Optimizing Revenue with Correct Documentation and Coding

SALLY STREIBER, BS, MBA, CPC, CEMC

BETHANY PARSELL, MSN, APRN, CNP, CUNP

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OAAPN Reimbursement Goals

To be recognized as credentialed and contracted providers

Full recognition of APRNs as primary care providers by all insurance payers

Promote equitable and fair reimbursement for APRN health care services

- Equal pay for equal work
- Accurate co-pays
- Removal of requirement that the APRNs collaborating physician be a recognized and credentialed network provider
- Proper credentialing

Ohio Specific Payer Issues

Review insurance Matrix

Work toward 100% reimbursement

100% Medicaid reimbursement!

Refusal of insurer to note the APRN as the PCP on the members ID card

Insurer not credentialing an APRN because the provider panel is “full”

6 week requirement on Medco-14 through BWC

100% Medicaid Reimbursement

Your OAAPN reimbursement team created a white paper and rule review language advocating for 100% Medicaid reimbursement during the rule writing process for non-institutional rate increases!

Further meetings scheduled during Statewide!

BWC

Had a meeting with BWC

- Took two years to solidify
- First time OAAPN met with BWC in our history

Submitted language for removal of the required physician signature on the Medco-14 after 6 weeks

Working through continued follow-up and engagement with stakeholders to get this removed

- Requesting letters from rural providers about this barrier to care

Ohio Department of Health

Working toward the ability to certify children for eligibility for CMH

Language written to change rule

Second meeting scheduled with ODH during Statewide!

OAAPN Member Benefits

Engages legal counsel to assist in addressing member reimbursement problems

Meets with all insurers to resolve member problems as they are reported

Promotes regular communication with Medicaid

Seeks expert billing and coding advice for member questions

Works with national leadership to address practice barriers

Just ask, OAAPN can help!

Architecture

- All aspects of the medical encounter contribute to the building/billing of CPT codes.

This involves the proper registration of the patient, the appropriate assessment of the patient's situation, the care given, the documentation of this care and the mechanism for turning all of this information into billable code.

Foundations

Documentation

- Clinical Arena
  - What is documentation?
  - Why do we document?

Clinical Arena

What is documentation?

A chronological record of patient care composed of pertinent facts, findings and observations. This includes a health history containing past and present illnesses, examinations, tests, treatments and outcomes.

Clinical Arena

Why do we document?

- Enhances the provider's ability to evaluate and plan the patient's immediate treatment and to monitor that care/treatment over time.
- Promotes communication and continuity of care among providers
- Provides for accurate and timely claim review and payment
- Permits utilization review and quality of care evaluation
- Collects data used in research and education

Foundations

Payer Arena

- What do Payers wants to see?
- Why?

Payer Arena

What do Payers want to see?

- Place of Service
- Medical Necessity
- Appropriateness of therapeutic / diagnostic services provided
- Accurate reporting of services rendered

Payer Arena

Why?

- Payers have contractual obligation to those who pay for coverage
- Documentation standards may be present in contracts (example CPT versus CMS)
- $$Cash Management$$

Foundations

General Principles of Medical Documentation

Neat and Legible

In each encounter:

- Reason for the encounter – Medical Necessity
- Relevant History and Physical
- Assessment, Clinical Impression/ Diagnosis
- Plan of Care
- Date and Legible Identification of Provider

Foundations

General Principles of Medical Documentation

If not documented, rationale for ordering diagnostics or other ancillary services should be easily inferred

Past and present diagnoses should be accessible

Health risk factors should be identified

Foundations

General Principles of Medical Documentation

Progress, response to and changes in treatment and revisions in diagnosis should be present

CPT and ICD-10-CM codes on the claim form should be supported by the documentation in the medical record

Diagnosis Coding

Diagnosis code(s) selected must be reflected in the documented medical record

- Always distinguish between acute, chronic and acute on chronic conditions
- Identify how an injury occurred – this will require an ICD-10 code of “W”, “X” and/or “Y”
- Always assign the ICD-10 code to the highest level of specificity (4th, 5th, 6th or 7th character)
- Always code all diagnoses addressed and documented in the medical record
- Always code all diagnoses which were considered when creating your assessment and plan
- When ordering diagnostic testing, use the ICD-10 code that supports the reason for the testing

Diagnosis Coding

Diagnosis code(s) selected must be reflected in the documented medical record

- "Rule-out's" do not have ICD-10 codes – use signs and/or symptoms if a definitive diagnosis is not available
- Routine lab tests performed in the absence of symptoms use:
  - Z00.00 – Encounter for general adult medical examination without abnormal findings
  - Z00.01 – Encounter for general adult medical examination with abnormal findings
- Routine tests ordered due to a personal or family history use the corresponding "Z" diagnosis code
- **Remember to add in appropriate Social Determinants of Health diagnoses**

Proper Selection

Evaluation and Management Coding is always based on two things:

1. What you are doing and
2. Where you are

Where – Place of Service

Place of Service (POS) tells the payer what fee schedule to use

- Telehealth with Patient not in their Home (POS) 02
- Telehealth with Patient in their Home (POS) 10
- Walk-in Retail Health Clinic (POS) 17
- Office is Place of Service (POS) 11
- Outpatient Hospital (Off Campus) is (POS) 19
- Outpatient Hospital (On Campus) is (POS) 22
- Inpatient is Place of Service (POS) 21
- Skilled Nursing Facility is Place of Service (POS) 31
- Nursing Facility is Place of Service (POS) 32

Where – Place of Service

Place of Service (POS) tells the payer what fee schedule to use

Here's why POS is so important:

	Office (POS 11)	wRVU	Outpatient Hospital (POS 22)	wRVU	Payment Facility Billing
99202	$69.63	0.93	$47.07	0.93	$$
99203	$108.56	1.60	$81.36	1.60	$$
99204	$161.60	2.60	$130.70	2.60	$$
99205	$213.53	3.50	$177.37	3.50	$$

What is the Minimal Information Required to Create a Billing Encounter?

Minimum of Five Pieces of Data:

- Patient
- Provider of Service
- Date of Service
- Actual Service
- Diagnosis to Support Performing the Service

What is the Minimal Information Required to Create a Billing Encounter That is Likely to Be Paid?

Information from the prior slide plus:

Correct Demographics

Correct Insurance Information

Accurate Charge Entry

Accurate Edits

Accurate Claim Submission

Accurate Claim Adjudication

New vs. Established Patient

A new patient is one who has not received any professional services from the provider or another provider of the same specialty **and subspecialty** in your billing practice within the past 3 years.

In the instance where a physician or other QHCP is on call for or covering for another physician or QHCP, the patient's encounter will be classified as it would have been by the physician or other QHCP who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

Medicare views this differently: Advanced Practice Nurses and Physician Assistants are viewed as their own specialty by credential. (CNP, CNS, PA)

Best Practice: If the patient was seen by you in the past three years, regardless of what practice you were associated with, treat the encounter as an established patient visit. Many payers view the relationship of the patient to the provider as the defining factor, not the fact that you may be working for a different practice (different tax ID).

Original Components of E & M's – But only MDM or Time Determine the Level of Service

History

Physical Examination

Medical Decision Making *

Time*

* Indicates determination of level of service

Components of the History

Comprised of the following:

Chief Complaint (CC)

History of Present Illness (HPI)

Review of Systems (ROS)

Past Medical, Family and/or Social Histories (PFSH)

Chief Complaint

A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is reason for the encounter.

i.e.- Why is the patient being seen?

May be in the patient's own words

May be gathered by ancillary staff

History of Present Illness

A chronological description of the development of the present illness. It can include:

- **1)location, 2)quality, 3)severity, 4)duration, 5)timing, 6)context, 7)modifying factors, and 8)associated signs and symptoms**
- **L I T T – Location, Intensity (Severity), Timing and Treatment (Modifying Factors)**

Extended HPI requires at least four elements **OR**

the status of at least three chronic or inactive conditions

May be documented by ancillary staff with verification by billing provider

Review of Systems

An inventory of body systems seeking to identify signs and/or symptoms that the patient has been and/or is experiencing

Recognized Body Systems for Review of Systems

- Constitutional
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Psychiatric
- Neurologic
- **Endocrine**
- Hematologic/Lymphatic
- Allergy/Immunologic

Review of Systems

Think Review of **Symptoms**

When a *comprehensive* ROS is needed, the correct documentation is:

- *"All other systems have been reviewed and are negative except as previously noted"*
- *"Unless noted in the HPI, all other systems have been reviewed and are negative for complaint"*
- *"Unremarkable"* and *"Noncontributory"* must be avoided

Past Medical, Family and Social Histories

Past History: patient's past experiences with illnesses, operations, injuries, and treatments

Family History: review of medical events in the patient's family including diseases which may be hereditary or place patient at risk

Social History: age appropriate review of past and current activities; alcohol, tobacco, illicit drug use

Proper Coding Documentation

Correct documentation is:

Past, family, and social history ***obtained*** but not pertinent to current problem.

"Unremarkable" and *"Noncontributory"* must be avoided

Physical Examination – General Information

The following body areas are recognized: (applicable to 1995 CMS)

- head including the face
- neck
- chest including the breasts and axilla
- abdomen
- genitalia, groin, buttocks
- back, including spine
- each extremity

1995 Physical Examination Guidelines

- Constitutional (vital signs and general appearance)
- Eyes
- Ears/Nose/Mouth/Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/ Immunologic

Physical Examination – CPT Guidelines

The levels of E/M services are based on 4 types of examination. These types are dependent upon the number of body areas and/or organ systems examined for the general examination.

The types are:

- Problem Focused
- Expanded Problem Focused
- Detailed
- Comprehensive

Physical Exam – CPT versus CMS Guidelines

Type of Examination	**1995**	**1997**
Problem Focused	Limited Exam, affected area/system (one)	1 to 5 bullets
Expanded Problem Focused	2 to 7 systems	At least 6 bullets
Detailed	2 to 7 systems (more detail)	At least 12 bullets **(At least 9 bullets for Eye and Psych)**
Comprehensive	8 or more systems	Perform and document every element identified by a bullet in a shaded system/ body area and document at least one element in an unshaded system/body area

1997 Cardiovascular Examination Requirements

1997 Documentation Guidelines: Cardiovascular Examination	
Content and Documentation Requirements	
Level of Exam	**Perform and Document**
Problem Focused	**One to five** elements identified by a bullet
Expanded Problem Focused	**At least six** elements identified by a bullet
Detailed	**At least twelve** elements identified by a bullet
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a **shaded border** and at least one element in each box with an unshaded border
System/Body Area	**Elements of Examination**
Constitutional	• Measurement of **any three of the following seven vital signs:** 1. Sitting or Standing Blood Pressure 2. Supine Blood Pressure 3. Pulse Rate and Regularity 4. Respirations 5. Temperature 6. Height 7. Weight • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Cardiovascular	• Palpation of heart (e.g, location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) • Auscultation of heart including sounds, abnormal sounds and murmurs • Measurement of blood pressure in two or more extremities when indicated (e.g., aortic dissection, coarctation) Examination of: • Carotid arteries (e.g., waveform, pulse amplitude, bruits, apical-carotid delay) • Abdominal aorta (e.g., size, bruits) • Femoral arteries (e.g., pulse amplitude, bruits) • Pedal pulses (e.g., pulse amplitude) • Extremities for peripheral edema and/or varicosities

System/Body Area	Elements of Examination
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place and person • Mood and affect (e.g., depression,anxiety, agitation)
Eyes	• Inspection of conjunctivae and lids (e.g., xanthelasma)
Ears, Nose, Mouth and Throat	• Inspection of teeth, gums and palate • Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	• Examination of jugular veins (e.g., distension; a, v or cannon a waves) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Musculoskeletal	• Examination of the back with notation of kyphosis or scoliosis • Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs • Assessment in muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
Extemities	• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., stasis dermatitis, ulcers, scars, xanthomas)

Evaluation and Management Coding – Current Requirements

AMA Evaluation and Management Current Status

- Extensive E/M guideline additions, revisions and restructuring
- Most Evaluation and Management Codes are impacted
- Deletion of code 99201, 99241, 99251, 99343
- Components for code selection:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

AMA Evaluation and Management Changes

Summary of Major E/M Revisions since 2021:

- E/M level of service can be based on:
  - **MDM**
    - Extensive clarifications provided in the guidelines to define the elements of MDM
  - **Time:** Total time spent with the patient on the date of the encounter
    - Including non-face-to-face services
    - Clear time ranges for each code
- Addition of a shorter 15-minute prolonged service codes (99417, 99418 or "G" codes for Medicare and Medicare Managed Care Payers)
  - To be reported only when the visit is based on time **and** after the total time of the highest level service has been exceeded

MDM Terms and Definitions

Definition Examples

Problem Addressed: The problem must be evaluated or treated at the encounter in order to be considered as being addressed.

A notation in the medical record that another provider is managing a problem without additional assessment or care coordination being documented does not qualify as being addressed or managed by the provider.

Referral without documented evaluation (by history, physical examination or diagnostic study[ies] or consideration of treatment does not qualify as being addressed or managed.

MDM Terms and Definitions

Definition Examples

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. **For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for 'self-limited or minor' or 'acute, uncomplicated.'** Systemic symptoms may not be general, but may be single system.

MDM Terms and Definitions

Definition Examples

Stable, chronic illness: A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). **'Stable' for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or function.** For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

MDM Terms and Definitions

Definition Examples

***Chronic illness with exacerbation, progression, or side effects of treatment*:** A chronic illness that is acutely worsening, **poorly controlled** or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents **a condition likely to result in a high risk of morbidity without treatment**.

MDM Terms and Definitions

Definition Examples

Acute illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without function impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Multiple morbidities requiring intensive management: A set of conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital. **(Only applicable to Initial Nursing Facility Encounters)**

Important Topics*

Documentation of Medical Decision Making

- Remember to document the additional “by the way” problems that occur during the visit
- Use severity terminology, i.e., moderate or severe
- Document testing as ordered/reviewed vs. independently interpreted
- Document discussions with other providers
- Document history obtained from and/or discussions with family members or other caregivers

*All of these items are routinely missing from documentation

Office and Outpatient Hospital Encounters

Time Based Billing for New Patient and Established Patient Visits - Effective 1/1/2021					
New Patient E/M Codes	**Total Time 2023**	**Estab. Patient E/M Codes**	**Total Time 2023**	**Ambulatory Consultations**	**Total Time 2023 Meet or Exceed**
99201	**Code Deleted**	99211	None	**99241**	**Code Deleted**
99202	15 - 29 minutes	99212	10 - 19 minutes	99242	20 minutes
99203	30 - 44 minutes	99213	20 - 29 minutes	99243	30 minutes
99204	45 - 59 minutes	99214	30 - 39 minutes	99244	40 minutes
99205	60 - 74 minutes	99215	40 - 54 minutes	99245	55 minutes
99417 Prolonged	Ea Addl 15 min counting from 60 min	99417 Prolonged	Ea Addl 15 min counting from 40 min	99417 Prolonged	Ea Addl 15 min
G2212 Medicare	Ea Addl 15 min counting from 74 min	G2212 Medicare	Ea Addl 15 min counting from 54 min	**Medicare Consults bill New Patient Visits**	

Physician/Other Qualified Health Care Professional Time Includes the Following Activities When Performed on the Date of the Patient Encounter:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, test or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Office and Outpatient Hospital Encounters

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	**N/A**	**N/A**	**N/A**	**N/A**
99202 **99212** **99242**	**Straightforward**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
99243
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury requiring hospital or observation level of care
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretations, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212 99242	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

99203
99213
99243
	Low	Low
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury;
		or
		• **1** stable, acute illness;
		or
		• **1** acute, uncomplicated illness or injury requiring hospital or observation level of care
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretations, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

How to Count Data Points

If you order it and it's done outside of your practice, count it.

If you order it and it's done inside your practice, don't count it **but bill for it.**

If you are reviewing studies that were ordered by another provider (outside of your practice and specialty) you can count this for data calculation.

If you ordered it and counted it at a prior visit, you cannot count the review in a visit at a later date. Review is expected when ordering tests.

If you order a test that is going to be read or interpreted by another specialty and you provide your personal interpretation of the image, tracing or specimen (raw data) you count the order and the personal interpretation in your data points. This must be documented something like this:
I personally reviewed the _____ from _____ and this is my personal interpretation:

Office and Outpatient Hospital Encounters

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		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management

99204
99214
99244
	Moderate	**Moderate**
		• **1** or more chronic illnesses with 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 with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			*(Must meet the requirements of at least **1** of the 3 categories)*
			Category 1: Tests, documents or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretations of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management

99204
99214
99244
	Moderate	**Moderate**
		• **1** or more chronic illnesses with 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 with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

Prescription Drug Management

Instruction from CGS (Ohio Medicare MAC)

- The medical decision making to adjust any prescription medication when addressing and managing a problem or disease requires a higher complexity than refilling or continuing a medication; therefore, **the documentation must be clear and concise when describing why a prescription medication was changed or continued.** Simply providing a list of the patient's medications or stating 'reviewed' would not be considered prescription drug management complexity.

Office and Outpatient Hospital Encounters

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99205 **99215** **99245**	**High**	**High** • **1** or more chronic illnesses with severe exacerbation, progression or side effects of treatment; **or** • **1** acute or chronic illness or injury that poses a threat to life or bodily function	**High** *(Must meet the requirements of at least **2** of the 3 categories)* **Category 1: Tests, documents or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretations of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** ***Examples only:*** • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management

99205
99215
99245
	High	**High**
		• **1** or more chronic illnesses with **severe** exacerbation, progression, or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization or escalation of hospital-level care
				• Decision not to resuscitate or to de-escalate care because of poor prognosis
				• Parenteral controlled substances

Time-Based Billing

Coding can be based on either

Medical Decision Making

or

Time

Time

Time spent by Provider – face-to-face and non-face-to-face time

- Preparing to see the patient
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary appropriate physical examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests or procedures
- Referring and communicating with other providers (if not reported separately)
- **Documenting clinical information in your medical record**
- Independently interpreting results and communicating results to patient/family/caregiver
- Care coordination (if not reported separately)

Only the time of Billing Providers can be used

Document Details of Time Spent

Amount of Time Spent: Prep Time on Date of Patient Encounter: ☐ _____ minutes Time Spent with Patient/Family/Caregiver: ☐ _____ minutes Additional Time Spent on Patient Care Activities: ☐ _____ minutes Documentation Time in Medical Record: ☐ _____ minutes Other Time Spent on Date of Patient Encounter: ☐ _____ minutes Provide Details Pertaining to Other Time Spent
Total Time on Date of Patient Care Encounter: ☐ _____ minutes

New Patient Visits – Office / Outpatient Hospital

Office / Outpatient Consultation Encounters

- 99202 – 99205

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare Office	Medicare Outpatient	Medicaid Office	Medicaid Outpatient
99202	New Patient Visit, Level 2	0.93	$ 69.83	$ 47.07	$38.93	$20.84
99203	New Patient Visit, Level 3	1.60	$ 108.56	$ 81.36	$57.76	$32.94
99204	New Patient Visit, Level 4	2.60	$ 161.60	$ 130.70	$88.07	$56.15
99205	New Patient Visit, Level 5	3.50	$ 213.53	$ 177.37	$110.67	$72.01

Established Patient Visits – Office / Outpatient Hospital

Office / Outpatient Consultation Encounters

- 99211 – 99215

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare Office	Medicare Outpatient	Medicaid Office	Medicaid Outpatient
99211	Established Patient Visit, Level 1	0.18	$ 21.91	$ 8.62	$14.50	$5.55
99212	Established Patient Visit, Level 2	0.70	$ 54.32	$ 34.85	$26.73	$12.81
99213	Established Patient Visit, Level 3	1.30	$ 87.21	$ 64.65	$43.61	$24.85
99214	Established Patient Visit, Level 4	1.92	$ 123.57	$ 95.45	$66.14	$39.90
99215	Established Patient Visit, Level 5	2.80	$ 173.48	$ 140.10	$89.63	$57.36

Consultations – Office / Outpatient Hospital

Office / Outpatient Consultation Encounters

- 99242 – 99245

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare Office	Medicare Outpatient	Medicaid Office	Medicaid Outpatient
99242	Outpatient/Office Consult Level 2	1.34	N/A	N/A	$ 39.00	$ 23.66
99243	Outpatient/Office Consult Level 3	1.88	N/A	N/A	$ 53.41	$ 32.90
99244	Outpatient/Office Consult Level 4	3.02	N/A	N/A	$ 78.63	$ 51.82
99245	Outpatient/Office Consult Level 5	3.77	N/A	N/A	$ 97.57	$ 66.28

“Consultations” and Medicare Patients

Outpatient or Office

- Use New Patient Visit Codes unless the patient is known to your practice and has been seen within the past three years
- If the patient has been seen within the last three years, use Established Patient Visit Codes

Prolonged Services – 99417

- Shorter increment – each 15 minutes – but only used when billing by time
- For use only with 99205, 99215, 99245, 99345, 99350 and 99483
- Only reportable on the date of service of the Evaluation and Management Code
- If Prolonged Services is less than 15 minutes, there will be no Prolonged Service reported
- Can bill 99358 Prolonged Services without Direct Patient Contact on a date **other than** the date of the encounter
- **Medicare will be utilizing G2212 codes for Ambulatory Visit Prolonged Services.**
- **Medicare will be utilizing G0318 codes for Home and Residence Visit Prolonged Services.**

How to Bill with Prolonged Services 99417

Total Duration of New Patient Office Visits Billed with 99205	
Total Time	Billed Codes:
60 - 74 minutes	99205 only
75 - 89 minutes	99205 and 99417 X 1
90 - 104 minutes	99205 and 99417 X 2
105 minutes and so on	99205 and 99417 X 3 or more for each additional 15 minutes

Total Duration of Established Patient Office Visits Billed with 99215	
Total Time	Billed Codes:
40 - 54 minutes	99215 only
55 - 69 minutes	99215 and 99417 X 1
70 - 84 minutes	99215 and 99417 X 2
85 minutes and so on	99215 and 99417 X 3 or more for each additional 15 minutes

How to Bill with Prolonged Services G2212
Use with Medicare and Medicare Managed Care Payers

Total Duration of New Patient Office Visits Billed with 99205	
Total Time	Billed Codes:
60 - 74 minutes	99205 only
At least 89 minutes	99205 and G2212 X 1
At least 104 minutes	99205 and G2212 X 2
At least 119 minutes and so on	99205 and G2212 X 3 or more for each additional 15 minutes

Total Duration of Established Patient Office Visits Billed with 99215	
Total Time	Billed Codes:
40 - 54 minutes	99215 only
At least 69 minutes	99215 and G2212 X 1
At least 84 minutes	99215 and G2212 X 2
At least 99 minutes and so on	99215 and G2212 X 3 or more for each additional 15 minutes

Work RVU's

New Patient E/M Codes	2020 wRVU	2023 wRVU	Change	Percentage Change
99201	0.48	Deleted	N/A	
99202	0.93	0.93	0.00	0%
99203	1.42	1.60	0.18	13%
99204	2.43	2.60	0.17	7%
99205	3.17	3.50	0.33	10%

Established Patient E/M Codes	2020 wRVU	2023 wRVU	Change	Percentage Change
99211	0.18	0.18	0.00	0%
99212	0.48	0.70	0.22	46%
99213	0.97	1.30	0.33	34%
99214	1.50	1.92	0.42	28%
99215	2.11	2.80	0.69	33%

Inpatient and Observation Encounters

Time Based Billing for IP, Obs and Same Day In and Out Patient Visits - Effective 1/1/2023					
Initial IP or Obs E/M Codes	**Total Time 2023 Meet or Exceed**	**Subs IP or Obs E/M Codes**	**Total Time 2023 Meet or Exceed**	**Same Day I/O E/M Codes**	**Total Time 2023 Meet or Exceed**
99221	40 minutes	99231	25 minutes	99234	45 minutes
99222	55 minutes	99232	35 minutes	99235	70 minutes
99223	75 minutes	99233	50 minutes	99236	85 minutes
99418 Prolonged	Ea Addl 15 min counting from 75 min	99418 Prolonged	Ea Addl 15 min counting from 50 min	99418 Prolonged	Ea Addl 15 min counting from 85 min
G0316 Medicare	Time Threshold 90 min	G0316 Medicare	Time Threshold 65 min	G0316 Medicare	Time Threshold 110 min
Inpatient or Observation Status Consultations - 99251 Deleted				**Discharge Day Management**	
99252	35 minutes	99255	80 minutes	99238	No Time Required
99253	45 minutes	99418 Prolonged	Ea Addl 15 min counting from 80 min	99239	> 30 min Time Required
99254	60 minutes	**Medicare Consults bill Initial IP/Obs Codes**		**DDM Time Spent on Date of Encounter**	

Physician/Other Qualified Health Care Professional Time Includes the Following Activities When Performed on the Date of the Patient Encounter:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, test or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver

Inpatient and Observation Encounters

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed at the Encounter	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
	N/A	**N/A**	**N/A**	**N/A**
99221 **99231** **99252**	**Straightforward**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99221
99231
99234
99253
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable, chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
		or
		• **1** stable, acute illness;
		or
		• **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretations, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

Inpatient and Observation Encounters

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99222 **99232** **99235** **99254**	**Moderate**	**Moderate** • **1** or more chronic illnesses with 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 with systemic symptoms; **or** • **1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least **1** of the 3 categories)* **Category 1: Tests, documents or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretations of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** ***Examples only:*** • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

Inpatient and Observation Encounters

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed at the Encounter	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99223 **99233** **99236** **99255**	**High**	**High** • **1** or more chronic illnesses with severe exacerbation, progression or side effects of treatment; **or** • **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least **2** of the 3 categories)* **Category 1: Tests, documents or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretations of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** ***Examples only:*** • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Inpatient Encounter Coding

Initial Hospital Care Encounters
- 99221 – 99223

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare Inpatient	Medicaid Inpatient	Time/Min
99221	Initial Hospital Day, Level 1	1.92	$ 81.81	$ 37.61	30
99222	Initial Hospital Day, Level 2	2.61	$ 127.86	$ 55.71	50
99223	Initial Hospital Day, Level 3	3.86	$ 170.31	$ 76.84	70

Inpatient Encounter Coding

Subsequent Hospital Care Encounters
- 99231 – 99233

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare Inpatient	Medicaid Inpatient	Time/Min
99231	Subsequent Hospital Day, Level 1	0.76	$ 48.92	$ 17.49	15
99232	Subsequent Hospital Day, Level 2	1.39	$ 77.67	$ 28.18	25
99233	Subsequent Hospital Day, Level 3	2.00	$ 116.86	$ 40.28	35

Inpatient Discharge Day Management

Discharge Day Management

- 99238
- 99239 (Time based – more than 30 minutes)

Procedure Code	Description	wRVU	Medicare Inpatient	Medicaid Inpatient	Time/Min
99238	Discharge Day Management	1.50	$ 78.90	$ 31.62	N/A
99239	Discharge Day Management > 30 min	2.15	$ 112.05	$ 41.78	>30

Admit/Discharge or Observation In and Out on Same Day

Admit/Discharge or Observation – In and Out on the Same Date of Service

- 99234 – 99236

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare Inpatient	Medicaid Inpatient	Time/Min
99234	Admit/Discharge, Same Day, Level 1	2.56	$ 97.13	$ 58.36	40
99235	Admit/Discharge, Same Day, Level 2	3.24	$ 156.40	$ 79.55	50
99236	Admit/Discharge, Same Day, Level 3	4.20	$ 205.04	$ 96.73	55

Consultations – Inpatient Hospital

Office / Outpatient Consultation Encounters

- 99252 – 99255

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare Inpatient	Medicaid Inpatient
99252	Inpatient Consultation Level 2	1.50	N/A	$ 36.96
99253	Inpatient Consultation Level 3	2.27	N/A	$ 49.25
99254	Inpatient Consultation Level 4	3.29	N/A	$ 69.17
99255	Inpatient Consultation Level 5	4.00	N/A	$ 92.32

“Consultations” and Medicare Patients

Inpatient, Observation, Nursing Facilities and Partial Hospital Settings

- Use Initial Hospital Care or Initial Nursing Facility Care Codes
- Follow-up encounters are billed with Subsequent Hospital Care or Subsequent Nursing Facility Care Codes

Nursing Facility Encounters

Time Based Billing for Nursing Facility and Consult Patient Visits - Effective 1/1/2023					
Initial NF E/M Codes	**Total Time 2023 Meet or Exceed**	**Subs NF E/M Codes**	**Total Time 2023 Meet or Exceed**	**NF Consult E/M Codes**	**Total Time 2023 Meet or Exceed**
99304	25 minutes	99307	10 minutes	99252	35 minutes
99305	35 minutes	99308	15 minutes	99253	45 minutes
99306	45 minutes	99309	30 minutes	99254	60 minutes
99418 Prolonged	Ea Addl 15 min counting from 45 min	99310	45 minutes	99255	80 minutes
G0317 Medicare	Time Threshold 95 min	99418 Prolonged	Ea Addl 15 min counting from 45 min	99418 Prolonged	Ea Addl 15 min counting from 80 min
Medicare Consults bill Initial NF Codes		G0317 Medicare	Time Threshold 85 min	**Medicare Consults bill Initial NF Codes**	
Discharge Day Management		99238	No Time Required	99239	> 30 min Time Required

Physician/Other Qualified Health Care Professional Time Includes the Following Activities When Performed on the Date of the Patient Encounter:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, test or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Nursing Facility Encounters

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99304 **99307** **99252**	**Straightforward**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99304
99308
99253
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable, chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
		or
		• **1** stable, acute illness;
		or
		• **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretations, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

Nursing Facility Encounters

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99305 **99309** **99254**	**Moderate**	**Moderate** • **1** or more chronic illnesses with 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 with systemic symptoms; **or** • **1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least **1** of the 3 categories)* **Category 1: Tests, documents or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretations of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** ***Examples only:*** • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

Nursing Facility Encounters

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed at the Encounter	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management

99310
99255
99306
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			*(Must meet the requirements of at least **2** of the 3 categories)*
			Category 1: Tests, documents or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretations of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization or escalation of hospital-level care
				• Decision not to resuscitate or to de-escalate care because of poor prognosis
				• Parenteral controlled substances

99306	**High**	• Multiple morbidities requiring intensive management **(only applicable for 99306)**		

Nursing Facility Coding

Initial Nursing Facility Care Encounters

- 99304 – 99306

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare Facility	Medicaid Facility	Time/Min
99304	Initial Nursing Facility Day, Level 1	1.50	$ 78.59	$ 34.05	25
99305	Initial Nursing Facility Day, Level 2	2.50	$ 130.14	$ 45.28	35
99306	Initial Nursing Facility Day, Level 3	3.50	$ 177.83	$ 55.71	45

Nursing Facility Coding

Subsequent Nursing Facility Care Encounters
- 99307 – 99310

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare Facility	Medicaid Facility	Time/Min
99307	Subsequent Nursing Facility Day, Level 1	0.70	$ 38.45	$ 18.11	10
99308	Subsequent Nursing Facility Day, Level 2	1.30	$ 72.38	$ 29.76	15
99309	Subsequent Nursing Facility Day, Level 3	1.92	$ 103.69	$ 41.58	25
99310	Subsequent Nursing Facility Day, Level 4	2.80	$ 149.32	$ 51.54	35

Nursing Facility Discharge Day Management

Nursing Facility Discharge Day Management

- 99315
- 99316 (Time based – more than 30 minutes)

Procedure Code	Description	wRVU	Medicare Facility	Medicaid Facility	Time/Min
99315	Nursing Facility Discharge Day Management	1.50	$ 79.47	$ 31.99	N/A
99316	Nursing Facility Discharge Day Management > 30 min	2.50	$ 128.29	$ 41.91	>30

Home/Residence Encounters

Time Based Billing for Home and Residence Patient Visits - Effective 1/1/2023					
Initial Home/ Residence E/M Codes	**Total Time 2023 Meet or Exceed**	**Subs Home/ Residence E/M Codes**	**Total Time 2023 Meet or Exceed**	**Ambulatory Consult E/M Codes**	**Total Time 2023 Meet or Exceed**
99341	15 minutes	99347	20 minutes	99242	20 minutes
99342	30 minutes	99348	30 minutes	99243	30 minutes
99344	60 minutes	99349	40 minutes	99244	40 minutes
99345	75 minutes	99350	60 minutes	99245	55 minutes
99417 Prolonged	Ea Addl 15 min counting from 75 min	99417 Prolonged	Ea Addl 15 min counting from 60 min	99417 Prolonged	Ea Addl 15 min counting from 70 min
G0318 Medicare	Time Threshold 140 min	G0318 Medicare	Time Threshold 110 min	**Medicare Consults bill New Patient Visits**	

Physician/Other Qualified Health Care Professional Time Includes the Following Activities When Performed on the Date of the Patient Encounter:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, test or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Home/Residence Encounters

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed at the Encounter	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99341 **99347** **99242**	**Straightforward**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99342 **99348** **99243**	**Low**	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable, chronic illness; **or** • **1** acute, uncomplicated illness or injury **or** • **1** stable, acute illness; **or** • **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretations, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**

Home/Residence Encounters

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99344 **99349** **99244**	**Moderate**	**Moderate** • **1** or more chronic illnesses with 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 with systemic symptoms; **or** • **1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least **1** of the 3 categories)* **Category 1: Tests, documents or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretations of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** ***Examples only:*** • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

Home/Residence Encounters

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management

99345
99350
99245
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			*(Must meet the requirements of at least **2** of the 3 categories)*
			Category 1: Tests, documents or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretations of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization or escalation of hospital-level care
				• Decision not to resuscitate or to de-escalate care because of poor prognosis
				• Parenteral controlled substances

Home Care New Patients

Home Care New Patient Encounters
- 99341, 99342, 99344, 99345

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare in Home	Medicaid in Home	Time/Min
99341	Home Care New Patient Level 1	1.00	$ 47.69	$ 38.08	20
99342	Home Care New Patient Level 2	1.65	$ 76.41	$ 52.98	30
99344	Home Care New Patient Level 3	2.87	$ 140.83	$ 98.21	60
99345	Home Care New Patient Level 4	3.88	$ 197.66	$ 118.60	75

Home Care Established Patients

Home Care Established Patient Encounters
- 99347 – 99350

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making **or**
  - Total time on the date of the encounter

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare in Home	Medicaid in Home	Time/Min
99347	Home Care Established Patient Level 1	0.90	$ 43.68	$ 29.81	15
99348	Home Care Established Patient Level 2	1.50	$ 74.42	$ 44.64	25
99349	Home Care Established Patient Level 3	2.44	$ 124.66	$ 66.16	40
99350	Home Care Established Patient Level 4	3.60	$ 181.99	$ 96.09	60

Prolonged Services – 99418

- Shorter increment – each 15 minutes – but only used when billing by time
- For use only with 99223, 99233, 99236, 99255, 99306 and 99310
- Only reportable on the date of service of the Evaluation and Management Code
- If Prolonged Services is less than 15 minutes, there will be no Prolonged Service reported
- Can bill 99358 (Prolonged Services without Direct Patient Contact on a date **other than** the date of the encounter
- **Medicare will be utilizing G0316 codes for Acute Care Facility Prolonged Services.**
- **Medicare will be utilizing G0317 codes for Nursing Facility Prolonged Services.**

Emergency Medicine Visits – Outpatient Hospital

Emergency Medicine Encounters

- 99281 – 99285

- Coding Requirements:
  - Medically appropriate history and/or physical examination*
  - Medical Decision Making

*Not used in code level selection

Procedure Code	Description	wRVU	Medicare Outpatient	Medicaid Outpatient
99281	Emergency Medicine Visit Level 1	0.25	$ 11.77	$ 11.62
99282	Emergency Medicine Visit Level 2	0.93	$ 41.61	$ 19.95
99283	Emergency Medicine Visit Level 3	1.60	$ 71.52	$ 35.55
99284	Emergency Medicine Visit Level 4	2.74	$ 120.19	$ 59.35
99285	Emergency Medicine Visit Level 5	4.00	$ 175.09	$ 88.90

Newborn Care Services

99460 – Initial hospital or birthing center care, per day, for normal newborn infant

99461 – Initial care, per day, of normal newborn infant seen in other than hospital or birthing center

99462 – Subsequent hospital care, per day, of normal newborn

99463 – Initial hospital or birthing center care, per day, of normal newborn infant admitted and discharged on the same date

Procedure Code	Description	wRVU	Medicare Inpatient	Medicaid Inpatient	Time/Min
99460	Initial Care, per day, for E/M of normal newborn infant seen in hospital or birthing center	1.92	$ 91.02	$ 74.73	Per Diem
99461	Initial Care, per day, for E/M of normal newborn infant seen in other than hospital or birthing center	1.26	$88.33/ $60.52	$67.94/ $47.18	Per Diem
99462	Subsequent Hospital Car, Per Day, for Evaluation and Management of Normal Newborn	0.84	$ 40.21	$ 33.10	Per Diem
99463	Hospital Care for Evaluation and Management of Normal Newborn Infant Adm/Dsch Same Date	2.13	$ 106.74	$ 88.52	Per Diem

Critical Care

99291 – 30 – 74 minutes

99292 – each additional 30 minutes

- Time Based Charging Only
- REQUIREMENT: In the provider's judgment there must be a high probability of the imminent failure of a body system.
- Best Practice: Name the body system

Must be time devoted to the patient's care but is not limited to face-to-face time (may include time for review of information pertinent to the care of the patient)

Must document the amount of time in the medical record

Per Medicare you may only report +99292 when you have met the full additional 30 minute component (74 + 30 minutes = 104 minutes)

Procedure Code	Description	wRVU	Medicare Office	Medicare Facility	Medicaid Office	Medicaid Facility
99291	Critical Care 30 - 74 minutes	4.50	$ 266.83	$ 210.58	$ 98.58	$ 69.33
+99292	Critical Care each addl 30 minutes	2.25	$ 117.55	$ 105.81	$ 49.37	$ 37.08

Prolonged Services without Direct Patient Contact

Prolonged Services without Direct Patient Contact

All Places of Service

- 99358 – Prolonged provider services before and/or after direct patient care; first hour (30 – 74 minutes)
- +99359 – each additional 30 minutes
- **Medicare no longer pays these codes**

Procedure Code	Description	wRVU	Medicare Office	Medicare Outpatient	Medicaid Office	Medicaid Outpatient	Time/Min
99358	Prolonged Service without Patient Contact, first hour	2.10	N/A	N/A	N/A	N/A	>31
+99359	Prolonged Service without Patient Contact, each additional 30 min	1.00	N/A	N/A	N/A	N/A	>16

Transitional Care Management

Level of Medical Decision Making	Face-to-face Visit within 7 days	Face-to-face Visit within 8 to 14 days
Moderate Complexity	99495	99495
High Complexity	99496	99495

Transitional Care Management

Three Components of Transitional Care Management

Communication of patient and/or caregiver within two business days of discharge

Non-Face-to-Face Services

- Review discharge information
- Follow-up on any needed testing or treatment
- Interact with other healthcare providers who will provide care and arrange for follow-up or needed services
- Provide Education to patient, family, guardian or caregiver(s)
- Establish referrals and assist with scheduling with community providers and services

Face-to-Face Visit

- One visit is required within 14 days of discharge

Transitional Care Management

99495 – Transitional Care Management

Covers 30 days beginning on the date of discharge

Communication of patient and/or caregiver within two business days of discharge

Medical decision making must be of **at least moderate complexity**

Face-to-face visit **within 14 calendar days of discharge**

Transitional Care Management

99496 – Transitional Care Management

Covers 30 days beginning on the date of discharge

Communication of patient and/or caregiver within two business days of discharge

Medical decision making must be of **high complexity**

Face-to-face visit **within 7 calendar days of discharge**

Chronic Care Management

99490 – Chronic Care Management

Requires at least 20 minutes of **clinical staff time** directed by a qualified health care professional, per calendar month when the following requirements are met:

- Two or more chronic conditions expected to last at least 12 months or until death and
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline and
- Comprehensive care plan established , implemented, revised or monitored

+99439 – each additional 20 minutes of **clinical staff time** directed by a qualified health care professional, per calendar month

Chronic Care Management

99491 – Chronic Care Management

Requires at least 30 minutes of **qualified health care professional time**, per calendar month when the following requirements are met:

- Two or more chronic conditions expected to last at least 12 months or until death and
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline and
- Comprehensive care plan established, implemented, revised or monitored

+99437 – each additional 30 minutes of **qualified health care professional staff time** directed by a qualified health care professional, per calendar month

Complex Chronic Care Management

99487– Complex Chronic Care Management

Requires at least 60 minutes of **clinical staff time** directed by a qualified health care professional, per calendar month when the following requirements are met:

- Two or more chronic conditions expected to last at least 12 months or until death and
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline and
- Comprehensive care plan established , implemented, revised or monitored
- Moderate or high complexity medial decision making

+99489 – each additional 30 minutes of **clinical staff time** directed by a qualified health care professional, per calendar month

Chronic vs. Complex Chronic Care

Chronic and Complex Chronic:

- Two or more chronic conditions expected to last at least 12 months or until death and
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline and
- Comprehensive care plan established, implemented, revised or monitored

Complex Chronic (additional requirements):

- Moderate or high complexity medical decision making (required)
- Need for the coordination of a number of specialties and services; **OR**
- Inability to perform activities of daily living and/or cognitive impairment resulting in poor adherence to the treatment plan without substantial assistance from a caregiver; **OR**
- Psychiatric and other medical comorbidities (eg, dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care; **AND/OR**
- Social support requirements or difficulty with access to care

Preventative Visits

Age of Patient	New Patient	Est. Patient
< 1 Year of Age	99381	99391
Age 1 - Age 4	99382	99392
Age 5 - Age 11	99383	99393
Age 12 - Age 17	99384	99394
Age 18 - Age 39	99385	99395
Age 40 - Age 64	99386	99396
Age 65 and Older	99387	99397

Preventative Visit and Sick Visit on the Same Day

When an issue is encountered or a pre-existing condition is addressed during the preventative visit

Bill an established patient visit code that has independent documentation to support the level chosen

This should involve a significant work effort

Use modifier -25 on the established patient visit CPT code to indicate a separate service

Womens' Wellness Examination

Should include at least seven of the following:

Breast examination and inspection

Digital rectal examination

Pelvic examination including:

- External genitalia
- Urethra and urethral meatus
- Bladder
- Vagina
- Cervix
- Uterus
- Adnexa/parametria
- Anus and perineum

Womens' Wellness Examination

Medicare – Coding of Service

G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination

Q0091 – Screening Pap smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Womens' Wellness Examination

Medicare – Diagnosis Coding of Service – **Low Risk – Every 2 years (or 23 months past the month of the last covered exam)**

Diagnosis Codes (any of the following):

- Z01.411 – Encounter for gynecological examination (general) (routine) with abnormal findings
- Z01.419 – Encounter for gynecological examination (general) (routine) without abnormal findings
- Z12.4 – Encounter for screening for malignant neoplasm of cervix
- Z12.72 – Encounter for screening for malignant neoplasm of vagina
- Z12.79 – Encounter for screening for malignant neoplasm of other genitourinary organs
- Z12.89 – Encounter for screening for malignant neoplasm of other sites

Womens' Wellness Examination

Medicare – Diagnosis Coding of Service – **High Risk – Annually (or 11 months past the month of the last covered exam) or childbearing age with abnormal Pap test within the past 3 years**

Diagnosis Codes (any of the following):

- Z72.51 – High risk heterosexual behavior
- Z72.52 – High risk homosexual behavior
- Z72.53 – High risk bisexual behavior
- Z77.29 – Contact with and (suspected) exposure to other hazardous substances
- Z77.9 – Other contact with and (suspected) exposure to other hazardous substances
- Z91.89 – Other specified personal risk factors, not elsewhere classified
- Z92.850 – Personal history of CAR T cell therapy
- Z92.858 – Personal history of other cellular therapy
- Z92.86 – Personal history of gene therapy
- Z92.89 – Personal history of other medical treatment

Womens' Wellness Examination

Medicaid Traditional and Commercial Products

Patients age 20 and under

- Use Preventive Medicine codes (99383 – 99385, 99393 – 99395)
- Diagnosis Codes: Z00.00 or Z00.01 (Adult)
- Diagnosis Codes: Z00.121 or Z00.129 (Child)

Patients age 21 and over

- Preventive Medicine Codes may be applicable (Plan Specific)
- Use regular Evaluation and Management Code (99202 – 99215)
- Diagnosis Codes: Z00.00 or Z00.01 (Adult)

Variations on Preventive Examinations

Preventive Examination with Pap/Pelvic/Breast :

- Bill with the appropriate preventive examination code only
- (99381 – 99397)

Preventive Examination with deferred Pap/Pelvic/Breast:

- Bill with the appropriate preventive examination code only
- (99381 – 99397)

Telemedicine Definitions

- Virtual Visit – requires both audio and visual components
- Telephone Visit – requires only audio
- Physical Examination by Gross Inspection – actual physical examination component that can be performed by looking at the patient

Telemedicine Definitions

- Time-Based Billing - the total amount of face-to-face time between the patient and provider in an ambulatory environment or the amount of time solely devoted to the patient in an inpatient world.
- Time-based billing can be documented two different ways:
  - Add the amount of minutes be category per the 2021 Evaluation and Management Changes for New and Established Patient Visits.
  - "I spent _____ minutes with this patient and/or family. More than 50% of the time was spent in counseling and/or coordination of care." (Fill in the amount of time based on the definitions above).
- Time-based billing is often a good choice for billing new patient visits and consultations when performed virtually.

Telemedicine Documentation Suggestions

Add these statements to your EMR – through defined output or as macros.

Virtual Visit Statement –

An interactive audio and video telecommunication system which permits real time communications between the patient (at the originating site) and provider (at the distant site) was utilized to provide this telehealth service.

Telephone Visit Statement –

A telephone visit (audio only) between the patient (at the originating site) and the provider (at the distant site) was utilized to provide this telehealth service.

Consent – Adult –

Verbal consent was requested and obtained from [Patient First Name] [Patient Last Name] on this date [Date of Visit] [Time of Visit], for a telehealth visit.

Consent – Minor –

Verbal consent was requested and obtained for minor [Patient First Name] [Patient Last Name] from (parent/guardian) INSERT NAME on this date [Date of Visit] [Time of Visit], for a telehealth visit.

Insurance Coverage for Telehealth Services

Patient location –During the PHE, waivers allowed patients to receive telehealth services in any geographic region and any location, including their homes.

- *For Medicare*= this waiver is extended UNTIL AT LEAST DECEMBER 31st, 2024
- *For Medicaid*= this waiver is now PERMANENT.
- *For mental health services*= this waiver is now PERMANENT.

In-person visit requirements–UNTIL AT LEAST DECEMBER 31st, 2024, there are no prior or ongoing in-person visit requirements. Beginning Jan 1st 2025, patient must be seen in person within 6 months prior to a telehealth visit and every 12 months thereafter.

Insurance Coverage for Telehealth Services

Audio-only visits – during the PHE payment for audio-only services was allowed at rates equivalent to synchronous telehealth E/M codes:

- • *For Medicare* = this will be CONTINUED UNTIL AT LEAST DECEMBER 31st, 2024.
- Mental health services audio-only was previously continued PERMANENTLY
- • *For Medicaid* = in Ohio, this waiver is now PERMANENT
- • *For commercial insurers*, we continue to monitor but many have indicated "until further notice" while others continue to indicate "until end of PHE."

Insurance Coverage for Telehealth Services

Providers eligible to provide telehealth – physicians, NPs, PAs, Nurse midwifes, clinical nurse specialists and registered nurse anesthetists, clinical psychologists, social workers and dieticians

- UNTIL AT LEAST DECEMBER 31st, 2024 the list of eligible providers is expanded to include PT/OT, Speech language pathologists, and audiologists.

Telemedicine

Hospital and professional organizations are working to make current telemedicine billing options permanent.

Some of these changes will likely remain but some will not.

It is important to visit your payer sites often to look for updated.

Payers will not hesitate to deny or reject billed services – knowledge is power.

Incident-To Visits

Incident-to is a CMS invention

- Not appropriate in Outpatient Hospital environment
- Appropriate only in Office or Free-Standing Clinic Environments
- APRN must be in the employ of the provider who will be billing for the service

Incident-To Visits

The physician must first see the patient and establish a plan of care

Subsequent services must be performed at “a frequency that reflects the physician’s continuing active participation in, and management of, the course of treatment.”

Not applicable for New Patient Visits

Not applicable for New Problems

Split/Shared Visits

The APRN and the physician must be from the same practice

Location and type of service determines the type of visit

The CPT code used for billing must reflect the combined service and documentation of both the APRN and the physician

Ancillary personnel may document the History of Present Illness, Review of Systems, Past Medical, Family and Social Histories as in any other E/M service – but verify the content

Split/Shared Visits

Documentation guidelines are the same regardless of the provider's credentials

Medical record should clearly show the documentation of each provider

Each provider must document independently

Visits must occur on the same date of service

Split/Shared Visits

Places of Service Where Split/Shared Visits May Occur

- Hospital Outpatient
- Hospital Emergency Room
- Hospital Inpatient
- Hospital Discharge Day Management
- Skilled Nursing Facility (some c

Subject to Hospital By-Laws

Split/Shared Visits

Services eligible for Split Shared Billing

Shared/split services may also be provided to the following in addition to emergency department (ED) visits, observation care, and discharge management:

- Initial, Subsequent and Discharge Visits (hospital/facility settings only)
- Emergency Department Visits
- Critical Care Services
- Certain **Skilled** Nursing Facility visits (does not apply to visits the physician is required to perform in their entirety)
- Prolonged Services

Selection of Who Bills and Level of Service

E/M Category of Code	2022/2023 - How to choose who gets to bill	How to select the level of service
Outpatient	History, Physical Exam or MDM **OR** more than half of the total time	History, Physical Exam, **MDM** **OR** Total Time
Inpatient/Obs Hospital and Skilled Nursing Facility	History, Physical Exam or MDM **OR** more than half of the total time	History, Physical Exam, MDM **OR** Total Unit Time
Emergency Department	History, Physical Exam or MDM **OR** more than half of the total time	History, Physical Exam, MDM **Can't select ED codes based on time**

Split/Shared Visits

Beginning in 2022 and continuing in 2023, the definition of Substantive Portion will apply

<table>
<tr><td rowspan="3">Who can bill the Split/Shared Visit?</td><td>2023 and Proposed for 2024</td><td>Possibly in 2025</td></tr>
<tr><td><u>Non Critical Care:</u>
a) Whomever performs one of three key components (HX, Exam, MDM)
OR
b) Whomever spends more than half the total visit time</td><td rowspan="2"><u>All Services:</u>

Whomever spends more than half the total visit time.</td></tr>
<tr><td><u>Critical Care:</u>
Whomever spends more than half the total visit time.</td></tr>
<tr><td>Leveling</td><td colspan="2">MDM or Time may still be used to level the Split Shared visit, regardless of the "substantive portion" methodology used</td></tr>
<tr><td>Face-to-Face Requirement</td><td colspan="2">Beginning in 2022, one of the practitioners must have had face-to-face (in person) contact with the patient, but this does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit.
- When the substantive portion is time, it can be entirely w/ or w/o direct patient contact, and will be determined by the proportion of total time, NOT whether the time involves direct or in-person patient contact.</td></tr>
</table>

Split/Shared Visits

Examples:

Using Key Component method (History, Physical Exam, MDM)

- When one of the three components is used, the billing provider must have performed that component in its entirety to bill. For example, if MDM is used as substantive portion both providers could perform aspects of the MDM but the billing provider must have performed all portions of MDM that were required to select the visit level billed.
  - Outpatient Example (MDM is the billable component): Nurse Practitioner Lee completes the HPI & examines the patient + Dr. Jones performs all the elements of MDM required to meet a 99213.
    - Dr. Jones bills for the visit as criteria for substantive portion was met

Using Time method (More than half of the total time)

- Example: Nurse Practitioner Lee provides 20 min. of Critical Care + Dr. Jones provides 45 min. of Critical Care | Total Time = 65 min. Dr. Jones may bill for the visit as she provided more than half of the 65 total min.

Shared Visits (Split/Shared)

Critical Care

Total critical care time provided by a physician and an APP in the same group on the same date of service can be aggregated with the billing submitted by the provider who furnished the substantive portion of the total critical care time.

If the total critical care time exceeds 74 minutes (meaning 75 minutes and beyond) bill an additional unit or units of 99292.

Both providers must document their total time spent in rendering critical care to the patient as well as the critical nature of the patient's condition and the role each provider played in the care of the patient.

If the total time of both providers exceeds 74 minutes, the billing provider will bill both codes – 99291 plus 99292.

Split/Shared Visits

Modifier required in 2022

Effective January 1, 2022, CMS will require a new Split Shared Modifier to be added to **ALL** split/shared services.

Modifier **FS**- Split/Shared E/M visit

Some Commercial Payers will not accept the –FS modifier – your billing system should edit for this and remove the modifier

Prolonged Services may be Split/Shared (billing methodology)

Prolonged Services include HCPCS/CPT codes 99417, 99418, G2212

Split/Shared Visits

Places of Service NOT appropriate for split/shared visits

- Nursing Facility
- Domiciliary (Assisted Living)
- Home Care Visits

Split/Shared Visits

CPT Codes where Split/Shared Visits are NOT Appropriate:

- Consultations (99242 – 99245, 99252 – 99255)

- Points to consider:
  - Medicare is now silent on Split/Shared Visits as this concept pertains to Consultation encounter
  - Review the payer manuals for this point

Scribing

Benefits:

Anyone can scribe for anyone

- Includes your ancillary team members

Layman’s environment

Writes exactly what the clinician says

Scribing

Limitations:

Anyone can scribe for anyone

- Includes your ancillary team members – meaning that there may be limited knowledge about what you are talking about

Writes exactly what the clinician says – verbatim

Global Period

Period of time where routine patient care (related to the surgical procedure) is generally included in the reimbursement for the surgical procedure

“Minor” procedure – 0 – 10 days

“Major” procedure – 90 days

Global Period

Items included:

- Dressing changes
- E&M services related to the original surgery, all settings
- Incisional care
- Postoperative pain management by the provider
- Removal of staples, tubes, drains, casts, splints and cutaneous sutures
- Routine, typical postoperative care or treatment (including complications) that are related to the original surgery but do not require a return trip to the operating room
- Insertion, irrigation and removal of catheters

Modifiers to Use with Evaluation and Management Codes

These modifiers are used to send a very precise message about the visit

-AI

-24

-25

-32

-57

Modifier - AI

For Medicare Only

Indicates that the Provider reporting 99221 – 99223 is the Admitting Provider

Is only applicable on Initial Hospital Care CPT Codes

Modifier - 24

Indicating that an unrelated evaluation and management service was performed by the same provider during the global period

Modifier - 25

Indicates a significant, separately identifiable evaluation and management service by the same provider was performed on the same day of the procedure or other service

Use this modifier if charging a established patient visit along with a preventative visit

Use this modifier if a surgical procedure with a global period of 0 – 10 days is performed

Modifier - 32

Indicates a mandated service

- Often related to second opinions required by an insurance company
- May be required in cases covered by Workers' Compensation

Modifier - 57

Indicates that the decision for surgery has been made during this evaluation and management encounter

- It is extremely important to use this modifier when the patient will be taken to surgery on the same day as the evaluation and management service
- This modifier is used if the expected surgery has a global period of 90 days

Additional Modifiers

- RT – Right side

- LT – Left side

- 50 – Bilateral

- 53 – Discontinued Service

- 55 – Postoperative Care Only

- Q0 – Investigational clinical service provided in a clinical research study that is in an approved clinical research study

- Q1 – Routine clinical service provided in a clinical research study that is in an approved clinical research study

Additional Modifiers

- - FA – Left hand, thumb
- - F1 – Left hand, second digit
- - F2 – Left hand, third digit
- - F3 – Left hand, fourth digit
- - F4 – Left hand, fifth digit
- - TA – Left foot, great toe
- - T1 – Left foot, second digit
- - T2 – Left foot, third digit
- - T3 – Left foot, fourth digit
- - T4 – Left foot, fifth digit
- - F5 – Right hand, thumb
- - F6 – Right hand, second digit
- - F7 – Right hand, third digit
- - F8 – Right hand, fourth digit
- - F9 – Right hand, fifth digit
- - T5 – Right foot, great toe
- - T6 – Right foot, second digit
- - T7 – Right foot, third digit
- - T8 – Right foot, fourth digit
- - T9 – Right foot, fifth digit

Sports Exams

- Comprehensive Sports Exam – Non-symptomatic Patient
  - History – includes a comprehensive body system review and comprehensive or interval past medical, family and social history as well as a comprehensive assessment/history of pertinent risk factors
  - Physical Examination – Multi-system examination with the understanding that the extent of the exam is based on the age of the patient and the risk factors identified
  - Suggested Billing: 99381 – 99397 (Preventive Medicine Visits)
  - Diagnosis Coding: Z02.5 – Encounter for examination for participation in sports

Sports Exams

- Limited Sports Exam – Non-symptomatic Patient
  - Limited History and Physical Examination is expected
  - This, generally, would not be reported to insurance
  - Suggested Billing: 99080 – Special reports such as insurance forms, more than the information conveyed in the usual medical communication or standard reporting form
  - Diagnosis Coding: Z02.5 – Encounter for examination for participation in sports
- Limited Sports Exam – Symptomatic Patient
  - This becomes a regular New Patient or Established Patient Visit
  - Coding: 99202 – 99215 as appropriate for the situation
  - Diagnosis Coding: Based on the findings during the encounter
  - No additional billing for the Sports Exam portion of the encounter

Work Exams

- May be provided under contract with a company
- Suggest a “Special Code” or Mnemonic Code to represent service
- No actual CPT code for this purpose
- Possible Diagnosis Code: Z02.1 – Encounter for pre-employment examination

Cerumen Removal

69209 – Removal impacted cerumen using irrigation/lavage, unilateral

69210 – Removal impacted cerumen requiring instrumentation, unilateral

- There must be documentation that supports the medical necessity for these services
  - Cerumen impairs the clinical examination of the external auditory canal, tympanic membrane or middle ear
  - Cerumen is extremely hard, dry, and irritative causing pain, itching, hearing loss, etc.
  - Cerumen is associated with foul odor, infection or dermatitis
  - Obstructive copious amounts of cerumen cannot be removed without magnification and instrumentation requiring a provider's skill
- These are **unilateral codes**
- Use modifiers RT and/or LT for additional information about the location
- If both ears are involved code either two units, two charges with RT and LT modifiers or one charge with -50 modifier (bilateral)

Foreign Body Removals and Other Skin Procedures

10120 – Incision and removal of foreign body, subcutaneous tissue; simple

10121 – Incision and removal of foreign body, subcutaneous tissue; complicated

11740 – Evacuation of subungual hematoma

16000 – Initial treatment, first degree burn, when no more than local treatment is required

- Always list the percentage of body surface involved and depth of burn

69200 – Removal foreign body from external auditory canal; without general anesthesia

Suture/Staple Removal

Unless you performed the procedure that placed the sutures or staples, bill this as an Evaluation and Management Code

Brief History: How did the patient get to this point?

Physical Examination: Constitutional (fever?), Integumentary, Other Body Systems as appropriate to evaluate post-operative condition

Medical Decision Making: New Problem to Examiner; Likely no data; Minor Problem – Straightforward Medical Decision Making

Suggested Billing Code: 99202 – 99203 or 99212 – 99213

If complications, possibly a higher level of service

Fluoride Varnish

CPT 99188 – Application of topical fluoride varnish by a physician or other qualified health care professional

CDT D1206 or D1208 – Use will depend on the type of fluoride being utilized; D1206 is for varnish; D1208 is for fluoride.

Review your payer manuals or contact provider assistance at your payers to determine how to bill for fluoride varnish.

Ohio Medicaid (next slide) requires medical providers to use dental codes (CDT codes) on medical claims which is very unusual in coding.

Link is for MAL 651 for **non-dental** practitioners at Federally Qualified Health Centers or Rural Health Clinics

https://medicaid.ohio.gov/resources-for-providers/policies-guidelines/medicaid-advisory-letters/medicaid-advisory-letters

Fluoride Varnish

OAC 5160-4-33 – a physician, advanced practice registered nurse, physician assistant may apply and bill for the application of fluoride varnish and must provide three related services:

As part of the application of fluoride varnish, a practitioner provides three related services:
(1) An oral assessment for the identification of obvious oral health problems and risk factors, which may be omitted if an oral assessment is conducted or has been conducted during an early and periodic screening, diagnostic, and treatment (EPSDT) visit;
(2) Communication with the parent or guardian about the fluoride varnish procedure and proper oral health care for the child; and
(3) If the child has obvious oral health problems and does not have a dental provider, referral to a dentist or to the county department of job and family services.

Payment for the application of fluoride varnish is made separately from payment for a well child visit or a sick child visit.

Billed with CDT D1206 on a Provider Claim Form

Immunization Administration

90460 – Immunization administration **through 18 years of age** via any route of administration, **with counseling** by qualified health care professional; first or only component of **each** vaccine or toxoid administered

+90461 - each additional vaccine or toxoid component administered

Immunization Administrations with counseling are based on the number of vaccine components in the vaccine and not the number of injections/administrations given

- A component refers to all antigens in a vaccine that prevent diseases caused by one organism
- Combination vaccines are vaccines that contain multiple vaccine components (e.g. DTaP contains three (3) components
- Billing for a DTaP would be 90460 +90461 + 90461
- Counseling must be face-to-face; suggest providing data sheets for each vaccine or combination vaccine administered

Immunization Administration

Vaccine	Number of Components	Immunization Administration Code(s) Reported
HPV	1	90460
Influenza	1	90460
Meningococcal	1	90460
Pneumococcal	1	90460
Td	2	90460 + 90461
DTaP or TdaP	3	90460 + 90461 x 2
MMR	3	90460 + 90461 x 2
DTaP-Hib-IPV (Pentacel)	5	90460 + 90461 x 4
DTaP-HepB-IPV (Pediarix)	5	90460 + 90461 x 4

Immunization Administration

Recommended Diagnosis Coding for Immunization Administration

Patients age 17 years or younger

- Z00.129 – Routine infant or child health check; **without** abnormal findings
- Z00.121 – Routine infant or child health check; **with** abnormal findings
- Z23 – Encounter for immunizations

Adult Influenza, Pneumococcal and Hepatitis B

Criteria to determine the correct influenza vaccine:

- Type of influenza vaccine being administered
  - Preservative free or not specified as preservative free
  - Trivalent or quadrivalent
  - Increased antigen
  - Pandemic formulation
- How will the vaccine be administered:
  - Intramuscular (IM)
  - Intranasal
  - Intradermal (ID)

Medicare Seasonal Influenza Virus Vaccine (two slides)
Administration Code: G0008
Diagnosis Code: Z23
Frequency: Once per influenza season
Yellow highlight is from Medicare Preventive Data

Vaccine Codes	Vaccine Codes & Descriptors
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use
90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use
90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use
90661	Influenza virus vaccine, trivalent (IIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use

Medicare Seasonal Influenza Virus Vaccine
Administration Code: G0008
Diagnosis Code: Z23
Frequency: Once per influenza season
Yellow highlight is from Medicare Preventive Data

Vaccine Codes	Vaccine Codes & Descriptors
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use
90689	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use
90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use
Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)
Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)
Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)
Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)
Q2039	Influenza virus vaccine, not otherwise specified

Pneumococcal Vaccine
Administration Code: G0009
Diagnosis Code: Z23
Frequency: Per schedule

Vaccine Codes	Vaccine Codes & Descriptors
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use
90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use

Hepatitis B Vaccine
Administration Code: G0010
Diagnosis Code: Z23
Frequency: Per schedule

Vaccine Codes	Vaccine Codes & Descriptors
90739	Hepatitis B vaccine (HepB), adult dosage, 2 dose schedule, for intramuscular use
90740	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use
90743	Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use
90744	Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use
90746	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use
90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use
90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use

Medicare Wellness Visits – Traditional Medicare

Initial Preventive Physical Examination (IPPE) G0402	Annual Wellness Visits (AWV) G0438 and G0439	Routine Physical Examination
• Used only once in the first 12 months of Medicare coverage • No Copayment or Deductible	• Covered once every 12 months (visit can be in same month as pervious calendar year) • No Copayment or Deductible	• Not covered by Traditional Medicare; prohibited by statute • Patient pay 100% out-of-pocket

Medicare Wellness Visits

G0402 – IPPE – Welcome to Medicare Visit – limited to a new beneficiary no later than the first 12 months of Medicare Part B eligibility date

G0438 – Annual Wellness Visit – Initial Visit

G0439 – Annual Wellness Visit – Subsequent Visit (must be at least 11 months after G0438, can be in same month as previous calendar year)

Medicare Wellness Visit Guide

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

Medicare Wellness Visits

G0402 – Initial Preventive Physical Examination - IPPE

- Collect Past Medical, Surgical and Family History
- History of Alcohol, Tobacco and Illicit Drug Use
- Current Medications and Supplements
- Establish a list of current providers and suppliers
- Diet and Physical Activities
- Pay close attention to opioid use
- Review potential risk factors for Depression
- Review functional ability and level of safety – ADL's, Fall Risk, **Hearing Impairment**, Home Safety
- Assessment – Height, weight, BMI, BP and **Visual Acuity Screening,** other factors deemed appropriate
- Provide information about Advanced Directives and carrying out beneficiaries wishes
- Establish a written screening schedule
- Establish a list of risk factors and conditions for which interventions are recommended or underway
- Furnish health advice or referral to health education or preventive counseling services
- May provide a once-in-a-lifetime screening ECG as appropriate (G0403 complete)

Medicare Wellness Visits

G0438 – Annual Wellness Visit – Initial Visit – (12 months must have passed since the billing of the IPPE (G0402))

- Health Risk Assessment
- Collect or update Past Medical, Surgical and Family History
- Current Medications and Supplements
- Establish a list of current providers and suppliers
- Assessment – Height, weight (BMI) and BP
- Assess for cognitive impairment
- Review potential risk factors for depression
- Review functional ability and level of safety
- Establish a written screening schedule
- Establish a list of risk factors and conditions for which interventions are recommended or underway
- Furnish health advice or referral to health education or preventive counseling services
- Provide information about Advanced Directives and carrying out beneficiaries wishes

Medicare Wellness Visits

G0439 – Annual Wellness Visit – Subsequent Visit – (12 months must have passed since the billing of the AWV - Initial (G0438))

- Update the Health Risk Assessment
- Update the Past Medical, Surgical and Family History
- Update the list of current providers and suppliers
- Assessment – Weight and BP
- Assess for cognitive impairment
- Update the written screening schedule
- Update the list of risk factors and conditions for which interventions are recommended or underway
- Furnish health advice or referral to health education or preventive counseling services
- Provide information about Advanced Directives and carrying out beneficiaries wishes

Billing Guidance

Diagnosis Coding:

- There is no specific diagnosis code requirement for Medicare Annual Wellness Visits. Selects a diagnosis code consistent with the patient's exam.
- May be performed by a physician, qualified advanced practice provider or medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of medical professionals directly supervised by a physician
- If appropriate, you may perform a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service during the encounter for the Annual Wellness Visit. Use a modifier -25 on the E/M code.

Health Risk Assessment

At a minimum:

- Demographic data
- Health status self-assessment
- Psychosocial risks including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, and fatigue
- Behavioral risks including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle (for example, seat belt use), and home safety
- Activities of Daily Living (ADLs) including dressing, feeding, toileting, grooming, physical ambulation including balance/risk of falls and bathing; and Instrumental ADLs (IADLs), including using the telephone, housekeeping, laundry, mode of transportation, shopping, housekeeping, managing medications, and handling finances

Medicare Wellness Visits

Procedure Code	Description	wRVU	Medicare Office	Medicare Outpatient	Medicaid Office	Medicaid Outpatient
G0402	IPPE - Welcome to Medicare Visit	2.60	$ 163.73	$ 128.59	N/A	N/A
G0438	Initial Medicare Wellness Visit	2.60	$ 160.42	N/A	N/A	N/A
G0439	Subsequent Medicare Wellness Visit	1.92	$ 125.02	N/A	N/A	N/A

Medicare Advantage Plan Guidance

Medicare Advantage Plan	Covers additional E&M for significant /separate service same day as AWV/IPPE when billed w/25 modifier	Covers Preventive Services Codes 99381-99397	Covers Preventive Service + additional E&M for separate same day service when billed w/25 modifier	Follows CMS Coverage Guidelines on Preventive Screening***	Tele-Health for AWV (only G0438 & G0439) Covered? *HCCs CAN be coded during TeleHealth Visit*	Guidelines for Annual Exam Visit/Calendar vs Rolling Year
Anthem	Yes	Yes	Yes	Yes	Yes*	Calendar
Aetna	Yes	Yes	Yes	Yes	Yes	Calendar
Buckeye (MyCare/DNSP)	Yes	Yes	Yes	Yes	Yes	Rolling
CareSource (MyCare/DNSP)	Yes	Yes	Yes	Yes	Yes	Calendar
Humana	Yes	Yes	Yes	Yes	Yes	Calendar
Medical Mutual of Ohio	Yes	Yes	**No**	Yes	Yes	Calendar
Summacare	Yes, when a problem visit occurs the day of an AWV	**No**	Yes	Yes	Yes	Calendar
United Healthcare	Yes	**99385, 99386, 99387 99395, 99396, 99397**	Yes	Yes	Yes	Calendar
Traditional Medicare	Yes	**No**	**No**	*n/a*	Yes	**Visit can be in same month as previous calendar year**

Advanced Care Planning

99497 – Advanced Care Planning

- Advanced care planning including explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate (CPT midpoint rule applies so minimum of 16 minutes must be spent to use this code)
- +99498 – each additional 30 minutes

Diagnosis Coding:

- There is no specific diagnosis code requirement for Medicare Annual Wellness Visits. Selects a diagnosis code consistent with the patient's exam.

Billing:

- Medicare waives both the ACP coinsurance and the Medicare Part B deductible when:
  - Given on the same day as the covered Annual Wellness Visit
  - Given by the same provider as the covered Annual Wellness Visit
  - Billed with modifier -33 (Preventive Service)
  - Billed on the same claim as the Annual Wellness Visit
  - Deductible and coinsurance are waived **once per year**
  - No limit on the number of times you can report Advanced Care Planning in a given time period – you must document the change in the patient's health status and/or their wishes regarding end-of-life care

Alcohol Misuse Screening and Counseling

HCPCS/CPT Codes:

G0442 – Annual alcohol misuse screening, 5 – 15 minutes

G0443 – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Diagnosis Coding Suggestions:

G0442 – Z13.89 – Screening for other disorder

G0443 – F10.10 – Alcohol abuse, uncomplicated

Patient Pays:

No copayment, coinsurance or deductible

Coverage:

All patients are eligible for alcohol screening

Eligibility for counseling if they:

- Screen positive (those who misuse alcohol but whose levels or patterns of alcohol consumption don't meet alcohol dependence criteria)
- Are competent and alert at the time you deliver counseling
- Get counseling from qualified primary care physicians or other primary care practitioners in a primary care setting

Frequency:

G0442 (annual screening)

For those who screen positive for misuse, four times per year for G0443 counseling

Source: NCD 210.8

Intensive Behavioral Therapy (IBT) for Cardiovascular Disease

HCPCS/CPT Codes:

G0446 – Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

Diagnosis Coding:

No specific diagnosis code is required but should use diagnosis codes that influence Cardiovascular Health (i.e. hypertension, diabetes mellitus, hyperlipidemia, obesity)

Patient Pays:

No copayment, coinsurance or deductible

Source: NCD 210.11

Frequency:

Annually

Coverage:

All patients who are:

Competent and alert at the time you deliver counseling

Getting counseling by a qualified primary care physician or other primary care practitioner in a primary care setting

Consists of the following three components (documented in the medical record):

- Encourage aspirin use for the primary prevention of Cardiovascular Disease when the benefits outweigh the risks for men age 45 – 79 years and women 55 – 79 years;
- Screening for high blood pressure in adults age 18 years and older and;
- Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age and other know risk factors for cardiovascular and diet-related chronic disease

Depression Screening

HCPCS/CPT Codes:

G0444 – Depression Screening; 5 to 15 minutes

You must deliver the screening in primary care settings with staff-assisted depression care supports in place to ensure accurate diagnosis, effective treatment, and follow-up.

Diagnosis Coding Suggestions:

Z13.89 – Screening for other disorder

Patient Pays:

No copayment, coinsurance or deductible

Coverage:

All patients with Medicare Part B

Frequency:

Annually

Cannot be billed in conjunction with IPPE or Initial AWV **(cannot bill with G0402 or G0438, can bill with G0439)**

Source: NCD 210.9

Lung Cancer Screening Counseling & Annual Screening for Lung Cancer With Low Dose Computed Tomography

HCPCS/CPT Codes:

G0296 —
Counseling visit to discuss need for lung cancer screening using low dose CT scan (ldct) (service is for eligibility determination and shared decision making)

Diagnosis Coding:

F17.210 – Nicotine dependence, cigarettes, uncomplicated

F17.211 – Nicotine dependence, cigarettes, in remission

F17.213 – Nicotine dependence, cigarettes, with withdrawal

F17.218 – Nicotine dependence, cigarettes, with other nicotine-induced disorders

F17.219 – Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders

Z87.891 – Personal history of tobacco dependence/ personal history of nicotine dependence

Patient Pays:

No copayment, coinsurance or deductible

Coverage:

Patients who meet all categories:

- Aged 55–77
- Asymptomatic (no signs or symptoms of lung cancer)
- Tobacco smoking history of at least 20 pack-years (1 pack-year = smoking 1 pack per day for 1 year; 1 pack = 20 cigarettes)
- Current smoker or quit smoking within the last 15 years
- Get a written order for lung cancer screening with LDCT that meets the requirements described in the National Coverage Determinations Manual, Chapter 1, Part 4, Section 210.14

Frequency:

Annually for covered patients:

First year: Before the first lung cancer LDCT screening, you must counsel the patient **at a shared decision-making visit**

Subsequent years: The patient must get a written order during any appropriate visit with a physician or qualified NPP

Source: NCD 210.14

Counseling to Prevent Tobacco Use

HCPCS/CPT Codes:

99406 —
Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407 —
Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes

Coverage:

Outpatient and hospitalized patients with Medicare Part B who meet these criteria:

- Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
- Are competent and alert during counseling
- A qualified physician or other Medicare-recognized practitioner provides counseling

Frequency:

Two cessation attempts per year

- Each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year

Patient Pays:

No copayment, coinsurance or deductible

Source: NCD 210.4.1

Diagnosis Coding:

F17.210 – Nicotine dependence, cigarettes, uncomplicated
F17.211 – Nicotine dependence, cigarettes, in remission
F17.213 – Nicotine dependence, cigarettes, with withdrawal
F17.218 – Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219 – Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
F17.220 – Nicotine dependence, chewing tobacco, uncomplicated
F17.221 – Nicotine dependence, chewing tobacco, in remission
F17.223 – Nicotine dependence, chewing tobacco, with withdrawal
F17.228 – Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17.229 – Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
F17.290 – Nicotine dependence, other tobacco products, uncomplicated
F17.291 – Nicotine dependence, other tobacco products, in remission
F17.293 – Nicotine dependence, other tobacco products, with withdrawal
F17.298 – Nicotine dependence, other tobacco products, with other nicotine-induced disorders
F17.299 – Nicotine dependence, other tobacco products, with unspecified nicotine-induced disorders
T65.211A – Toxic effect of chewing tobacco, accidental (unintentional), initial encounter
T65.212A – Toxic effect of chewing tobacco, intentional self-harm, initial encounter
T65.213A – Toxic effect of chewing tobacco, assault, initial encounter
T65.214A – Toxic effect of chewing tobacco, undetermined, initial encounter
T65.221A – Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter
T65.222A – Toxic effect of tobacco cigarettes, intentional self-harm, initial encounter
T65.223A – Toxic effect of tobacco cigarettes, assault, initial encounter
T65.224A – Toxic effect of tobacco cigarettes, undetermined, initial encounter
T65.291A – Toxic effect of other tobacco and nicotine, accidental (unintentional), initial encounter
T65.292A – Toxic effect of other tobacco and nicotine, intentional self-harm, initial encounter
T65.293A – Toxic effect of other tobacco and nicotine, assault, initial encounter
T65.294A – Toxic effect of other tobacco and nicotine, undetermined, initial encounter
Z87.891 – Personal history of tobacco dependence/ personal history of nicotine dependence

Intensive Behavioral Therapy (IBT) for Obesity

HCPCS/CPT Codes:

G0447 —
Face-to-face behavioral counseling for obesity, 15 minutes

G0473 —
Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes

Coverage:

A screening for obesity in patients with Medicare Part B who:

- Have a body mass index (BMI) ≥ 30 kilograms (kg) per meter squared
- Are competent and alert during counseling
- Get counseling from a qualified primary care physician or other primary care practitioner in a primary care setting

Frequency:

We pay up to 22 visits billed with codes G0447 and G0473, combined, in a 12-month period:

- **First month:** 1 face-to-face visit every week
- **Months 2–6:** 1 face-to-face visit every other week
- **Months 7–12:** 1 face-to-face visit every month if patient meets certain requirements (if patient loses at least 3 kg (6.6 lbs.) during first 6 months)

Diagnosis Coding:

Z68.30 – Body mass index [BMI] 30.0 – 30.9, adult
Z68.31 – Body mass index [BMI] 31.0 – 31.9, adult
Z68.32 – Body mass index [BMI] 32.0 – 32.9, adult
Z68.33 – Body mass index [BMI] 33.0 – 33.9, adult
Z68.34 – Body mass index [BMI] 34.0 – 34.9, adult
Z68.35 – Body mass index [BMI] 35.0 – 35.9, adult
Z68.36 – Body mass index [BMI] 36.0 – 36.9, adult
Z68.37 – Body mass index [BMI] 37.0 – 37.9, adult
Z68.38 – Body mass index [BMI] 38.0 – 38.9, adult
Z68.39 – Body mass index [BMI] 39.0 – 39.9, adult
Z68.41 – Body mass index [BMI] 40.0 – 44.9, adult
Z68.42 – Body mass index [BMI] 45.0 – 49.9, adult
Z68.43 – Body mass index [BMI] 50.0 – 59.9, adult
Z68.44 – Body mass index [BMI] 60.0 – 69.9, adult
Z68.45 – Body mass index [BMI] 70 or greater, adult

Patient Pays:

No copayment, coinsurance or deductible

Source: NCD 210.12

Obesity Counseling – Group (2-10) People

G0473 – Obesity Counseling, Group - (2-10) People

Requirements:

- BMI >30
- Alert and competent
- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2 – 6; and
- One face-to-face visit every month for months 7 – 12, if beneficiary meeting the 3kg (6.6 lbs.) weight loss requirement during the first 6 months as required to continue for eligible visits in months 7 – 12.
- If the required 3kg (6.6 lbs.) weight loss did not occur, the patient may be reassessed after an additional 6 months.

Diagnosis Coding: Z68.30 – Z68.45 – BMI 30.00 – 39.99 to BMI 70 or greater

Limit: 22 visits in 12 month period

No copayment, coinsurance or deductible

Source: NCD: 210.12

Obesity Counseling

Preventive Medicine Counseling - **ALWAYS CHECK YOUR PAYER POLICIES AND GUIDELINES**

- 99401- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to **an individual** (separate procedure); approximately 15 minutes
- 99402 - ; approximately 30 minutes
- 99403 - ; approximately 45 minutes
- 99404 - ; approximately 60 minutes
- 99411 – Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in **a group** setting (separate procedure); approximately 30 minutes
- 99412 - ; approximately 60 minutes
- Billing providers can bill regular Evaluation and Management Codes for individual counseling – likely would bill by time

Obesity Counseling

Document the 5 A's Approach

- Ask
  - Ask for permission to discuss weight
  - Explore readiness for change
- Assess
  - Assess obesity class and stage
  - Assess for drivers, complications, and barriers
- Advise
  - Advise on obesity risks
  - Explain benefits of modest weight loss
  - Explain need for long-term strategy
  - Discuss treatment options
- Agree
  - Agree on realistic weight-loss expectations
  - Focus on behavioral goals (SMART) and health outcomes
  - Agree on treatment plan
- Assist
  - Address drivers and barriers
  - Provide education and resources
  - Refer to appropriate provider (as necessary)
  - Arrange follow-up

Medical Nutrition Therapy

97802 – Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97803 - ; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97804 - ; group (2 or more individuals), each 30 minutes

These codes are for dietetic professionals – if you can bill for Evaluation and Management Services, these codes cannot be used.

wRVU's and Reimbursement

Procedure Code	Description	wRVU	Medicare Office - DO	Medicare Outpt - OH	Medicaid Office - DO	Medicaid Outpt - OH
99495	Transitional Care Mgmt, Mod MDM, 14 Days	2.78	$196.50	$136.85	N/A	N/A
99496	Transitional Care Mgmt, High MDM, 7 Days	3.79	$266.31	$186.58	N/A	N/A
99497	Advanced Care Planning; First 30 min, Face-to-Face	1.50	$80.70	$73.90	N/A	N/A
+99498	Advanced Care Planning; Each Additional 30 min, Face-to-Face	1.40	$70.21	$69.90	N/A	N/A
99490	Chronic Care Management Services, at least 20 minutes per calendar month; care directed by provider but performed by supervised staff	1.00	$60.52	$49.39	N/A	N/A
+99439	Chronic Care Management Services, each additional 20 minutes per calendar month; care directed by provider but performed by supervised staff	0.70	$45.56	$34.12	N/A	N/A
99491	Chronic Care Management Services, at least 30 minutes per calendar month; care personally performed by the billing provider	1.50	$82.56	$73.90	N/A	N/A
+99437	Chronic Care Management Services, each addition 30 minutes per calendar month; care personally performed by the billing provider	1.00	$58.04	$49.39	N/A	N/A
99487	Complex Chronic Care Management Services, at least 60 minutes per calendar month; care directed by provider but performed by supervised staff	1.81	$127.47	$88.84	N/A	N/A
+99489	Complex Chronic Care Management Services, each additional 30 minutes per calendar month; care directed by provider but performed by supervised staff	1.00	$67.62	$49.08	N/A	N/A
G0296	Counseling Visit for Lung Cancer Screening with Low Dose CT Scan	0.52	$27.72	$25.24	$22.38	$21.06
G0442	Annual Alcohol Misuse Screening, Face-to-Face, 15 Min	0.18	$17.59	$8.93	N/A	N/A
G0443	Behavioral Counseling for Alcohol Misuse, Face-to-Face, 15 Min	0.45	$25.04	$22.56	N/A	N/A
G0444	Annual Depression Screening, 15 Min	0.18	$17.59	$8.93	N/A	N/A
G0446	Intensive Behavioral Therapy for Cardiovascular Disease, Individual, 15 Min	0.45	$25.34	$22.56	N/A	N/A
G0447	Obesity Behavioral Counseling, Individual, 15 Min	0.45	$25.04	$22.56	N/A	N/A
G0473	Obesity Behavioral Counseling, Group (2 - 10 people), 30 Min	0.23	$12.17	$11.25	N/A	N/A

Medicare Preventive Services

Data Mining and Benchmarking

Data Mining –

The process of analyzing data from different perspectives and summarizing it into useful information

This information may be used to highlight areas of risk, opportunities for revenue enhancement or both

Benchmarking –

The process of understanding how your organization compares with similar organizations

Data Mining

Process of analyzing data from different perspectives

Summarizing the data into useful information

Locating the needle in a haystack

Data Mining

Useful for:

- Identification of potential errors that may pose risk
- Establishing a baseline
- Identification of areas for potential education
- Locating opportunities for pre-bill edits or reviews

Data Mining

Most Important Reason

- This is what CERT, RAC and CMS are doing to locate problems
  - Find the potential issues first
  - Be proactive
  - Take the opportunity to find issues and fix them before an outside entity finds the issues for you
- Used by Medicare, Medicaid and Commercial Payers

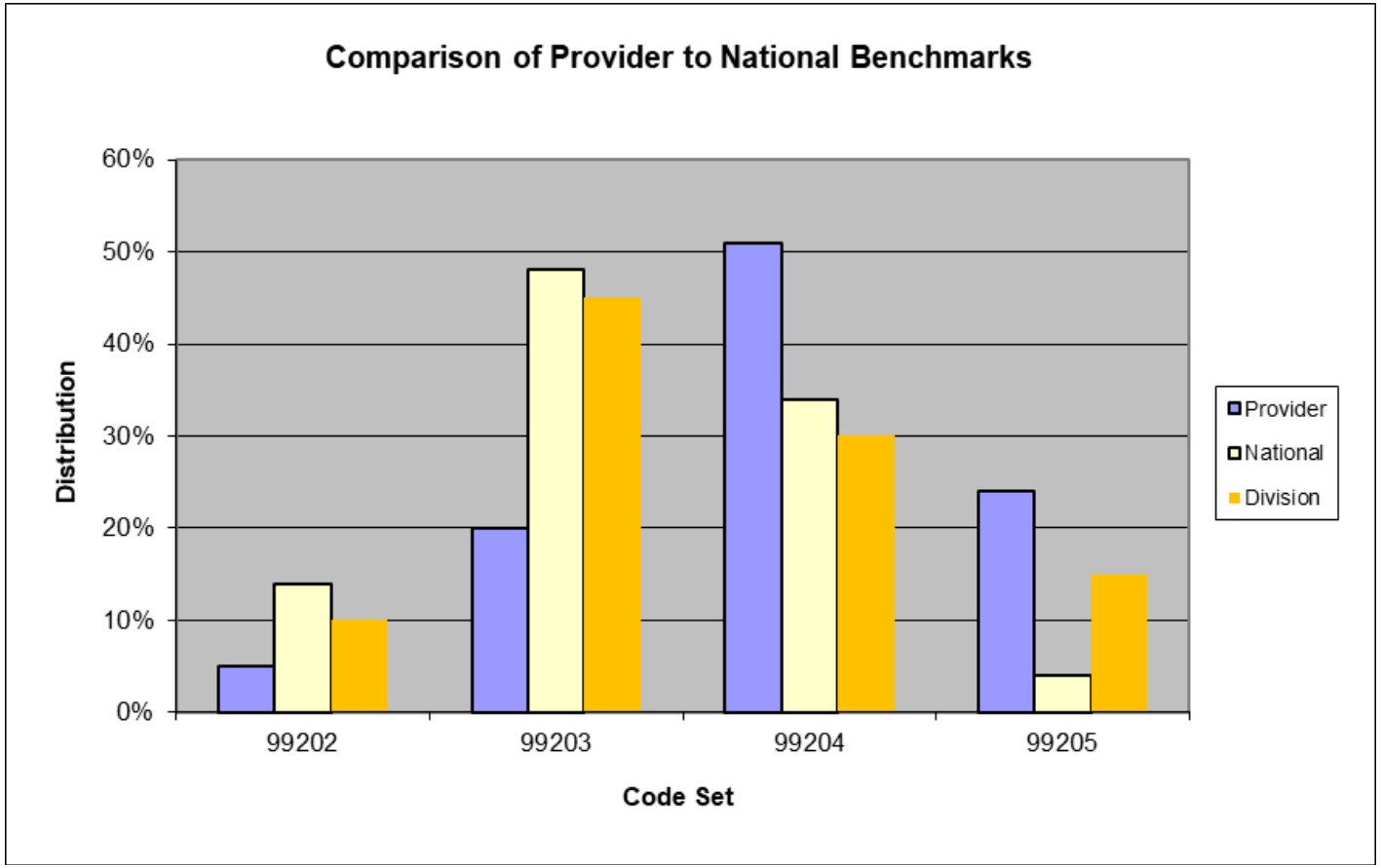
Data Mining and Benchmarking

- Look for what is reasonable and explainable
- Usually, the aberration will stand out
- Medicare has paid claims data in the CMS website (2021) – make your own benchmarks
- Data may be available through vendors or your professional associations
- You will find both Risk and Reward
- Always research what you find
- Always discuss opportunities armed with facts

Data Mining – New Patient Office/Clinic Visits
Provider "C" Data – Consistent with Benchmarks

New Office Visit - Four Quarters Ending 09/30/2023								
YOUR PRACTICE								
DIVISION	BILLING PROV	CPT	SUM UNIT	SUM CHGS	% per provider	Nat'l Benchmark	Difference	Division Distribution
ANY DEPARTMENT	PROVIDER "C"	99202	5	$ 575	5%	14%	-9%	10%
		99203	20	$ 3,500	20%	48%	-28%	45%
		99204	51	$ 16,830	51%	34%	17%	30%
		99205	24	$ 8,400	24%	4%	20%	15%
	PROVIDER "C"		**100**	**$ 29,305**				

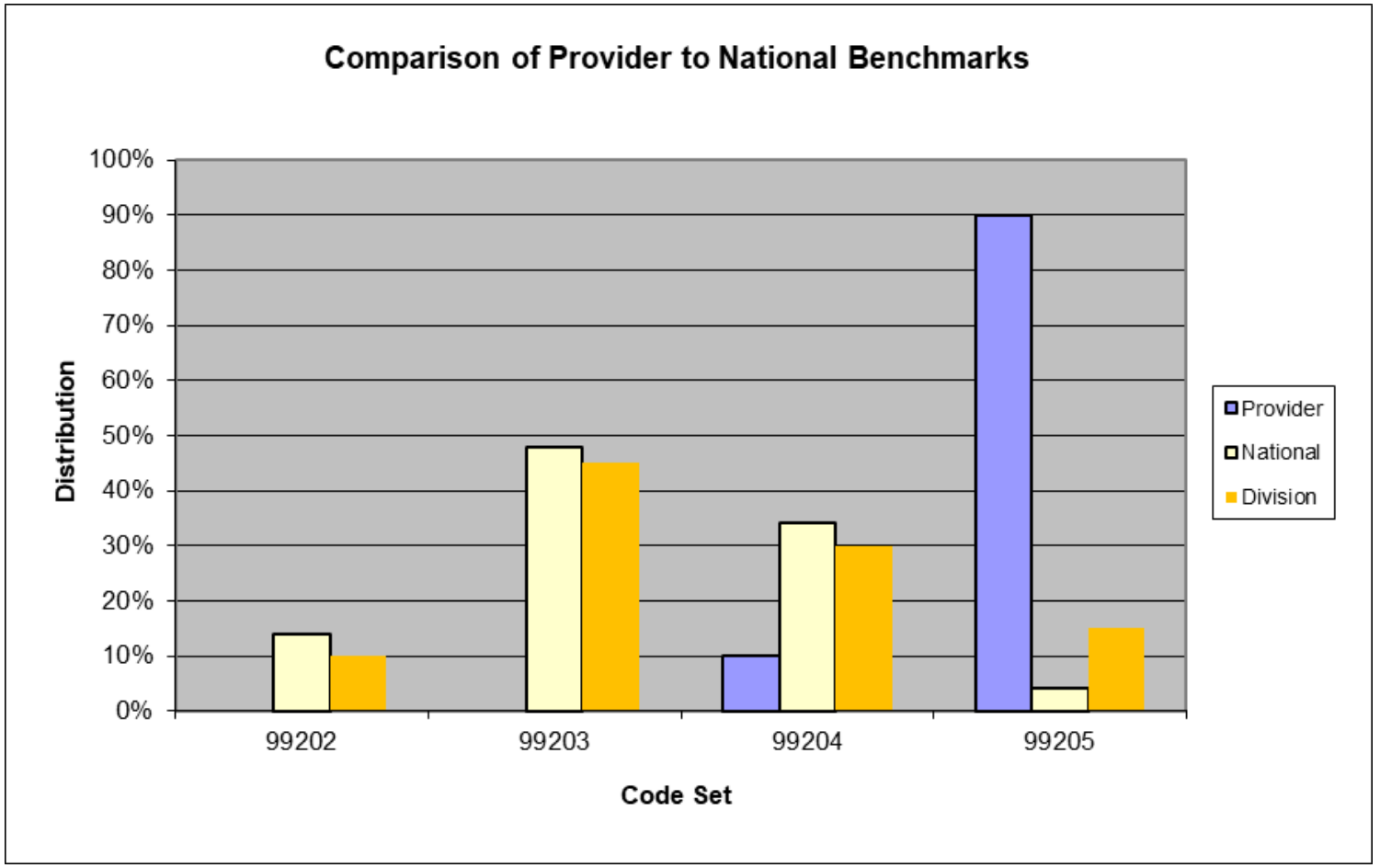
Data Mining – New Patient Office/Clinic Visits
Provider "C" Graph – Consistent with Benchmarks



Data Mining New Patient Office/Clinic Visits
Provider “A” Data – Above Benchmarks

New Office Visit - Four Quarters Ending 09/30/2023								
YOUR PRACTICE								
DIVISION	**BILLING PROV**	**CPT**	**SUM UNIT**	**SUM CHGS**	**% per provider**	**Nat'l Benchmark**	**Difference**	**Division Distribution**
ANY DEPARTMENT	**PROVIDER "A"**	99202	0	$ -	0%	14%	-14%	10%
		99203	0	$ -	0%	48%	-48%	45%
		99204	10	$ 3,300	10%	34%	-24%	30%
		99205	90	$ 31,500	90%	4%	86%	15%
	PROVIDER "A"		**100**	**$ 34,800**				

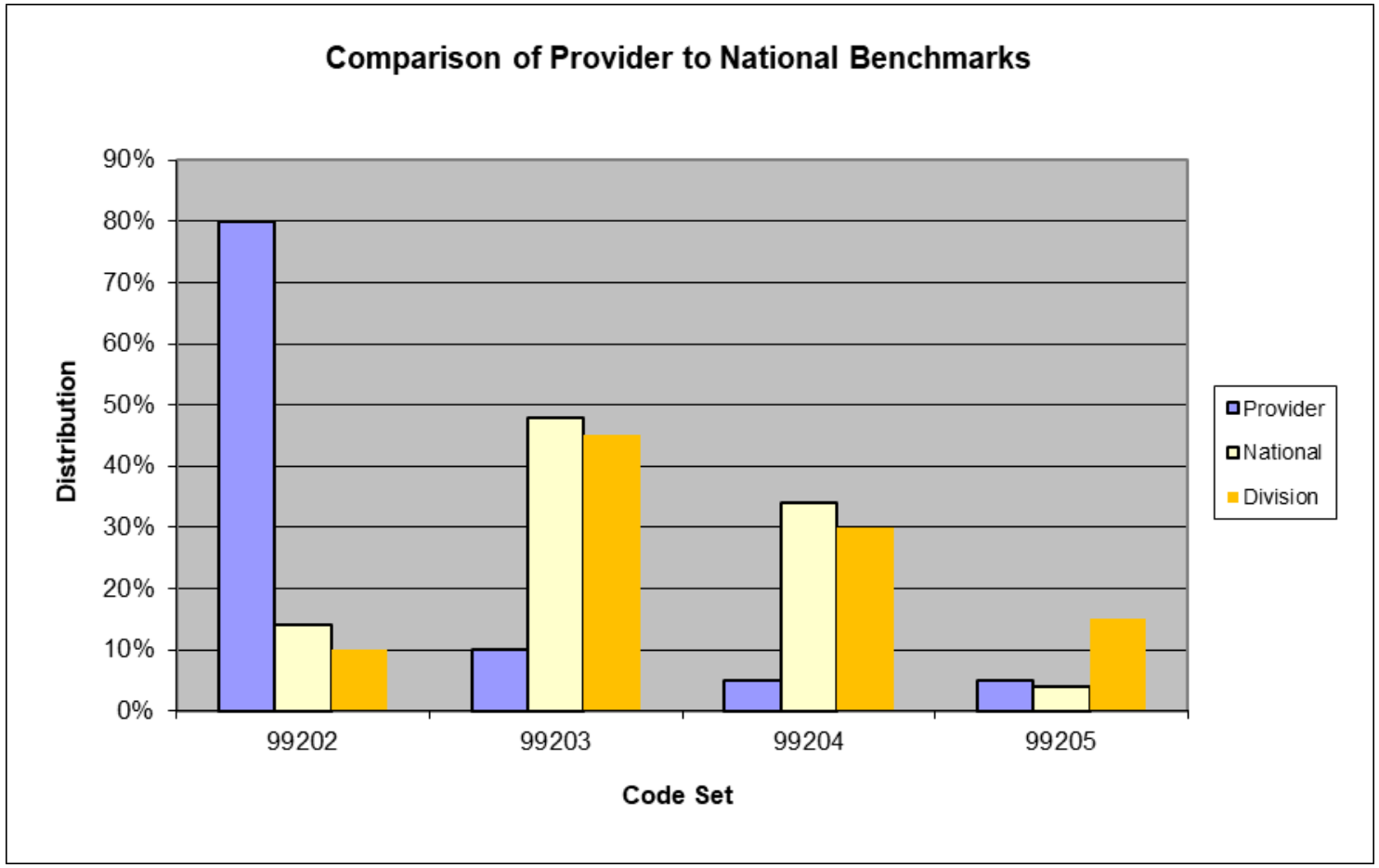
Data Mining New Patient Office/Clinic Visits
Provider "A" Graph – Above Benchmarks



Data Mining New Patient Office/Clinic Visits
Provider “B” Data – Below Benchmarks

New Office Visit - Four Quarters Ending 09/30/2023								
YOUR PRACTICE								
DIVISION	BILLING PROV	CPT	SUM UNIT	SUM CHGS	% per provider	Nat'l Benchmark	Difference	Division Distribution
ANY DEPARTMENT	PROVIDER "B"	99202	80	$ 8,625	80%	14%	66%	10%
		99203	10	$ 1,750	10%	48%	-38%	45%
		99204	5	$ 1,650	5%	34%	-29%	30%
		99205	5	$ 1,750	5%	4%	1%	15%
	PROVIDER "B"		**100**	**$ 13,775**				

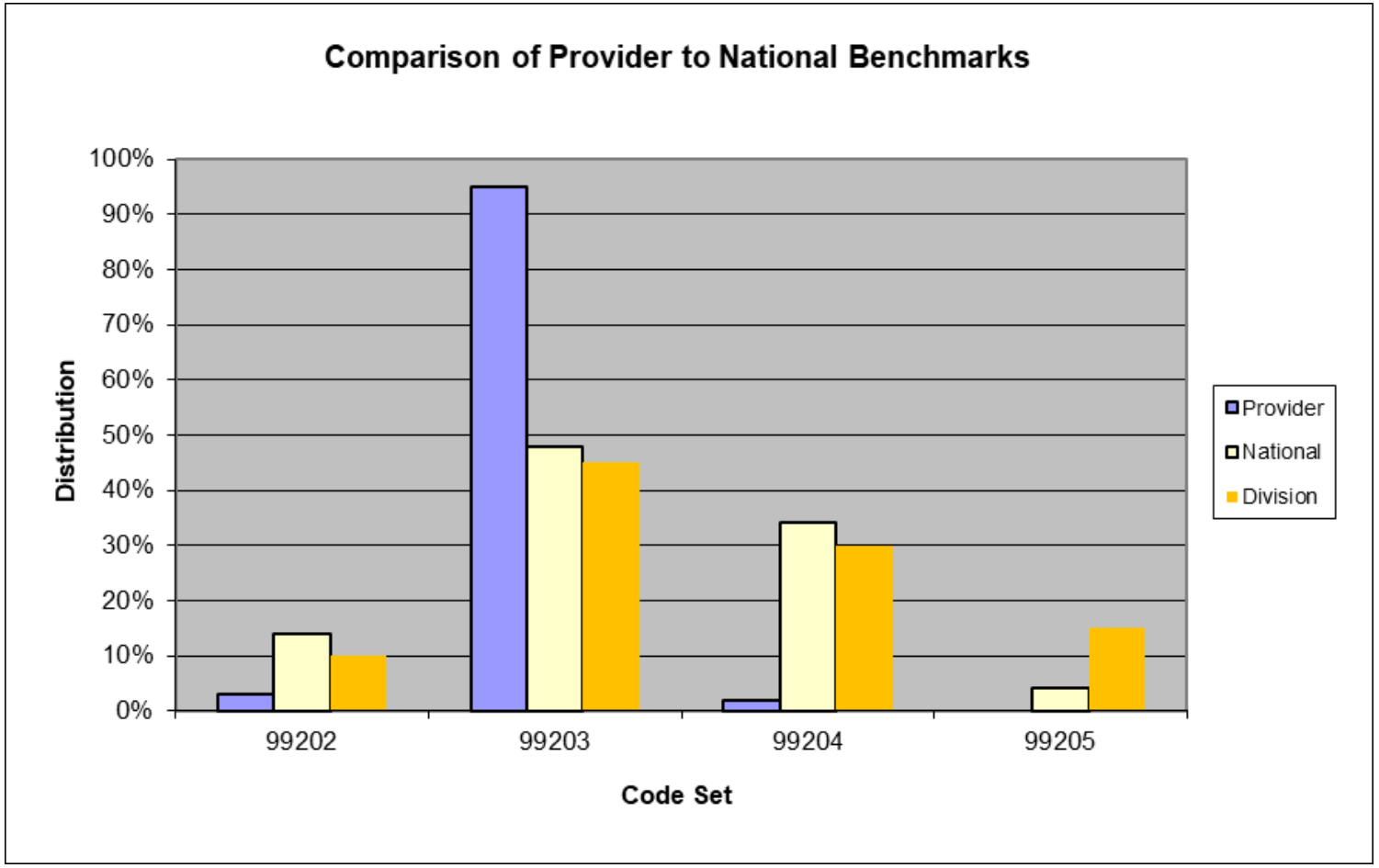
Data Mining New Patient Office/Clinic Visits
Provider "B" Graph – Below Benchmarks



Data Mining New Patient Office/Clinic Visits
Provider "D" Data – Clustered

New Office Visit - Four Quarters Ending 09/30/2023								
YOUR PRACTICE								
DIVISION	**BILLING PROV**	**CPT**	**SUM UNIT**	**SUM CHGS**	**% per provider**	**Nat'l Benchmark**	**Difference**	**Division Distribution**
ANY DEPARTMENT	**PROVIDER "D"**	99202	3	$ 345	3%	14%	-11%	10%
		99203	95	$ 15,400	95%	48%	47%	45%
		99204	2	$ 660	2%	34%	-32%	30%
		99205	0	$ -	0%	4%	-4%	15%
	PROVIDER "D"		**100**	**$ 16,405**				

Data Mining New Patient Office/Clinic Visits
Provider "D" Graph – Clustered



Data Mining Exercise

Utilizing the forms in the next slides, create data mining information using the following information:

New Patient Visit Totals (Units)

- 99202 – 30
- 99203 – 29
- 99204 – 28
- 99205 – 13

Data Mining Exercise

Utilizing the forms in the next slides, create data mining information using the following information:

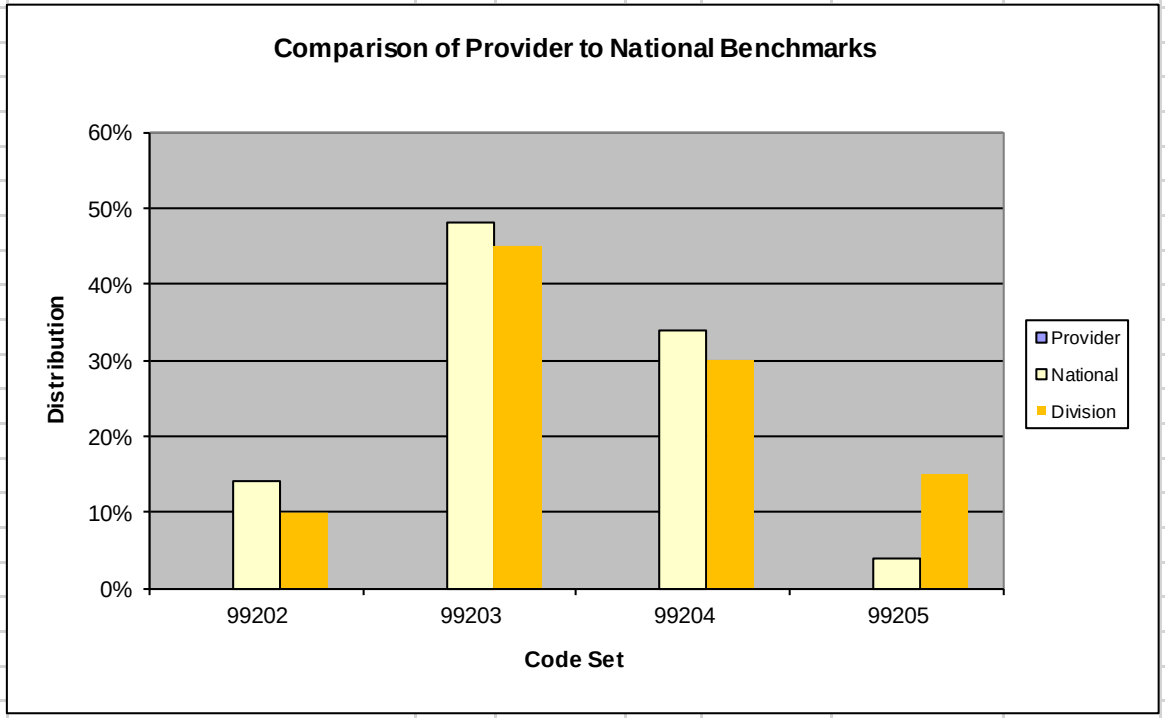
New Patient Visit Benchmarks

- 99202 – 30%
- 99203 – 29%
- 99204 – 28%
- 99205 – 13%

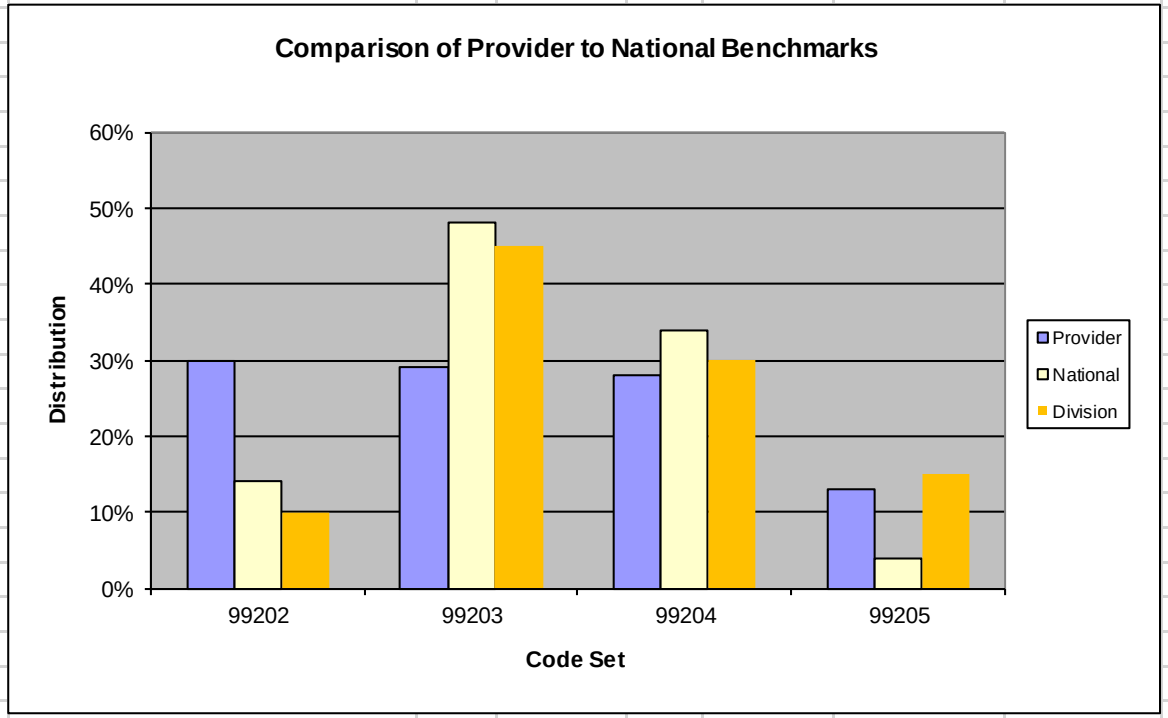
New Office Visit - Four Quarters Ending 09/30/2023

SOURCE: YOUR BILLING SYSTEM

DEPARTMENT	BILLING PROVIDER		CPT	SUM UNIT	% per provider	Nat'l Benchmark	Division
YOUR PRACTICE	PROVIDER "YOU"		99202			14%	10%
			99203			48%	45%
			99204			34%	30%
			99205			4%	15%
	PROVIDER "YOU"	Total		0			



New Office Visit - Four Quarters Ending 09/30/2023							
	SOURCE: YOUR BILLING SYSTEM						
DEPARTMENT	BILLING PROVIDER		CPT	SUM UNIT	% per provider	Nat'l Benchmark	Division
YOUR PRACTICE	PROVIDER "YOU"		99202	30	30%	14%	10%
			99203	29	29%	48%	45%
			99204	28	28%	34%	30%
			99205	13	13%	4%	15%
	PROVIDER "YOU"	Total		100			



What the Data Tells You and What You Should Be Asking

Possibly under billing – very high volumes of lower level codes

- What does the documentation support?
- Possible missed revenue opportunities
- Undervaluing the work of the provider
- What is the acuity of the patient base?

Data mining should be done on all code sets that are regularly used by each provider and for the group in total

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

Questions?

Contact Information:
Sally Streiber, BS, MBA, CPC, CEMC
Practical Coding Solutions, LLC
Email:
practicalcodingsolutions@gmail.com
Cell: 330-704-8857 (please text)

For reimbursement questions please send to:
Bethany Parsell MSN, APRN, CNP, CUNP
Director of Reimbursement
The Ohio Association of Advanced Practice Nurses
Call or text: 567-232-1310
Email: bethanyoaapn@gmail.com

Or info@oaapn.org