Coding and Reimbursement: What You Don't Know Can Hurt You!!

Wendy L. Wright, MS, RN, ARNP, FNP, FAANP
Adult / Family Nurse Practitioner
Owner – Wright & Associates Family Healthcare
Partner – Partners in Healthcare Education

Objectives

- Upon completion of this lecture, the nurse practitioner will be able to:
  - Identify some of the most common CPT codes utilized in a primary care setting
  - Discuss ways to effectively code in order to optimize billing and collectibles
  - Identify common mistakes made with coding

Patient # 1

- Cc: Cold symptoms x 2 days
- 8 year old child presents today complaining of a runny nose-yellow discharge x 1 day. Began 2 days ago. Seems to be worsening. Has treated with OTC decongestants without relief. Now accompanied by fever or 99.2, 1 episode of vomiting last evening and a nonproductive cough. Feels miserable

ROS:
Ears-denies pain or discharge
Nose-denies sinus pain, Mouth- denies sore throat, Neck: denies stiffness
Skin: denies rash
Abd: denies pain, nausea, diarrhea; No vomiting since last evening.
Lungs: denies SOB, pain with inspiration
GU: Last urination 2 hours ago
PMH: Asthma
PFSH: No strep exposure; no one else ill; No cigarette exposure

Patient # 1

- Physical examination
  - 8 year old female in NAD; wd/wn; smiling and playing with sibling
  - VS: T 99.1; R: 18 even, nonlabored; pulse: 102; BP: 98/60; Weight; 87 pounds
  - Eyes: Conjunctiva with injection; no discharge; PERRL; EOMI
  - Skin: pink/warm/dry; no pallor or rashes
  - Ears: Canals/TMs normal
  - Nose: Turb/mucosa pink; clear discharge; sinuses nontender without erythema

Patient # 1

- Physical examination
  - Mouth: Mucosa moist; Post pharynx/tonsils pink; no exudate
  - Nodes: nonpalp,nontender
  - Lungs: clear to A & P
  - Heart: S1S2; RRR; no S3, S4, murmurs
  - Abdomen: Soft; + BS; no masses, tenderness, hsm, bruits, rebound, guarding
  - Neck: no rigidity

Diagnoses

- Viral URI-No need for antibiotics at this time
- Vomiting-1 episode; Most likely secondary to postnasal drip; well-hydrated at present; will continue to monitor
- Cough-most likely related to viral syndrome
- Asthma-appears to be stable but at risk for exacerbation given URI

How Would You Code This Visit?

- A. 99211
- B. 99212
- C. 99213
- D. 99214
- E. 99215

It Is Essential That The Nurse Practitioner Understand Coding Because…

- Proper coding can improve billables
- Proper coding can reduce the number of rejected claims
- Whereas, improper coding can cause the practice to be audited and potentially fined
- Improper coding can affect the practice's billables:
  - Either decreasing your billing inappropriately or…
  - Increasing your billing inappropriately which may result in substantial fines

Undercoding Can Really Cost the Practice

- Difference between: 99213 and 99214: $20.00
- 15 patients per day x $20.00 = 300.00:
- 4 days per week x $300.00 = 1200.00 / week
- $1200.00 per week x 50 weeks/year = 60,000.00 per year of lost revenue

Reality: Reimbursement from Medicare: Fee for Service

- 99211: $20.89
- 99212: $37.21
- 99213: $51.68
- 99214: $81.06
- 99215: $118.84

Here's the Latest

- Nurse practitioner's see: 11 – 20 patients daily
- NP's make approximately 65 – 70K yearly
- Average bill paid to NP's by Medicare: $39.00

Buppert, C. Lecture in Albany, NY on 03-25-06

Projected Yearly Income from NP

- 11 patients daily
  - 39.00 per visit; $100,815.00 yearly
- 20 patients daily
  - $39.00 per visit; $183,300.00 yearly

Buppert, C. Lecture in Albany, NY on 03-25-06

What Are We Looking At For Profit?

- Collectables: 183,300.00
- Salary: 70,000
- Benefits: 17,500
  - (25% of pay)
- Overhead: 70,000
  - (same as salary for assistants, rent)
- Profit: $25,800

Why Are Nurse Practitioner's Let Go??

- Collectables: 100,815.00
- Salary: 70,000.00
- Benefits: 17,500.00
- Overhead: 70,000.00
- Profit: NONE
  - Loss of 56,685.00

How Can We Generate More?

- More patients?
  - NO!!!!!!
- Better coding and reimbursement?
- Higher level visits?
- Keeping more procedures in house?

Terminology

Codes Are Divided Into Three Levels

- Three levels of codes
  - Level I: CPT-4 Codes
    - E&M Codes (Medical evaluation and surgical procedures)
  - Level II: National Codes
    - Expanded codes that allow you to charge for supplies
  - Level III: Local Codes
    - 5 digit alpha-numeric code, starts with the letter W, X, Y or Z
    - Allow the Medicare carrier to identify items that are endemic to a particular geographic region or locality
    - W9005: Follow-up on an emergency room visit

CPT-4 CODES

- Current Procedural Terminology (CPT) is a national system utilized to identify and bill for particular services or procedures
- Developed by the American Medical Association and the Health Care Financing Administration (HCFA) **No longer called HCFA
  - Center for Medicare and Medicaid Services
- Has been adopted by Medicare and third party payers I.e. insurance companies
- Each insurance company, including Medicare, has a corresponding fee attached to each CPT code

Medicare

- Medicare reimburses or pays less for diagnoses such as depression, anxiety, bipolar disorder
- The patient has an increased payment responsibility with these diagnoses

CPT – 4 CODES

- Always a five digit code
- Code ranges from 99201 – 99499
- These codes are often referred to as E&M codes
  - Evaluation and Management Coding
  - These particular codes represent a health care provider's cognitive services (office/clinic visits), consultations, preventive medication examinations and critical care services
  - This is the code used when you take a history, perform an examination, make a diagnosis and then…recommend treatment

Additional E & M Codes

- In addition to the E&M codes utilized for office visits, you will also use other CPT – 4 codes to bill for various procedures
- Each specialty has a corresponding set of numbers:
  - Anesthesiology: 00100-01999 and 99100 – 99140; Surgery: 10040-69979; Radiology: 70010 to 79999; Pathology and Laboratory: 80002-89399; Medicine: 90701-99199
  - Examples would include:
    - Suturing: 12001 (Simple repair), irrigation of ear wax (69210), audiometry (92552) and nebulizer treatments (94664)

ICD-9 Code

- Code used to indicate a particular medical diagnosis
- All medical diagnoses have a 3-6 digit code
  - I.e. Diabetes: 250; Chronic Renal Failure: 585
- The more digits present, the more specific the code
- In general, the more specific the code, the more accurate the coding.

Coding a Visit

- When you code a visit using an E&M code, it is important to make sure that the ICD-9 codes is/are consistent with the E&M code
  - For instance, you can not bill a high level visit (99214) and then use an ICD-9 for a viral pharyngitis
  - Well….you can do this but you better have documentation to support this in the event of an audit

Words of Warning

- Only include the diagnosis or diagnoses (ICD-9) being addressed at that visit:
  - Many people believe that by adding diagnoses you can justify the increase in billing/receivables
  - This is NOT true
    - You must have documentation from that visit to support each of those diagnoses
      - Only include secondary diagnoses if they influence the patient's current problem or if you addressed them and documented it

Other Words of Warning

- Many insurances do not reimburse for diagnoses such as:
  - Obesity
  - Tobacco Use
  - Presbyopia
    - "Ophthalmology" code

Another Word of Warning

- Only you should be coding your visit
  - No one should be reviewing the super bill or encounter sheet and making changes without your knowledge
- You are responsible for the billing done on your behalf so you better have a clear understanding of what is being done by the medical biller or billing company

Specific Evaluation and Management Codes (E and M Codes)

Evaluation and Management Services

- The descriptors for the levels of E&M services recognize 7 components which are used in defining the levels of E&M services:
  - History
  - Physical Examination
  - Medical Decision Making
  - Counseling
  - Coordination of Care
  - Nature of the Presenting Problem
  - Time (Least important component)

Evaluation and Management Services

- History
- Physical Examination
- Medical Decision Making

**These 3 components are the key components in selecting the level of E/M services

Of Secondary Importance…

- Counseling
- Coordination of Care
- Nature of the Presenting Problem
  - These are of secondary importance

**Time, as previously mentioned, is the least important component

These Are The Things We Do Every Day.

Now...We Just Have To Document Them Appropriately In Order To Get Reimbursed Correctly

History

- The E&M Codes as they pertain to history are based upon four components of the history.
- History is comprised of:
  - Chief complaint
    - Document what the person is in for!
  - HPI
    - Location
    - Quality
    - Severity
    - Duration
    - •Timing
    - •Context
    - •Modifying factors
    - •Associated signs and symptoms

History

- History is comprised of:
  - ROS
  - Past History, Family History and/or Social History
    - Only as these pertain to their HPI

  **It is the thoroughness and number of the above that you perform that determines your type of history for which you code

Components	99211	99212	99213	99214	99215
History					
CC/HPI (8)		Cc/1 – 3	Cc/1 – 3	Cc/4 or >	Cc/4 or >
ROS (14)		N/A	Problem Pert	2 – 9	10 or >
PMFSH		N/A	N/A	1 of 3	3 of 3

Established Patient: Must meet or exceed 2 of 3 sections
New Patient: Must meet or exceed 3 of 3 sections

Physical Examination

- The physical examination coding is divided into two categories: **General Multi-System Exam (GMSE)** or a Specialty Exam
- The body is divided into organ systems
  - Constitutional, ENMT, Eyes, Cardiovascular, Gastrointestinal, Musculoskeletal, Neurologic, Psychiatric, Hematologic/Lymphatic/Immunologic, Respiratory, Skin, GU – Male and Female

Physical Examination

- The physical examination coding is divided into two categories: **General Multi-System Exam (GMSE)** or a Specialty Exam
- It is the number of "bullets" in each of these sections performed by you that determine the level of the physical examination

Constitutional

- Bullets: must measure any 3 of the following 7 vital signs
  - Sitting or standing blood pressure
  - Supine blood pressure
  - Pulse rate and regularity
  - Respiration
  - Temperature
  - Height
  - Weight
  - May be obtained by the ancillary staff
- General appearance of the patient
  - Development
  - Nutrition
  - Habitus
  - Deformities
  - Attention to Grooming

Eyes

- Bullets
  - Conjunctivae and lids
  - Pupils and irises (reaction to light etc)
  - Ophthalmoscopic examination

ENT

- Bullets
  - Inspection of ears and nose
  - Otoscopic examination of canals and tympanic membrane
  - Hearing
  - Inspection of nasal mucosa, septum, and turbs
- Bullets continued
  - Inspection of lips, teeth and gums
  - Examination of the oropharynx

Physical Examination

- The levels of the E&M codes are based on 4 levels of physical examination:
  - Problem – Focused (99212):
    - Specialty exam: Limited examination of the affected body area or organ system
    - GMSE: 1-5 bullets in 1 or > organ systems or body areas
  - Expanded Problem-Focused (99213)
    - Specialty exam: As above, plus any other symptomatic or related body area or organ system
    - GMSE: 6 bullets in 1 or > organ systems or body areas

Physical Examination

- Detailed (99214)
  - Specialty exam: An extended examination of the affected body area or organ system or any other symptomatic or related body area or organ system
  - GMSE: 6 or > organ systems or body areas with at least two bullets addressed per system (12 items)
- Comprehensive (99215):
  - Specialty exam: A general multisystem evaluation or a complete examination or a single organ system
  - GMSE: 9 or > organ systems with at least 2 bullets per system (18 items)

Physical Examination Components

Components	99211	99212	99213	99214	99215
Physical Examination GMSE	Provider presence not required	1 – 5 bullets in 1 or > organ systems	6 – 11 bullets in 1 or > organ systems	2 bullets in 6 organ systems or 12 bullets	2 bullets in 9 organ systems or 18 bullets

Complexity or Level of Medical Decision Making

- This is probably the most difficult or nebulous section of the coding
- Complexity of decision making is broken down into 4 levels:
  - Straightforward
  - Low Complexity
  - Moderate Complexity
  - High Complexity

Complexity of Medical Decision Making

Number of Dx or Management options	Amt +/or Complexity of Data	Risk of complications +/or morbidity	Type of Decision Making
Minimal 99212	Minimal or none	Minimal	Straightforward
Limited 99213	Limited	Low	Low complexity
Multiple 99214	Moderate	Moderate	Moderate complexity
Extensive	Extensive	High	High complexity

At least 2 of 3 criteria must be met to code for that level of complexity

Established Patient: Must meet or exceed 2 of 3 sections					
Components	99211	99212	99213	99214	99215
History CC/HPI (8) ROS (14) PMFSH		1 – 3 N/A N/A	1 – 3 Problem Pert N/A	4 or > 2 – 9 1 of 3	4 or >10 or >3 of 3
Physical Examination GMSE	Provider presence not required	1 - 5+	6 - 11	2 bullets in 6 areas or 12 bullets	2 bullets in 9 areas or 18
Decision Making # of Dx Amt/complexity Risk of compli-cations		1 None Minimal	2 Limited Low	3 Moderate Moderate	4 Extensive Extensive

Let's Take A Look At Some Coding...

Office Visits (E&M Codes)

- E&M Codes are separated into new patients and established patients
  - Reimbursement is higher for new patients
  - Please remember, a patient can be considered new if…he or she has not been seen in the facility within the past 3 years

For Instance…

- 99201: New patient code (equivalent to 99211 code)
  - In order to code for this level in a new patient, 3 out of the 3 criteria must be met or exceeded

New patient: Must meet or exceed 3 of 3 sections					
Components	99211	99212	99213	99214	99215
History CC/HPI (8) ROS (14) PMFSH		1 – 3 N/A N/A	1 – 3 Problem Pert N/A	4 or > 2 – 9 1 of 3	4 or > 10 or >
3 of 3
Physical Examination GMSE	Provider presence not required	1 - 5+	6 - 11	2 in 6 areas or 12 bullets	2 in 9 areas or
18
Decision Making # of Dx Amt/complexity Risk of complic		1 None Minimal	2 Limited Low	3 Moderate Moderate	4 Extensive Extensive

Established Patient Codes

- 99211
  - May not require the presence of a clinician
  - Presenting problems are minimal
  - 5 minutes spent performing these services
  - We use this for nurse visits
    - Example: Vitamin B12 injection by nursing staff; Dressing change; Allergy injection, Nurse confirms a rash has disappeared and gives note to return to school; Read PPD, Blood pressure check; Peak flow meter check

Comparison of Requirements

Level of Visit	History	Exam	**Dx	**Data Reviewed	**Risk
99211	None	None	None	None	None
99212	1 descriptor	1bullet in 1 or more systems	1 minor or established	Order or study 1 lab	1 minor prob Noninv labs
99213	1 descriptor 1 ROS	6 bullets in 1 or more systems 6	2 minor or estab; or 1 new	Order or study 2 labs; or review old records	2 minor; 1 chronic stable or 1 acute
99214	4 descriptors 2 ROS 1 PFSH	2 bullets in 6 systems or more 12	1 new or 1 worse and 1 minor	Order or study 3 labs, or order 1 lab and summarize	1 chronic problem – worse; 1 chronic stable & 1 acute
99215	4 desc, 2 PSFH, 10 ROS	2 bullets in 9 systems 18	1 new	4 labs	1 severe chronic, 1 life threatening

Additional Codes, Rarely Utilized, That May Significantly Increase Your Billables

Modifiers

Modifiers

- These are used by health care providers to indicate that a particular service or procedure has been modified by some special circumstance but not changed in its definition
  - Service or procedure was performed by more than one provider
  - Only part of a service was performed
  - Unusual events occurred

Modifiers can also be used to...

- Indicate that a service or procedure has both a professional and technical component
- Service or procedure has been increased or decreased
- Bilateral procedure was performed
- Service or procedure was provided more than once

Modifier 25

- Modifier 25 is utilized for the following conditions:
  - Condition 1: If the nurse practitioner is performing some type of preventive service, I.e. a physical examination, and encounters a problem or abnormality that is significant enough to require additional work to perform the key components of a problem oriented E/M service, then the appropriate code can also be used

Examples From My Practice

- 52 year old man presents for a complete physical examination. Needs to renew his antihypertensive medications. On ROS: Increasing urination, polyphagia and a 45 pound weight loss within the last 3 months
- Last physical examination: approximately 10 years ago despite encouragement from previous physicians

Mr. H's Physical Examination Findings

- BP 124/80; Weight 208 pounds
- Pulse: 108 and regular
- Heart: S1S2; RRR; +S4; No murmurs or S3
- Lungs: clear
- Eyes: PERRLA; Fund: Optic disc: round, regular; No cupping. Retina: pink; no exudates or hemorrhages
- PV: DPPT: 2+ bilaterally
- Neuro: Sensation intact to light touch and vibration
- Urine dip: 4+ glucose; no ketones
- Finger stick: 448

Mr. H

- Codes utilized: Complete physical examination
- And...
  - Modifier 25 plus 99214 code because of his new onset Type 2 diabetes

Another Example

- The nurse practitioner sees the patient for a follow-up of his hypertension and diabetes. During the visit, the patient mentions an abnormal nevus that seems to be enlarging
  - During the visit you examine it and feel very strongly that it is a melanoma
  - You decide to biopsy that day

You can...

- Code the visit as a 99213 using the diagnostic code: Diabetes and Hypertension
- Add a modifier 25 and also bill for the surgical procedure during the same visit

It is Essential to Remember...

- An insignificant or trivial problem or abnormality that is encountered in the process of performing the preventive evaluation and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported

Additional Modifiers

- Modifier 50: bilateral procedure
  - Bilateral digital block for lacerations of index fingers on both hands
- Modifier 21: Prolonged Evaluation and Management Services
  - When the face-to-face services provided is prolonged or greater than that usually required for the highest level of evaluation and management service within a given category
- Modifier 51: Multiple Procedures
  - Cryosurgery for verruca vulgaris
  - Biopsy of an abnormal nevus
  - Shave excision for infected nevus

Billing for Outpatient Procedures

- It is essential to provide the billing company with as much information as possible regarding the procedure
  - For instance: skin tag vs. seborrheic keratosis vs. basal cell vs. squamous cell vs. malignant melanoma
  - With skin tag removals, the person is billed based upon the number of skin tags removed. Therefore, important to keep count of the numbers removed.
    - 11200: Removal of skin tags up to 15 lesions
    - 11201: each additional 10 lesions
  - Abscess I & D: give type of cyst and location

Billing of Outpatient Procedures

- Important to also give details as to how the lesions are removed:
  - For instance:
    - Shave excision (give size of lesion and location)
      - 11300: Shaving of dermal lesion on trunk, arms or legs: <0.5 cm
      - 11301: lesion diameter: 0.6 – 1.0 cm
      - 11305: Shaving of a dermal lesion on scalp, neck, hands, feet, genitalia: <0.5 cm
    - Lesion Destruction: Give type of lesion (benign vs. malignant and location)
      - Also want to give the number of lesions destroyed through procedure such as cryosurgery or electrocautery

Excision: Malignant Lesion

- Code is dependent upon size of lesion
  - Therefore, need to provide a good estimation of the lesions diameter
    - 11600: lesion < 0.5 cm
    - 11601: lesion: 0.6-1.0 cm
    - New information: diameter can now include margins

Don't Forget....

- Specimen handling fee for any specimen that gets handled/prepared: 99000
  - Pap
  - Throat culture
- Immunization administration fee: 90471
- Injection administration fee: 90772
- Collect capillary blood: 36416
- Collect venous blood: 36415
- Occult blood: 82270
- Wet mount: 87210

Remember....

- Medicare does not reimburse for preventative services i.e. physical examinations
- It is wrong to use and E&M code (i.e. 99213) code to get it covered if you performed a physical examination

Only Exception....

- New Patient Physical – "Welcome to Medicare"
  - Must be done within 6 months of beginning Medicare
  - G0344, Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first six months of Medicare enrollments.
  - Electrocardiogram, routine ECG is no longer part of this PE
- IMPORTANT – MUST BILL under the number of the person actually doing the physical examination.....

Incident to....

"Incident to" Services

- Incident to...means incident to a physician's professional service
- Only utilized for the Medicare system
- This can be utilized with or without the nurse practitioner having obtained a Medicare number
- The nurse practitioner must be an employee of the physician or the physician group

"Incident to" Services

- In order to qualify for this service, the nurse practitioner must provide these services under a physicians direct personal supervision
  - Three O's
    - Old patient
    - Old Problem
    - On Site

Let's Talk About Incident To...

- Examples:
  - Nurse practitioner wants to bill all services under a physician's number using the incident to code:
    - Think about this realistically
    - This gives the practice an additional 15% beyond what the nurse practitioner would receive with his/her own number but...
    - What happens if the physician is late?
    - What happens if the physician is called out of the office?
    - What happens if the patient mentions a sore throat in the course of a visit?

Continued...

- Also...
  - Because the visit is incident to a physician, the nurse practitioner is really only able to use 99211 or 99212 code; very rarely 99213 (very few follow-ups deserve a 99213 or higher code).
    - Billing incident to with high level codes frequently signals for an audit
  - Most nurse practitioners on their own use 99213 and above for codes
  - In fact, using this code regularly may significantly decrease your revenue...not increase it.

Here's What We Do...

- The billing company is instructed to never use incident to unless the NP instructs them to do so
- We all have our own Medicare billing number and will occasionally see a patient in follow-up for the physician
- It is then that we will instruct the company to bill using the incident to modifier

Remember

- Incident to...can never be used to bill for an inpatient service
  - It is a code that only applies to billing in an outpatient "clinic" setting

Home Visits

- It is permissible to bill "Incident to" for home visits but both the nurse practitioner and the physician must be in the patient's home

Long Term Care Facilities

- It is possible to bill "Incident to" in Long-term care facilities but:
  - 1. The visit must be done in an "office" within the facility
  - 2. Both the physician and the nurse practitioner must be present with the patient

Documentation

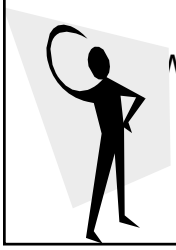
- Now that we have spent this time discussing the various ways to bill and code, I would be remiss if I did not emphasize how important it is to make sure that your documentation matches your level of coding
- If you are ever audited and the documentation fails to match your coding consistently, you may be accused of Medicare/Medicaid fraud

"The single most important component of reimbursement is the requirement for accurate documentation of what the clinician sees and does."

Mazzocco, W. Key Elements of Reimbursement Coding: A Guide for Nurse Practitioners; Advance for Nurse Practitioners; Sept 2001

How Can You Simplify the Coding Process?

- Use reference sheets to scan for physical examination and medical decision making/complexity rather
- Using handwritten notes, it is very hard to accurately document the criteria necessary to meet the various levels
  - Consider dictation
  - Consider forms



Remember...
with the IRS, ignorance is not a good defense

How Did You Code the Child?

- A. 99211
- B. 99212
- C. 99213
- D. 99214
- E. 99215

What Would You Code This Visit As?

- Most NP's would code a 99213:
- I would code it as a 99214

- CC/HPI: 4 or more components
- ROS: 2-9 body systems
- PMFSH: 1 out of the 3
- Physical exam: 2 components in 6 areas (12)
- Decision making: multiple (3);
- **Must meet or exceed 2 out of 3 of these

Established Patient: Must meet or exceed 2 of 3 sections					
Components	99211	99212	99213	99214	99215
History CC/HPI (8) ROS (14) PMFSH		1 – 3 N/A N/A	1 – 3 Problem Pert N/A	4 or > 2 – 9 1 of 3	4 or >10 or >3 of 3
Physical Examination 97 Multisystem Exam	Provider presence not required	1 - 5+	6 - 11	2 in 6 areas or 12	2 in 9 areas or 18
Decision Making # of Dx Amt/complexity Risk of complic		1 None Minimal	2 Limited Low	3 Moderate Moderate	4 Extensive Extensive

Undercoding Can Really Cost the Practice

- Difference between: 99213 and 99214: $20.00
- 15 patients per day x $20.00 = 300.00:
- 4 days per week x $300.00 = 1200.00 / week
- $1200.00 per week x 50 weeks/year = 60,000.00 per year of lost revenue

Happy Coding!

Any Other Thoughts Regarding Improving Your Billables?

Thank You

I Would Be Happy To Entertain Any Questions

Wendy L. Wright, ARNP

(W) 603-472-7097
email: WendyARNP@aol.com
www.4healtheducation.com