CODING AND BILLING

Introduction

Staff play a major role in the documentation for payment by insurance companies. It is very important to do your part and do it correctly or the doctor has to go back and do it if he wants to be paid and not have the money requested back from him in an audit.

I. COMPLETING MIPS INFORMATION

A. There are criteria that the front desk has to enter to be compliant with MIPS (Merit based Incentive Payment System) for Medicare.
B. This needs to be completed before they are taken back by the tech.
C. Some practices are mandated to participate with the new payment system and some it is optional at this point.
D. If a provider has more than $90,000 in allowed charges, or provides care for 200 or fewer Medicare Part B beneficiaries, they are not required to participate in 2018. If you choose not to participate and you are required to, there will be penalties, and if you do not participate and you are not required, you will get no future increases in fees.

II. WHAT WENT INTO CHOOSING THE PROPER CODE PRIOR TO 2021?

Four things that determine which level of service to bill.
A. Extent of History Taking
B. Extent of Examination
C. Complexity of Medical Decision Making
D. Determine which Procedure Code

III. WHAT GOES INTO CHOOSING THE PROPER CODE AFTR 1/1/2021?

A. Two options on how you evaluate your patient to get paid by insurance
B. Time Spent on patient data and face to face time with a patient
C. Complexity of Medical Decision Making
D. Determine which Procedure Code

IV. STREAMLINING E/M PAYMENT 2021 CMS

A. The largest change to the current coding & payment structure for E/M visits since inception in 1995
B. Time consuming
C. E/M code inflation
D. Patient perception and often times distracted physicians
E. Expense of IT, training, billing staff, technicians, scribes, etc

V. BENEFITS OF E/M CODE CHANGES

A. Patients over Documentation
B. Reduced doctor and staff time
C. Streamlining documentation of history & examination
D. Less in medical records
E. Improved chances of surviving chart audits

F. Expanded schedules in offices allowing more appointments a conservative reduction of 2.11 minutes per visit, a physician who sees 20 patients per day could realize over 180 hours of freed time to focus on patient care – American Medical Association

VI. BENEFITS OF CHANGES TO E/M REQUIREMENTS

A. Greatly reduced documentation of History & Exam
B. No need for copy forward functions
C. No duplication of data
D. No value assigned to non-essential or extraneous notes
E. Problem Focused System History & ROS do not need to be completed each visit
F. No need to complete examination elements that do not change or contribute to the current assessment and plan of care
G. ONLY document essential elements of history and exam

VII. CHANGES TO E/M CODE SELECTION

A. Eliminates all distinction between new vs established patients in selecting codes based on strict definitions of 3 of 3 (new) and 2 of 3 (established)
B. Same 2 of 3 Rule used for selecting codes for BOTH
C. Code selection based on Medical Decision Making as the key factor for the level of service
D. The extent of history obtained and examination performed are NOT elements in code selection
E. Volume of documentation should not be an influence upon code level selection

VIII. HISTORY

A. The techs are responsible for completing the patient's history.
B. This year the requirements for 99203/99213 and the 99204/99214 changed where history is concerned. There is no history requirement for the two codes above new or established. The doctor can decided how much history he needs case by case to make his medical decisions for the patient.
C. You need a history on every patient you bill a 92002/92012 or 92004/92014 code. The code definition in the CPT Book does not define how much history just a history.
D. This should be completed on the first visit and updated on each visit afterward**.**

IX. MEDICAL DECISION MAKING

There are four levels of decision making and they are as follows:

1. Straightforward
   #DX/RX Options-Minimal/Risk-Minimal
2. Low Complexity
   #DX/RX Options-Limited/Data-Limited/Risk-Low
3. Moderate Complexity
   #DX/RX Options-Multiple/Data-Moderate/Risk-Moderate
   Start a treatment-Change a treatment-Decision for surgery-Outside consult or referral
4. High Complexity
   #DX/RX Options-Extensive/Data-Extensive/Risk-High
   Wheels of the bus are coming off at 70 MPH.
   Threatens loss of eye sight

X. E/M CODING-OFFICE VISITS

A. 99201-DELETED
B. 99211-N/A-No requirements listed

C. 99202/99212
   1. Time- NP 15-29 minutes
   2. Est 10-19 minutes
   3. Total time the date of encounter
   4. Level 1-Straightforward Decision Making

D. 99203/99213
   - Time-NP 30-44 minutes
   - Est 20-29 minutes
   - Total time the date of encounter
   - Level 2- Low Complexity Decision Making

E. 99204/99214
   - Time-NP 30-44 minutes
   - Est 20-29 minutes
   - Total time the date of encounter
   - Level 2- Low Complexity Decision Making

F. 99205/99215
   - Time-NP 30-44 minutes
   - Est 20-29 minutes
   - Total time the date of encounter
   - Level 2- Low Complexity Decision Making

XI. USING TIME

A. Total TIME = face-to-face & non face-to-face but does
B. Not include time in activities performed by clinical staff
C. Preparing to see patient (review of tests)
D. Obtaining or reviewing separately obtained history
E. Performing appropriate examination
F. Counseling & educating patient/family/caregiver
G. Ordering medications, tests, procedures
H. Referring & communicating with other professionals
I. Documenting medical records
J. Independently interpreting results and communication with patient
K. Care coordination

XII. MEDICAL DECISION MAKING-Three Components for Determining the Complexity of MDM

A. Number and complexity of Problems addressed at the encounter
B. Amount and/or complexity of Data to be reviewed and analyzed
C. Risk of complications and /or morbidity or mortality of patient management

XIII. NUMBER & COMPLEXITY OF PROBLEMS

A. 99202 / 99212 – Minimal
   - 1 self limited or minor problem

B. 99203 / 99213 – Low
   - 2 or more self-limited or minor problems; OR
   - 1 stable chronic illness; OR
   - 1 acute, uncomplicated illness OR
   - An injury

C. 99204 / 99214 – Moderate
   - 1 or more chronic illnesses, w exacerbation, progression, or side effects of treatment; OR
   - 2 or more stable chronic illnesses; OR
   - 1 undiagnosed new problem with uncertain prognosis; OR

– 1 acute illness w systemic symptoms; ORr
– 1 acute complicated injury

D. 99205 / 99215 – High
- 1 or more chronic illnesses with severe exacerbations, progression, or side effects of treatment; OR
- 1 acute or chronic illness or injury that pose a threat to life or bodily function

XIV. AMOUNT OR COMPLEXITY OF DATA

A. 99202 / 99212
- Minimal or none

B. 99203 / 99213
- Limited / requires 1 of 2 categories
- Cat 1: tests & documents 2 from the following Review of prior external notes from each unique source Review results of each unique test Ordering each unique test OR
- Cat 2: assessment requiring an independent historian (s)

C.

A. **EYE CODES**

92004/92014 Comprehensive Ophthalmological Service

1. Need not be performed at one session
2. 8 or more of the Eye Elements documented
3. **Includes** history, medical observation, external &
   i. Ophthalmoscopic examinations, gross visual fields,
   ii. Sensorimotor examination
4. Often includes biomicroscopy, examination with cycloplegia or mydriasis and tonometry
5. **May include,** but not required to dilate, but some years you had to do a dilation to bill this code. You need to reference the code book each year to verify wording.
6. **Always includes** initiation of diagnosis and treatment programs.
7. This year, the wording states as indicated includes the prescription of medication, and arranging for special ophthalmological diagnositic or treatment services, consultations, laboratory procedures, and radiological services, not including over the counter treatments. Some years, you had to do one of the above to bill this code but at the current time it is as the doctor indicates need. There are a few states that have a Local Determination that states glasses can be considered a prescription of medication and Texas is one of those states.

B. 92002/92012 Intermediate Ophthalmological Service
1. Includes 7 or less of the Eye Elements
2. Evaluation of new or existing condition, complicated with a new diagnostic or management problem, not necessarily relating to the primary diagnosis
3. Includes history, medical observation, external & adnexa, & other diagnostic Procedures as indicated may include use of mydriasis for ophthalmoscopy

C. 92015 Refraction
1. Billed in addition to 99XXX/92XXX
2. Non-covered service on most insurance
3. Charge only for “RX-able” refractions
4. Do not forget to charge for the final refraction when changing spectacles in a post-operative cataract patient

D. S0620/S0621 Routine Comprehensive Eye Exam including Refraction
1. The only code for routine/refractive eye exam
2. Can be used for private pay patients exams
3. Billed at a different fee than a medical exam

CONCLUSION

Choosing the proper procedure code is a formula based on what your doctor and staff have documented in the patient's chart. All CPT codes have specific criteria that you have must meet to bill the code. If you do not know the criteria for the code you are choosing, you probably shouldn't be the person making that decision. This course covers the CPT procedure codes which is just one part of the process. The ICD-10 diagnosis codes are the other part of coding. ICD-10 codes are broken down very specifically. The codes on the claim form must match the documentation in the patient record exactly. If the codes do not carry forward from the electronic medical record into the fee slip, the chart needs to be returned to the doctor so he can choose the appropriate diagnosis. This insures that the billing code matches the exam notes. If your practice wants you to do the coding there are certifications and training material to equip you to accomplish this successfully.