CODING AND BILLING
The link between documentation and reimbursement potential
Marianne Buzby, MSN, CPNP-PC

CONFLICT OF INTEREST DISCLOSURE

Conflict(s) of Interest
None
Marianne Buzby

A conflict of interest exists when an individual is in a position to profit directly or indirectly through application of authority, influence, or knowledge in relation to the affairs of PENS. A conflict of interest also exists if a relative benefits or when the organization is adversely affected in any way.

OBJECTIVES

• Review general principles of Evaluation and Management (E/M) documentation
• Describe in detail the categories and elements used to select the appropriate level of service
• Audit Case Studies
GENERAL PRINCIPLES

• Medical record should be complete and legible
• Documentation should include:
  • Reason for encounter
  • Relevant history, physical exam, and prior diagnostic test results
  • Assessment, clinical impression/diagnosis
  • Medical plan of care
  • Date and signature
  • Rationale for diagnostics and other services ordered
  • Health risk factors
  • Progress, response to treatments, revised diagnoses
  • Diagnosis and treatment codes

COMMON SETS OF CODES

• CPT = Current Procedural Terminology
  • Used to report care provided by a medical provider
  • Updated every October
  • Maintained by AMA (American Medical Society)
  • Sections
    • Evaluation and Management
    • Anesthesia
    • Radiology
    • Pathology
    • Medicine

COMMON SETS OF CODES

• E/M codes = Evaluation and Management Codes
  • Category 1 of CPT codes
  • Patient type:
    • New/established patient
  • Site of service
    • Office/outpatient
    • Hospital: observation, inpatient
    • Emergency Department
    • Home health care
    • Rest home, boarding home, assisted living
  • Type of visit
    • Consultation
    • Critical Care: adult, pediatric, neonatal
    • Prolonged services
    • Preventive Medicine
    • Non-face-to-face
    • Complex chronic care coordination
COMMON SETS OF CODES

• HCPCS = Healthcare Common Procedural Coding System
  • Codes used to identify procedures, services, drugs, and devices provided to the patient
    • Ambulance services
    • Durable medical equipment (DME)
    • Prosthetics
    • Orthotics
    • Supplies used outside office
  • Level 1 codes are the CPT codes developed and maintained by AMA
  • Level 2 codes are divided into sections based on specialty, developed and maintained by CMS
    • “E” codes for DME (i.e., Blood glucose monitors)

COMMON SETS OF CODES

• ICD 10 = International Classification of Diseases 10th revision
  • Diagnosis codes
    • Maintained by WHO (World Health Organization)
    • 68,000 codes, new ones added Oct 1 each year
    • Need to code to the highest level of specificity
    • Begin with a letter, usually 3-7 characters

HOW DO WE IMPLEMENT THESE CODES?

Documentation guidelines:
• Provide a framework for documentation of E&M services
• Implemented in 1995
• Revised in 1997
  • Chronic conditions were added to the history
  • Physical exam requirements are different
COMPONENTS OF E&M SERVICES

• New versus established patient
• History
• Physical exam
• Medical decision making
• Appropriate level of service for the care provided
  • Must include a CPT for E&M services, and ICD code
  • May include CPT procedure codes as well

NEW VS ESTABLISHED PATIENT

• New patient has not received services from the billing provider or another provider in the same practice plan within the past 3 years
• Establish patient has received services from the billing provider or another provider in the same practice plan within the past 3 years

HISTORY COMPONENT SUBCATEGORIES

• History of present illness (HPI)
• Review of systems (ROS)
• Past, family, and social history (PFSH)
**HISTORY OF PRESENT ILLNESS**

- Chief Complaint (CC)
- History of Present Illness (HPI)
  - Acute
    - Location
    - Quality
    - Severity
    - Duration
    - Timing
    - Context
    - Modifying factors
    - Associated signs and symptoms
  - Chronic
    - Number of chronic conditions
    - Status of chronic conditions

**REVIEW OF SYSTEMS (ROS)**

- Constitutional
- Psychiatric
- Eyes
- ENT
- CV
- Respiratory
- Skin
- GI
- GU
- Endocrine
- Musculoskeletal
- Allergy/Immunology
- Neurologic
- Hematologic

**PAST, FAMILY, AND SOCIAL HISTORY**

- Past medical: illnesses, operations, injuries, treatments
- Family: medical events in the patient’s family including diseases that may be hereditary or place the patient at risk
  - 3 generations
- Social: “age appropriate” review of past and current activities
  - Who do you live with?
  - What grade are you in school?
  - Activities (clubs, sports, etc) outside of school
HISTORY: LEVEL OF SERVICE

- Level of service is determined by the number of items documented in each subcategory

<table>
<thead>
<tr>
<th>History: Level of Service</th>
<th>HPI</th>
<th>ROS</th>
<th>PPHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-focused</td>
<td>1-3 elements</td>
<td>Not required</td>
<td>Not required</td>
</tr>
<tr>
<td>Expanded problem-focused</td>
<td>1-3 elements</td>
<td>1 system</td>
<td>Not required</td>
</tr>
<tr>
<td>Detailed</td>
<td>4 or more elements</td>
<td>2-3 systems</td>
<td>1 area</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>4 or more elements</td>
<td>10 or more systems</td>
<td>2 or more areas</td>
</tr>
</tbody>
</table>

PHYSICAL EXAM: SUBCATEGORIES

- The body areas:
  - Head, including face
  - Neck
  - Chest including breasts and stethescope
  - Abdomen
  - Extremities
  - Genitalia, groin, buttocks
  - Ear, nose, mouth

- The organ systems:
  - Cardiovascular
  - Respiratory
  - GI
  - Gyn/obstetric
  - Neurological
  - Rheumatological
  - Psychiatric
  - Skin/physial/immunological

PHYSICAL EXAM

- A brief notation indicating “normal” or “negative” is sufficient to document normal findings
- “Abnormal” findings should be described
- Documentation for each element must satisfy any numeric requirements (3 vital signs)
- Elements with multiple components but with no specific requirements (such as exam of liver and spleen) require documentation of at least one component
PHYSICAL EXAM: LEVEL OF SERVICE

<table>
<thead>
<tr>
<th>Level of Service</th>
<th>Number of Body Areas/Organ Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-focused</td>
<td>5-10 elements in one or more organ systems or body areas</td>
</tr>
<tr>
<td>Expanded problem-focused</td>
<td>At least 6 elements in one or more organ systems or body areas</td>
</tr>
<tr>
<td>Detailed</td>
<td>Includes at least 1 organ system or body area. For medicine or system sections, documentation of at least two elements is expected. Alternatively, may include documentation of at least 15 elements within two organ systems or body areas.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Includes at least 9 organ systems or body areas. For each system or organ section, documentation of at least two elements is expected.</td>
</tr>
</tbody>
</table>

“Rule of Sixes”

- Problem-focused: <6 (1-5) bullets in 1+ system
- Expanded problem-focused: 6-11 bullets in 1+ system
- Detailed: 12+ bullets in 2+ systems
- Comprehensive: 18+ bullets in 9+ systems

MEDICAL DECISION MAKING SUBCATEGORIES

- Options for diagnosis or management considered
- Data reviewed
  - Amount and complexity of medical records, diagnostic tests and/or other information that must be obtained, reviewed and analyzed
- Risk
  - Risk of significant complications, morbidity and/or mortality as well as comorbidities associated with the patient’s presenting problems, diagnostic procedures, and/or possible management options
**FINAL SCORE**

**MEDICAL DECISION MAKING: LEVEL OF SERVICE**

<table>
<thead>
<tr>
<th>Type of Medical Decision Making</th>
<th>Options for Diagnosis or Management</th>
<th>Data Reviewed</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Multiple</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

**BRINGING IT ALL TOGETHER:**

**SELECTING THE APPROPRIATE OFFICE VISIT CODE**

- **Office Visit CPT Coding Guidelines - New Patient**

- **Office Visit CPT Coding Guidelines - Established Patient**
LET'S PRACTICE

HISTORY COMPONENT

Name: J.B. Date: 4/26/2019

Chief Complaint: 14 year old male with Type 1 Diabetes Mellitus diagnosed on or about the age of 7 years 5 months, active at diagnosis, no blood sugar data, 26.1 kg, vital signs normal, J.B. is able to perform routine activities with little difficulty. Since diagnosis, J.B. has been treated with insulin injections and oral hypoglycemic agents.

Allergies: None.

Medication: Started insulin therapy on 1/1/2019. Since J.B.'s last visit on 1/2/2019, he has had the following changes in his insulin regimen:

- Insulin: Regular
- Dosage: 40 units q.d.
- Frequency: 3 times daily
- Other: None

Hypoglycemia: Since J.B.'s last visit, he has had mild episodes of hypoglycemia requiring glucose or carbohidrates.

Ketones: None.

ROS COMPONENT

PFSH COMPONENT

Family History: No changes in the family medical history since the last visit.

Behaviors: No substance use.

Risk Factors: No smoking or alcohol use.

Past Medical History:

- Headaches: None
- Skin: None
- Oral: None
- Gastrointestinal: None
- Respiratory: None
- Cardiovascular: None
- Neurological: None
- Renal: None
- Musculoskeletal: None
- Dermatological: None
- Endocrine: None
- Psychosexual: None

Presenting Symptoms:

- Headache: None
- Fatigue: None
- Angina: None
- Dyspnea: None
- Constipation: None
- Diarrhea: None
- Hemorrhoids: None
- Night sweats: None
- Pain: None
- Orthostatic hypotension: None
- Skin findings: None

Physical Examination:

- Vital Signs: BP 120/80, HR 70, RR 14, temperature 98.6°F
- Head: Normal cranial nerves, no masses, no scalp tenderness
- Eyes: Normal, no conjunctival injection
- Ear: Normal, no discharge
- Nose: Normal, no deviations
- Throat: Normal, no tonsillar enlargement
- Neck: Normal, no masses
- Chest: Normal, no wheezing
- Heart: Normal, no murmurs, no gallops
- Abdomen: Soft, nontender, no masses
- Back: Normal, no tenderness
- Extremities: Normal, no edema
- Neurological: Normal, no motor or sensory deficits

Laboratory:

- Blood glucose: 100 mg/dL
- Hemoglobin A1c: 7.5%
- Lipid panel: Total cholesterol 180 mg/dL, HDL 45 mg/dL, LDL 100 mg/dL
- Thyroid function tests: Normal

Other:

- Exercise: Regular
- Diet: Healthy
- Smoking: No
- Alcohol: No
- Stress levels: Low
- Sleep: adequate

Plan:

- Continue insulin therapy: Regular 40 units q.d.
- Monitor blood glucose levels:
  - Before meals
  - 1 hour after meals
  - Before bedtime
- Reassess in 3 months for further adjustment of treatment plan.
WHAT IS THE LEVEL OF SERVICE FOR HISTORY IN THIS DOCUMENTATION?

<table>
<thead>
<tr>
<th>Level of Service</th>
<th>NHF</th>
<th>ROS</th>
<th>PFSU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-focused</td>
<td>1-3 elements</td>
<td>Not required</td>
<td>Not required</td>
</tr>
<tr>
<td>Expanded problem-focused</td>
<td>1-5 elements</td>
<td>1 system</td>
<td>Not required</td>
</tr>
<tr>
<td>Detailed</td>
<td>4 or more elements</td>
<td>2-3 systems</td>
<td>1 area</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>4 or more elements</td>
<td>15 or more systems</td>
<td>2 or more areas</td>
</tr>
</tbody>
</table>

PHYSICAL EXAM COMPONENT

WHAT IS THE LEVEL OF SERVICE FOR THE PHYSICAL EXAM IN THIS DOCUMENTATION?

<table>
<thead>
<tr>
<th>Exam Level of Service</th>
<th>Number of Body Areas/Organ Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-focused</td>
<td>Includes at least 5 organ systems or body areas. For each area or system selected, documentation of at least two elements is expected. Alternatively, may include documentation of at least 12 elements within two organ systems or body areas.</td>
</tr>
<tr>
<td>Expanded problem-focused</td>
<td>At least 15 elements in one or more organ systems or body areas</td>
</tr>
<tr>
<td>Detailed</td>
<td>Includes at least 8 organ systems or body areas. For each area or system selected, documentation of at least two elements is expected. Alternatively, may include documentation of at least 12 elements within two organ systems or body areas.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Includes at least 10 organ systems or body areas. For each area or system selected, documentation of at least two elements is expected.</td>
</tr>
</tbody>
</table>
WHAT IS THE LEVEL OF SERVICE FOR THE MEDICAL DECISION MAKING IN THIS DOCUMENTATION?

<table>
<thead>
<tr>
<th>Type of Medical Decision Making</th>
<th>Options for Diagnosis or Management</th>
<th>Data Reviewed</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Multiple</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extreme</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

*At least two of the three criteria in the row must be met or exceeded to qualify*
APPROPRIATE VISIT LEVEL CODE FOR JSB

- History is comprehensive
- Physical exam is comprehensive
- Medical decision making is moderate complexity

Office Visit CPT Coding Guidelines - Established Patient

<table>
<thead>
<tr>
<th>Office Visit Code</th>
<th>Type of History</th>
<th>Type of Exam</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Non-required</td>
<td>Not required</td>
<td>Not required</td>
</tr>
<tr>
<td>99232</td>
<td>Problem oriented</td>
<td>Problem oriented</td>
<td>Simple decision</td>
</tr>
<tr>
<td>99223</td>
<td>Extended - problem oriented</td>
<td>Extended - problem oriented</td>
<td>Low complexity</td>
</tr>
<tr>
<td>99244</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate complexity</td>
</tr>
<tr>
<td>99205</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High complexity</td>
</tr>
</tbody>
</table>

ONE MORE COMPONENT: TIME

- When > 50% of the face to face time is devoted to counseling or coordination of care, you may billed based on the amount of time spent with the patient
- Documentation must include a statement of how much time was spent with the patient, > 50% was in face to face counseling, and a description of what was discussed

AND ONE MORE COMPONENT: A PROCEDURE
BILLING FOR DIABETES EDUCATION

WHO IS ELIGIBLE TO BILL FOR DIABETES EDUCATION?

• Physicians
• Advanced practice providers: CNS, NP, PA
• Social workers
• Psychologists
• Registered dietitian

Any professional certified as a CDE who is employed by a DSME/T program:
• AADE – DEAP accreditation
• ADA – ERP recognition

DIABETES EDUCATION BILLING

• Billing for Education

<table>
<thead>
<tr>
<th>Allowable Number of Visits for DMT and/or HMT</th>
<th>DMT</th>
<th>Follow-Up Visits</th>
<th>HMT</th>
<th>Visits ( billed as an individual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>Initial Visit: One hour</td>
<td>Maximum nine hours</td>
<td>Up to 3 hours (Additional hours may be ordered by the physician)</td>
<td></td>
</tr>
<tr>
<td>Subsequent Years</td>
<td>NA</td>
<td>Minimum two hours</td>
<td>NA</td>
<td>Maximum two hours (Additional hours may be ordered by the physician)</td>
</tr>
</tbody>
</table>
CPT CODES FOR DIABETES EDUCATION

HCPCS CODES FOR DIABETES EDUCATION

• G0108: Diabetes outpatient self-management training services, individual, per 30 mins
• G0109: Diabetes outpatient self-management training services, group session (2 or more), per 30 mins

DIABETES EDUCATION BILLING

• Billing for Education
• Billing for Technology
  • Pump technology
  • CGMS technology
CPT CODES FOR MEDICAL NUTRITION THERAPY

• G0270: Medical nutrition therapy; reassessment and subsequent intervention for change in diagnosis, individual, per 15 mins
• G0271: Medical nutrition therapy; reassessment and subsequent intervention for change in diagnosis, group (2 or more), per 30 mins

HCPCS CODES FOR MEDICAL NUTRITION THERAPY

• G0270: Medical nutrition therapy; reassessment and subsequent intervention for change in diagnosis, individual, per 15 mins
• G0271: Medical nutrition therapy; reassessment and subsequent intervention for change in diagnosis, group (2 or more), per 30 mins

REFERENCES

## REFERENCES

<table>
<thead>
<tr>
<th>Reference</th>
<th>Author(s)</th>
<th>Title</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry 1</td>
<td>Author 1</td>
<td>Title 1</td>
<td>Year 1</td>
</tr>
<tr>
<td>Entry 2</td>
<td>Author 2</td>
<td>Title 2</td>
<td>Year 2</td>
</tr>
<tr>
<td>Entry 3</td>
<td>Author 3</td>
<td>Title 3</td>
<td>Year 3</td>
</tr>
</tbody>
</table>