

Hot Topics in E & M Coding for the ID Practice



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Disclaimer

- This information is being presented based on the preliminary information that is currently available from CMS regarding consultation coding for 2010.
- It is your responsibility to stay informed over the next few weeks as additional information is made available via CMS transmittals, MedLearn articles, and information from your Medicare carrier. The most recent info:
 - Transmittal 1875 12/14/09
<http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf>
 - MedLearn Matters MM6740 12/14/09



Consultations 2010 ... CPT

- A consultation is a type of evaluation and management service provided by a physician at the request of another physician or appropriate source ***to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem***
- The written or verbal request for consult may be made by a physician or other appropriate source ***and documented in the patient's medical record by either the consulting or requesting physician or appropriate source.*** The consultant's opinion and any services that were ordered or performed must be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.
- Still cautioned about ***transfer of care***
- Billing for consultations based on new wording ***"on the unit"***

Consultations 2010 ...

Medicare

- Medicare has decided not to pay for consultations starting in 2010. Instead the RVU's have been reallocated and increased for the other visit codes.
 - **Office, use new or established patient visit codes (3 yr rule will apply)**
 - **Hospital and Nursing Facility, use admission codes**
- Office: Codes formerly used for consultation services 99241 – 99245 crosswalk exactly with documentation requirements of 99201 – 99205. If patient seen in last 3 years by physician of same group of same specialty, then use 99212 – 99215.
- Hospital and Nursing Facility: Codes formerly used for consultation services 99251 – 99255 ***do not crosswalk*** with admission codes (5 levels of consults versus 3 levels of admissions)



New vs. Est Patients

- Per CPT: Solely for purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by a physician and reported by a specific CPT code(s).



New vs. Est Patient

- Per CPT: A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.
 - Dr. ID1 saw the patient six months ago. Dr. ID2 is now seeing the patient for a totally different problem
 - Established patient to Dr. ID2
- Specialty designations, as recognized by Medicare

99201- 99205 New Patient Office/Other Outpatient Services (3/3 Key Elements)

99201	PF Hx	PF Exam	SF MDM	10 min.
99202	EPF Hx	EPF Exam	SF MDM	20 min.
99203	Detailed Hx	Detailed Exam	Low MDM	30 min.
99204	Comp Hx	Comp Exam	Moderate MDM	45 min.
99205	Comp Hx	Comp Exam	High MDM	60 min.



99211- 99215 Established Patient Office/Other Outpatient Services (2/3 Key Elements

99211	"nurse visit"			5 min.
99212	PF Hx	PF Exam	SF MDM	10 min.
99213	EPF Hx	EPF Exam	Low MDM	15 min.
99214	Detailed Hx	Detailed Exam	Moderate MDM	25 min.
99215	Comp Hx	Comp Exam	High MDM	40 min.



Hospital Admissions

- No three-year rule
- For Medicare, the admission code will be billed by the “physician-formerly-known-as-a-consultant” per hospital admission. Multiple physicians may be billing the 99221 – 99223 on the same patient. Admitting physician of record will use modifier -AI.
 - ID saw the Medicare patient during an admission six weeks ago. The patient is admitted again, the ID doc is “consulted” again (for the same or a different problem). ID doc bills 99221-99223.



Crosswalk Inpatient Consultations to Admission codes

99251	PF Hx	PF Exam	SF MDM	99499*
99252	EPF Hx	EPF Exam	SF MDM	99499*
99253	Det Hx	Det Exam	Low MDM	99221
99254	Comp Hx	Comp Exam	Moderate MDM	99222
99255	Comp Hx	Comp Exam	High MDM	99223



Inpatient Admissions

- CPT's intent of 99221 – 99223:
 - Report the first hospital inpatient encounter
 - Not necessarily the date of admission
 - Not used if patient seen subsequently that date and discharged
 - ***New for 2010, these are the codes recognized by Medicare for all physicians seeing the patient for the first time during a hospital stay***
 - ***Used in place of consultation codes***
 - ***If documentation is less than documentation requirements for 99221, use the unlisted code 99499***
 - ***Admitting physician of record will use modifier -AI***
 - ***Diagnosis coding issues ... medical necessity will prevail***



Inpatient Admissions

- 99221 requires
 - Detailed history and
 - Detailed exam and
 - Straightforward medical decision making
- 99222 requires
 - Comprehensive history and
 - Comprehensive exam and
 - Moderate medical decision making
- 99223 requires
 - Comprehensive history and
 - Comprehensive exam and
 - High medical decision making
- If documentation is less than that required for 99221, **code 99499 (unlisted E/M code) **Medicare contractors with varying instructions**



Modifier for Admitting Physician of Record

- What modifier should the admitting physician of record use?
 - AI is a new HCPCS modifier for “principal physician of record” **Confirmed in Transmittal 12/14**
 - Informational modifier
 - Specialist claims should not be held up if admitting physician of record forgets to use the AI
 - If AI is used unnecessarily, claims should not deny ... no edit in place currently



Questions

- Use of 99499 for what used to be 99251 and 99252 ... can Medicare handle all these claims that will need special processing?
 - Differing instructions from Medicare contractors
- Since Medicare will no longer recognize “consultations” ...
 - Will the “no shared/split consultation with NPP” go away?
 - Will there be any requirements regarding the documentation of the request or a report?



Coding for OBS patients

- Consultations for patients in OBS status
 - The ordering physician for the OBS status will use the OBS admission codes 99218 – 99220
 - The “specialist” will use the outpatient visit codes 99201 – 99215
 - Three year rule will apply



Medicare as Secondary Payor (MSP)

- **12/14/09 Transmittal states “these rules are applicable for Medicare secondary payer claims as well as for claims in which Medicare is the primary payer.”**
 - Read their options for suggestions on filing of claims appropriately
- Will other government payors follow Medicare’s lead on this ?
- What about Medicare HMO payors?
- Private Payors?



Scenarios

- On the next few slides, I have created some common scenarios. The answers are based on what we know today.



Scenarios

- Patient is seen by family practice for non-healing wound and sent on to the ID provider. FP does a request, ID does a report.
 - Non-Medicare Rules
 - Consultation (does not appear to be transfer of care)
 - Medicare Rules
 - New patient (unless seen in the past 3 years)



Scenarios

- ID is asked by Hospitalist (or Internist) to see patient in the hospital. ID provides opinion and report to Hospitalist (or Internist)
 - Non-Medicare Rules
 - Consultation 99251 - 99255
 - Medicare Rules
 - Admission code 99221 - 99223



Scenarios

- ID sees the established patient in the office for non-healing wound, which he plans to treat on an outpatient basis. A week later, the patient ends up in the ER with an exacerbation of the problem and is admitted by the family practice physician. The ID doc is asked to see the patient (again for the same problem) in the hospital.
 - Non-Medicare Rules
 - Subsequent hospital visit 99231 – 99233
 - Continuation of care from the office
 - Medicare Rules
 - Admission 99221 - 99223



Scenarios

- ID is asked to see the patient by the ED physician. After evaluating the patient, the ID doc reports to the ED physician that the patient does not need to be admitted and can be discharged from the ED
 - Non-Medicare Rules
 - Consultation 99241 – 99245
 - Medicare Rules
 - Outpatient visit 99212 – 99215 or **ER visit 99281 - 99285**



Scenarios

- ID is asked to see the patient by the ED physician. After evaluating the patient, the ID doc decides to admit the patient. The ID doc subsequently (same DOS) sees the patient on the floor.
 - Non-Medicare Rules
 - Admission 99221 – 99223
 - Medicare Rules
 - Admission 99221 – 99223 with modifier AI



Scenarios

- ID asked by Ortho to see the patient in consultation regarding management of patient's chronic conditions (ie HIV) following hip surgery.
 - Non-Medicare Rules
 - Transfer of care (never should have been coding these as consultations) Subsequent hospital visit 99231 – 99233
 - Medicare Rules
 - Admission code 99221 – 99223



Caution

- I have been receiving questions from physicians on how they can capture their former RVU's. Some are suggesting using more prolonged services or critical care in the hospital setting.
 - Comment: If the services didn't meet criteria for prolonged services or critical care before, they certainly won't now.
 - However ... that doesn't mean this isn't an educational moment for our physicians regarding the appropriate use of prolonged services and critical care codes. And we will be doing so towards the end of this presentation.



Implementation of this revised coding methodology

- Stay current with Medicare information over the next few weeks and months
- Be careful when “doing the math” ... redistribution of RVUs and assumptions made by CMS for budget neutrality. Watch for latest conversion factor information.
- Send inquiries to private payors on how they will be handling the consultation issue
- Track claims through your claims processing system
- Think about the best way to handle the attempt at cross-walking the codes
 - Front end?
 - Physician responsibility?
 - Back end?



Some reminders on E & M Coding and Documentation

- Medical Necessity and other documentation criteria
- 1995 and 1997 Documentation Guidelines
- History
- Examination
- Medical Decision Making
- Coding based on time instead
- Critical care and prolonged services



E/M Documentation

- **Medical Necessity**, above all else...
- Record must be complete and legible
 - Even the signature or identification
 - Signature log
- Record stands on its own...but can incorporate by reference



Templates and other tools

- History forms completed by patient or staff with past history, family history, social history, and system review
 - This information needs to be incorporated by reference appropriately
- Progress notes that prompt the provider of documentation requirements (and may reduce transcription costs)
- Build a helpful encounter form
 - New vs. established E/M codes don't crosswalk
 - Include all levels
 - Common procedures
- The electronic medical record



E/M Codes

- Evaluation and Management
- Determined by site of service
 - Office, outpatient
 - Observation
 - ED
 - Inpatient
- Categorized as new vs. established for office services
 - New if not seen within past three years by provider of same specialty in same group practice
- Categorized as initial vs. subsequent for hospital services



Differences in '95 and '97 versions of Guidelines

- Major changes in examination section
 - '95 is more general
 - '97 is very specific (bullets)
 - '97 contains specialty specific exams
- History section has one major change for '97
 - History: HPI can be status of 3 chronic or inactive conditions
 - Instead of the “usual” HPI elements of: location, quality, severity, duration, timing, context, modifying factors, associated signs/symptoms



3/3 or 2/3 ??

- Key components = history, examination, and medical decision making
- New patient visits, consultations, hospital admits are examples that require 3/3
- Established patient visits, daily hospital care are examples that require 2/3



History...HPI and ROS

- Based on Chief Complaint (CC), History of Present Illness (HPI), Review of Systems (ROS) and Past, family, social history (PFSH)
- Page 6 of DG:
 - Can incorporate by reference information recorded by ancillary staff or patient or information elsewhere in chart ... ROS and PFSH only
 - Update the information
 - Document date and location of that information
 - If unable to get history, say why
 - “all others negative” and “noncontributory”



History ...Past, Family, Social

- Only one item from an area is “required”
- For higher levels of care, some codes require something from all three history areas: past, family, and social



Examination

- 1995 guidelines are more generic by body system
- 1997 guidelines are very specific..the “bullets”
 - numeric requirements must be met
 - parenthetical examples are for clarification and guidance only
 - “and” really means “or”



Medical Decision Making

- Point system for number of dx/management options
 - More credit for new problems vs established problems
 - More credit for worsening established problem vs stable established problem
- Point system for data
 - Order or review: lab, X-ray, EKG, etc.
 - Extra credit if personally review image or test
 - Additional credit for discussing test results with another dr or obtaining hx from other than patient
- Table of Risk
 - Nature of presenting problem, diagnostic procedure(s) ordered, management option(s) selected
 - expand list of examples, especially high risk...specialty specific



Coding by time

- Time becomes the controlling factor (as opposed to history, exam, MDM) when:
 - Greater than 50% of the face-to-face time was spent counseling and/or coordinating care
 - Face-to-face time versus unit/floor time in hospital and nursing facility
 - Patient must be present !!
 - For example:
 - 99214 = 25 minutes
 - 99215 = 40 minutes



Critical Care

- 99291 for first hour; 99292 for each additional 30 minutes
 - See grid in CPT book for exact times
- Need to combine critical care time within a calendar day
- Can bill “regular” E/M additionally **IF** visit was earlier in day and later the patient required critical care. E/M code will need –25 modifier.
- Only one provider at a time
 - Documentation of time is very important to “prove” there is no overlap with another physician



Critical Care

- Patient must meet critical care criteria
 - “Critical care is the direct delivery by a physician of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition”
- Read the CPT book for further information on what are considered “critical care services”



Prolonged Services

- Add-on codes to your “regular” E/M service to indicate additional time spent with patient
 - For office, it’s face-to-face time
 - For hospital or nursing facility, it’s unit/floor time (that’s a change for 2009) However, Medicare still refers to it as face-to-face time.
 - Time does not need to be continuous
 - Multiple providers need to add their time together



Prolonged Services

- Office 99354 and 99355
 - 30-74 minutes = 99354
 - 75-104 minutes = 99354, 99355
 - 105+ minutes = 99354, 99355 x 2 (plus additional units of 99355 as appropriate)
- Inpatient 99356 and 99357
 - 30-74 minutes = 99356
 - 75-104 minutes = 99356, 99357
 - 105+ minutes = 99356, 99357 x 2 (plus additional units of 99357 as appropriate)
- The typical time specified for the base CPT code needs to be subtracted from the total time



Medicare Resources

- Prolonged Services
 - MLN Matters MM5972 7/1/08
 - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5972.pdf>

- Critical Care
 - MLN Matters MM5993 7/7/08
 - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5993.pdf>



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