



*Simple Coding Steps to Benefit your Practice*

■ SERVING MEDICAL PRACTICES FOR OVER 20 YEARS ■



## Simple Coding Steps

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- Evaluation & Management Utilization comparison
- Consult vs. New Patient service
- Billing based on time
- Modifier 25
- Modifier 57
- Communication with Coding staff



## Utilization Data of E & M codes

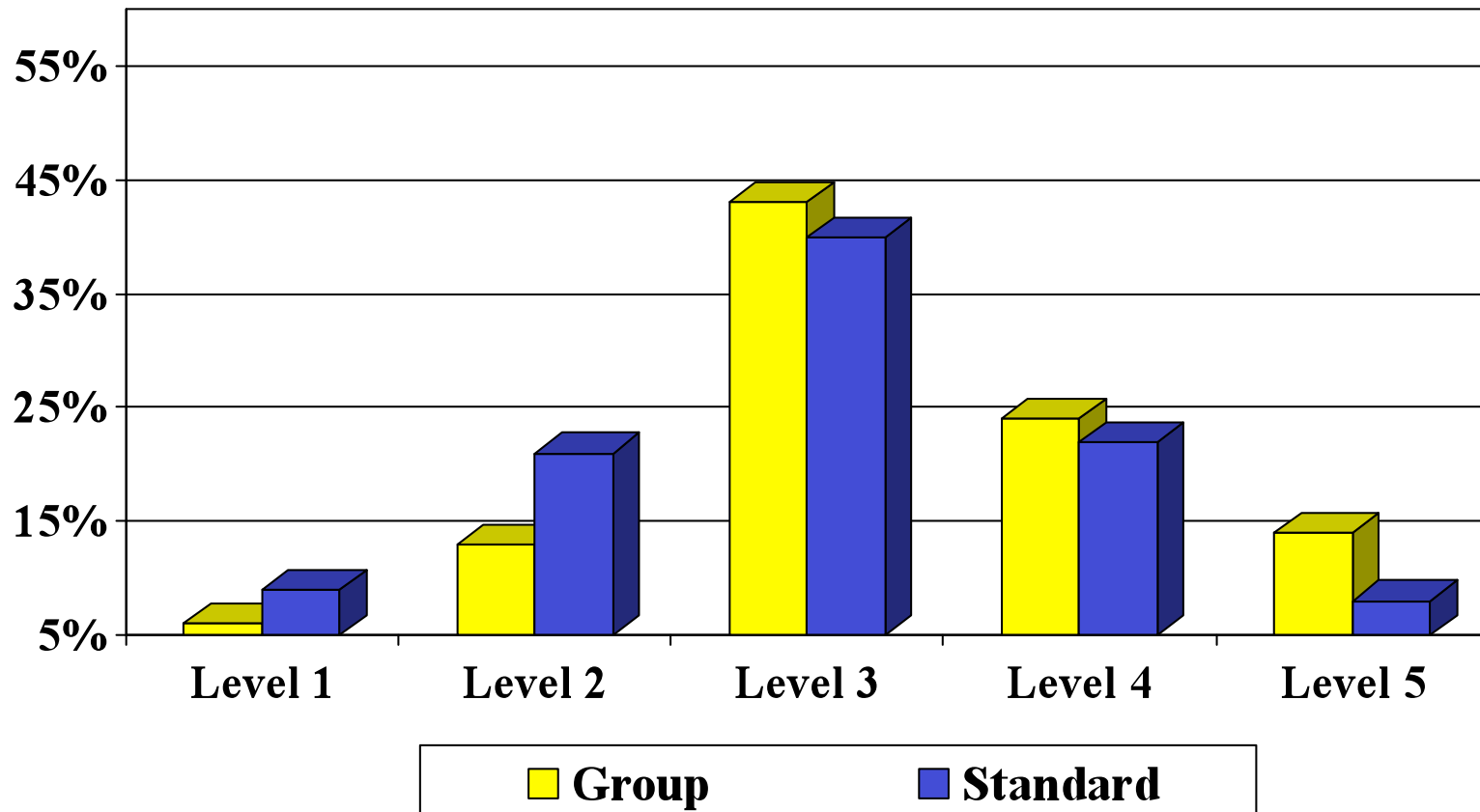
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Evaluation and Management services warrant attention

- Utilization distribution
  - Compare group data to a national or local standard - CMS or MGMA
  - Compare physician level data to group and national standard data
- Identify trends and outliers.
- Develop an educational plan for improvement.

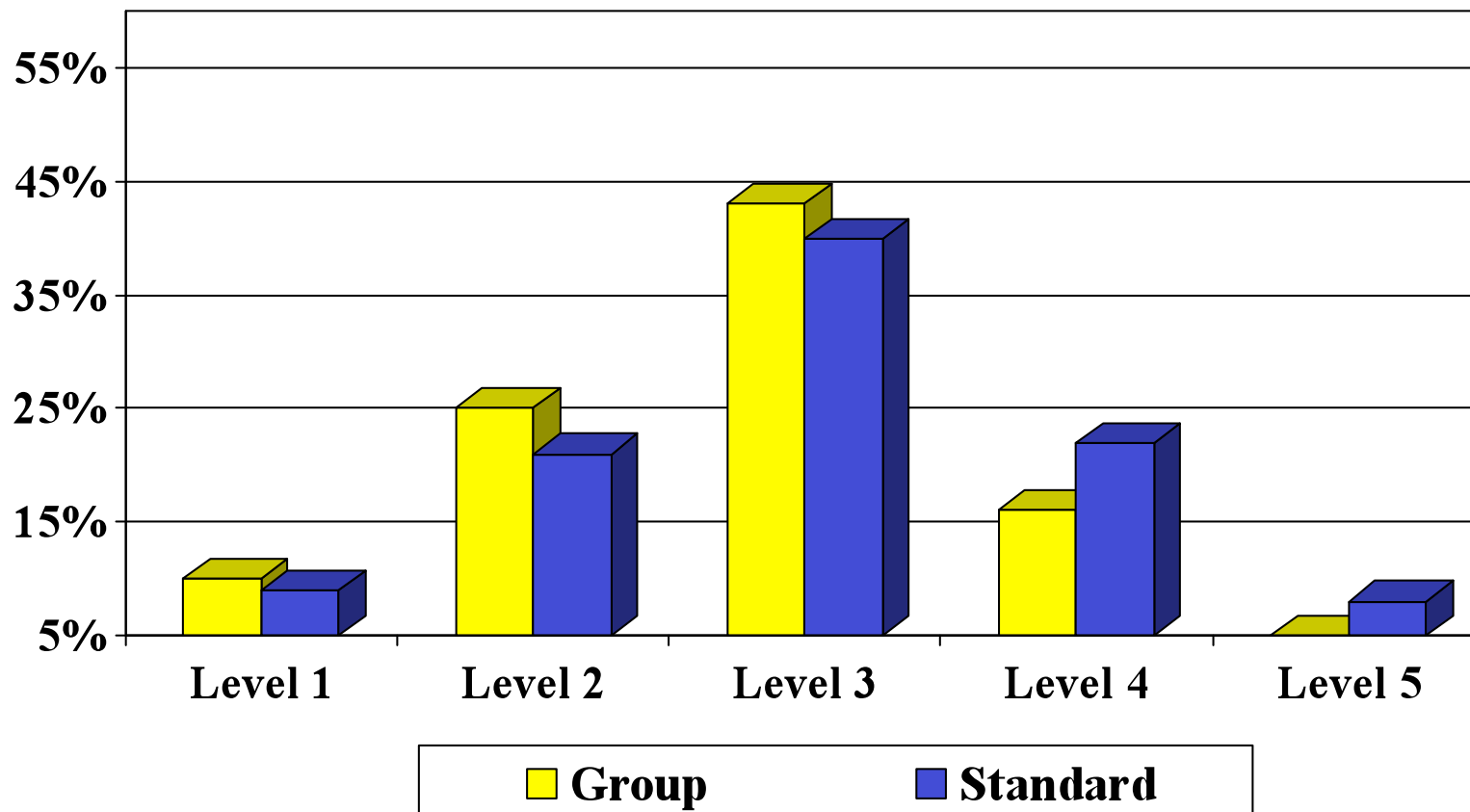


# E & M Utilization Data Practice Vs. Standard Possible Over-coding

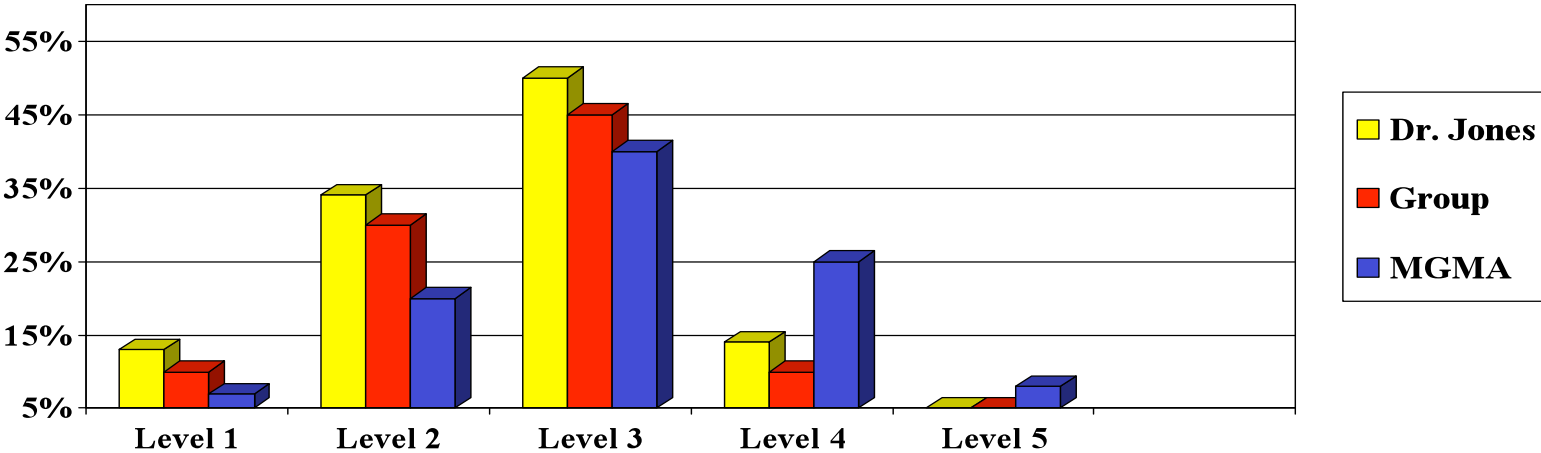
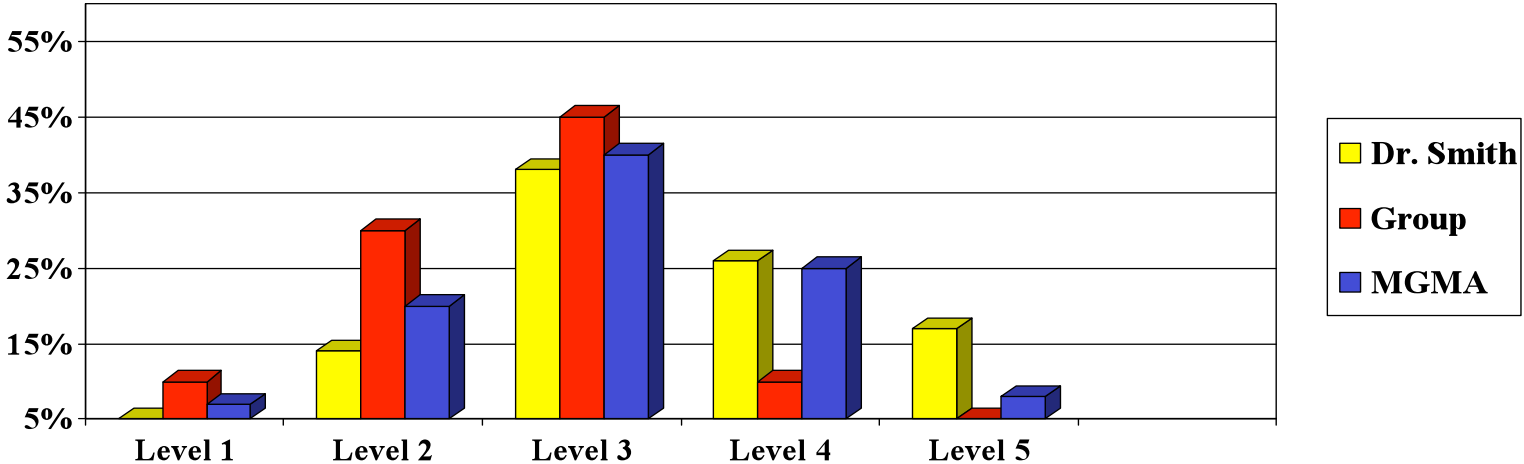




# E & M Utilization Data Practice Vs. Standard Possible Under-coding



# Individual Utilization Data





# Established Patient Services Financial Impact of a One Level Shift

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	Medicare	% Increase
99211	\$9.97	
99212	\$26.56	166%
99213	\$39.18	48%
99214	\$65.15	66%
99215	\$104.32	60%



## Consultation vs. Visit

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A consultation is distinguished from a visit as it is provided by a physician whose opinion or advice regarding a specific problem is requested by another physician. There are three basic documentation criteria that **must** be included in the medical record to support a consultation code.

- A **request** for advice or opinion from another physician.
- **Render** an opinion/recommendation after performing the service
- A **response/report** to the requesting physician regarding the results of the consultation. This may take the form of a formal letter to the requesting MD or a CC to the requesting MD on the dictated note.



## Consultation vs. New Patient Visit Financial Impact

	New Patient	Consultation	Revenue Increase
Level 1	\$26.06	\$37.62	44%
Level 2	\$51.52	\$76.64	49%
Level 3	\$79.29	\$102.92	30%
Level 4	\$117.57	\$152.04	29%
Level 5	\$156.75	\$202.50	29%



## Time as the Determining Factor for Problem Based Visits

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**Time** may be used as the determining factor when a patient visit is dominated by time.

Documentation must include;

- Provider must record total duration of the visit.
- Provider must give a ratio, that at least half of the time was spent on counseling and coordination of care.
- The nature of the counseling and coordination of care must be documented.



## Time Thresholds for E & M Office Services

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New Patient	99201	99202	99203	99204	99205
Time	10	20	30	45	60
Established Patient	99211	99212	99213	99214	99215
Time	5	10	15	25	40



## Adequate Time Statements

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- A total of 15 minutes were spent face to face during this encounter and greater than 50% of this visit was based on counseling and coordination of care regarding the above-mentioned topics.
- A total of 60 minutes were spent face to face during this encounter and 40 minutes were spent on counseling and coordination of care regarding the prognosis and possible treatment options.



## Example of time-based problem visit



A provider sees a patient previously diagnosed with cancer to discuss surgical treatment options. The physician provides extensive counseling about risks and possible outcomes and expectation. The total time spent is 30 min.

***If billing based solely on time, your documentation should state the following:***

A total of 30 min were spent face to face during this encounter and greater than 50% of this visit is based on counseling and coordination of care regarding surgical treatment options and risk.



## E & M and Procedures



All procedures include a mini- E & M visit related to that procedure. These mini E & M visits are included in the RVU or allowable calculations by each carrier.

Any E & M service above and beyond the usual preoperative and postoperative care must be documented and may be billed.

The E & M that is above and beyond that usual pre- and postoperative must include HEM; History, exam and medical decision-making.



## Modifiers Identify These Special Services

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**Modifier 25** -Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service. Append to the E & M code when the procedure performed is minor (0 or 10 day global).

**Modifier 57** - Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery. Append to the E & M code when the procedure performed is major (90 day global).



## Modifier 25 Documentation

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- The patient's medical record documentation is expected to **clearly** evidence that the E & M service was “above and beyond” the usual pre-operative and post-operative care associated with the procedure
- The need to perform an independent E & M service may be prompted by a complaint, symptom, condition, problem, or circumstance which may or may not be related to the procedure (or other service) provided.
- Different diagnoses from those related to the procedure are not required for reporting of a significant, separately identifiable E & M service performed on the same date.



## Modifier 25

### When is it warranted?

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- A patient presents for chemotherapy, but a reaction to the medication requires the oncologist to provide a level-two E/M. Report the appropriate chemo code (such as 96413), and append modifier 25 to E & M code 99212.
- A new consult patient presents with a complaint of difficulty swallowing. The physician takes a complete history and performs an extensive exam. He then performs Laryngoscopy, which reveals a mass in the larynx. Report the Laryngoscopy (31575). Append modifier 25 to E & M code for consultation (99244 or 99245).



## Modifier 25

### When is it not warranted?

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- Patient returns for re-evaluation of her heel pain, and follow-up cortisone injection to her first of 10 days prior. During this return visit, she reported that the pain level had reduced by 60%. The still tender site was palpated and a 2<sup>nd</sup> injection of cortisone was administered to the area. Impression: plantar fasciitis right heel.
- An established patient presents to the office for a re-treatment of a wart. The patient had Cryotherapy 12 days prior but one of the warts was resistant. Physician performs exam of the affected area and reapplies the liquid nitrogen.



## Modifier 57 Documentation

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To append modifier 57 properly, documentation must clearly support that;

- The E/M service occurred the day of or the day before a major surgical procedure (a procedure with a 90-day global period).
- The E/M service must prompt the surgical procedure that follows.
- The E/M service must be related to the procedure that follows.
- The same physician (or tax ID) provides the E/M service and the surgical procedure.



## Modifier 57

### When is it warranted?

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- Two days after an otolaryngologist admits a patient with parotitis to the hospital, the patient develops a parotid abscess that requires complicated draining. In this case, you should report both the parotid drainage (42305) and the appropriate-level hospital visit (for example, 99232) with Modifier 57 appended.
- An established patient reports with an injured wrist, and the orthopedist diagnoses a displaced distal radius fracture that is reduced at that visit. Report both the closed fracture treatment code 25605 and the appropriate level established patient E & M (99214). Append Modifier 57 to the E & M code.



## Modifier 57

### When is it not warranted?

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- A patient presents with neck pain to a pediatrician. The pediatrician performs a history, examination and medical decision-making; diagnoses the child with a fractured clavicle; and refers that patient to an orthopedist for treatment that day. The pediatrician will report only the appropriate level E & M.
- A patient presents to the surgeon's office on the day prior to a scheduled surgery for a complete H & P. After completing the exam, it is determined that the patient is fit to undergo surgery. No service should be reported. This service is included in the global surgical allowance.



## Provider and Coder Communication

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- Provider-Coder communication must be a two way street.
- Develop a secure system by which providers and coders can communicate directly for clarification and education.
- Do not allow surgeries to be coded without the full and authenticated operative note.
- Forewarn coding staff of new procedures or unusual cases.



## Title of Operation vs. Full operative Report

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Title of Operation: Exploratory lap, TAH-BSO

Operative Note detail: TAH-BSO, frozen section demonstrated Grade II endometrial cancer with 10% myometrial invasion. Decision was made to proceed with bilateral total pelvic lymph node dissection.

**Coded from heading: 58150** - Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); = \$1,029.24

**Coded from Operative Note: 58210** - Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s) =\$1,896.03



## Title of Operation vs. Full operative Report

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Title of Operation: Arthroscopic Medical Meniscectomy

Operative Note detail: Diagnostic Arthroscopy shows severely inflamed synovium in medial, lateral and patello-femoral compartments. Medial compartment shows a horizontal cleavage tear of medial meniscus. A three compartment synovectomy was performed. Medial Meniscectomy was performed with a biter and a shaver.

**Coded from heading: 29881** - Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) = \$695.86

**Coded from Operative Note: 29876** - Arthroscopy, knee, surgical; synovectomy, major, two or more compartments (eg, medial or lateral) and 29881-51 (as above) = \$931.11