How Academic General Internists Can Obtain Higher Reimbursement Without Doing Any More Work:
Understanding and Applying the CPT Coding System

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Workshop Overview

- Introduction
- Evaluation and Management ("E/M") Codes
- Office Visits
- Case management and care plan oversight
- Procedural services
- Preventive Services
- Preoperative Consultations
- Resident Supervision
- Compliance Plans

• Developed by AMA
• Endorsed by CMS
  – CMS has a supplemental system, “HCPCS” for services specifically covered by Medicare
    • Preventive services (stool occult blood, PAP, etc)
    • Medications such as influenza vaccine
    • Home health care plan certification
CPT system, cont’d

• All codes have a code number, usually 5 digits, a description, and an RVU value
• RVU: Relative Value Unit—a measure of resources needed to provide a service, and a reimbursement methodology
  – Work RVU (wRVU)
  – Practice expense RVU
  – Malpractice expense RVU
Overview

• Background Assumptions
• Rapid Review of E/M Coding Basics
• Minimal Requirements
  – Level 4 problem focused return
  – Level 4 chronic disease management return
• Documentation Requirements
  – Level 5 return
  – Initial level 4/5
• Cases
Assumptions

• If you find E/M coding confusing and its rules arcane, you aren’t alone.

• CMS Website: “Status report on revising documentation guidelines for E/M services”
  - 1995 physical exam “requirements not clear”
  - 1997 physical exam requirements “confusing” “often not relevant”
  - Level of Service=$^{99}(HPI + PFSH) + \pi ROS + PE^3 + MDM \star r^2 / \# of Minutes

(www.cms.gov/medlearn/062200EM.pdf)
Assumptions

- Roughly 80% of attending encounters in a typical outpatient general internal medicine clinic will involve deciding between level 3 and level 4 return visit.
- Generally better to use the 1995 rules, not the 1997 rules, with 1 exception:
  - Status of 3 chronic conditions (1997) = 4 elements of HPI.
### Rapid Review of E/M Coding

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*(Time based visits document > 50% of time in counseling and/or coordination of care)*
**Rapid Review**

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The value of the work you do is not diminished by the fact that you are so highly skilled that for you a complex task has become easy...
Rapid Review

• HPI Elements:
  • Location, quality, severity, duration, timing, context, modifying factors, associated signs & symptoms

• ROS (14 Systems)
  • Constitutional, Allergic/Immunologic, Endocrine, Eyes, Ears/Nose/Mouth/Throat, Resp, Cardiac, GI, GU, Musculoskeletal, Neuro, Psych, Heme/Lymph and Skin
Rapid Review

- Past Hx (PFSH) has 3 Areas
  - Medical
  - Family
  - Social
- Remember you can link to PFSH (or ROS) in a prior note, provided any updates are noted.
Rapid Review

• PE has body areas or systems:
  • Systems = Constitutional/General, Eyes, Ears/Nose/ Mouth/Throat, Respiratory, Cardiac, GI, GU, Musculoskeletal, Skin, Neuro, Psych, Heme/Lymphatic
  • Body areas= Head, neck, chest, abdomen, genitalia, back, each extremity

• Comprehensive exam requires 8/12 systems
Minimal Requirements-
Level 4 Problem Oriented Return

- Any 2 of 3 (Hx, Exam, Decision Making)
- Detailed History
  - Chief complaint (May be part of HPI)
  - HPI: 4 elements
  - 1 PFSH (Link to problem list and/or med list)
  - ROS: 2 systems. OK to include systems documented in HPI. A symptom can’t be counted both as an element and a ROS.
Minimal Requirements-
Level 4 Problem Oriented Return

• Detailed Exam: Extended exam of the affected body area(s) and other symptomatic or related organ systems
Minimal Requirements-
Level 4 Problem Oriented Return

• Moderately Complex Decision Making (2/3)
• Moderate Risk
  – Mild exacerbation of a chronic illness
  – Undiagnosed new problem (e.g., breast lump)
  – Prescription drug management or medication side effect
• Multiple diagnoses/management options
• Moderate complexity of data
Minimal Requirements-Level 4 Chronic Disease Mgmt Return

- Any 2 of 3
- Detailed History
  - Chief Complaint
  - HPI: Status of 3 chronic or inactive conditions or 4 elements
  - 1 PFSH
  - ROS: 2 systems. Consider separate ROS section if HPI=3 chronic conditions
Minimal Requirements-Level 4
Chronic Disease Mgmt Return

- Detailed Exam
  - If HPI=3 chronic conditions defer to Medical Decision Making
    - 1997 Detailed Exam= 12 elements in 2 or more systems
  - If HPI= 4 elements, see problem focused return

- Moderately Complex Decision Making
  - See problem focused return
  - Risk includes:
    - Two or more stable or chronic conditions
Documentation Requirements for Other Visits

• Level 5 return
  – If the visit complexity is high, either perform a comprehensive (8+ system) exam or document 10+ ROS and 2 PFSH

• New Level 4/5
  – Consider new patient history form for efficient 10+ ROS. Document 3 PFSH. 8+ system exam.
Problem Oriented Return

- Problem List/Medication List- See 12/5/03 dictation
- Current Concerns:
  - Low back pain. The patient awoke 1 week ago with a constant, sharp, non-radiating low back pain associated with an intermittent feeling of spasms. Her pain improves somewhat with ibuprofen, is now 6/10 in intensity. Remote hx of a similar episode. Denies trauma, fevers, weakness, or bowel/bladder symptoms.
Problem Oriented Return (Cont.)

• Exam

• Assessment/Plan
  – Low back pain, probably muscular. No red flags for a serious underlying condition. Continue ibuprofen. Cyclobenzaprine 10 mg tid prn spasms, #12. Return if not significantly improved 2-3 weeks, sooner if symptoms worsen significantly.
Chronic Disease Return #1

- Problem List/Med List- See 1/10/04 Dictation

- Current Concerns
  - 1) Cerebrovascular Disease. No TIA symptoms.
  - 2) HTN. She is tolerating her atenolol well.
  - 3) Hyperlipidemia. Her 12/03 lipid panel showed an LDL of 120.

- ROS
  - No exertional chest pain. Notes reflux symptoms every 1-2 weeks, controlled with Tums.
Chronic Disease Return #1 (Cont.)

- Exam. BP 124/82. Weight 190 lbs.
- A/P
  - 1) Cerebrovascular disease. Continue aspirin. Repeat duplex in 1 year.
  - 2) HTN. Stable. Continue atenolol.
  - 3) Hyperlipidemia. Above her target LDL given her cerebrovascular disease. Increase lovastatin to 20 mg/day. Lipid panel and ALT at her follow up visit in 3 months.
Chronic Disease Return #2

• Problem List/Medication List- See 10/21/03 dictation, with the adjustment that bupropion is being discontinued

• Current Concerns
  – 1) HTN. His BP is usually around 120/80 when checked at work. He has no side effects from HCTZ.
Chronic Disease Return #2 (Cont.)

- 2) Depression. Mood is much better after 8 months of treatment. He would like to discontinue bupropion.
- 3) Asthma. No recent exacerbations.

• PE. BP 130/80. P 70. Chest-Clear
• A/P
  - 1) HTN. Adequately controlled. Continue HCTZ
  - 2) Depression. Resolved. Bupropion 150 mg/day for 10 days then D/C. If his mood worsens significantly, he will restart it. Recheck in 3 months.
Chronic Disease Return #3

• Problem List/Medication List- See 1/9/04 dictation, except metformin is now 1 gm bid.

• Current Concerns:
  – 1) Diabetes. 12/03 HgA1C 7.5%. Denies hypoglycemic episodes or foot ulcers.
  – 2) Hyperlipidemia. 12/03 LDL 120. Trying to follow a low fat diet.
  – 3) DJD. Knee pain adequately controlled with salsalate.
Chronic Disease Return #3 (Cont.)

• PE. BP 124/70. P 62. Weight 199.
• A/P
  – 1) Diabetes. Metformin increased as above. Counseled about diet/exercise.
  – 2) Hyperlipidemia. Risks and benefits of diet/exercise vs statins discussed. Continue diet and exercise. Repeat lipid panel at his follow-up in 3 months.
Preoperative Consults

• A 75 year old clinic patient of yours is scheduled for elective prostatectomy. He has well controlled hypertension, type 2 diabetes and DJD. Current medications include ASA, HCTZ, and metformin. His surgeon asks you to do a preoperative evaluation to help plan his medication use during surgery.

• You do a detailed history (status of chronic disease, cardiac and pulmonary ROS, med review)

• You do a detailed exam (5 systems: constitutional, pulmonary, cardiac, GI, musculoskeletal)

• You do moderate complexity decision making

• How do you code this encounter?
Preoperative Consults, cont’d

• If this were a return office visit, it would be a level 4 return visit: 99214 (1.1 wRVU)

• However, since he was referred to you for consultation for a specific problem, it can be coded as a level 3 outpatient consultation: 99243 (1.72 wRVU)
  – Your note must indicate the reason for the referral, and a copy must go to the surgeon

• The coded diagnoses should include the reason he was referred (HTN, DM), and the procedure that is planned (prostatectomy)
Case Management

- A 70 year old clinic patient of yours is admitted to the hospital with pneumonia. Medical history includes diabetes and osteoarthritis.
- The hospitalization goes well, except she develops a grade 2 pressure sore on her right heel.
- She is discharged home with home health nursing visits to manage her pressure sore. You receive the home health agency care plan.
- What do you do with it?
Home Health Care Plan Certification

- Certification of home health care plan
- Medicare covered service: use HCPCS code
- Done for 60 day period
- Initial certification: HCPCS G0179 (0.67 wRVU--same as level 3 return visit)
- Recertification: HCPCS G0180 (0.45 wRVU--same as level 2 return visit)
Care Plan Oversight

• A 50 year old C7 quadriparetic man receives daily home health nursing for his bowel and bladder program, as well as skin assessment and medication oversight. He works full time, and his quadriparesis resulted from an on-the-job injury.

• You spend 15 minutes reviewing his care plan for the next 60 days, then return it to his home health agency.
Care Plan Oversight, cont’d

• Applies to a broad range of services
• Can only be done by 1 physician for any given time period
• Report total time per 30 day period
• Time is either 15-29 min OR ≥ 30 min
• Our patient is 15 minutes, CPT 99374 (1.1 wRVU)
Case Management, cont’d

- You notice Mr. X, a long time patient of your clinic schedule
- He is a 78 year old patient who lives at home, but suffers from dementia
- The patient has a spouse-caretaker, a home health nurse, and a department of aging case manager
- When you go into the exam room, you are surprised to see them all there, but not Mr. X. They want to discuss behavioral problems he has been having
- Can you bill for this service?
Case Management, cont’d

• Interdisciplinary care conferences
• Not currently covered by CMS
• You can bill the patient or the family member for this service
• CPT 99361; (0 wRVU--you have to determine your fee)
Procedural Services

- Identified by CPT code
- Covers the spectrum from minor office based procedures to inpatient based surgery
- Global surgical period: physician services for a period of time around procedure
  - Example: Postop care of cholecystectomy
Procedural Services, cont’d

• Common office procedures for general internists
  – Destruction of premalignant lesion (CPT 17000, 0.6 wRVU)
  – Cryotherapy of warts (CPT 17110, 0.65 wRVU)
  – Subdeltoid bursa injection (CPT 20610, 0.79 wRVU)
  – Paracentesis (CPT 49080, 1.35 wRVU)
Procedural Services, cont’d

- Mindset of CPT is that procedures occur as a separate service, on a scheduled basis
- For general internists, this is often not the case
- You can bill (and get paid) for simultaneous E and M and procedural services
Procedural Services, cont’d

- A 60 year old woman presents for routine follow-up of hypertension. She takes HCTZ and atenolol. She feels well except for mild fatigue. Her BP today is 130/80.
- She asks you to examine some red spots on her forehead
- You identify 3 actinic keratoses and freeze them
- How do you code this visit?
Procedural Services, cont’d

- Management of hypertension: 99213 (wRVU 0.67)
- Destruction of skin lesion
  - For first lesion: 17000 (0.60 wRVU)
  - For second: 17003 (0.15 wRVU)
  - For third: 17003 (0.15 wRVU)
- Attach 25 modifier to the E/M service
Preventive Services

• Mindset of CPT is that NO symptom or disease evaluation and management is done

• Requires the following:
  – Comprehensive history
  – Comprehensive pt-appropriate exam
  – Appropriate counseling

• Insurance coverage varies greatly
Preventive Services, cont’d

- For patients desiring preventive service, report using CPT codes
  - Determined by age and new vs. established
  - Established patient age 40-64, CPT 99396 (1.53 RVU; level 4 return 1.1, level 5 return 1.67)
- For commercially insured patients, often paid without deductibles, so patients are motivated to have this reported correctly
- Not covered by Medicare
Preventive Services, cont’d

- Medicare DOES cover a group of preventive services
- Breast and pelvic exam (G0101)
- Screening PAP (Q0091)
- Digital rectal exam (G0102)
- Screening FOB and others
- Others determined by statute
Preventive Services, cont’d

• A 50 year old man presents for his “annual checkup”. He is healthy except for stable, well controlled HTN, treated with HCTZ 25 mg q day. As you talk to him, it is clear that he expects age appropriate preventive services, as well as assessment and management of his disease.

• How do you proceed?
Preventive Services, cont’d

• You tell the patient that you have time to do both preventive services and assessment of his HTN today, but that you need to bill him for both
• You could offer to do 1 service today, and the other service on a different day
Preventive Services, cont’d

• You do a comprehensive history and exam, with extra attention paid to cardiovascular system, neurologic system, and potential side effects of HCTZ
• You order appropriate testing and counsel about his medication
• You document the preventive service and disease management service
• How should you code this encounter?
Preventive Services, cont’d

• You can use the following codes:
• For the preventive service, CPT 99396 (1.53 wRVU)
• For the disease management service, CPT 99213 (0.67 wRVU)
• Attach a 25 modifier to the E/M code (99213)
Resident Supervision

- Resident and teaching physician (TP) see patient
- Only resident sees the patient: primary care exception rule
Resident Supervision

- Resident and teaching physician (TP) see patient
  - TP performs or witnesses “key portion”--broad leeway to choose these
  - TP documents participation--may be brief, summary comments; link to the resident’s entry
  - documentation of the key elements may be satisfied by combining notes made by the resident and the TP
  - for details, see: http://cms.hhs.gov/manuals/pm_trans/R1780B3.pdf
Primary Care Exception Rule

- Not a rule but a set of guidelines
- Teaching physicians may submit claims for low and mid-level E/M services furnished by residents in the absence of a teaching physician
- New or established patients
  - limited to levels 1 through 3
  - cannot be used for billing procedures
Primary Care Exception Rule, cont’d

- Facility criteria
- Resident criteria
- Teaching physician criteria
Primary Care Exception Rule, cont’d

• Facility Guidelines
  – outpatient department of hospital
  – affiliated ambulatory care center
  – resident time must be a factor in determining direct GME payments to teaching hospital
  – not applicable to
    • private MD office
    • MD office away from hospital
    • home visits
Primary Care Exception Rule, cont’d

• Facility Guidelines cont’d
  – patient should consider the center to be primary location for health care
  – residents are expected to care for the same group of established patients.
  – scope of practice
    • acute care, chronic care and coordination of care
    • comprehensive care not limited by organ system or diagnosis
Primary Care Exception Rule, cont’d

• Resident Guidelines
  – resident must have completed 6 months of training in GME approved program
  – residents are expected to care for the same group of established patients.
Primary Care Exception Rule, cont’d

• Teaching Physician Guidelines
  – 1:4 faculty to resident ratio
  – no other responsibilities at the time of service
    • includes supervision of other personnel
  – must be immediately available
  – must review resident care during or immediately after each visit
Primary Care Exception Rule, cont’d

• Teaching Physician Guidelines cont’d
  – document the extent of participation in the provided service
  – primary responsibility for patient care
  – ensure that care was reasonable and necessary
Primary Care Exception Rule: Getting Started

- Prior approval is not necessary
- Must attest in writing that all conditions are met
- Must maintain records demonstrating ongoing qualification for the exception
- Recommend multiple sets of documentation
  - clinic, program, billing office
- Check with compliance office at your institution
Compliance Plans and Faculty Practices

- Most important thing is to know your local staff
- Faculty practice plans usually have compliance agreements for members to follow
EVALUATIONS