

**Unlocking the Secrets  
of Coding:  
Maximizing Your  
Bottom Line**

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**Disclaimer**

This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational a guide and should not be considered a legal/consulting opinion.

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**PHYSICIANS QUALITY  
REPORTING INITIATIVE - PQRI**

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**PQRI – Factors in Selection Process of Measures**

- Clinical conditions usually treated
- Types of care typically provided
  - e.g. **Preventive, chronic, acute**
- Settings where care is usually delivered
  - e.g. **Office, ED, Surgical suite**
- Quality improvement goals for 2011

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**Physician Quality Reporting Initiative**

- Reporting Period
  - **January 1, 2011 to December 31, 2011**
- **OR**
  - **July 1, 2011 to December 31, 2011**
- Incentive payment
  - **1% Medicare payments made to EP or Group**
  - **Based on 2011 claims received no later than February 28, 2012**

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**PQRI Proposed Changes 2011**

- Added 20 new Individual quality measures
- Added 1 new Measures group
- Reduced reporting sample for claims based reporting of individual measures to 50% from 80%
- Creates a new Group Practice Reporting Option (GPRO) that would allow group practices with fewer than 200 EPs to participate

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PQRI Proposed Changes 2011

- 2011-2014 additional 0.5% incentive payment
  - **Provide data on measures through an Maintenance of Certification Program (MOCP)**
  - **Operated by a specialty body of American Board of Medical Specialties (ABMS)**
  - **Additional criteria identified**
  - **12 month reporting period**

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PQRI Reporting Mechanism

- Through Claims or Qualified Registry
  - **Individual quality measures**
  - **Measures groups**
- Qualified Registry\*\*
- Qualified EHR product

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Asthma Assessment

**Coding Specifications**

Codes required to document patient has asthma and a visit occurred:

A line item ICD-9-CM diagnosis code for asthma and a CPT code are required to identify patients to be included in this measure.

All measure-specific coding should be reported ON THE SAME CLAIM.

Asthma line item ICD-9-CM diagnosis codes

- 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92 (asthma)

AND

CPT codes

- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215

Quality codes for this measure:

CPT II Code descriptors

(Data collection sheet should be used to determine appropriate code.)

- **CPT II 1005F:** Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire)
- **CPT II 1005F-SP:** Asthma symptoms not evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire, reason not otherwise specified)

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**EHR Incentive Program  
Medicare – Start 2011**

- EP's incentive payments
  - **5 years**
- First year of participation
  - **Must begin prior to 2015**
- "Meaningful Use" demonstrated
  - **by 2015**
  - **Or "payment adjustments"**
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ICN# 903691 (September 2010)

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**EHR Incentive Program  
Medicaid– Start 2011**

- EP's incentive payments
  - **6 years**
- First year of participation
  - **Must begin prior to 2016**
- "Meaningful use"
  - **No adjustments**

ICN# 903691 (September 2010)

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**Relative Value Unit**

- Malpractice Expense
- Practice Expense
- Physician Work
  
- Total RVU x multiplier = reimbursement
  
- Medicare 2010 = \$28.39
- Medicare 2009 = \$36.06

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**OFFSETTING REVENUE LOSSES AND GAINS**

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Components of Medicare RVU

**THREE COMPONENTS**

- **Work RVU (wRVU) ≈ 52%**
  - Relative time, effort, and skill needed by a provider in the provision of a procedure
- **Practice Expense RVU (peRVU) ≈ 44%**
  - Costs associated with maintaining a practice, such as rent, equipment, supplies and staff
- **Malpractice Expense RVU (mRVU) ≈ 4%**
  - Professional liability insurance

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RVU

Description	Code	Work	Practice Expense	Malpractice	TOTAL RVU
Office Visit	99213	0.97	0.80	0.05	1.82
Lesion Removal	11100	0.81	1.75	0.08	2.64
Colonoscopy	45378	3.69	1.82	0.42	5.93
Total Hip Replacement	27130	21.79	13.26	3.08	38.13
EKG	93000	0.17	0.36	0.02	0.55
EKG – only interpretation	93005	0.00	0.29	0.01	0.30

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### Relative Value Unit

- Level 3 Office – 99213
- RVU 1.82
- Medicare Payment \$51.69 (approx)

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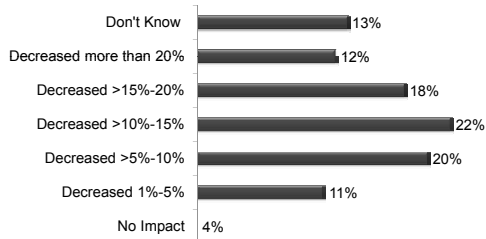
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### 2010 Elimination of Consults Affect on Revenue



AMA Survey April 2010

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### The Money

	Office Visits	Office Consultations	Difference
Level 1	15.05	38.33	23.28
Level 2	30.67	71.54	40.88
Level 3	51.69	98.23	46.56
Level 4	77.53	145.07	67.57
Level 5	104.51	178.29	73.81

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### Summary of 2010 CPT Changes to Consultations

- Transfer of care
- Consults for 2 reasons
- Documentation of request for consult
- Documentation of findings
- Emergency department
- Other E&M services before admission
- 2 consults in one day

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### OIG 2006 Study - Consultations

- Data from 2001
- Medicare inappropriately allowed \$1.1 billion
  - **75% of consultation services**
    - Wrong type or level of service
    - Did not meet definition
    - Lack of appropriate documentation
- Study of 400 Level 5 consultations



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### History Forms

- Compliant
- Clear
- Concise
  
- Correctly referenced

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Office Services  
Previously Consultations

- Code based on relationship with patient
  - **New (99201-99205)**
    - 3 year rule
  - **Established patients (99211-99215)**



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MCM Chapter 12 Section  
30.6.7

- Interpret the phrase “new patient” to mean a patient who has not received any professional services, i.e., evaluation and management service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.



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Office Services  
Previously Pre-Operative  
Consultations

- Code based on relationship with patient
  - **New (99201-99205)**
    - 3 year rule
  - **Established patients (99211-99215)**
  - Use “pre-operative clearance” diagnosis



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### Hospital Services Previously Consultations

- Think of admission codes Initial Encounter Codes
  - **99221-99223**
- First physician visit with a patient in the hospital is billed with an Initial Encounter Code
- Multiple physicians may bill Initial Encounter Codes
  - **Physician of record appends modifier**

*CMS* Centers for Medicare & Medicaid Services

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### Hospital Services Previously Consultations

- Code based on documentation of E&M Elements of visit
  - **History, Exam and Medical Decision Making**
    - Consultation coding had 5 levels of service
    - Initial Care Codes have 3 levels of service

*CMS* Centers for Medicare & Medicaid Services

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HOSPITAL INITIAL CARE	HISTORY	EXAM	MDM
LEVEL 1	Detailed or Comprehensive	Detailed or Comprehensive	Straightforward or Low
LEVEL 2	Comprehensive	Comprehensive	Moderate
LEVEL 3	Comprehensive	Comprehensive	High

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PATIENT:			DATE:	PHYS:
History	Prob Focused	Exp Prob Focused	Detailed	Comp
Exam	Prob Focused	Exp Prob Focused	Detailed	Comp
MDM	Straight-forward	Low	Mod	High
Where was E&M service performed				
Office ER	Unit Floor	NH	Was Pt seen on unit floor on date	YES NO
Requesting Physician		Admit Phys		Total Time

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### 3 Key Components

- History
- Examination
- Medical Decision Making
- *Contributing factors*
  - Time
  - Nature of Presenting Problem
  - Counseling/coordination of care

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**TIME**  
TWO KINDS

**1:35**

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**COUNSELING &  
COORDINATION OF CARE**

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**CPT - Time**

- When counseling and/or coordination of care constitute more than 50% of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or unit/floor time in the hospital or nursing facility) time may be considered the key or controlling factor to qualify for a particular level of E/M service.”

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**Medicare Policy  
PHYS - 001**

- In Office - Face to Face time
  - **Physician with patient**
- In hospital “unit floor” time
  - **Physician time with patient or on unit associated with patient**

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### Medicare Policy PHYS - 001



- “The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.”

*CMS* Centers for Medicare & Medicaid Services

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CPT CODE	TYPICAL TIME
Office	
New Patient	
99201	10
99202	20
99203	30
99204	45
99205	60
Office	
Est. Patient	
99212	10
99213	15
99214	25
99215	40

CPT CODE	TYPICAL TIME
Hospital	
Initial Care	
99221	30
99222	50
99223	70
Subsequent	
Hospital	
Care	
99231	15
99232	25
99233	35

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### CPT Assistant – August 2004

- “Counseling is a discussion with a patient and/or family concerning one or more of the following areas:
  - Diagnostic results, impressions and/or recommended diagnostic studies
  - Prognosis
  - Risks and benefits of management (treatment) options
  - Instructions for management (treatment) and/or follow-up
  - Importance of compliance with chosen management (treatment) options
  - Risk factor reduction
  - Patient and family education”




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**PROLONGED CARE**

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Office Services  
Previously Consultations

- Consider Prolonged Care codes where appropriate
  - **Bullet points determine code (i.e. 99213)**
  - **Time spent determines prolonged care**
  - **NOT same concept as “counseling & coordination of care”**

CMS / Centers for Medicare & Medicaid Services

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Prolonged Physician Services  
Office

- + 99354 – Prolonged physician service office or other outpatient setting: first hour
- + 99355 - each additional 30 minutes
  - **Face to Face time (CPT & CMS)**
  - **List separately in addition to code for office or other outpatient Evaluation and Management service**

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### Prolonged Physician Services Hospital

- + 99356 – Prolonged physician service inpatient setting: first hour
- + 99357 - each additional 30 minutes
- **Face to Face time (CMS)**
- **Unit Floor (CPT)**
- **List separately in addition to code for inpatient Evaluation and Management service**

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### Prolonged Care Hospital - Medicare

- “In the case of prolonged hospital services, time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient, or waiting for test results, for changes in the patient’s condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services. “




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### Why Consider Prolonged Care?

- **Prolonged Care Outpatient office RVU 2.69**
  - 99213 Established patient RVU 1.81
- **Prolonged Care Inpatient RVU 2.38**
  - 99221 Initial care day RVU 2.64

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### 45 Minute E&M Service

- If the dominate service has traditional elements of History, Exam and Medical Decision making.
  - **99213 (1.82) + prolonged service (2.69) = 4.51 RVU**
- Bill If the dominant service is counseling and time is the basis of the code selection
  - **99215**
  - **TOTAL 3.68 RVU**
- **Based on Documentation**



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### 80 Minute Service

- If the dominate service has traditional elements of History, Exam and Medical Decision making
  - **99222 (3.58) + prolonged care (2.38) = 5.86 RVU**
  - Published time 50 minutes
- 99253 Consultation - 3.22 RVU
- **BILL BASED ON DOCUMENTATION**



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### TIME

#### Prolonged Care

- Code selected based on requirements of elements of E&M visit
  - **History, Exam, MDM**
- Additional time spent face to face beyond published time for code
  - **Minimum 30 minutes beyond**
- E&M code billed and also prolonged care code

#### Counseling and Coordination of Care (C&C)

- More than 50% of face to face time spent in discussions with patient
- E&M Code selected based on total time of visit
- Documentation total time and % of time spent C&C
- May have elements of E&M in documentation

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Prolonged Physician Services

CPT CODE	TYPICAL TIME	THRESHOLD TO BILL PROLONGED
Office		
New Patient		
99201	10	40
99202	20	50
99203	30	60
99204	45	75
99205	60	90
Office		
Est. Patient		
99212	10	40
99213	15	45
99214	25	55
99215	40	70

CPT CODE	TYPICAL TIME	THRESHOLD TO BILL PROLONGED
Hospital		
Initial Care		
99221	30	60
99222	50	80
99223	70	100
Subsequent		
Hospital		
Care		
99231	15	45
99232	25	55
99233	35	65

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CRITICAL CARE TIME

**2 Part Form for chart note**

- Total Time\*
- Documentation of "critical diagnosis"
- Documentation of procedures
  - Time for each
- Charting time counts

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**SERVICES PERFORMED BUT FORGOTTEN**

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### Initial Prevent Physical Examination - IPPE

- Relative Value Units Increased in 2010  
↑1.12 units to 3.69



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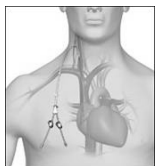
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### Lungs and Pleura

- 32552 - Removal of indwelling tunneled pleural catheter with cuff



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### Smoking Cessation



- **99406** - Smoking and tobacco use cessation counseling visit;  
– intermediate, greater than 3 minutes up to 10 minutes
- **99407** - intensive, greater than 10 minutes

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### Patient Education and Training

- 98960 – Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face to face with the patient each 30 minutes
- 98961 – 2-4 patients
- 98962 – 5-8 patients

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### Patient Education & Training

- Curriculum
  - “**curriculum that is intended to promote wellness, prevention, and delay comorbidities**”
    - CPT Assist
  - **Curriculum...treatment of established illness(s)/disease(s) or to delay comorbidity (s)**
    - CPT 2010

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### Patient Education & Training

- Qualifications of non-physician healthcare professional and the content of training
  - **consistent with guidelines or standards established or recognized by**
    - A physician society
    - Non-physician healthcare professional society/association
    - Other appropriate source

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Nurse Visits - 99211

- Services must be reasonable and necessary for diagnosis or treatment of illness or injury
- Medicare requires documentation of both elements
  - **Evaluation**
    - A clinically relevant and necessary exchange of information between the provider and the patient.
  - **Management**
    - Demonstrates influence on patient care.

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Nurse Visits - 99211

- "Incident to" service
  - **Plan of care must be in chart**
  - **Physician must be in office**



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Nurse Visits - 99211

- CERT errors
  - **Submitted documentation supports visit was for laboratory services only, without notation of other face-to-face services.**
  - **Documentation reviewed includes no supporting documentation or presenting problem/symptom or medical evaluation provided.**
  - **Documentation supports prothrombin anticoagulation check (CPT 85610) which is found billed separately for same date of service.**



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Nurse Visits - 99211

- CERT errors
  - "Patient had labs done only. Did not see the doctor."
  - Documentation consists of protime results and instructions on drug dosage.
  - Flow sheet received contains only the "results of the test, continue same, and check in 2 weeks."
  - Submitted documentation is insufficient to support minimal office visit. Received from follow up is a progress note indicating patient was notified of lab results.




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Parting Coding Tips  
Complex Patients

- Code with Specificity
  - DVT
  - HTN
  - DM
  - OA
  - H1N1
  - Chronic illnesses

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QUESTIONS???



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Thank you !

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