Coding and Billing for Lifestyle Medicine

Presented to

Tools for Healthy Change

June 21, 2014
Agenda

• Understanding Documentation Guidelines and key components of E/M Services
  • History, Exam, Medical Decision Making
  • Time based E/M Services

• Understanding coding guidelines and identify risk areas for E/M services with:
  • Patient Status
  • Billing for Time Spent Counseling
  • Obesity Counseling – diagnosis and CPT codes
  • Preventative with Sick Visits
  • Welcome to Medicare Physicals
  • Medicare Annual Wellness Visit
  • E/M Modifiers
New versus Established

- E/M codes are divided on the patient status
- A new patient is one who has not received any face-to-face professional service from a provider of the same specialty or exact same subspecialty in the same group practice, within three years
  - New group
  - New Specialty

- If a provider is covering, the encounter is classified as it would have been by the patient’s provider.
For coding purposes, face-to-face time for office/outpatient visits or consult services is defined as only that time that the physician spends face-to-face with the patient and/or family.

When greater than 50% of the face-to-face time is spent in counseling or coordination of care, time may be considered in selecting the code level for the encounter.

Tip: If the visit does not include any interval history ("S" of SOAP note), no Physical Exam ("A"), such as a return visit to discuss test results, treatment options, compliance with treatment plan, etc. this lengthy visit would qualify for the “Time” component for code selection.
Time and Counseling Coding Issues

- Physicians will often need to utilize the “Time” factor and frequently undercode counseling types of services.
- Diagnosis code sequencing is essential for follow-ups; avoid denials
  
  - After Depression or any other mental health diagnosis, etc. is determined, what physicians are actually providing is medication management. Use the V code for the subsequent encounters.
  
- **V58.83** Encounter for therapeutic drug monitoring or if it is a long term current use drug, use the appropriate V58 code series.

Nancy Enos, FACMPE CPC CPC-I
Time Spent Counseling

- Does the note state the total time of the visit?
- Does the note describe the content of counseling/coordination of care?
- Does the note reveal that more than half of the time was spent counseling and/or coordinating care?
Time and Counseling Diagnosis Coding Issues- Signs and Symptoms

- Anorexia - 783.0 (loss of appetite)
- Abnormal loss of weight 783.2X
- BMI V85.0-V85.54

**Excludes:**
- anorexia nervosa (307.1)

- Anorexia is an unexplained loss of appetite. Do not use this code to report anorexia nervosa, which is found in category 307
Overweight and Obesity

- ICD-9 code is 278.00
  - Morbid Obesity 278.01
  - Overweight 278.02
  - Obesity hypoventilation syndrome 278.03
  - Localized adiposity 278.1

- Use Additional Code to identify Body Mass Index (BMI) if known, with V85.0-V85.54
Body Mass Index (BMI)

- V85.0 BMI less than 19, adult
- V85.1 BMI between 19-24, adult
- V85.2 BMI between 25-29, adult
- V85.3 BMI between 30-39, adult
- V85.4 BMI 40 and over, adult
Weight Management

- Health and Behavior Assessment or Intervention:
  - For dietitians, certified diabetes counselors, nurses, or behavioral health professionals for identifying the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. These services do not represent and should not be reported on the same day as preventive medicine counseling services.
Weight Management

- **CPT 96150** - Health and behavior assessment (e.g. health-focused clinical interview, behavioral observations, psycho-physiological monitoring, and health-oriented questionnaires) each 15 minutes face-to-face with the patient, initial assessment
- **CPT 96151** - Health and behavior reassessment (e.g. health-focused clinical interview, behavioral observations, psycho-physiological monitoring, and health-oriented questionnaires) each 15 minutes face-to-face with the patient, initial assessment
- **CPT 96152** - Health and behavior intervention, each 15 minutes, face-to-face, individual
- **CPT 96153** - Health and behavior intervention, each 15 minutes, face-to-face, group (2 or more)
- **CPT 96154** - Health and behavior intervention, each 15 minutes, face-to-face, family (patient present)
- **CPT 96155** - Health and behavior intervention, each 15 minutes, face-to-face, family (patient not present)

*Use of the appropriate E&M service code should be filed when these services are performed by a physician.
Prolonged Services Face-to-Face

- 99354-99355 Outpatient
- 99356-99357 Inpatient
  - minimum of 60 minutes
  - Beyond the normal time frame
  - *Actual treatment* vs. Counseling
  - Add on to E&M code at any level
  - Document time
## Code Selection

<table>
<thead>
<tr>
<th>CODE</th>
<th>Office Visit Est. 2/3</th>
<th>HISTORY</th>
<th>EXAM</th>
<th>MDM</th>
<th>Time</th>
</tr>
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<tbody>
<tr>
<td>99211</td>
<td>Office visit, No. Phys. Required</td>
<td>N/A</td>
<td>N/A</td>
<td>minimal</td>
<td>5 min</td>
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<tr>
<td>99212</td>
<td>Office visit, Est. (Prob focused)</td>
<td>Problem Focused</td>
<td>1</td>
<td>Straightforward</td>
<td>10 min</td>
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<tr>
<td>99213</td>
<td>Office visit, Est (Low)</td>
<td>Exp. Problem Focused</td>
<td>2-4</td>
<td>Low</td>
<td>15 min</td>
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<tr>
<td>99214</td>
<td>Office visit, Est. (Mod.)</td>
<td>Detailed</td>
<td>5-7</td>
<td>Moderate</td>
<td>25 min</td>
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<tr>
<td>99215</td>
<td>Office visit Est. (High)</td>
<td>Comprehensive</td>
<td>8</td>
<td>High</td>
<td>40 min</td>
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<table>
<thead>
<tr>
<th>CODE</th>
<th>Office Visit New 3/3</th>
<th>HISTORY</th>
<th>EXAM</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>IOV (No Referral)</td>
<td>Problem Focused</td>
<td>1</td>
<td>Straightforward</td>
<td>10 min</td>
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<tr>
<td>99202</td>
<td>IOV (No Referral)</td>
<td>Exp. Problem Focused</td>
<td>2-4</td>
<td>Straightforward</td>
<td>20 min</td>
</tr>
<tr>
<td>99203</td>
<td>IOV (No Referral)</td>
<td>Detailed</td>
<td>5-7</td>
<td>Low</td>
<td>30 min</td>
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<tr>
<td>99204</td>
<td>IOV (No Referral)</td>
<td>Comprehensive</td>
<td>8+</td>
<td>Moderate</td>
<td>45 min</td>
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<tr>
<td>99205</td>
<td>IOV (No Referral)</td>
<td>Comprehensive</td>
<td>8+</td>
<td>High</td>
<td>60 min</td>
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<table>
<thead>
<tr>
<th>Code</th>
<th>Office Consults 3/3</th>
<th>HISTORY</th>
<th>EXAM</th>
<th>MDM</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td>99241</td>
<td>Office Consult minimal</td>
<td>Problem Focused</td>
<td>1</td>
<td>Straightforward</td>
<td>15 min</td>
</tr>
<tr>
<td>99242</td>
<td>Office Consult Prob. Focused</td>
<td>Exp. Problem Focused</td>
<td>2-4</td>
<td>Straightforward</td>
<td>30 min</td>
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<tr>
<td>99243</td>
<td>Office Consult (Low)</td>
<td>Detailed</td>
<td>5-7</td>
<td>Low</td>
<td>40 min</td>
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<tr>
<td>99244</td>
<td>Office Consult (Mod.)</td>
<td>Comprehensive</td>
<td>8+</td>
<td>Moderate</td>
<td>60 min</td>
</tr>
<tr>
<td>99245</td>
<td>Office Consult (High)</td>
<td>Comprehensive</td>
<td>8+</td>
<td>High</td>
<td>80 min</td>
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<table>
<thead>
<tr>
<th>Code</th>
<th>Prolonged Services</th>
<th>Time</th>
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<tbody>
<tr>
<td>99354</td>
<td>Office Prolonged Service</td>
<td>add on to base code</td>
</tr>
<tr>
<td>99355</td>
<td>Each Additional 30 minutes</td>
<td>1 unit each 30 min</td>
</tr>
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Nancy Enos, FACMPE CPC CPC-I
Is the Service a Consultation?

- Was the advice or opinion of the provider requested?
- Was the opinion issued as per guidelines?
- Are these facts clearly documented in the medical record?
- “Six R’s”
  - Request (From whom?)
  - Reason for consultation
  - Review of previous records
  - Render patient evaluation (H&P)
  - Recommendation for plan of treatment
  - Report (separate if not shared record)
Consultations – not covered by Medicare and others following Medicare rule

- **99241 – 99245: Outpatient Consultations**
  - Office consults must be requested by another physician
  - Example- Medicare will pay for surgical clearance
  - Use if patient is considered observation status or consult is requested in ED and patient is discharged

- **99251 – 99255: Initial Inpatient Consultations**
  - Use if patient status is inpatient admission
Preventative Medicine

• Codes are based on New vs. Established
  • **New and Established Patient**
  • Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.
Preventative Medicine Issues

- The extent and focus of the service will vary based on the age of the patient.

- If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported.
Preventative Medicine Issues

- Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

- An insignificant or trivial problem or abnormality that is encountered in the process of performing the preventive medicine evaluation and management service 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.
Preventative or Sick?

- A 72 year old established patient presented for a well check-up. The patient’s daughter claimed the patient had been walking with a limp and complaining of lower leg pain for the past 3 days after falling from the bed.
- The provider focused on further (extensive) evaluation of these symptoms and indicated a plan of x-ray and possible referral to orthopedics. The preventative exam was completed. The bill would look something like this:
Preventative Medicine and E/M

CPT: 99397
(Est.) Preventive medicine, 65+ years

DX 1: V70.0 Physical Exam

and also

CPT: 99213-25 E/M Service-(EPF,EPF,LC)

DX 2: 729.5 Pain in limb

DX 3: E880.9 Fall-Other stairs or steps
Nurse Visits 99211

- According to the CPT manual, a 99211 is an office or other outpatient visit "that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services."
- Unlike the rest of the office visit codes, 99211 does not have any documentation requirements for the history, physical exam or complexity of medical decision making. The nature of the presenting problem need be only "minimal," such as monthly B-12 injections, suture removal, dressing changes, allergy injections with observation by a nurse, and peak flow meter instruction.
- Do not use for “shot visits” the administration codes include the work of 99211.
- Remember, if you bill a 99211 you must collect a copay.
Counseling/Risk Factor

- 99401 (weight management)
  - Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without a specific illness for which the counseling might otherwise be part of a treatment - 15 minutes

- 99402
  - 30 minutes

- 99403
  - 45 minutes

- 99404
  - 60 minutes
Behavior Change/Interventions

- 99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
  - 99407 greater than 10 minutes
- 99408 Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
  - 99409 greater than 30 minutes
Medicare Screening Services

- The Patient Protection and Affordable Care Act (PPACA) changed coverage of preventative care services to Medicare.
- Since January 1, 2011 CMS covered Annual Wellness Visits.
- Other screening services may be covered based on frequency and patient risk.
- Check Medicare’s billing guide for G-Codes to report screening procedures and V-codes allowed as diagnoses.
Medicare Covered Screening Services

- Bone Mass Measurement
- Cardiovascular Screening
- Colorectal Cancer Screening
- Diabetes Screening
- Flu (Influenza) Injections
- Glaucoma Screening
- Hepatitis B Injections
- Initial Preventive Physical Examination

- Mammography Screening
- Medical Nutrition Therapy
- Pneumococcal Pneumonia Vaccination (PPV)
- Prostate Cancer Screening
- Screening Pap Smears
- Screening Pelvic Examinations
- Smoking and Tobacco-Use Cessation
- Ultrasound Screening for Abdominal Aortic Aneurysm
Advanced Beneficiary Notice (ABN) Requirements

- A physician should obtain an Advanced Beneficiary Notice (ABN) when services provided fall outside of Medicare coverage requirements. The ABN can be found on the CMS website at: [http://www.cms.gov/cmsforms/downloads/cmsr-131-g.pdf](http://www.cms.gov/cmsforms/downloads/cmsr-131-g.pdf)

- Physicians, practitioners and hospitals will be liable for Screening services unless they issue an appropriate Advanced Beneficiary Notice
Medicare Preventative Services

- Under PPACA (Patient Protection and Affordable Care Act, or Healthcare Reform) coverage for preventative services has been expanded.
- Medicare continues to define the conditions of coverage of preventative services.
- Not all commercial plans will follow the Medicare Guidelines.
Welcome to Medicare Exam (IPPE)

- Once in a lifetime exam
- Covered within the first 12 months of enrollment in Medicare Part B
  - Includes: Height, weight, body mass index
  - Referrals for necessary diagnostic testing
  - Blood Pressure
  - Education, counseling and health risk assessment
Welcome to Medicare

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
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<tbody>
<tr>
<td>G0402</td>
<td>“Welcome to Medicare” – Initial Preventative Physical Exam</td>
</tr>
<tr>
<td>G0403</td>
<td>Electrocardiogram, routine ECG w/12 leads; screening for the initial preventative PE</td>
</tr>
<tr>
<td>G0404</td>
<td>.....”tracing only, without interpretation and report</td>
</tr>
<tr>
<td>G0405</td>
<td>.....”interpretation and report only</td>
</tr>
</tbody>
</table>

G0403, G0404, G0405 can be billed in addition to G0402. EKG is no longer a required part of IPPE. No specific diagnosis (ICD-9) is required. Co-insurance, co-pay and/or deductible waived only for G0402.
First Annual Wellness Visit (AWV)

- Once in a lifetime exam including Personalized Prevention Plan Services (PPPS)
- Person Covered-
  - One who is no longer within 12 months after the effective date of first Medicare Part B Coverage
  - One who has not received either an initial preventative physical exam or an AWV within the past 12 months.
AWV Includes

- Establish or update the individual’s medical and family history.
- List the individual’s current medical providers and suppliers and all prescribed medications.
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements.
- Detect any cognitive impairment.
- Establish or update a screening schedule for the next 5 to 10 years including screenings appropriate for the general population, and any additional screenings that may be appropriate because of the individual patient’s risk factors.
- Furnish personalized health advice and appropriate referrals to health education or preventive services.
Annual Wellness Visit (AWV)

- Review of individual’s potential for depression
  - Including current or past experiences
  - Review functional ability and level of safety based on direct observation or screening questions/questionnaire
Annual Wellness Visit (AWV)

- Establish a written screening schedule for the individual, such as a checklist for the next 5-10 years, as appropriate
  - Patient’s health status
  - Screening History
  - Age appropriate preventive services
Annual Wellness Visit (AWV)

- Community-based lifestyle interventions to reduce health risks and promote self-management and wellness
  - Weight loss
  - Physical activity
  - Smoking cessation
  - Fall prevention
  - Nutrition
Annual Wellness Visit (AWV)

- Any other element(s) determined appropriate by the Secretary of Health and Human Services through the National Coverage Determination (NCD) process
- Not subject to “incident-to”
- Who may perform?
  - Doctor of medicine, – Doctor of osteopathy
  - Nurse practitioner, – Physician assistant, – Clinical nurse specialist
  - Health professional, which includes:
  - Health educator, • Registered dietitian
  - Nutrition professional, • Team of such medical professionals who are working under the direct supervision of a physician
Subsequent Wellness Visit (SWV)

- Performed 11 months after AWV & includes
  - Update to medical/family history
  - Measurements of weight (or waist circumference), blood pressure and routine measurements as deemed appropriate
  - Update to list of current medical providers/suppliers
  - Detection of any cognitive impairment
  - Update to written screening schedule
  - Update to list of risk factors
  - Furnish appropriate health advice and referral as appropriate
# Annual & Subsequent Wellness Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0438</td>
<td>Annual Wellness Visit, includes Personalized Prevention Plan of Service (PPPS), first visit</td>
</tr>
<tr>
<td>G0439</td>
<td>Annual Wellness Visit, includes PPPS, Subsequent Visit</td>
</tr>
</tbody>
</table>

No specific diagnosis (ICD-9) is required. Co-insurance, co-pay and/or deductible waived. When a significant, separately identifiable medically necessary E/M service in addition to the SWV, use 99201-99215 with modifier -25; however co-pay, deductible, co-insurance required for E/M Service.

E/M Service must be separately documented, no “double dipping” in history or exam.
Shared Medical Appointments (SMA)

- Currently, there are no Evaluation and Management (E/M) codes specific to SMA
- When each patient is provided a medically necessary, one-on-one encounter, use E/M codes to reflect problem visits
  - Diabetes
  - Obesity
  - Hypertension
  - Depression
Is a Shared Medical Appointment Billable with E/M codes?

- AAFP asked CMS if an E/M code such as 99213 might be appropriate to bill for a f-t-f visit in the course of a SMA, the context of which is educational.
CMS Guidelines to AAFP

The response from CMS was, "...under existing CPT codes and Medicare rules, a physician could furnish a medically necessary face-to-face E/M visit (CPT code 99213 or similar code depending on level of complexity) to a patient that is observed by other patients. From a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary." The letter went on to state that any activities of the group (including group counseling activities) should not impact the level of code reported for the individual patient.
Key Components of SMA

- One-on-One E/M requires 2/3 key components
  - History
    - History of Present Illness
    - ROS
  - Exam
    - Vital Signs
  - MDM
    - Diagnosis, Labs
  - Time spent in counseling/coordination of care
    - For patients with chronic disease this format is recommended
Other Code Options

- If your group visits include the services of nutritionists or a behavioral health specialist, contact payers to determine if that portion of the group visit can be directly billed by the non-physician provider. This typically would include codes for medical nutrition therapy (97804) or health and behavior intervention (96153).

Other codes that may be applicable are the codes for education and training for patient self-management involving a standardized curriculum (98961-98962). Neither these codes nor medical nutrition or behavioral health therapy are billed by physicians. Physicians must use evaluation and management codes to report these services.

Code 99078 describes physician educational services in a group. Again, it is necessary to contact the payer to verify that coverage of this service is a payable benefit.
Guidance from the CDC on Health Risk Assessment

- At the request of the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC) is providing initial guidance on the development of a health risk assessment tool.

Insurance Coverage Issues

- Insurance plans vary on the range of services covered by a patient’s policy
- High deductibles, copays, co-insurance should be verified before providing a service
- Medical Necessity is key
- Preventive services are often covered but research your contacted payers for their reimbursement policies
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• The AMA assumes no liability for the data contained herein.
About the Speaker

Nancy M Enos, FACMPE, CPMA CPC-I, CEMC is an independent consultant with the MGMA Health Care Consulting Group. Mrs. Enos has 35 years of experience in the practice management field. Nancy was a practice manager for 18 years before she joined LighthouseMD in 1995 as the Director of Physician Services and Compliance Officer. In July 2008 Nancy established an independent consulting practice, Nancy Enos Medical Coding (www.nancyenoscoding.com).

As an Approved PMCC and ICD-10 Instructor by the American Academy of Professional Coders, Nancy provides coding certification courses, outsourced coding services, chart auditing, coding training and consultative services and seminars in CPT and ICD-9 and ICD-10 Coding, Evaluation and Management coding and documentation, and Compliance Planning. Nancy frequently speaks on coding, compliance and reimbursement issues to audiences including National, State and Sectional MGMA conferences, and at hospitals in the provider community specializing in primary care and surgical specialties.

Nancy is a Fellow of the American College of Medical Practice Executives. She serves as a College Forum Representative for the American College of Medical Practice Executives. She is on the board of Eastern Section MGMA and serves as Past President.