure checked because he is having what he considers to be a severe headache. Because the wound repair has 10 days of post-operative care included in its global period, the -24 modifier must be appended to the office visit service for evaluation of the headache. Additionally, a separate diagnosis, not related to the laceration, should be used as the primary diagnosis for the office visit to substantiate the use of the -24 modifier.

**Modifier -25** is used 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. 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. A different diagnosis may be reported if present, however. The physician must remember that the -25 modifier goes on the E/M code, not the code for the procedure or other service.

Example: A patient presents at the family physician’s office suffering from shoulder pain. Upon examination of the patient, the physician determines the patient has bursitis and would benefit from an injection of cortisone into the shoulder joint. In addition to documenting the elements of the E/M visit, the physician documents an operative note describing the joint injection, identifying the medication and amount injected into the shoulder.

The E/M visit is billed, appending the -25 modifier to the code. The appropriate code for the joint injection is billed, with no modifier, and the appropriate code is billed to identify the name and amount of the medication injected.

In this scenario, because the patient came into the office as a consequence of the shoulder pain, that should be the primary diagnosis used for the E/M service, and the bursitis diagnosis would be used for the injection and medication.

Third-party payers sometimes deny E/M services and procedural services billed on the same day, even when the physician appends the -25 modifier. These services should be appealed for appropriate payment.

Modifier - 26 is used to report only the physician (professional) component of a service that is a combination of a physician component and technical component. Before using this modifier, one must make sure there isn’t a separate CPT code that describes the professional component only of the service.

Example: A family physician is evaluating a patient with shortness of breath and orders a chest x-ray. The x-ray equipment in the office is currently being serviced and will not be available until the next day. The physician sends the patient upstairs to another office to have the x-ray taken and asks the patient to return to his office with the x-ray films so he may read and interpret the films. The family physician reads the chest x-ray, documents his interpretation and makes a decision as to how best to treat the patient’s problem. The other office will bill for the technical component of the x-ray, and the family physician will append the -26 modifier to the CPT code for the chest x-ray to indicate he performed the professional component or interpretation.

Modifier - 50 is used to report bilateral procedures that are performed at the same operative session. The use of this modifier is only applicable to services/procedures performed on identical anatomic sites, aspects or organs. Some CPT codes, by definition, are bilateral in nature and it would not be appropriate to add the bilateral modifier to those services, i.e., removal of impacted cerumen.

Example: A patient comes in to the family physician’s office to have joint injections in both the right and left elbows. Because the physician does the exact same procedure twice, once on the right and once on the left, the service is reported as a bilateral service appending the -50 modifier to the CPT code for intermediate joint injection.

Diagnostic as well as therapeutic procedures may require the use of the bilateral modifier if the anatomic structures are found bilaterally and the identical procedure is performed on both sides.

Modifier - 51 is used to report multiple procedures, other than E/M services, that are performed at the same session by the same provider. The primary procedure or service should be reported as listed. The additional procedure(s) or service(s) should be identified by attaching the -51 modifier to the additional procedure or service.
Example: A patient goes to her family physician’s office complaining of a 4-week history of pain in her right lateral epicondyle and right deltoid region. She has been caring for her grandchildren ages 2 and 7 and finds it difficult to lift because of the pain in her arm and shoulder. She receives Kenalog injections in the right elbow and shoulder.

This service is billed as multiple procedures rather than bilateral procedures, because the injections were given in different sites, and they are two different procedure codes. The shoulder injection is billed as the primary procedure using the appropriate CPT code for a joint injection of a major joint. There is no modifier appended to that procedure. The elbow injection is billed as the additional procedure, using the CPT code for intermediate joint injection and the -51 modifier is appended to that CPT code.

It is customary for third-party payers to discount the reimbursement for the additional procedure(s). For this reason it is important that the physician list the most comprehensive procedure/service first on the claim form with no modifier attached and apply the modifier (-51) to the additional or less comprehensive service.

Modifier - 52 is used to report a service that has been partially reduced or eliminated at the physician’s discretion. The service provided can be identified by its usual procedure number and the addition of the modifier -52 to indicate that the service is reduced. This modifier provides a means of reporting reduced services without disturbing the identification of the basic service.

Documentation should be present in the medical record explaining the circumstances surrounding the reduction in the service. Some third-party payers may require the submission of this documentation with the claim to allow the payer to access the correct reimbursement.

Example: A patient presents to the physician’s office with a chief complaint of wrist pain after falling from a chair at home. AP and lateral x-ray views of the wrist revealed a Colles’ fracture of the right wrist. The family physician performed a closed treatment with manipulation. Following the treatment, the physician ordered a post-reduction x-ray.

The closed treatment of the fracture would be reported with the CPT code for that service, along with the appropriate codes for both x-rays. The first x-ray code would not be appended with a modifier. However, the second x-ray code would require the -52 modifier to indicate it was a limited comparative radiographic study.

Modifier - 55 is used when one physician performs the post-operative management and another physician has performed the surgical procedure. The modifier is used to identify the postoperative management service. The physician who performs the postoperative management reports the operative procedure code with the -55 modifier appended.

Example: A cardiothoracic surgeon performed a percutaneous balloon valvuloplasty on the patient’s pulmonary valve due to pulmonary value insufficiency. The surgeon followed this patient in the hospital, but upon discharge wrote a transfer of care order to the patient’s family physician in a community near the patient’s home, who will follow up with post-operative care.

The family physician who assumes the post-operative care for this patient would report the CPT code for the valvuloplasty appended with the -55 modifier after the first post-discharge visit with the patient.
**Modifier - 79** is used to report the performance of an unrelated procedure or service during the post-operative period of another procedure or service. This modifier is used only to indicate that the unrelated procedure was performed by the same physician during the post-operative period of the original procedure.

A different diagnosis code should be reported, linked to the unrelated procedure. Failure to use this modifier when appropriate may result in denial of the subsequent surgery or procedure claim.

Example: A patient who is currently being treated for a non-displaced right Colles fracture comes to the family physician’s office complaining of pain and swelling of the left knee. Upon examination the physician determines there is fluid under the knee cap, and subsequently does an aspiration of fluid from that knee. The arthrocentesis of the left knee would be billed with the appropriate CPT code to report the service appended with the -79 modifier.

**Modifier - 80** is used to report surgical assistant services. From a CPT coding perspective, this modifier is intended to be used to report physician services. However, many users report these modifiers for a variety of non-physician surgical assistant services.

Example: The family physician’s patient is undergoing a balloon angioplasty by the cardiac surgeon. Because the family physician has a special interest in his cardiac patients, and has had the appropriate training, the cardiologist asks the family physician to be the assistant surgeon for this patient. The family physician will bill exactly the same CPT code for the angioplasty that the surgeon bills, but will append the -80 modifier to his service.

The most common misinterpretation of the assistant surgeon modifier(s) is to report physician assistant (PA) or nurse practitioner (NP) assistant surgical services. Some third-party payers do consider this an acceptable means of reporting non-physician assistants during surgery. Many have established their own guidelines for reporting assistant surgeon services. Each practice should check with the various third-party payers with whom they contract to review their guidelines for billing for surgical assistance.

Payment for surgical assistant services also varies by third-party payer. While Medicare traditionally allows 16% of a surgeon’s fee for the surgical assistant, other payers sometimes allow between 16% and 22%.
A Listing of Common HCPCS Level II Modifiers:

The HCPCS Level II codes are alphanumeric codes developed by CMS (Centers for Medicare and Medicaid Services) as a complementary coding system to the AMA’s CPT codes. HCPCS Level II codes describe procedures, services and supplies not found in the CPT manual. Similar to the CPT coding system, HCPCS Level II codes also contain modifiers that serve to further define services and items without changing the basic meaning of the CPT or HCPCS Level II code with which they are reported. HCPCS Level II modifiers range from -AA to -VP.

It is important to note that HCPCS Level II modifiers may be used with CPT codes, just as CPT modifiers can be used with HCPCS Level II codes. In some cases, a report may be required to accompany the claim to support the need for a particular modifier’s use, especially if the presence of a modifier causes suspension of the claim for manual review and pricing.

The following list is not an exclusive listing of HCPCS Level II modifiers. They are some of those more commonly used by family physicians and are listed here as a reminder to consider their use when appropriate. Please refer to the current edition of HCPCS Level II national codes for the appropriate use of each modifier.

<table>
<thead>
<tr>
<th>AS</th>
<th>Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td>Upper left, eyelid</td>
</tr>
<tr>
<td>E2</td>
<td>Lower left, eyelid</td>
</tr>
<tr>
<td>E3</td>
<td>Upper right, eyelid</td>
</tr>
<tr>
<td>E4</td>
<td>Lower right, eyelid</td>
</tr>
<tr>
<td>FA</td>
<td>Left hand, thumb</td>
</tr>
<tr>
<td>F1</td>
<td>Left hand, second digit</td>
</tr>
<tr>
<td>F2</td>
<td>Left hand, third digit</td>
</tr>
<tr>
<td>F3</td>
<td>Left hand, fourth digit</td>
</tr>
<tr>
<td>F4</td>
<td>Left hand, fifth digit</td>
</tr>
<tr>
<td>F5</td>
<td>Right hand, thumb</td>
</tr>
<tr>
<td>F6</td>
<td>Right hand, second digit</td>
</tr>
<tr>
<td>F7</td>
<td>Right hand, third digit</td>
</tr>
<tr>
<td>F8</td>
<td>Right hand, fourth digit</td>
</tr>
<tr>
<td>F9</td>
<td>Right hand, fifth digit</td>
</tr>
<tr>
<td>LT</td>
<td>Left side</td>
</tr>
<tr>
<td>Q5</td>
<td>Service furnished by a substitute physician under a reciprocal billing arrangement.</td>
</tr>
<tr>
<td>Q6</td>
<td>Service furnished by a locum tenens physician.</td>
</tr>
<tr>
<td>Q8</td>
<td>Physician providing service in an urban HPSA.</td>
</tr>
<tr>
<td>QW</td>
<td>CLIA waived test</td>
</tr>
<tr>
<td>RT</td>
<td>Right side</td>
</tr>
<tr>
<td>TA</td>
<td>Left foot, great toe</td>
</tr>
<tr>
<td>T1</td>
<td>Left foot, second digit</td>
</tr>
<tr>
<td>T2</td>
<td>Left foot, third digit</td>
</tr>
<tr>
<td>T3</td>
<td>Left foot, fourth digit</td>
</tr>
<tr>
<td>T4</td>
<td>Left foot, fifth digit</td>
</tr>
<tr>
<td>T5</td>
<td>Right foot, great toe</td>
</tr>
<tr>
<td>T6</td>
<td>Right foot, second digit</td>
</tr>
<tr>
<td>T7</td>
<td>Right foot, third digit</td>
</tr>
<tr>
<td>T8</td>
<td>Right foot, fourth digit</td>
</tr>
<tr>
<td>T9</td>
<td>Right foot, fifth digit</td>
</tr>
<tr>
<td>TC</td>
<td>Technical component</td>
</tr>
<tr>
<td>GA</td>
<td>Waiver of liability statement on file (Medicare patients)</td>
</tr>
<tr>
<td>GC</td>
<td>This service has been performed in part by a resident under the direction of a teaching physician.</td>
</tr>
<tr>
<td>GE</td>
<td>This service has been performed by a resident without the presence of a teaching physician under the primary care exception.</td>
</tr>
<tr>
<td>GW</td>
<td>Service not related to the hospice patient’s terminal illness.</td>
</tr>
<tr>
<td>GY</td>
<td>Item or service statutorily excluded or does not meet the definition of any Medicare benefit.</td>
</tr>
</tbody>
</table>

There are many more HCPCS Level II modifiers available. Check your current HCPCS Level II manual for appropriate selection.
CHAPTER 6

THE CONSULTATION FOR SURGICAL CLEARANCE

Family physicians are frequently asked to perform “surgical clearance” on an existing patient before the patient undergoes a surgical procedure by a surgeon. The question is then asked — is this an established patient visit or a consultation?

Often, this service is a consultation. If all the parameters of a consultation are met:

1) There is a request by a physician for the family physician’s opinion and/or advice (can this patient withstand the operation?);

2) There is a reason for the consultation (what does the surgeon need to know about the patient’s underlying illnesses or condition during this operative period?); and,

3) A report goes back to the requesting source (your report of clearance or clearance with modifications), then the service should be billed at the appropriate level of either outpatient or inpatient consultation. Even if you are treating the patient or managing the problem in question, as long as the three criteria for consultation are met, that would be the appropriate service to bill.

Remember, if it is a surgical clearance, the primary diagnosis for the consultation would be an ICD-9-CM code that begins with a V and indicates the service is a pre-surgical examination. The secondary diagnosis would then be the underlying illness for which the patient is being treated by the family physician, and an additional secondary diagnosis would be the reason for the surgery. You will most likely need to report the Universal Provider Identification Number (UPIN) of the requesting physician as well.

Family physicians sometimes lose reimbursement to which they are entitled because these services are billed incorrectly.
Preventive medicine services are often referred to as “well checks” or “annual exams.” The extent and focus of these services is largely dependent on the age of the patient. The CPT codes themselves are differentiated by new patient (99381 – 99387) versus established patient (99391 – 99397) and are age sensitive.

The comprehensive nature of preventive medicine services reflects an age and gender appropriate history and exam and is NOT synonymous with the “comprehensive” history and examination required in other Evaluation and Management services (99201 – 99350).

The comprehensive history for Preventive Medicine services:

- Is not problem oriented.
- Does not include chief complaint or present illness.
- Does include a comprehensive systems review.
- Does include a comprehensive or interval past, family, social history.
- Does include a comprehensive history of pertinent risk factors.

The comprehensive examination is multi-system, but the extent of the exam is based on the age of the patient and risk factors identified.

There is no medical decision making required for preventive medicine services.

The service codes do include counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the preventive medicine service. If those services are provided at a separate encounter or visit, then the services should be billed using one of the counseling codes identified by either individual counseling or group counseling. These counseling services might include such things as weight reduction, smoking cessation or general nutrition counseling (non-illness related).

Third-party payers have varying payment policies governing the reimbursement for these services. However, most payers allow the services at least annually for children, adolescents, teens and adults. Services for newborns and infants are often allowed more frequently.

It is preferable for the physician’s practice to ask the patient to verify coverage with his/her insurance company before the physician provides a preventive medicine service. If there is no coverage for preventive medicine services, then it is customary to ask for payment at the time of service.
### SCREENING SERVICES

Congress, in recent years, has added several important screening services to Medicare's benefit package. Here are several cases in which you can be reimbursed by Medicare for preventive services. Make sure you use the appropriate diagnosis when billing Medicare for these services.

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Covered Procedure Codes</th>
<th>Covered Diagnosis</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bone Mass Measurement</strong></td>
<td>G0130, 76070, 76071, 7075, 76076, 76078, 76977, 78350</td>
<td>256.2, 256.3, 256.9, 627.2, 627.4, 627.8, 627.9</td>
<td>Once every 23 months</td>
</tr>
<tr>
<td><strong>Colon Cancer Screenings</strong></td>
<td></td>
<td>No specific requirement except for high risk: V10.05, V10.06, 555.0-555.2, 555.9, 556.0-556.3, 556.8, 556.9, 558.2, 558.9</td>
<td>Once every 12 mo. Once every 47 mo. Once every 24 mo. Once every 10 yrs. See G0104 and G0105*</td>
</tr>
<tr>
<td>Fecal Occult Blood Test</td>
<td>G0107, G0104, G0105, G0232, G0106, G0120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexible Sigmoidoscopy</td>
<td></td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy (HIGH Risk)</td>
<td></td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy (Not HIGH Risk)</td>
<td></td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>Barium Enema</td>
<td></td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>Flu (Influenza) Injections</td>
<td>90657-90659, G0008</td>
<td>V04.8</td>
<td>Once a year</td>
</tr>
<tr>
<td>Glaucoma Screening</td>
<td>G0117, G0118</td>
<td>V80.1</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Hepatitis B Injections</td>
<td>G0010, 90740, 90743, 90744, 90746, 90747</td>
<td>V05.3</td>
<td>Once in a Lifetime Except HIGH Risk</td>
</tr>
<tr>
<td>Mammography Screening</td>
<td>G0202, 76092, 76085</td>
<td>V76.12</td>
<td>Once a year</td>
</tr>
<tr>
<td>Medical Nutrition Therapy</td>
<td>97802 – 97804</td>
<td>Diabetes or Renal Failure (With referral from physician only)</td>
<td>1st yr 3 hours Each add’l. year 2 hr</td>
</tr>
<tr>
<td>Pneumococcal (Pneumonia) Vaccination</td>
<td>G0009, 90732</td>
<td>V03.82</td>
<td>Once in a lifetime Except HIGH Risk</td>
</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td>G0102, G0103</td>
<td>V76.44</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Digital Rectal Exam (DRE)</td>
<td></td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>Screening PSA Blood Test</td>
<td>Q0091, P3000, P30001, G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148</td>
<td>V76.2, V76.49, V15.89</td>
<td>Once every 24 months</td>
</tr>
<tr>
<td>Screening Pap Smears</td>
<td>G0101</td>
<td>V76.2, V76.49, V15.89</td>
<td>Once every 24 months; Once every 12 months for HIGH Risk</td>
</tr>
<tr>
<td>Screening Pelvic Examinations</td>
<td></td>
<td>**</td>
<td></td>
</tr>
</tbody>
</table>

* Alternative to procedure codes G0106, G0120
** High Risk patients may have more than one vaccination as long as it has been 5 years since the last vaccination. Other third-party payers may reimburse for these services as well. Check with your payers.
CARE PLAN OVERSIGHT

Care plan oversight (CPO) is physician supervision of patients under either a home health agency (HHA) or hospice agency where the patient requires complex or multi-disciplinary care modalities requiring ongoing physician involvement.

Effective 1/1/95, the Health Care Financing Administration extended Medicare coverage for CPO services, and allows separate payment for CPO services exceeding 30 minutes per month only for those patients who are receiving Medicare covered home health or hospice benefits.

Medicare does not pay for care plan oversight services for nursing facility or skilled nursing facility patients.

CPT Codes

Effective for claims submitted January 1, 1998 and after, three new CPT codes for CPO services differentiate among patients receiving home health, hospice and nursing facility services. Physicians must use CPT code 99375 to bill CPO services for beneficiaries receiving Medicare covered home health services and CPT code 99378 to bill CPO services for beneficiaries receiving Medicare covered hospice services. The CPT descriptions follow:

99375 - Physician supervision of a patient under care of a home health agency (patient not present) requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient’s care, integration of new information into the medical treatment plan and/or adjustment of the medical therapy, within a calendar month; 30 minutes or more.

99378 - Physician supervision of a hospice patient (patient not present) requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone) with other health care professionals involved in patient’s care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more.

99380 - Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone) with other health care professionals involved in patient’s care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more.

CPT code 99380 is bundled status, and no separate payment will be allowed since payment for care planning for nursing home patients is bundled into the physician’s payment for evaluation and management services.
Conditions of Coverage

The physician cannot bill CPO services with other services on the same claim. **CPO services must be billed separately.** Physicians must bill care planning only once per calendar month and must bill only one month’s services per line item. The claim must not be submitted until after the end of the month in which the service was performed.

Other conditions of coverage:

- The beneficiary must require complex or multi-disciplinary care modalities requiring ongoing physician involvement in the patient’s plan of care;
- The beneficiary must be receiving Medicare covered home health care or hospice services during the period in which the care plan oversight services were furnished;
- The physician who bills CPO must be the same physician who signed the home health or hospice plan of care;
- The physician must furnish at least 30 minutes of care plan oversight (see countable services) within the calendar month for which payment is claimed and no other physician has been paid for care plan oversight within that calendar month;
- The physician must have provided a covered physician service that required a face-to-face encounter with the beneficiary within the six months immediately preceding the provision of the first care plan oversight service (face-to-face encounter does not include EKG, lab services, or surgery);
- The care plan oversight billed must not be routine post-operative care provided in the global surgical period of a surgical procedure billed by the physician;
- For beneficiaries receiving Medicare covered home health services, the physician must not have a significant financial or contractual interest in the home health agency as defined in 42CFR 424.22 (d);
- For beneficiaries receiving Medicare covered hospice services, the physician must not be the Medical Director or an employee of the hospice or provide services under arrangements with the hospice;
- The care plan oversight services must be personally furnished by the physician who bills them;
- Services furnished “incident to” a physician’s service do not qualify as CPO and do not count toward the 30-minute requirement;
- The physician may not bill CPO during the same calendar month in which he or she bills the Medicare monthly capitation payment end stage renal disease (ESRD) benefit for the same beneficiary;
- The physician billing for care plan oversight must document in the patient’s record those services that were furnished and the date and length of time associated with those services.
Countable Services
The following activities are countable services toward the 30-minute minimum requirement for care plan oversight:

• Review of charts, reports, treatment plans, or lab or study results, except for the initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter;
• Telephone calls with other health care professionals (not employed in the same practice) involved in the care of the patient;
• Team conference (time spent per individual patient must be documented);
• Telephone or face-to-face discussions with a pharmacist about pharmaceutical therapies;
• Medical decision making;
• Activities to coordinate services are countable if the coordination activities require the skills of a physician.

Non-Countable Services
The following activities are services not countable toward the 30-minute requirement:

• Services furnished by nurse practitioners, physician assistants, and other non-physicians cannot be billed under the care plan oversight service. This includes the time spent by staff getting or filing charts, calling HHAs, patients, etc.
• The physician’s telephone call to patient or family, even to adjust medication or treatment. The physician’s time spent to telephone prescriptions to the pharmacist is not countable since these activities do not require physician work or meaningfully contribute to the treatment of the illness or injury.
• Travel time, time spent preparing claims and for claims processing.
• Initial interpretation or review of lab or study results that were ordered during or are associated with a face-to-face encounter.
• Low intensity services included as part of other evaluation and management services.
• Informal consults with health professionals not involved in the patient’s care.
• The physician’s time spent discussing with his/her nurse and conversations the nurse had with the HHA do not count toward this 30-minute requirement. The time spent by the physician working on the care plan after the nurse conveyed the pertinent information to the physician is countable toward the 30-minutes, however.
• Only one physician per month will be paid for CPO for a patient. Other physicians working with the physician who signed the plan of care are not permitted to bill for these services.
• The work included in hospital discharge day management (99239-99239) and discharge from observation (99217) is not countable toward the 30 minutes per month required for the billing of care plan oversight. Physicians may bill for work on the same day as discharge, but only for those services separately documented as occurring after the patient is actually physically discharged from the hospital.
Claim Submission Requirements

Care plan oversight services are billed separately from evaluation and management codes for office/outpatient, hospital, home, nursing facility or domiciliary services.

Physicians must submit the 6-character Medicare provider number of the HHA or hospice rendering covered Medicare services during the period in which the care planning was furnished. The physician is responsible for obtaining the Medicare provider number of the HHA or hospice that is responsible for the plan of care he or she has signed for the beneficiary and that is rendering Medicare covered services to the beneficiary.

For paper claims, the 6-character Medicare provider number of the HHA or hospice must be entered in block 23 of the HCFA-1500 claim form.

For electronic claims submitted in ANSI-837 format, the HHA or hospice Medicare provider number must be entered in 2-250-NM109; use qualifier MP for NM108 and FA for NM101.

The dates of service entered on the claim form must be the first and last dates for the month that documented care-planning services were actually provided, not the calendar month that the claim is being submitted. Submit claims after the end of the month in which services were rendered.

Billing Tips

The following tips will assist you in the proper submission of CPO claims:

• You must submit the 6-character Medicare provider number for the HHA or hospice rendering covered Medicare services during the period in which the care planning was furnished.

• Claims submitted with invalid Medicare HHA or hospice Medicare provider numbers will be denied. Claims submitted for CPO services where the Medicare HHA or hospice number is missing will be returned.

• The physician is accountable for obtaining the Medicare provider number for the HHA or hospice that is responsible for the plan of care he or she has signed for the beneficiary.

• The HHA or hospice plan must be signed before CPO services are billed. The physician who bills for CPO services must be the same physician who signed the home health or hospice plan of care.

Claims submitted with invalid Medicare HHA or hospice Medicare provider numbers will be denied. Claims for CPO services will also be denied when a review of beneficiary claim history fails to identify a covered physician service requiring face-to-face encounter by the same physician during the six month period preceding the provision of the first CPO service. Evaluation and Management codes in the ranges of 99201-99263 or 99281-99357 are considered evidence that a face-to-face encounter occurred.
**Documentation**

Physicians requesting payment for care plan oversight services must document in their records the care plan oversight services they furnish. The dates and exact duration of time spent on the services for which payment is sought must be noted. Care plan oversight is recognized by Medicare as a physician service and must be provided and documented only by the responsible physician.

The following providers CANNOT bill Medicare for care plan oversight services:

- Rural health clinics (RHCs)
- Nurse practitioners
- Physician assistants
- Medical directors of hospice
- Hospice employees

**Patient Awareness**

Typically, care plan oversight services do not involve a face-to-face encounter between the patient and the physician. Therefore, the patient may not be aware that the services were provided. Physicians can help by informing their patients that Medicare will pay for these services when the specified conditions are met. Beneficiaries will also be notified regarding the allowed care plan oversight services via their Medicare Summary Notice (MSN) statements.

1,2,3 As of January 1, 2001, Medicare will no longer pay for services billed with codes 99375 and 99378. CPT 2001 definition of CPO includes medical professionals’ telephone calls to “others involved in the patient's care,” including family members. Medicare allows payment for phone calls only to other "medical professionals."

Two new HCPCS (Level II) codes have been established that retain the 2000 CPT definitions and allow payment:

**G0181** - Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care.

**G0182** - Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care.
CARE PLAN OVERSIGHT DOCUMENTATION

Patient Name: ________________________________

HOME HEALTH SERVICE DATES From __________ To __________

Name of Home Health Agency: ____________________________________________

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Description of Service</th>
<th>Billable Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pt Issue -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pt Issue -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pt Issue -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pt Issue -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pt Issue -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan -</td>
<td></td>
</tr>
</tbody>
</table>

Diagnosis: ________________________________

Total Time

Physician’s Signature: ________________________________
Many family physicians find it beneficial to employ non-physician medical providers (NPPs) to help care for their patient base. Those non-physician providers commonly used in a family practice setting are nurse practitioners (NP), clinical nurse specialists (CNS) and/or physician assistants (PA).

Which patients are seen by the NPP varies by practice setting and practice needs. It is up to each individual practice to decide how to use the non-physician provider and set protocol for the practice. Here are a few things to keep in mind when employing non-physician providers.

1. Verify the license and scope of practice allowed by the license for each non-physician provider. Scope of practice allowed by each license often varies.

2. Check with third-party payers to verify how they require services of non-physician providers to be reported and how they reimburse claims for these providers. Payment policies vary widely by insurance carriers and payers. Your billing staff will need to know the “ins” and “outs” of billing for these providers.

Medicare currently allows nurse practitioners, clinical nurse specialists, and physician assistants to practice either independently as part of a family practice or provide services “incident to” a physician’s service. Make sure you are familiar with the guidelines for each type of practice arrangement. The table on the following page discusses the billing guidelines and documentation requirements for both types of service provision.

If the services are provided “incident to” those services of a physician, review Medicare’s definition of “incident to” services. They are services and supplies that are:

- An integral, although incidental, part of the physician’s professional service;
- Commonly rendered without charge or generally not itemized separately in the physician’s bill;
- Of a type that are commonly furnished in physicians’ offices or clinics; and,
- Furnished by the physician or by auxiliary personnel under the physician’s direct supervision (physician is physically present in the office suite when the services are provided).

3. Enroll non-physician providers correctly with each of your payers. Again, enrollment requirements will vary widely and each practice will need to maintain compliance with its third-party payers.
## Non-Physician Providers - Medicare Billing and Documentation Guidelines

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Billing As Independent Provider</th>
<th>Billing As “Incident To”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QUALIFICATIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Must be a NP or PA licensed to practice in the state in which services are furnished</td>
<td>Must be a NP or PA licensed to practice in the state in which services are furnished</td>
<td></td>
</tr>
<tr>
<td>Must have Medicare and Medicaid provider number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To prescribe, NPP must have BNE Rx authorization number</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>REIMBURSEMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesser of 80% of actual charge, or 80% x 85% of physician fee schedule</td>
<td>80% x 100% of physician fee schedule</td>
<td></td>
</tr>
<tr>
<td>NPP must not bill Medicare if billing would result in duplicate payment of the same services (to facility or doctor)</td>
<td>Must meet “incident to” guidelines</td>
<td></td>
</tr>
<tr>
<td>NP-payment to NPP PA-payment to physician or group</td>
<td>Payment to physician or physician group</td>
<td></td>
</tr>
<tr>
<td><strong>SUPERVISION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD in office suite and immediately available</td>
<td>Not required</td>
<td>Yes, MD present in office suite and immediately available</td>
</tr>
<tr>
<td>MD responsible for (aware of) care</td>
<td>Not required</td>
<td>Yes, MD responsible for and aware of care</td>
</tr>
<tr>
<td><strong>SERVICES</strong></td>
<td>Within scope of practice, as defined by state law</td>
<td>Within NPs’ scope of practice, in accordance w/ state law</td>
</tr>
<tr>
<td>M edically reasonable and necessary for patient</td>
<td>M edically reasonable and necessary for patient</td>
<td></td>
</tr>
<tr>
<td>NPPs are paid for “covered services” — services Medicare covers when provided by a licensed physician. This includes E/M visit codes 99201 - 99205 and 99211 - 99215 performed and documented solely by the NPP</td>
<td>M ust meet “incident to” guidelines. NPP is employee of billing MD, services performed in office setting only; MD initiates care and provides subsequent services reflecting active management of case; services are incidental parts of physician’s service to patient</td>
<td></td>
</tr>
<tr>
<td>Diagnostic tests - direct supervision</td>
<td>If licensed to provide, no supervision required as of 01/01/2000</td>
<td>NPP performs test, MD must be in office suite and available</td>
</tr>
<tr>
<td>Diagnostic tests - personal supervision</td>
<td>If licensed to provide, no supervision required as of 01/01/2000</td>
<td>If NPP performs test, MD must be in room during procedure</td>
</tr>
<tr>
<td><strong>DOCUMENTATION</strong></td>
<td>NPP documents in accordance with CPT guidelines</td>
<td>NPP documentation using CPT guidelines is sufficient</td>
</tr>
<tr>
<td>Countersignature by MD</td>
<td>Not required</td>
<td>Not required</td>
</tr>
<tr>
<td>MD makes personal note</td>
<td>Not required</td>
<td>Not required</td>
</tr>
<tr>
<td>NPP/MD jointly review case</td>
<td>If NPP deems it appropriate to review the case with a physician, this would be noted</td>
<td>NPP bills in MD’s name and documents using CPT guidelines; no MD note or co-signature is required</td>
</tr>
<tr>
<td>NPP/MD jointly develop protocol</td>
<td>When protocols, policies and practice guidelines are developed jointly by a NPP and a physician, they should be signed by both at least annually</td>
<td></td>
</tr>
</tbody>
</table>
Client: __________________ Dr: __________________ Signature: Yes No D.O.S: __________ Match: Yes No

Patient #: __________________ Primary DX Billed: ________ □ Agree □ Disagree 2nd Dx: ________ □ Agree □ Disagree

### Chief Complaint:

<table>
<thead>
<tr>
<th>History</th>
<th>Problem Focused</th>
<th>Exp. Prob. Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ HPI (history of present illness) elements:</td>
<td>□ Brief (1-3)</td>
<td>□ Brief (1-3)</td>
<td>□ Extended (4+ or status of 3+ chronic/ inactive cond.)</td>
<td>□ Extended (4+ or status of 3+ chronic/ inactive cond.)</td>
</tr>
<tr>
<td>□ Location</td>
<td>□ Constitution (wt. loss, etc.)</td>
<td>□ Ear, nose, mouth, throat</td>
<td>□ Integumentary (skin, breast)</td>
<td>□ Ear, nose, mouth, throat</td>
</tr>
<tr>
<td>□ Severity</td>
<td>□ Integumentary (skin, breast)</td>
<td>□ Cough</td>
<td>□ Extremity</td>
<td>□ Extremity</td>
</tr>
<tr>
<td>□ Timing</td>
<td>□ Pulmonary</td>
<td>□ Vomiting</td>
<td>□ Eyes</td>
<td>□ Pulmonary</td>
</tr>
<tr>
<td>□ Modifying factors</td>
<td>□ Cardiovascular</td>
<td>□ Vomiting</td>
<td>□ Musculo</td>
<td>□ Cardiovascular</td>
</tr>
<tr>
<td>□ Modifying factors</td>
<td>□ Musculo</td>
<td>□ Vomiting</td>
<td>□ Neuro</td>
<td>□ Musculo</td>
</tr>
<tr>
<td>□ Associated signs and symptoms</td>
<td>□ Respiratory</td>
<td>□ Vomiting</td>
<td>□ Allergy</td>
<td>□ Respiratory</td>
</tr>
</tbody>
</table>

### ROS (review of systems):

- Constitutional (fatigue, etc.)
- Integumentary (skin, breast)
- Ocular
- Cardiovascular
- Musculo
- Neuro
- Allergy

### PFSH (past medical, family, social history) areas:

- Past history (the pt’s experiences with illnesses, operations, injuries & treatments)
- Family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk)
- Social history (an age appropriate review of past and current activities)

Circle an entry for history in the table above. a) If a column has 3 elements circled, draw a line up that column to the top row and circle the type of history. b) If no column has all of the elements circled, find the circle(s) farthest to the left. Draw a line up that column to the top row and circle the type of history.

### EXAM

**Body areas:**
- Head, including face
- Chest, including breast and axilla
- Abdomen
- Back, including spine
- Neck
- Genitalia, groin, buttocks
- Each extremity

**Organ systems:**
- Constitutional (e.g. vitals, gen app)
- Ear, nose, mouth, throat
- Resp
- Musculo
- Psych
- GI
- Skin
- Hem/Lymph/imm.
- Eyes
- Cardiovascular
- GU
- Neurol

### COMPLEXITY Number of Diagnoses or Treatment Options

<table>
<thead>
<tr>
<th>Problem to Exam Physician</th>
<th>No. x Points = Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max = 2 1</td>
</tr>
<tr>
<td>Established problem (to examiner); stable, improved</td>
<td>1</td>
</tr>
<tr>
<td>Established problem (to examiner); worsening</td>
<td>Max = 2 2</td>
</tr>
<tr>
<td>New problem (to examiner); no additional work-up planned</td>
<td>Max = 2 3</td>
</tr>
<tr>
<td>New prob. (to examiner); add, work-up planned</td>
<td>4</td>
</tr>
</tbody>
</table>

### TOTAL

Bring total to line A in Final Result for Complexity.

**Amount and/or Complexity of Data to be Reviewed**

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

### TOTAL

Bring total to line B in Final Result for Complexity.

### TIME

If the physician documents total time and suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

#### Does documentation reveal total time? - Time: Face-to-face in outpatient setting

- Unit/Floor in inpatient setting

- Yes □ No □

#### Does documentation describe the content of counseling or coordinating care?

- Yes □ No □

#### Does documentation reveal that more than half of time was counseling or coordinating care?

- Yes □ No □

---

<table>
<thead>
<tr>
<th>Final Result for Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>C</td>
</tr>
</tbody>
</table>

Type of decision making:

| Straight Forward | Low Comp | Mod Comp | High Comp |

Draw a line down any column with 2 or 3 circles and circle the level of decision-making in that column. Otherwise, draw a line down the column with the 2nd circle from the left.
### Risk of Complications and/or Morbidity or Mortality

<table>
<thead>
<tr>
<th>Level Of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| Minimal       | • One self-limited or minor problem, e.g., cold, insect bite, tinea corporis | • Laboratory tests requiring venipuncture  
• Chest x-ray  
• EKG/EEG  
• Urinalysis  
• Ultrasound, e.g., echo  
• KOH prep | • Rest  
• Gargles  
• Elastic bandages  
• Superficial dressing |
| Low           | • Two or more self-limited or minor problems  
• One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH  
• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain | • Physiologic tests not under stress, e.g., pulmonary function tests  
• Non-cardiovascular imaging studies with contrast, e.g., barium enema  
• Clinical laboratory tests requiring arterial puncture  
• Skin biopsies | • Over-the-counter drugs  
• Minor surgery with no identified risk factors  
• Physical therapy  
• Occupational therapy  
• IV fluids without additives |
| Moderate      | • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment  
• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast  
• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonia, colitis  
• Acute complicated injury, e.g., head injury with brief loss of consciousness | • Physiologic tests under stress, e.g., cardiac stress test, fatal contraction stress test  
• Diagnostic endoscopies with no identified risk factor  
• Deep needle or incisional biopsy  
• Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac cath.  
• Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis | • Minor surgery with identified risk factors  
• Elective major surgery (open percutaneous or endoscopic) with no identified risk factors  
• Prescription drug management  
• Therapeutic nuclear medicine  
• IV fluids with additives  
• Closed treatment of fracture or dislocation without manipulation |
| High          | • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
• Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure  
• An abrupt change in neurologic status, e.g., seizure, TIA, weakness, or sensory loss | • Cardiovascular imaging studies with contrast with identified risk factors  
• Cardiac electrophysiological tests  
• Diagnostic endoscopies with identified risk factors  
• Discography | • Elective major surgery (open percutaneous or endoscopic) with identified risk factors  
• Emergency major surgery (open percutaneous or endoscopic) with identified risk factors  
• Emergency major surgery (open percutaneous or endoscopic)  
• Parenteral controlled substances  
• Drug therapy requiring intensive monitoring for toxicity  
• Decision not to resuscitate or to de-escalate care because of poor prognosis |

Result - circle nearest to the bottom. Bring result to Line B in Final Result for Complexity.

Comments:
# OUTPATIENT, CONSULTS (Outpatient, Inpatient & Confirmatory) and ER

## NEW / CONSULTS / ER

Requires 3 components within shaded area

<table>
<thead>
<tr>
<th>History</th>
<th>PF</th>
<th>EPF</th>
<th>D</th>
<th>ER: EPF</th>
<th>C</th>
<th>ER:D'</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>ER: EPF</td>
<td>C</td>
<td>ER:D'</td>
<td>C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Decision Making</th>
<th>SF</th>
<th>SF</th>
<th>ER:L</th>
<th>ER:M</th>
<th>M</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average time (minutes)</td>
<td>10 New 99201</td>
<td>20 New 99202</td>
<td>30 New 99203</td>
<td>45 New 99204</td>
<td>60 New 99205</td>
<td></td>
</tr>
<tr>
<td>Confirmatory consults &amp; ER have no average time</td>
<td>15 OP consult 99241</td>
<td>30 OP consult 99242</td>
<td>40 OP consult 99243</td>
<td>60 OP consult 99244</td>
<td>80 OP consult 99245</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20 IP consult 99251</td>
<td>40 IP consult 99252</td>
<td>55 IP consult 99253</td>
<td>80 IP consult 99254</td>
<td>110 IP consult 99255</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Confirm consult 99271</td>
<td>Confirm consult 99272</td>
<td>Confirm consult 99273</td>
<td>Confirm consult 99274</td>
<td>Confirm consult 99275</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ER 99282</td>
<td>ER 99283</td>
<td>ER 99284</td>
<td>ER 99285</td>
<td>ER 99286</td>
<td></td>
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</table>

## ESTABLISHED

Requires 2 components within shaded area

<table>
<thead>
<tr>
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<th>PF</th>
<th>EPF</th>
<th>D</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
</tr>
</tbody>
</table>

## INPATIENT

### INITIAL HOSPITAL / OBSERVATION

Requires 3 components within shaded area

<table>
<thead>
<tr>
<th>History</th>
<th>D or C</th>
<th>C</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>D or C</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Decision</th>
<th>SF/L</th>
<th>M</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Status</td>
<td>SF/L</td>
<td>M</td>
<td>H</td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td>30 Init. hosp. 99221</td>
<td>50 Init. hosp. 99222</td>
<td>70 Init. hosp. 99223</td>
</tr>
<tr>
<td>Services/CPT:</td>
<td>Observ 99218</td>
<td>Observ 99219</td>
<td>Observ 99220</td>
</tr>
<tr>
<td></td>
<td>Adm/Dis/99234</td>
<td>Adm/Dis/99235</td>
<td>Adm/Dis/99236</td>
</tr>
</tbody>
</table>

### Subsequent Inpatient / Follow-up Consult

Requires 2 components within shaded area

<table>
<thead>
<tr>
<th>History</th>
<th>PF interval</th>
<th>EPF interval</th>
<th>D interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
</tr>
</tbody>
</table>

## NURSING FACILITY

### ANNUAL ASSESSMENT/ADMISSION

Requires 3 components within shaded area

<table>
<thead>
<tr>
<th>History</th>
<th>D interval</th>
<th>D interval</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Decision</th>
<th>SF/L</th>
<th>M to H</th>
<th>M to H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Status</td>
<td>Stable, Recovering, Improving</td>
<td>Complication, New Problem, Major Permanent Change</td>
<td>Creation of Medical Plan of Care Required</td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td>30 99301</td>
<td>40 99302</td>
<td>50 99303</td>
</tr>
</tbody>
</table>

### Subsequent Nursing Facility

Requires 2 components within shaded area

<table>
<thead>
<tr>
<th>History</th>
<th>PF interval</th>
<th>EPF interval</th>
<th>D interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
</tr>
</tbody>
</table>

## DOMICILIARY (Rest Home, Custodial Care and Home Care)

### New - requires 3 components within shaded area

<table>
<thead>
<tr>
<th>History</th>
<th>PF</th>
<th>EPF</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complexity of Medical decision</th>
<th>SF/L</th>
<th>M</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>No average time established</td>
<td>Domiciliary 99321 Home Care 99341</td>
<td>Domiciliary 99322 Home Care 99342</td>
<td>Domiciliary 99323 Home Care 99343</td>
</tr>
</tbody>
</table>

### Established - requires 2 components within shaded area

<table>
<thead>
<tr>
<th>History</th>
<th>PF</th>
<th>EPF</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
</tr>
</tbody>
</table>

| Level | I | II | III | I | II | III |

| Level | I | II | III | I | II | III |

**PF** = Problem focused, **EPF** = Exp. prob. focused, **D** = Detailed, **C** = Comprehensive, **SF** = Straight Forward, **L** = Low, **M** = Moderate, **H** = High
PATIENT NAME: _______________  DOB: _______________  DOS: _______________

CHIEF COMPLAINT:  

1) HISTORY:

☐ unable to obtain (indicate reason)

MEDICATIONS:  

☐ unchanged from ________

ALLERGIES:  ☐ NKDA

Review of Systems:

<table>
<thead>
<tr>
<th>System</th>
<th>NL</th>
<th>Comments (positives or pertinent nega)</th>
<th>NL</th>
<th>Comments (positives or pertinent nega)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears/Nose/Mouth/Throat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integumentary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Endocrinologic</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Hematologic</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Immunologic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FhX  ☐ unchanged from ________  ShX  ☐ unchanged from ________  PMhX  ☐ unchanged from ________

Occupation  
Marital Status  
Tobacco  
Alcohol  
Illicit Drugs

2) EXAMINATION:  ✔ each item/system examined; elaborate all abnormal findings

Constitutional: T: __________ P: __________ RR: __________

H: __________ WT: __________ B/P: __________

☐ See Vital Sign Flow Sheet

☐ Appearance: ____________________________________________

Eyes:  ☐ no sceral icterus

☐ PERRLA

Ears Nose Mouth Throat:  ☐ nil teeth, lips, gums

☐ mucous membranes moist

☐ clear oropharynx

Neck:  ☐ nil appearance and movements; nil JVP

☐ trachea midline

☐ no thyroid enlargement, masses

Respiratory:  ☐ symmetrical chest expansion and respiratory effort

☐ clear to auscultation and palpation

Cardiovascular:  ☐ nil sounds; no murmurs, gallops, rubs

☐ RRR

☐ no edema

Abdominal:  ☐ nil sounds; no tenderness; no distention

☐ no hepatosplenomegaly

☐ no hernias present

Lymphatic:  ☐ no adenopathy (indicate below):

☐ cervical  ☐ axillary  ☐ inguinal  ☐ auricular

Extremities:  ☐ no edema

☐ no clubbing, cyanosis

Skin:  ☐ no rash or ulcers

☐ no nodules or sclerosis

Neuro:  ☐ alert and oriented x 3

☐ nil sensation

☐ nil gait

☐ nil muscle strength and tone

Other:  


3) MEDICAL DECISION MAKING:

Assessment and Plan: (Possible Dx/Treatment Options/Additional Testing/Therapeutic Intervention)

Data Review:

☐ interpreter used  ☐ old records reviewed

Counseling and/or Coordination of Care: (time__________)

Points of Discussion:

MD Print Name:__________________ Signature:__________________________ Date:________________
REFERENCE MATERIALS

Every practice needs current reference materials. The references include procedure and diagnostic codes, relative value scales, workers’ compensation fee schedules and other basic references. The following reference materials are considered fundamental and essential to medical billing.

- HCPCS (Healthcare Common Procedure Coding System) Level II
- International Classification of Diseases, 9th Revision, 3rd Edition (ICD-9-CM)

These may all be purchased online from the AMA or your favorite medical publishing firm:

- www.ama-assn.org
- www.unicormed.com
- www.ingenix.com

- Workers’ Comp Fee Schedule - www.workerscomp.ca.gov
  Call your State Department of Labor or Department of Workers’ Comp for other sources.

- Medicare Fee Schedule - www.medicarenhic.com
  Your Medicare carrier publishes the fee schedule and provides it free of charge to each Medicare provider. It can also be accessed on your local Medicare carrier Web site. There are four different fee schedules you may wish to access:
  1. Physicians Fee Schedule (for your locality)
  2. Injection Fee Schedule
  3. Laboratory Fee Schedule
  4. DME (Durable Medical Equipment) Fee Schedule

- Medicare Billing Guide
  There are a number of billing guides that will be helpful. Some examples are:
  - New Biller Guide (the basics)
  - Preventive Services Guide
  - Flu/PPV Guide
  - EMC (Electronic Medical Claim) Guide
  - Medicare and the Resident Physician (for new physicians)

The manuals can be requested from your Medicare carrier or accessed online using the publications and billing guides links at www.medicarenhic.com/caprodners/publications/billingguides.
• **Medicare Bulletins**

Medicare Bulletins are periodically published by each Medicare carrier. These bulletins detail Medicare billing issues and guidelines and discuss current billing parameters for Medicare. Most carriers publish a bulletin at least quarterly, while some publish more often. There are a few carriers that no longer mail the Medicare bulletins to providers, but the bulletins are available online at the carrier’s Web site. In California the bulletins may be accessed using the publications link at www.medicarenhic.com.

• **Correct Coding Initiative**

CMS implemented National CCI Edits in 1996 for the purpose of identifying and eliminating the incorrect coding of medical services. To purchase the CCI Edits, call the National Technical Information Service.

- To receive the information by fax call (703) 605-6880
- To order subscriptions call (703) 605-6060 or (800) 363-2068

CMS has made the CCI edits available online at www.cms.hhs.gov/physicians/cciedits.default.asp.

• **Medi-Cal/ Medicaid Provider Manual**

Medicaid/Medi-Cal manuals are published by the state Medicaid contractor and are mailed to all participating providers. This manual is periodically updated and it should be someone’s responsibility in each practice to make sure this manual is current. This manual is an excellent resource that details billing parameters for all of the Medi-Cal/Medicaid special programs. Many contractors have put the manual online and this is a more up-to-date means of accessing the current information. To access the California manual, go to www.medi-cal.ca.gov/publications/manuals/medical.

• **Provider Manuals for all Contracted Payers**

Provider manuals are available for all of your contracted payers, such as Blue Cross, Blue Shield, CHAMPS/Tricare, Aetna, etc. The manuals can usually be obtained by contacting your local provider relations representative. Many of the payers make their manual available online as well. You may need a user identification and password to access the manual, so check with each payer. Online examples are:

  www.mylifepath.com (Blue Shield)
  www.cigna.com
  www.mytricare.com

• **Reimbursement Articles from Family Practice Management**

Each issue of *Family Practice Management*, published by the American Academy of Family Physicians, offers reimbursement advice. These articles should be circulated throughout the billing department of each practice. If you don’t get this publication, or have misplaced an article, it can be accessed online at www.aafp.org/fpm.