Webinar #23

April 6, 2011

Your Host:

Inga C. Ellzey, MPA, RHIA, CDC

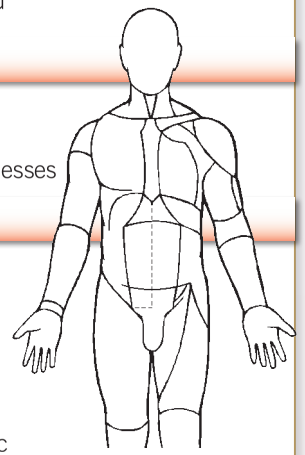
Components Available for Selecting E/M Codes

CC - CHIEF COMPLAINT (PRESENTING PROBLEM)

A concise statement of the reason for the visit must be recorded

HPI - HISTORY OF PRESENT ILLNESS

Location	Quality	Timing
Context	Severity	Duration
Modifying Factors	Signs and Symptoms	3+chronic illnesses



ROS - REVIEW OF SYSTEMS

1. Constitutional/Symptom*
2. Eyes
3. ENT and Mouth
4. Respiratory
5. Gastrointestinal (G.I.)
6. Genitourinary (G.U.)
7. Hematologic/Lymphatic
8. Musculoskeletal
9. Integumentary
10. Neurological
11. Psychiatric
12. Endocrine
13. Cardiovascular
14. Allergic/Immunologic

* (e.g., weight loss)

PFSH - PAST/FAMILY/SOCIAL HISTORY

1. Past illness, operations, injuries and treatments including prescriptions
2. Events in patient's family including hereditary diagnosis that places pt. at risk
3. Past and current social history (age appropriate)

MDM - MEDICAL DECISION MAKING

- For new patient indicate diagnosis/clinical impression
  This includes rule outs (R/O) and differential diagnoses
- For established diagnosis show
  a. Improved, well controlled, resolving, or resolved
  b. Inadequately controlled, worsening, or failure to change as expected

1. Treatment Options
   a. Medications prescribed (changes/additions)
   b. Scheduling diagnostic tests/procedures
   c. Referred to other provider
   d. Plan and follow-up
2. Data Provided
   a. Lab
   b. Pathology
   c. Journals/PDR
   d. Old record(s) review
3. Risk Management
   Indicate if any areas of risk were discussed or related to the patient

Only 2 of the 3 MDM criteria must be met for any level of care.

COMPREHENSIVE SINGLE-SYSTEM EXAMINATION

All 11 body areas with black headings and all bullets (•) within the headings must be done and document to bill 99204, 99205, and 99215.

SYSTEM/BODY AREA 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. Respiration
  5. Temperature
  6. Height
  7. Weight

The above may be measured and recorded by ancillary staff.

- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

EARS, NOSE, MOUTH, THROAT

- Inspection of lips, teeth and gums
- Examination of oropharynx (e.g., mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)

SKIN

- Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities

Inspection and/or palpation of skin and subcutaneous tissue (e.g. rashes, lesions, ulcers, susceptibility to and presence of photodamage) in eight of the following ten areas:

- Head, including the face
- Chest, including breasts and axilla
- Genitalia, groin, buttocks
- Right upper extremity
- Right lower extremity
- Neck
- Abdomen
- Back
- Left upper extremity
- Left lower extremity

For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and left upper extremity constitutes two elements.

- Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidrosis and bromhidrosis.

EYES

- Inspection of conjunctivae and lids

NECK

- Examination of thyroid (e.g., enlargement, tenderness, mass)

CARDIOVASCULAR

- Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)

GASTROINTESTINAL (ABDOMEN)

- Examination of liver & spleen
- Examination of anus for condyloma & other lesions

EXTREMITIES

- Palpation of lymph nodes in neck, axillae, groin and/or other location

LYMPHATIC

- Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)

NEUROLOGICAL PSYCHIATRIC

Brief assessment of mental status including:

- Orientation to time, place and person
- Mood and affect (e.g., depression, anxiety, agitation)

For **New Patients**, all 3 components must be met and documented.

Components Available for Selecting E/M Codes

For **Established Patients**, only 2 of 3 key components must be met and documented.

	99201, 99212*	99202, 99213	99203, 99214	99204, 99205, 99215
HISTORY	1 to 3 HPI Factors ROS - none required PFSH - none required	1 to 3 HPI Factors 1 ROS related to CC PFSH - none required	4 or more HPI factors or the status of at least 3 chronic or inactive conditions. ROS of 2 to 9 systems 1 of 3 PFSH	4 or more HPI factors ROS of 10 or more 3 of 3 PFSH (new patient) 2 of 3 PFSH (established patient)
EXAM	**PROBLEM FOCUSED** 1 to 5 elements identified by a bullet (•) on the reverse side of this matrix, in any area. These are referred to as elements.	**EXPANDED PROBLEM FOCUSED** 6 to 11 elements identified by a bullet (•) on the reverse side of this matrix, in any area. These are referred to as elements.	**DETAILED** 12 to 16 elements identified by a bullet (•) on the reverse side of this matrix, in any area. These are referred to as elements.	**COMPREHENSIVE** 17+ elements identified by a bullet (•) on reverse side of this matrix in the first 3 boxes, & at least one element in the remaining boxes for a complete single-system exam.

	99201, 99202, 99212	99203, 99213	99204, 99214	99205, 99215
MEDICAL DECISION MAKING	**Level of Risk - Straightforward** 1. Presenting Problems - One self-limited or minor problem, e.g., cold, insect bite, tinea corporis 2. Diagnostic Procedures Ordered - Laboratory tests requiring venipuncture - KOH prep 3. Management Options Selected - Rest - Elastic bandages - Superficial dressings	**Level of Risk - Low** 1. Presenting Problems - Two or more self-limited or minor problems - One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH - Acute uncomplicated illness or injury 2. Diagnostic Procedures Ordered - Skin biopsies 3. Management Options Selected - Over-the-counter drugs - Minor surgery with no identified risk factors	**Level of Risk - Moderate** 1. Presenting Problems - One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment - Two or more stable chronic illnesses - Undiagnosed new problem with uncertain prognosis 2. Diagnostic Procedures Ordered - Deep needle or incisional biopsy 3. Management Options Selected - Minor surgery w/ identified risk factors - Elective major surgery with no identified risk factors - Prescription drug management	**Level of Risk - High** 1. Presenting Problems - One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment - Acute or chronic illnesses or injuries that pose a threat to life or bodily function 2. Diagnostic Procedures Ordered - Confirmatory Pathology 3. Management Options Selected - Elective major surgery with identified risk factors - Drug therapy requiring intensive monitoring for toxicity

Visits Based on Time

	New Patients Office Visit 99201 to 99205	Estab. Patients Office Visit 99211 to 99215
Level 1	10 Minutes	5 Minutes
Level 2	20 Minutes	10 Minutes
Level 3	30 Minutes	15 Minutes
Level 4	45 Minutes	25 Minutes
Level 5	60 Minutes	40 Minutes

Complexity of Medical Decision Making (MDM)

Type of Decision Making	Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality
straightforward	minimal	minimal or none	minimal
low complexity	limited	limited	low
moderate complexity	multiple	moderate	moderate
high complexity	extensive	extensive	high

Note: To qualify for a given type of MDM, 2 of 3 elements in the risk table above must be met or exceeded.

Components Available for Selecting Consult Codes

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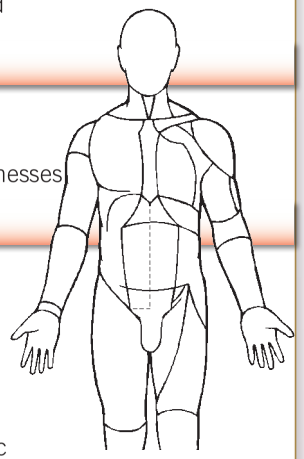

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- Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities

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NEUROLOGICAL PSYCHIATRIC

Brief assessment of mental status including:

- Orientation to time, place and person
- Mood and affect (e.g., depression, anxiety, agitation)

For **Inpatient Hospital** follow-up visits, use CPT codes 99231 to 99233

Components Available for Selecting Consult Codes Non-Medicare

For **Inpatient Nursing Facility** visits, use CPT codes 99307 to 99310

	99241, 99251	99242, 99252	99243, 99253	99244, 99245, 99254, 99255
HISTORY	1 to 3 HPI Factors ROS - none required PFSH - none required	1 to 3 HPI Factors 1 ROS related to CC PFSH - none required	4 or more HPI factors or the status of at least 3 chronic or inactive conditions. ROS of 2 to 9 systems 1 of 3 PFSH	4 or more HPI factors ROS of 10 or more 3 of 3 PFSH (new patient) 2 of 3 PFSH (established patient)
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Visits Based on Time

	Office or Other Outpatient Consults 99241 to 99245	Inpatient Consultations 99251 to 99255
Level 1	15 Minutes	20 Minutes
Level 2	30 Minutes	40 Minutes
Level 3	40 Minutes	55 Minutes
Level 4	60 Minutes	80 Minutes
Level 5	80 Minutes	110 Minutes

UPDATE!

Medicare and some commercial carriers no longer recognize or pay for the inpatient and outpatient consult codes. Check with your carrier for guidance.

Complexity of Medical Decision Making (MDM)

Type of Decision Making	Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality
straightforward	minimal	minimal or none	minimal
low complexity	limited	limited	low
moderate complexity	multiple	moderate	moderate
high complexity	extensive	extensive	high

Note: To qualify for a given type of MDM, 2 of 3 elements in the risk table above must be met or exceeded.

Factors that Affect E/M Selection

1. Patient Status

    a. New vs. established
    b. Inpatient versus outpatient
    c. New
        - 99201 to 99205 (Office)
        - 99221 to 99223 (Hospital)
        - 99304 to 99306 (SNF)
        - 99241 to 99245 (Consult Outpatient)
        - 99251 to 99255 (Consult Inpatient)
        - 99324 to 99328 (Custodial)
        - 99341 to 99345 (Home)

    d. Established
        - 99211 to 99215 (Office)
        - 99231 to 99233 (Hospital)
        - 99307 to 99310 (SNF)
        - 99241 to 99245 (Consult Outpatient)
        - 99251 to 99255 (Inpatient IP)
        - 99334 to 99337 (Custodial)
        - 99347 to 99350 (Home)

2. Types of Service

    a. Office visit
    b. Hospital visit
    c. Consultations
    d. Skilled Nursing Facility
    e. Domiciliary/Assisted Living
    f. Patient Home
    g. Hospice

3. Place of Service

    a. Office (11)
    b. Hospital (21)
    c. Skilled Nursing Facility (31)
    d. Domiciliary/Custodial Care Facility (33)
    e. Assisted Living (13)
    f. Ambulatory surgical center (24)
    g. Hospice (34)

To get complete list go to:

http://findacode.com/place-of-service-codes.html

4. Types of Providers

   a. MD/DO
   b. Nurse Practitioner
   c. Physician Assistant

5. Reimbursement Factors

   a. Ordering versus Supervising (see handout for instructions on billing)
   b. Ordering versus Rendering (see handout for instructions on billing)

Ordering versus Supervising Physician

1. *Ordering physician*: Is the physician or when appropriate, a non-physician practitioner who orders non-physician services for the patient.

    a. When a service is incident-to the service of a physician or non-physician practitioner, the name and assigned NPI of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in items 17 and 17B.

    For example, services for an NPP are incident-to the physician when the ordering physician has previously seen the patient, evaluated and recommended a treatment plan. At subsequent visits, the NPP sees the established patient for the established problem and renders follow-up services. The ordering physician is present in the office suite but does not have to see the patient during the encounter.

    When incident-to services are rendered under the above scenario, the name of the NPP does not appear on the claim. The services are billed under the name and NPI of the ordering physician.

    b. An ordering physician must be identified in the following:
    - Pathology services
    - Clinical laboratory

2. *Supervising physician:* Is the physician who is physically present in the office when the NPP is providing services under the incident-to guidelines.

    a. When the ordering is not present in the office suite during a follow-up visit by the patient, but the services are provided by the NPP as incident-to the services of another physician who is present in the office suite, in these instances:

    "The services must be billed under the name of the physician who is present in the office suite at the time the NPP provides the services, known as the supervising physician, must appear on the claim form. In group practices the ordering and supervising physicians are frequently different providers."

    b. The services are not incident-to when:
    - The physician or any physician in the group is not present in the office suite.
    - When the NPP sees a new patient.
    - When the NPP sees an established patient with a new problem.

3. *Referring physician*: Is the physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

   a. Referring provider information is usually required for consultation services for non-Medicare patients.
      - CPT codes 99241 to 99245
      - CPT codes 99251 to 99255

4. Simple Summary for completing the ordering versus supervising physician CMS-1500 form.

   Solo practice

   If there is only one provider in the practice, then:
   a. Item 17 = Provider's full name
   b. Item 17B = Provider's NPI
   c. Item 24J = Provider's NPI
   d. Item 31 = Signature of provider
   e. Item 33 = Provider's practice name, address, zip code, phone number, and NPI.

   Group practice

   In a group practice, the biller must distinguish and identify between the ordering provider and the supervising provider. Based on that information you bill:

   a. Item 17 = Ordering provider's full name
   b. Item 17B = Ordering provider's NPI
   c. Item 24J = Supervising provider's NPI
   d. Item 31 = Signature of supervising provider
   e. Item 33 = Group practice name, address, zip code, phone number, and NPI.

   Important: Do not confuse the ordering and the supervising physicians. Summary:

   a. When the ordering and the supervising physician or provider are different individuals, the ordering provider's name goes in box 17 and 17B of the CMS-1500 form.
   b. Ordering and supervising providers can also be Physician's Assistants, Nurse Practitioners or Certified Nurse Specialists.

      In those instances where the PA, NP or CNS is the supervising provider, the rules of incident-to billing must be followed. Most importantly all physicians and non-physician providers must be in the same group practice.

5. When a NPP refers a patient for consultative service, the name and NPI of the physician supervising the NPP appears in items 17 and 17B (e.g., the ordering provider.)

6. When a patient is referred to a physician who also orders and performs a diagnostic service, a separate claim form is required for the diagnostic service.

   a. Entering the original ordering/referring physician's name and NPI in items 17 and 17B of the first claim form.
   b. Entering the ordering (performing) physician's name and NPI in items 17 and 17B of the second claim form (the claim for reimbursement for the diagnostic service.)
   c. Incident to
      - Physician Assistants
      - Nurse Practitioner
      - Ancillary staff (nurses, medical assistants, aestheticians)

   d. General Supervision
      - Physician Assistants
      - Nurse Practitioners

   e. See *Incident to* matrix in handout

Incident-to Billing

Refer to the Cosmetic section of this manual for complete guidelines on incident-to billing for PAs and NPs.

Understanding incident-to billing and direct supervision is vital to the processing of correct claims and in order to avoid the submission of fraudulent claims.

Incident-to summary for PAs and NPs

1. Services eligible for "incident to" billing

    a. Doctor must always be on-site.
    b. Doctor does not have to see patient.
    c. PA/NP can only see established patients with established diagnoses and treatment plans that were established by the physician.
    d. Visit must be billed under supervising doctor's name and number.
    e. PA/NP is not identified on the CMS 1500 claims form at all.

2. Services *not eligible* for "incident to" billing

    a. New patient visits (e.g., CPT codes 99201 to 99205).
    b. Billing new problems seen by PA/NP on an established patient.
    c. No provider is on site to provide direction supervision.
    d. Doctor is on site, but patient is new, it's a consultation, or established patient with new problem not seen before by the physician.
    e. For the above "a to d", the following applies:
        - PA/NP's name and NPI are used to bill on the CMS-1500 form
        - Claims paid at 85% by Medicare
        - Group name and number are entered in block 33 of the CMS-1500 form
        - PA/NP's NPI entered and 24J of the CMS-1500 form

3. Doctor is not on site (whether new or established patient)

    a. Must be billed by PA/NP
    b. PA/NP's name and NPI are used to bill on the CMS-1500 form
    c. Paid at 85% by Medicare
    d. Group name and NPI entered in block 33 of the CMS-1500 form
    e. PA/NP's NPI entered and 24J of the CMS-1500 form

4. Incident-to Made Easy Chart for Non-Physician Providers (PAs or NPs)

Yes		Physician must **always** be on-site for all types of E/M services and procedures. NPPs can only see established patients.
Yes		NPP can only see established patients with established treatment plans
	No	The name of the NPP appears on CMS-1500 form
Yes		The name and NPI of the supervising provider who is physically on-site and supervising the NPP must appear on the claim in boxes 24J and 31
Yes		The name and NPI of the ordering provider who may be different than the supervising provider goes in block 17 and 17B
Yes		When the NPP is providing incident-to services, the services will be allowed at 100% of the supervising provider's fee schedule.

5. Non-Incident-to Made Easy Chart for PAs and NPs

Yes		The NPP can see new patients
Yes		The NPP can see established patients with new problems
Yes		The NPP can request consults from another member of his group
	No	The supervising provider must be on-site
Yes		The name and NPI of the NPP must appear on the claim in boxes 24J and 31 of the CMS-1500 claim form
	No	The name of the supervising provider appears on the CMS-1500 claim form
Yes		The services of the NPP will be paid at 85%

Levels of Care

1. 99xxx = visit codes

2. 99xx? = 5th digit determines the level
   - 99202 - level two visit
   - 99214 - level four visit

Level Determination

1. Determined by the provider's documentation to support the level billed

2. Is the level of care medically necessary?

   CMS Manual Publication 100-4, Chapter 12, Section 30.6.1 states:

   "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code."
   - Based on the chief complaint
   - Based on the frequency of visits
   - Based on the diagnosis(es)
     - Acute versus chronic
     - Active versus non-active

3. Have specific payer guidelines been met?

4. Has the visit been determined on time (>50% patient/physician face to face encounter)

Guidelines (1995 versus 1997)

1995 - Based on the number and/or extent of body areas or organ systems examined

http://www.cms.gov/MLNProducts/Downloads/1995dg.pdf

1997 - Based on specific bulleted items identified within the body area or organ system

http://www.cms.gov/MLNProducts/Downloads/Master1.pdf

a. Providers may use either
b. Whichever is most advantageous
c. One guidelines can be used per encounter
d. Cannot mix within one encounter

Definitions

New Patient: Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s).

A new patient is one who has not received *any professional services* from the physician, or another physician of the same specialty *who belongs to the same group practice, within the past three years.*

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

Consultations - The 4 Rs

1. Request (Medicare guidelines no longer in effect)
2. Reason (for evaluation of a specific problem)
3. Render opinion (findings and recommendations)
4. Report (Send letter to consult-requesting provider)

Consultation Summary Matrix

Medicare	Code	Commercial Carriers Code
New Patient Office	99201 to 99203	*99241 to 99243* or 99201 to 99203
Est. Patient Office	99212 to 99214	*99241 to 99243* or 99241 to 99243
Hospital Initial Visit	99221 to 99223	*99251 to 99253* or 99221 to 99223
FU Hosp. Same Admission	99231 to 99233	99231 to 99253
SNF Initial Visit	99304 to 99306	*99251 to 99253* or 99304 to 99306
SNF FU Same Admission	99307 to 99310	99307 to 99310

Note: For commercial carriers that still pay for consultations use the code in *italics*. If they do not use the second code listed.

We are not listing the level four and five codes, as they are impossible to justify in dermatology.

Transfer of Care

1. Doesn't occur in dermatology

2. Never use modifiers 54 and 55

See hand out for additional information on the consultation codes.

Consultations Eliminated in 2010 for Medicare Claims

1. CMS has passed legislation that will result in Medicare no longer recognizing or paying for inpatient and outpatient consultation codes typically billed by specialists.

   The affected deleted codes are as follows:

   a. Outpatient Consultation Codes: 99241 to 99245
   b. Inpatient Consultation Codes: 99251 to 99255

2. In lieu of the use of consultation codes, specialists would be required to use the regular new-patient and established-patient Evaluation and Management codes for payment purposes based on the status of the patient with the practice.

3. CMS recognizes that consultation codes are typically paid at a higher rate than equivalent evaluation and management (E/M) services, so in order to make up for the discrepancy, they have increased the RVUs for the regular office, inpatient and skilled-nursing-facility visits.

Q: When does this rule take effect?

A: Medicare started denying consultation services for any services billed on or after January 1, 2010.

Q: Will the consultation codes be deleted from the 2010 AMA CPT Book?

A: No. The codes continue to be listed in the 2010 book.

Q: Will the commercial, non-Medicare carriers stop paying for consultations?

A: You need to check with each of your carriers. Many carriers follow Medicare's lead, especially when it comes to not having to pay for physician services. You may have to contact your provider rep and/or Website for guidance on this issue.

Consultation Time Tables

	Initial Inpatient Consultation 99251 to 99255	Subsequent Hospital visits 99231 to 99233	Subsequent SNF visits 99307-99310
Level 1	20 minutes	15 minutes	10 minutes
Level 2	40 minutes	30 minutes	15 minutes
Level 3	55 minutes	40 minutes	25 minuites
Level 4	80 minutes	-	35 minutes
Level 5	110 minutes	-	*

Time limits for 99307 to 99310 were established in the 2008 CPT Book

	Office or Other Outpatient Visits 99241 to 99245	Estab. Patients Office Visits 99211 to 99215
Level 1	15 minutes	5 minutes
Level 2	30 minutes	10 minutes
Level 3	40 minutes	15 minutes
Level 4	60 minutes	25 minutes
Level 5	80 minutes	40 minutes

Outpatient Consultations

CPT Codes

99241 **Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.**

99242 **Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.**

99243 **Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.**

99244 **Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.**

99245 **Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.**

The Basics

1. Place of service

    a. In the office setting (Place of Service = 11)
    b. In the Emergency Room (Place of Service = 23)

2. Time limit between billing

    a. Codes 99241 to 99245 are not subject to the three-year new patient rule, and can be used if the patient is new or established.
    b. May be used again if an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and this is documented in the medical record. (Whether managed care organizations follow this rule varies from plan to plan.)
    c. There is no time limit or minimum between use of one consultation charge to the next as long as the criteria for a consultation are met.

3. NPI information

    Codes 99241 to 99245 require the NPI number of the referring doctor on the claim form for non-Medicare claims. This information is placed in blocks 17 and 17B of the CMS-1500 form.

4. E/M visits subsequent to an outpatient consultation

    a. Follow-up consultation codes in the outpatient setting are reported as established visits (e.g., following an already diagnosed problem).
    b. For office/ER/hospital observation unit use CPT codes 99212 to 99215.

5. Consultations within a group

    An outpatient consultation can be billed between members of the same group for non-Medicare patients. A common example occurs when a patient seen by the clinical dermatologist is referred to the Mohs surgeon in the practice for evaluation and treatment of a skin cancer.

    a. If the criteria for a consultation are met, then the Mohs surgeon can bill a consultation in addition to the performance of surgical services.
    b. The Mohs surgeon can bill a consultation service even if the other dermatologist in the practice billed another type of E/M visit on the same date of service.
    c. Modifier 25 must be appended to the consultation if billed on the same date of service as a procedure.
    d. A letter of findings must be forwarded to the consult-seeking provider.
    e. For Medicare patients, bill 99212 to 99214 for intra-group consultations.

Inpatient Consultations

CPT Codes

99251 **Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.**

99252 **Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.**

99253 **Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.**

99254 **Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.**

99255 **Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.**

The Basics

1. General guidelines

    a. Can only be used once per admission.
    b. Are not subject to the three-year new patient rule, and can be used again if the patient is new or established as long as they are not seen during the same admission.
    c. Require the NPI number of the consult-seeking doctor on the claim form for non-Medicare claims. (See CMS-1500 form blocks 17 and 17B.)
    d. Can be requested again by the same physician for the same diagnosis as long as there is a new admission.

2. Place of service

    a. In the Hospital (Place of service = 21)
    b. In the Nursing Facility (Place of service = 31)

3. Follow-up inpatient visits E/M codes

    The following codes are used for *follow-up visits subsequent* to an inpatient consult during
    the same admission:

    a. Hospital: 99231 to 99233 (Subsequent Hospital Care)
    b. Nursing Home: 99307 to 99310 (Subsequent Nursing Facility Care)

4. Billing follow-up inpatient E/M visits

    a. Follow-up inpatient visits may be billed if the doctor still has not made a definitive diagnosis and additional visits are needed.
    b. Are used if the consultant recommends management modifications during the same admission.
    c. Are used if the consultant advises a new plan of care in response to changes in the patient's status during the same admission.
    d. Are frequently used in the Nursing Facility when new problems develop during the same admission.
    e. Require the NPI number of the consult-seeking doctor on the claim (blocks 17 and 17B).

Key Components for E/M Services

History

Components of History

1. Chief Complaint (CC)

2. History of Present Illness (HPI)

   Two Types
   - *Brief* 1 to 3 factors
   - *Extended* 4+ factors

   Or updating the status of three chronic or inactive conditions

   HPI Factors
   - **Location**
   - **Duration**
   - **Signs and symptoms**
   - **Severity**
   - **Modifying factors**
   - Context
   - Timing
   - Quality

   Note: Those in **bold face** are the most commonly used in dermatology

3. Review of Systems (ROS)

   Three types
   - *Problem pertinent* (1 system)
   - *Extended (*2 to 9 systems)
   - *Complete* (10+ systems)

   Common dermatology questions that support medical necessity
   - Has trouble healing
   - Bleeds excessively due to aspirin or anticoagulant
   - Do you suffer from frequent rashes, chronic itching skin, dry skin, bacterial infections, or hives?
   - Has prosthetic hip replacement
   - Has pacemaker
   - Bleeds easily
   - Develops scars and keloids
   - Has gastrointestinal complications when taking system drugs
     - Vomiting

- Diarrhea
- Nausea

Note: Do not use vague terms like. "No other skin problems noted."

4. Past, Family, Social History (PFSH)

   Past = illnesses, injuries, current meds, allergies.

   Family = health status, disease or death of blood relatives

   Social = marital status, employment, drug use, sexual habits, smoking, hobbies

   Types - new patient
   - *Pertinent* (1 specific item form any 3 of the history categories - past, family or social)
   - Complete (1 specific item from each of the three history categories - past, family or social)
   - Past, Family, Social History (PFSH)

   Types - established patient
   - *Pertinent* (1 specific item form any 3 of the history categories - past, family or social)
   - Complete (1 specific item from two of the three history categories - past, family or social)

HISTORY GRID - Outpatient

	Brief		Extended	
HPI	1 to 3		4 or more	
ROS	None	Pert to Prob. = 1	Extended = 2 to 9	Complete
FSH	None		Pertinent	Complete
Overall History Level	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

Examination

1. Four Levels
   - Problem Focused (PF)
   - Expanded problem focused (EPF)
   - Detailed
   - Comprehensive

2. Examination elements
   - Body areas (e.g., face, scalp, chest, abdomen)

System/body area	Examination
Skin	● Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, susceptibility to and presence of photo damage) in eight of the following ten areas: ● Head, including the face ● Neck ● Chest, including breasts and axilla ● Abdomen ● Genitalia, groin, buttocks ● Back ● Right upper extremity ● Left upper extremity ● Right lower extremity ● Left lower extremity ***Note**:* For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and left upper extremity constitutes two elements. ● Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidrosis and bromhidrosis.

- Body systems (e.g., skin, lymphatic, constitutional, ears/nose/mouth/throat)

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. Respiration 5. Temperature 6. Height 7. Weight The above may be measured and recorded by ancillary staff. ● General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Ears, Nose, Mouth and Throat	● Inspection of lips, teeth and gums ● Examination of oropharynx (e.g., mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)
Eyes	● Inspection of conjunctivae and lids
Neck	● Examination of thyroid (e.g., enlargement, tenderness, mass)
Cardiovascular	● Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Gastrointestinal (abdomen)	● Examination of liver and spleen ● Examination of anus for condyloma and other lesions
Lymphatic	● Palpation of lymph nodes in neck, axillae, groin and/or other location
Extremities	● Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Neurological/ Psychiatric	Brief assessment of mental status including: ● Orientation to time, place and person ● Mood and affect (e.g., depression, anxiety, agitation)

Caution: Do not confuse “skin of the neck” with neck involving examination of the thyroid.

Do not confuse “skin of the upper and lower extremities” with examination of extremities, which includes inspection of the digits and nails.

3. Cannot use terms like:
   - Full body - exam
   - Waist-up exam
   - Full body screening
   - Must detail each body area examined
   - Check off means examined but normal
   - If normal, must add detail to check off

4. Body diagrams are great

Examination Guide

1995	**Problem Focused**	**Expanded Problem Focused** **Limited**	**Detailed** **Extended**	**Comprehensive**
	1 body area or organ system	2 to 4 body areas or organ systems	5 to 7 body areas or organ systems	8 organ systems or Complete single system exam
1997	Any 1 to 5 bullets	Any 6+ bullets	Any 12+ bullets	Perform all

Medical Decision Making

1. Four levels
   - Straight forward
   - Low complexity
   - Moderate Complexity
   - High Complexity

2. Elements
   - Number of diagnosis(es) and/or management options
     - Self-limited or minor problem
       -Runs its course, can be stable, improved or worse
     - Established problem - usually diagnoses have been made and
       -Treatment has been started, can be stable, improved, or worsening
     - New problem
       -No additional work-up planned
       -Additional work-up planned
   - Amount and/or complexity of data reviewed
   - Risk of complications and/or morbidity or mortality

3. Level Determination
   - On the table of risk, two of the three elements must be met or exceeded

Table of Risk

Number of DX/TX options	Minimal	Limited	Moderate	Extensive
Data Reviewed	Minimal	Limited	Moderate	Extensive
Highest Risk	Minimal	Low	Moderate	High
Types of Medical Decision Making	Straight forward	Low	Moderate	High

4. What increases risk?

   a. Prescription drugs
   b. Surgical procedures
   c. Diagnoses - number, nature, acute versus chronic

An Easy Way to Figure out the MDM is as Follows

1. Straightforward

   You have one diagnosis and literally, you don't do anything….Maybe a KOH that was negative.

   Use: 99201, 99202, 99212, 99241, 99242, 99251, 99252

2. Low

   a. You have one or more diagnoses and you do a biopsy or other minor procedure like LN2.
   b. You may recommend an over-the-counter drug or do a skin biopsy that has no suspected risk.

   Use: 99203, 99213, 99243, 99253

3. Moderate

   a. You have one or more diagnoses and you do minor surgery that you think has risk
   b. This could include BX, LN2, shave removal, excision, and/or your write a prescription.
   c. Just writing a prescription increases the risk to moderate.

   Use: 99204*, 99214, 99244*, 99254*

   *These codes are rarely billed by dermatologists!

4. High

   a. Chronic illness that doesn't seem to get better or has serious side effects, could affect life or body function,
   b. prescribing a drug requiring intensive monitoring like Accutane, Methotrexate, and/or
   c. a procedure that requires pathologic confirmation.

   Use: 99205*, 99215*, 99245*. 99255*

   *These codes are rarely billed by dermatologists!

Billing Level Four and Five levels of care

Billing Matrix 99204, 99205, 99215, 99244, 99245, 99254, 99255

History Number

CC	1 or more
HPI	4 or more
ROS	10 or more
PFSH	3 of 3 for new patient 2 of three for established patient.

Examination Number

Perform all elements identified by a bullet and at least one element in the remaining boxes for a complete single-system examination

This includes 16 skin areas plus examination of:

- Thyroid
- Peripheral vascular system
- Liver and spleen
- ANUS
- Lymph nodes
- Brief assessment of mental status
- Constitutional
  - Vital signs
  - General appearance

Medical Decision Making (99204, 99244, 99254) Level of Risk – Moderate

1. Presenting Problems
   - One or more chronic illnesses with mild exacerbation, progression or side effects of treatment
   - Two or more stable chronic illnesses
   - Undiagnosed new problem with uncertain prognosis

2. Diagnostic Procedures Ordered
   - Incisional biopsy

3. Management Options Selected
   - Minor surgery with identified risk factors
   - Elective major surgery with no identified risk factors
   - Prescription management

Medical Decision Making (99215, 99205, 99245, 99255) Level of Risk – High

1. Presenting Problems
   - One or more chronic illnesses with severe exacerbation, progression or side effects of treatment
   - Acute or chronic illnesses or injuries that pose a threat to life or bodily function

2. Diagnostic Procedures Ordered
   - Confirmatory Pathology

3. Management Options Selected
   - Elective major surgery with identified risk factors
   - Drug therapy requiring intensive monitoring for toxicity

See handout for more details

Billing Level Four and Five E/M visits

CPT Codes

99204 and 99205	**New patients (Level IV and V)**
99215	**Established patient (Level V)**
99244 and 99245	**Office consultation (Level IV or V)**
99254 and 99255	**Inpatient consultation (Level IV or V)**

Documentation

The above new patient and consultation visits require that all three of the key components (e.g., history, examination and medical decision making) are met in their entirety.

Many dermatologists are misled into thinking that a comprehensive history and examination involve only the integumentary system. The requirements for these level four and level five visits are much more intense and comprehensive, and involve not only the skin but many other organs and systems as well. In addition, a quality history form should be integrated into your practice's patient intake process in order to meet the detailed criteria for the history component of these visits, if performed and medically necessary.

1. History criteria

   The criteria for the history include the following:

   a. *Four* or more history of present illness (HPI) factors

      This includes:
      - Location
      - Duration
      - Signs and Symptoms
      - Modifying factors
      - Severity
      - Quality
      - Context
      - Timing

   b. Review of systems (ROS) of at least *ten* systems

      Systems include:
      - Constitutional/symptoms
      - Eyes
      - ENT and mouth
      - Respiratory

- Gastrointestinal (G.I.)
- Genitourinary
- Hematologic/lymphatic
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Cardiovascular
- Allergic/immunological
- Documentation of at least t*hree* past, family, or social history (PFSH)

2. Examination criteria

The documentation of the examination criteria is probably one of the most complicated and misunderstood aspect in the billing these high level E/M services. Most dermatologists feel that if they do a full body skin exam, that the level of care is justified. That is absolutely incorrect. The *comprehensive* skin examination must include the following *twenty four components in their entirety* and the decision to perform a comprehensive exam must be medically necessary based on the chief complaint.

a. *Sixteen* skin areas
   - Inspection of lips
   - Oral mucosa
   - Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest or public area (counts as one area)
   - Examination of head, chest, buttocks, neck, abdomen, back, and all four extremities (counts as 10 areas)
   - Inspection of eccrine and apocrine glands
   - Inspection of conjunctivae and eyelids
   - Inspection and palpation of digits and nails *plus*

b. Examination of thyroid
c. Examination of peripheral vascular system
d. Examination of liver and spleen
e. Examination of anus
f. Palpation of lymph nodes
g. Brief assessment of mental status
h. Constitutional
   - Vitals
   - General appearance

3. Medical Decision Making

Medical decision making for level four (99204/ 99244) is moderate and includes documentation of the following:

a. Presenting problems
   - *One* or more chronic illnesses with severe exacerbation, progression or side effects of treatment or
   - *Two* or more stable chronic illnesses or
   - Undiagnosed new problem with uncertain prognosis

b. Diagnostic procedure ordered
   - Incisional biopsy

c. Management options selected
   - Minor surgery with identified risk factors or
   - Elective major surgery with no identified risk factors or
   - Prescription drug management

Medical decision making requirements for level five (99205/ 99245) involves high risk:

a. Presenting problems
   - *One* or more chronic illnesses with severe exacerbation progression or side effects of treatment or
   - Acute or chronic illness or injuries that pose a threat to life or bodily function

b. Diagnostic procedure ordered
   - Confirmatory pathology

c. Management options selected
   - Elective major surgery with identified risk factors or
   - Drug therapy requiring intensive monitoring for toxicity

4. Established visit CPT code 99215 documentation

This code only requires that you meet *two of the three* of the key components in their entirety. This means that you must meet any of the following components.

a. History and examination or
b. History and medical decision making or
c. Examination and medical decision making

Important: Which ever two components you select to support your documentation, all the criteria of that component must be documented in full. If any portion of the criteria is not met for that key component, then your documentation will fail to support the service billed.

History

- *Four* or more HPI factors
- ROS of at least *ten* systems
- At least *two* PFSH

Medical Decision Making for CPT code 99215 visits is high and includes:

a. Presenting problems
   - *One* or more chronic illnesses with severe exacerbation, progression or side effects of treatment or
   - Acute or chronic illness or injuries that pose a threat to life or bodily function

b. Diagnostic procedure ordered
   - Confirmatory pathology

c. Management options selected
   - Elective major surgery with identified risk factors or
   - Drug therapy requiring intensive monitoring for toxicity

(Must have *two* of the three key components completed in full)

5. Counseling

For visits based solely on time, the extent of counseling must be clearly documented in the medical record.

Example: 15/25 minutes spent discussing diagnosis of hair loss, treatment options, and risk of treatments.

Time Table

Code	Time spent counseling
99204	45 minutes
99205	60 minutes
99244	60 minutes
99245	80 minutes
99215	40 minutes

When time is used to select a level of care, the key components do not have to be met in part or in full. The full weight of the visit will be based on documentation of time spent counseling.

6. Medical Necessity

The last issue regarding the higher levels of care concerns medical necessity. Not only must the documentation support the CPT code billed, but the carrier must feel that the extent of the history, exam, and medical decision making *were necessary to perform based on the patient's chief complaint and/or presenting problems*. Just because the documentation is complete and accurate may not satisfy an auditor. They will question, for example, why a comprehensive body examination was necessary when the presenting problem was a wart on the finger or acne of the face. The patient's history or the complexity of the problem must, must be consistent with what services the provider renders.

The carriers will compare your utilization of the higher levels to other dermatologists who have similar diagnoses, and yet only bill level three visits for new patients or consultations. So keep the following in mind when selecting your higher levels of care.

a. Show medical necessity
b. Support with documentation including, detailed history, comprehensive examination and evidence moderate or high risk MDM

Counseling

1. Only the doctor's time counts
2. There must be a patient present
3. Can be over various interactions during the day - add up total
4. Includes not only talking time but other time doing procedures or tests
5. Visit must be dominated by counseling (50% or more of total time spent physician/patient)
6. Nurses/MAs can only bill 99211 - no matter how long they spend
7. 15/25 minutes spent discussing Malignant Melanoma, TX options, prognosis

Table: Counseling base on time

	New Patients Office Visits 99201 to 99205	Estab. Patients Office Visits 99211 to 99215	Office or Other Outpatient Consults 99241 to 99245
Level 1	10 minutes	5 minutes	15 minutes
Level 2	20 minutes	10 minutes	30 minutes
Level 3	30 minutes	15 minutes	40 minutes
Level 4	45 minutes	25 minutes	60 minutes
Level 5	60 minutes	40 minutes	80 minutes

Nurse's Visits

Examples of when to bill 99211

1. Dressing Changes
2. Wound care observance
3. Suture removal

Examples of when NOT to bill 99211

1. The physician gave orders to the patient over the phone
2. The physician called in a prescription to the pharmacy (patient was not in the office)
3. The patient was called by the office to schedule or reschedule a procedure
4. Laboratory and/or pathology reports were reported to the patient over the telephone
5. The patient received photolight therapy services by a medical assistant or nurse. The nurse charted only the amount of light exposure that the patient received.
6. Patient came to the office for blood draw only. 36415 should be billed not 99211.
7. The patient was in the office merely to receive an IM or SubQ injection.
8. The patient was seen by the medical assistant or nurse for the sole purpose of having sutures removed, but no documentation was noted about the evaluation of the site or patient education.

Modifiers and 99211

1. If there is no postoperative period in place, no modifiers need to be appended to the E/M visit.
2. If there is a postoperative complication that requires a visit, then modifier 24 must be used.
3. Most insurance carriers, including Medicare, *will not* pay for any E/M visits during the postoperative period, even if there is a complication such as an infection. Most carriers will deny the service.
4. If such a denial occurs, an appeal or claim redetermination could be performed although in most instances, the carriers will not reverse their initial denial decision.

Documentation

1. Must be an evaluation and management service performed
2. See attached form (s)

Payment

1. Billed under name and NPI of provider
2. Allowed at 100% of physician payment
3. The name of the ancillary staff should not appear anywhere on the claim form.
4. The physician or provider must be on-site to supervise staff or 99211 cannot be billed.

Bundling and CPT Code 99211

Medicare's CCI Bundling Tables no longer allow 99211 to be billed with the following under any circumstances. The code has a -0- indicator code meaning that even with the correct modifier, 99211 will be denied if billed with the following services:

Column I	Column II
11719	**99211** (Nail trimming)
11720	**99211** (Nail debridemente
11721	**99211** (Nail Debridement)
95028	**99211** (Sensitivity testing)
95044	**99211** (patch testing)
96372	**99211** (IM, SubQ injections)
96405	**99211** (IL chemo injections)
96406	**99211** (IL chemo injections)
96910	**99211** (UVA light therapy)
96912	**99211** (UVB light therapy)

ICD-9-CM Coding and 99211

Q: What ICD-9-CM code would be appropriate to use when billing postoperative visits?

A: There are a variety of choices.

1. Visits when the pathology results are discussed should be billed using the diagnosis on the path report.

2. Wound checks when there is a complication should be billed using the complication diagnosis code:
   a. Infection - 998.59
   b. Contact Dermatitis - 692.9
   c. Wound abscess - 998.59
   d. Pain (NOS) - 780.96

3. Dressing changes should be billed as follows:
    a. Dressing change/ removal of non-surgical wound - V58.30
    b. Dressing change/ removal surgical wound - V58.31
    c. Suture removal can be billed using V58.32

Below we will pose various questions and answer questions commonly asked regarding dressing changes and suture removal services.

Q: Can CPT code 99211 be used for dressing change, wound care observance, or suture removal and is this reimbursed by insurance carriers?

A: There is a CPT code for postoperative follow-up visit (e.g., 99024). However, this is not a reimbursed code by Medicare or any commercial carriers that I know of. Most practices use this as an internal code to track "no charge" visits.

Q. Tell me more about the postop period.

What is most important to understand about billing for dressing changes or suture removal is knowing whether or not there is a global follow-up period in place for the surgical service rendered.

1. Many dermatologic services have a 10 or 90 day follow-up period included, while others have no global surgical package (e.g., no postoperative days).

2. Procedures such as biopsies (CPT codes 11100, 11101), shave removals (CPT codes 11300 to 11313, intralesional injections (CPT codes 11900, 11901, 96405, 96406), and Mohs (CPT codes 17311 to 17314) have no postoperative period.

    This means that if the patient requires follow-up visits immediately following the procedure for such services as dressing changes, wound checks, and/or suture removal, the visit should be billed as an E/M visit.

3. No modifiers should be needed on the E/M visit, unless some other procedure is billed on the same date of service, or there is a follow-up period in place because another *unrelated* surgical service was performed.

Q: What if there is no global postoperative period, what level of E/M visit should I bill?

A: 1. That depends entirely on what was done and documented. In most cases, the visit would be a level one new patient visit (99201), level two established patient visit (99212), or nurse visit (99211), since only one body area is examined and the history and/or medical decision making are low.

2. There may be instances when a visit may turn into an extended visit because the patient needed to be counseled. This happens frequently when a patient returns for follow-up care and the pathology report is discussed.

3. If the discussion turns into a 15 or 25 minute visit, the visit could be billed a 99213 or 99214 based on "time spent."

4. The time must be clearly documented in the chart.

Q: Can a physician or provider bill 99211?

A: 1. The 99211 E/M visit is a nurse visit and *should be used only by medical assistant or a nurse* when performing services such as wound checks, dressing changes, or suture removal.

2. CPT code 99211 *should never be billed for provider service (e.g., MDs, DOs, PAs, or NPs*.)

3. If a medical assistant or a nurse charges 99211, *a provider must always be on site* to provide direct supervision.

4. CPT code 99211 cannot be charged to any third party payer if there is no provider on site.

5. The provider does not personally have to see the patient, but must be in the office suite. This is part of the "incident to" guidelines.

Q: Do I need any modifiers appended to the E/M visit?

A: 1. If there is no postoperative period in place and no procedures were performed on the dame date of service, no modifiers need to be appended to the E/M visit.

2. If there is a postoperative complication that requires a visit, then modifier 24 must be used.

3. The vast majority of the insurance carriers, including Medicare, *will not pay* for any E/M visits during the postoperative period, even if there is a complication such as an Infection. Most carriers will deny the service.

4. If such a denial occurs, an appeal or claim redetermination could be performed although in most instances, the carriers will not reverse their initial denial decision.

5. If there is no postoperative period in effect, but a procedure is also billed on the same date of service, modifier 25 must be attached to the E/M visit.

Q: What if the patient just comes in for suture removal when the surgery was performed by another practice? Can I bill if the follow-up visit is billed during the postoperative period? How do I bill? Do I use modifiers 54 or 55?

A: 1. Do not use any modifiers such as 54 or 55 as they are not appropriate for the scenarios discussed above.

In most instances, you won't even know what CPT code was billed by the surgeon, how many postoperative days the procedure has, or how many postoperative days still remain. Since you are in a different practice, *you are not subject to the follow-up or global period of the other provider (e.g., performing surgeon).*

2. You should bill for the services you provide. Here are some guidelines.

a. If the patient is new to your practice, you may use 99201 to 99203 depending on the level of care rendered, degree of documentation, or the amount of time spent counseling.

b. If the patient is an established patient, you may use 99211 to 99215 depending on the level of care rendered, degree of documentation, or the amount of time spent.

Note: CPT code 99211 is only used if a nurse saw the patient.

3. The visit is rarely just a suture removal encounter. Even if sutures are removed, the wound site is usually evaluated for infection, healing, erythema, edema, etc.

a. The absence or presence of these symptoms should be noted in the chart.

b. Additionally wound care instructions are usually given and/or reiterated during the encounter. The provision of these instructions should also be noted in the chart.

c. It is not uncommon for the patient to ask questions about the diagnosis, prognosis, or degree of risk. In these situations, the length of time spent should be noted and may even determine the level of care billed.

Q: If I have a group practice and one of my colleagues does the follow-up for dressing changes, wound care checks, or suture removal for a surgical service I performed, can the visit be charged since he/she is not the same provider who performed the surgery?

A: No, your colleague cannot bill. He/she is subject to the same global surgical follow-up period because you are all part of the same practice. Billing for these visits would be unbundling, and could be construed as fraud.

Patient: _____ Date of Birth::____/____/____

Today's Date: ____/____/____

Reason for today's visit: ❑ Wound care check ❑ Dressing change ❑ Injection
❑ Suture removal ❑ Pathology report reviewed ❑ PDT

Site:		Site:		Site:		Site:	
	Circle		*Circle*		*Circle*		*Circle*
Bleeding	Y / N	Bleeding	Y / N	Bleeding	Y / N	Bleeding	Y / N
Erythema	Y / N	Erythema	Y / N	Erythema	Y / N	Erythema	Y / N
Healing well	Y / N	Healing well	Y / N	Healing well	Y / N	Healing well	Y / N
Infection	Y / N	Infection	Y / N	Infection	Y / N	Infection	Y / N
Oozing	Y / N	Oozing	Y / N	Oozing	Y / N	Oozing	Y / N
Swelling	Y / N	Swelling	Y / N	Swelling	Y / N	Swelling	Y / N
Sutures out	Y / N	Sutures out	Y / N	Sutures out	Y / N	Sutures out	Y / N
New Dressing	Y / N	New Dressing	Y / N	New Dressing	Y / N	New Dressing	Y / N

Notes:_____

_____

COMPLETED BY: _____ ___/___/___
Signature Date

Patient: _____ Date of Birth::____/____/____

Today's Date: ____/____/____

Reason for today's visit: ❑ Wound Care Check ❑ Dressing Change ❑ Injection
❑ Suture Removal ❑ Pathology report reviewed ❑ PDT

Site:		Site:		Site:		Site:	
	Circle		*Circle*		*Circle*		*Circle*
Bleeding	Y / N	Bleeding	Y / N	Bleeding	Y / N	Bleeding	Y / N
Erythema	Y / N	Erythema	Y / N	Erythema	Y / N	Erythema	Y / N
Healing well	Y / N	Healing well	Y / N	Healing well	Y / N	Healing well	Y / N
Infection	Y / N	Infection	Y / N	Infection	Y / N	Infection	Y / N
Oozing	Y / N	Oozing	Y / N	Oozing	Y / N	Oozing	Y / N
Swelling	Y / N	Swelling	Y / N	Swelling	Y / N	Swelling	Y / N
Sutures out	Y / N	Sutures out	Y / N	Sutures out	Y / N	Sutures out	Y / N
New Dressing	Y / N	New Dressing	Y / N	New Dressing	Y / N	New Dressing	Y / N

Notes:_____

_____

COMPLETED BY: _____ ___/___/___
Signature Date

E/M Medicare Utilization Percentages*

99201:	10.00%
99202:	50.40%
99203:	36.60%
99204:	2.74%
99205:	0.26%
99211:	1.97%
99212:	39.00%
99213:	52.76%
99214:	6.02%
99215:	0.25%
99241:	12.16%
99242:	49.83%
99243:	34.81%
99244:	2.94%
99245:	0.26%
99251:	13.160%
99252:	45.401%
99253:	32.321%
99254:	7.411%
99255:	1.707%

*** Based on the currently available 2008 data. Note these percentages will change in 2010 since Medicare is no longer paying for consultations.**

Signatures

1. Will only accept hand written, electronic signatures or facsimilies or original written or electronic signatures

2. This applies to all progress notes, order, treatment plans, and other related medical documents

3. No signature stamps allowed - they are banned and will result in claims denial

4. If audited, can use attestation statement

CMS has now stated unambiguously that all providers and suppliers must stop using physician signature stamps. In an MLN Matters article (SE0829) released July 29, 2008, CMS states, "Stamped signatures are not acceptable on any medical record."

CMS said in Transmittal 248 (Change Request 5971) that Medicare would no longer accept medical records with physician-stamped signatures. Some people questioned whether CMS was really taking such a strong position across the board for all medical records because the transmittal originally was released in response to hospice-certification concerns, even though it modified the Medicare Program Integrity Manual for all prepayment and post-payment medical reviews. It's clear now from the MLN Matters article that CMS's intentions all along were to end the use of physician signature stamps: The article states that Transmittal 248 was issued to bar the use of signature stamps.

"Medicare will [only] accept hand written, electronic signatures, or facsimiles of original written or electronic signatures. This includes progress notes, orders, and treatment plans and other related medical documents."

The reason for this crackdown is CMS's longstanding concern over abuse of signature stamps. "CMS has identified problems of noncompliance with existing statutes, regulations, rules, and other systemic problems relating to standards of practice for a valid physician's signature on medical orders and related medical documents."

Important: Because the transmittal, issued March 28, 2008, revised the program integrity manual section on medical reviews, all claims are affected. Any documentation signed by a physician signature stamp will be invalid, so in the eyes of an auditor, the documentation might as well be nonexistent.

Cheryl Rice, corporate director of corporate responsibility for Catholic Healthcare Partners in Cincinnati, says hospitals will have to convey to employed physicians that signature stamps are banned. Hospitals also should get the word out to community physicians because hospital payment may hinge on their compliance with the new CMS policy if their reports are part of a medical review.

In addition, as part of their certification process, Joint Commission surveyors are checking whether hospital medical record entries are dated, timed, and signed as instructed by the Conditions of Participation. "Since the Joint Commission is checking for authentication, hospitals need to be diligent in making sure their internal documentation is stamp free," Rice says. But, she says, questions remain as to whether CMS will apply the same prohibition on community physicians and external documentation routinely submitted to hospitals as part of the order process. "Hopefully, CMS will adopt a uniform policy prohibition to make hospital enforcement and compliance easier," says Rice.

Skin Cancer follow-ups

General Information

Distinguishing "screenings" or annual preventative exams from covered, dermatologic E/M visits.

1. A screening is a type of service where there is no chief complaint or concerns. In dermatology, is would seem unusual for a patient to seek dermatologic care and evaluation with absolutely no lesions present on their skin. Very few patients past the age of five have skin totally void or spots, birthmarks, lesions, or other noticeable skin conditions.

   Therefore, when patients seek the professional input of a dermatologist, even though they may state they want a skin "screening", it is most likely the result of their concern about a lesion(s) that they have noticed on their skin. It is the job of the nurse or the physician to draw out the reason for the visit during the history taking process.

   Patient: *"I am here today because my neighbor died of malignant melanoma and I want to make sure that I don't have anything that is cancerous. I want a full body check-up."*

   Nurse/physician: *"Mrs. Jones, can you point to or advise me of any spots on your skin that you are especially concerned about and which you want to make sure is examined today?"*

   Patient: *"Well, my husband did say that there was this black thing on my lower back."*

   Now you have your chief complaint. Whatever the "black spot" turns out to be is your diagnosis. Even though that lesion may not be anything, many spots, bumps and lesions are evaluated during the skin examination. Your diagnosis(es), are the lesions you examined, whether or not they need treatment.

   The level of care you select is based on the depth of your history, the extent of your examination, and the level of medical decision-making.

2. Patients with a personal history of skin cancer *do not* fall under the screening or preventative examination categories and should be billed using the guidelines listed on the following page.

3. Dermatologists do not perform annual, routine, *preventative* examinations and therefore rarely, if ever, bill these codes.

The Basics

1. Monitoring Patients With Personal History of Skin Cancer

   a. Providers who perform follow-up visits on patients who have had a malignant skin cancer(s) are not performing *routine* examinations or screenings.

   b. The visit is covered since skin cancers do not have a 100% cure rate.

   c. These visits should be billed using CPT codes 99201 to 99214.

   d. The frequency of follow-up visits should be consistent with the type of skin cancer being followed and is up to the provider's discretion.

   e. Patients with a personal history of actinic keratoses, but not skin cancer, are seen as deemed necessary by the physician. There is no ICD-9-CM code for "personal history of actinic keratoses."

2. How To Document The Progress Notes for Skin Cancer Visits

   9-15-11 "Patient seen/returns today to be monitored for the possible recurrence of a basal cell carcinoma of the left medial forehead excised 2-14-04 and to check for the development of new cancers in a high risk patient."

   This should be followed by documentation of the exam and appropriate medical decision making criteria based on the extent of the care rendered.

3. Physicians or staff frequently express concern regarding the use of V-codes as primary diagnoses.
   a. Medicare pays for V10.83 and V10.82 as a primary diagnosis.
   b. Commercial carriers are recognizing the V-codes. Fewer denials are occurring when the "personal history of skin cancer" V-codes are being used.

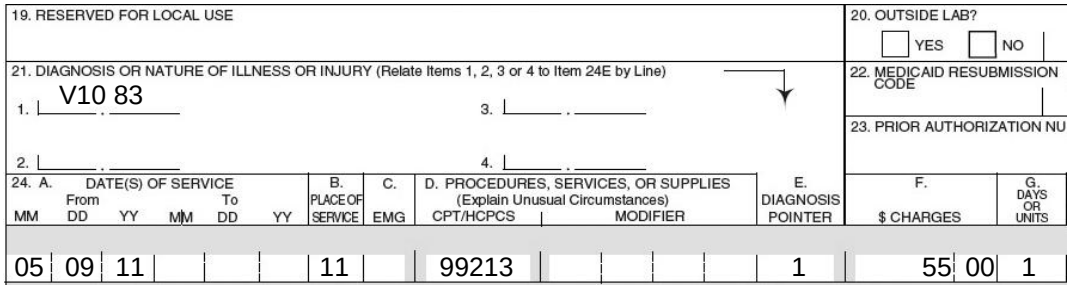
4. How to Complete the Claim Form

   ICD-9-CM Codes

V10.83	Personal history of malignant neoplasm of the skin
V10.82	Personal history of malignant melanoma of the skin

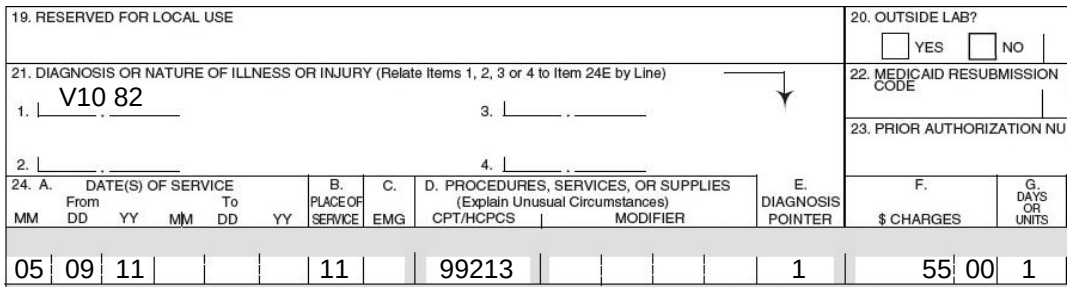
   These codes are not based on anatomical location. The codes remain the same no matter what location.

Example 1: Follow-up for basal cell carcinoma of the medial forehead. You bill:



19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? ☐ YES ☐ NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V10.83 3. 2. 4.												22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NU	
24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS
05	09	11				11		99213		1	55	00	1

Example 2: Follow-up for malignant melanoma of the right lateral leg near ankle. You bill:



19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? ☐ YES ☐ NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V10.82 3. 2. 4.												22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NU	
24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS
05	09	11				11		99213		1	55	00	1

Note: For carriers that do not recognize "V" codes, bill the follow-up skin exams listing the actual skin cancer diagnosis first followed by the personal history "V" code as the secondary diagnosis.

a. One would modify Example 1 on the previous page by changing the diagnosis to 173.5 followed by V10.83.
b. One would modify Example 2 on the previous page by changing the primary diagnosis to 172.5 followed by V10.82.

Preventative Screening Codes

1. Do not use

2. Are not meant for dermatology

3. CMS has published a list of specialties that can use these codes and dermatology is not included

4. Once a diagnosis has been made for the visit, these codes CANNOT be used

5. See handout for more details

CPT Codes

New Patient	*Established*	*Age of Patient*
99381	99391	(under 1 year of age)
99382	99392	(1 to 4 years)
99383	99393	(5 to 11 years)
99384	99394	(12 to 17 years)
99385	99395	(18 to 39 years)
99386	99396	(40 to 64 years)
99387	99397	(65 years and over)

Note: These codes should not be used by dermatologists.

Definition

99396 Periodic comprehensive preventive medicine re-evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate immunizations, laboratory/diagnostic procedures (40 to 64 years).

1. Dermatologists may bill the Preventive Medicine Services codes, *but* dermatologists do not perform these types of services. The CPT book clearly states:

    a. *"If an abnormality/ies is encountered or a pre-existing problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate office/outpatient code 99201 to 99215 should be reported.*

b. *Modifier 25 should be added to the E/M visit to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service."*

2. The codes are *not appropriate* for dermatologists.

    a. The codes are designed and used to report the preventive medicine evaluation and management of infants, children, adolescents and adults.
    b. The codes are divided by the age patient and the extent of the visit is determined largely the age group into which the patient falls.
    c. In dermatology, most visits are initiated by the patient based on chief complaints (e.g., patient is worried about some lesion or some skin condition).
    d. There are usually pre-existing dermatologic conditions which the dermatologist (or patient) is following and, in many cases, the *extent* of the history and exam is predicated on the chief complaint of the patient.
    e. Immunizations or diagnostic lab work is not routinely ordered as part of this type of visit.
    f. Dermatologists order tests or do procedures based solely on a diagnosed problem, not on the basis of preventing a future problem. In other words, dermatologists don't order routine CBCs! Lab work is only ordered when dealing with a skin condition or because the physician has diagnosed a lesion that requires some attention.

3. Dermatologists should bill the appropriate E/M codes 99201 to 99214 to represent these services.

Modifier 24

CPT Modifier

24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

The Basics

1. This is an E/M modifier. This modifier should be appended only to services that start with a "99" (e.g., 99212, 99214, etc.).

2. The modifier is used to show an office visit (E/M service) was performed *during a postoperative period* and that the office visit was *unrelated to the surgery*.

   The postoperative period starts the day following the surgical service. This would be at 12:01 a.m. of the next day.

3. Billing examples

   a. On 5-9-11, a patient had a basal cell carcinoma excised (CPT code 11603 with 10 postoperative days.) The patient returned on 5-16-11 with herpes zoster which was evaluated and treated. For the return visit you bill:

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 053 9 3. 2. 4.

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NU

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
05	16	11				11		99213	24	1	55 00	1

Note: Many claims filed with modifier 24 will be denied initially and will require an appeal with office notes.

b. On 5-9-11, a patient has a squamous cell carcinoma of the face excised and repaired with a flap (CPT code 14060 with 90 postoperative days). On 7-15-11, the patient is seen for her regular acne visit. Since this service is provided within the 90 day postoperative period for the flap, the correct way to bill is:

19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? ☐ YES ☐ NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 706.1 3. ____.____ 2. ____.____ 4. ____.____												22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NU	
24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER		F. $ CHARGES	G. DAYS OR UNITS
07	15	11				11		99212	24	1		40 00	1

Note: Many claims filed with modifier 24 will be denied initially and will require an appeal with office notes.

4. Postoperative complications

There are two types of postoperative complications:

a. Those that result *in an E/M visit* during which time the wound is inspected, possibly systemic or topical antibiotics are prescribed if there is an infection, and dressing is changed. These types of visits are not covered by Medicare even if modifier 24 is used. They are considered included in the surgical service. Most other carriers follow the same policy as Medicare.
b. Those that result *in another surgical service* being performed. These would include repair of a wound dehiscence, I&D of a hematoma, and secondary closure due to excessive bleeding in the area. These surgical complications are considered unrelated to the surgical service, and are covered by Medicare and commercial carriers by appropriate use of the 79 modifier.

5. Follow-up care during the postoperative period

Postoperative care includes dressing changes, wound care observation (whether for normal healing or complications), and suture removal.

6. Postoperative care by another provider in same group

If a postop visit is rendered by another doctor during the postop period, the following rules apply:

a. Providers in the *same specialty group or multi-specialty group* cannot charge for postop care provided to a patient if they are “on call” or “covering” for a another physician in the group practice.
b. These services are considered included in the postoperative package and *cannot be billed separately*.

7. Postoperative care by another provider in different practice

   Providers in a different practice (not affiliated with the provider who performed the surgery) may bill patients for postop care using the appropriate E/M visit.

   a. If the patient is new to the practice, a new patient visit may be billed. No modifiers are needed (other than those that would normally be needed - such as modifier 25 if other surgical services were billed additionally on that same date of service).
   b. If the patient is established to the practice, an established patient visit may be billed. No modifiers are needed (other than those that would normally be needed - such as modifier 25 if other surgical services were billed additionally on the same date of service).
   c. Diagnosis coding

      Use the following diagnoses:

      V67.00 Follow-up care following surgery
      V58.42 Encounter for aftercare following surgery for neoplasm
      V58.43 Encounter for aftercare following surgery for injury and trauma
      V58.49 Encounter for other specified aftercare following surgery
      V58.31* Dressing change/removal surgical wound
      V58.32* Suture removal

*These two diagnoses codes are the preferred way to code.

Modifier 25

CPT Modifier

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57.

For significant, separately identifiable non-E/M services, see modifier 59.

The Basics

1. This is an E/M modifier. This modifier should be appended only to services that start with a "99" (e.g., 99212, 99201, 99243, etc.).

   Do not use CPT code 99243 on Medicare claims.

2. The modifier is used to bill an office visit (E/M service) *on the same date* as a minor procedure or surgical service.

3. Billing new patient visits and a procedure(s)

   a. You *do not* need a separate diagnosis in order to bill an E/M visit and a procedure. Both the visit and the procedure can have the same ICD-9-CM code.

b. With a new patient visit (e.g., CPT codes 99201 to 99205) and consultations (99241 to 99245, 99251 to 99255):
   - Always bill a visit.
   - Be sure to properly document the level of care billed by meeting the criteria established by the 2010 AMA CPT book (based on the 1995 exam rules).
   - The visit billed must be medically necessary and performed, not just properly documented.
   - Do not use CPT codes 99241 to 99245 and 99251 to 99255 on Medicare claims.
   - Always use modifier 25 as your primary choice.
   - Use modifier 57 only if modifier 25 is denied and 57 is the carrier preference.

Note: Read the instructions on the use of modifier 57 carefully before use with any carrier as usage varies significantly from carrier to carrier.

Example: A new patient is seen today for a lesion of the nose that won't heal. After history and examination, the provider decides to biopsy the lesion.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 238.2 3. _____
2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE
23. PRIOR AUTHORIZATION NU

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
05	09	11				11		99201	25	1	50 00	1
05	09	11				11		11100		1	90 00	1

4. Billing established patient visits and a procedure(s)

   a. You *do not* need a separate diagnosis in order to bill an E/M visit and a procedure. Both the visit and the procedure can have the same ICD-9-CM code.
   b. Medicare usually does not deny the service if the 25 modifier is used, and the diagnosis represents a covered service.
   c. Commercial carriers frequently deny office visits when billed with a surgical service. However, when a review is performed and notes are sent, the visit is usually paid.
   d. Humana, Aetna, Cigna, and Anthem insurance carriers now recognize modifier 25.

Example: An established patient is seen today for their semi-annual skin check as the patient has had many actinic keratosis treated in the past. The details of a waist-up examination are performed and documented. At the time of this visit, three isolated actinic keratoses were also treated.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 702 0 3.
2. 4.

22. MEDICAID RESUBMISSION CODE
23. PRIOR AUTHORIZATION NU

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
05	09	11				11		99213	25	1	50 00	1
05	09	11				11		17000		1	60 00	1
05	09	11				11		17003		1	60 00	2

5. Filing appeals or redeterminations when an E/M visit is denied/bundled

   If a denial is received:

   a. Rebill with a cover letter indicating the reason for the review.
   b. Include definition of modifier 25 on pages 531 to 532 of the 2010 Professional AMA CPT book highlighting that different diagnoses are not required.
   c. Include progress notes. (Be sure they are legible and support the level of care you have billed.)
   d. When consultations are billed (e.g. CPT codes 99241 to 99245 or 99251 to 99255), be sure to include the letter of consultation. Do not use these codes for Medicare claims.

Modifier 57

CPT Modifier

57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

The Basics

1. This is an E/M modifier. (E/M services start with a “99”.)

2. This modifier is used for both new and established patient E/M visits and consultations.

3. The 2010 Medicare Correct Coding Initiative guidelines states that this modifier is used only to bill for an E/M visit on the day of a major surgical service. Major surgical services have 90 global postoperative days. These are usually flaps (14XXX series CPT codes) and grafts (15xxx series CPT codes).

4. The 2010 CPT descriptor implies that this modifier can be used in conjunction with any surgical service (not just major surgical services) when the decision to perform the surgery was made at the same time an E/M service was provided.

5. Very few carriers, including most Medicare carriers, acknowledge the use of this modifier.

6. Modifier 25 should always be used for both commercial and Medicare claims *unless written guidelines are provided from a contracted carrier for specific use of modifier 57.*

7. Medicare and modifier 57

   For Medicare claims billed with major surgical services (90 postop days), be sure to carefully monitor your EOMBs and carrier bulletins for modifier preference.

   Billing variations are significant from one carrier to another. You must check with your carrier to assure you are billing according to local carrier preference. The following combinations are examples of how various Medicare carriers prefer the claims to be submitted.

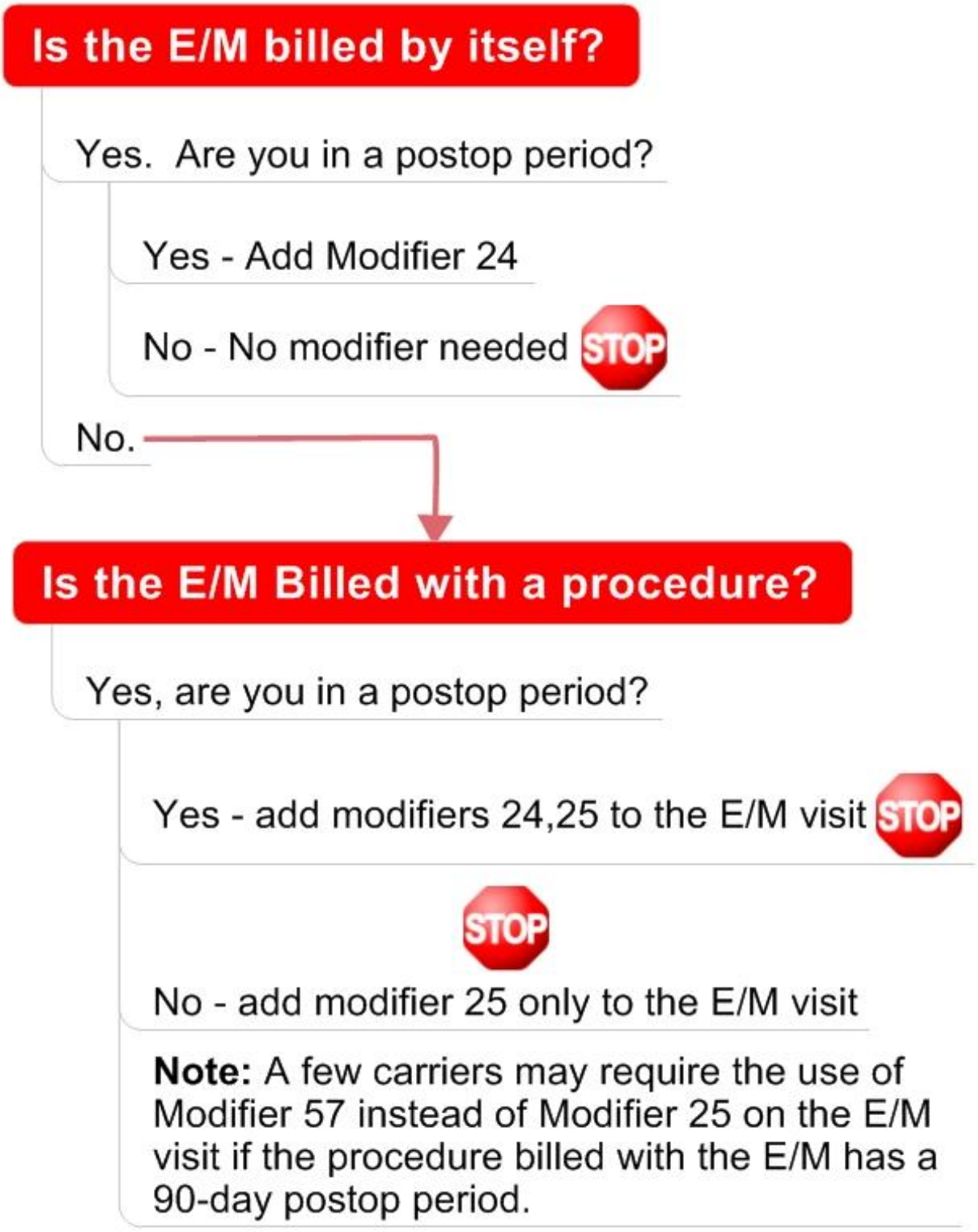
   a. 25 only
   b. 57 only
   c. 57 and 25
   d. 25 and 57

8. Billing example

A non-Medicare patient is sent to you by another doctor in order to evaluate a lesion of the nose which was biopsied by the referring doctor. Because the patient drove many miles, the decision to perform an excision was made today. The lesion was excised then repaired with a flap. According to the local carrier, the dermatologist can bill the consultation with the surgery by using modifier 57.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
05	09	11				11		99242	57	1	95 00	1
05	09	11				11		14040		1	660 00	1

a. The consultation code can be billed only if the criteria for a consultation visit are met and the documentation supports the level of care billed.
b. Some carriers will not pay for an E/M service and a surgery for the same date of service under any circumstance.



Let's Build a Chart

History of Present Illness

Chief Complaint #1: Spot on nose
Chief Complaint #2: Rash on right arm

CC#1: Spot on nose

Pt. had it for at least six months, won't heal, getting larger, very itchy, always red and scaly

HPI factors = 8

Location:	nose
Duration:	six months
Signs and symptoms:	won't heal, getting larger, itchy, red, and scaly
Severity:	very itchy

CC#2: Rash on right arm
Present for one week, spreading, does not itch or is not painful

HPI factors = 5

Location:	rt. arm
Duration:	one week
Signs and Symptoms:	spreading, negative itch, negative pain

Total HPI factors for this chart: 13

Review of Systems

No other skin problems noted

Note: This is vague, nebulous. This note doesn't tell what was asked. No credit for ROS

Suggested ROS for this note

1. Review new history form dated March 28, 2010

2. Update old history form dated January 15, 2009

3. Ask questions

    a. Do you suffer from frequent rashes, chronic itching, dry skin, bacterial infections, and hives?
    b. Bleeds easily
    c. Has trouble healing
    d. Develops scars and keloids
    e. Has gastrointestinal complications when taking system drugs
        - Vomiting
        - Diarrhea
        - Nausea

Let's Build a Chart

Examination

Exam: Exam today shows a 1.2 cm/d spot on nose, red, scaly. No other lesions see on face, lips or eyelids.

Examination of rt. arm shows a rash with small papules on the right anterior aspect of the arm.

Examination of left arm, abdomen, chest, back neck and lower extremities negative.

Total body areas examined = 12

1. face
2. lips
3. eyelids
4. four extremities
5. back
6. neck
7. chest
8. scalp
9. abdomen

Let's Build a Chart

Medical Decision Making

DX: AK vs. SCC nose
Contact Dermatitis (plants)

TX: Will biopsy to R/U SCC: will excise if positive
Topicort Cream BID

Return: one week

This is a moderate level of MDM because:

1. Patient has two or more illnesses (two undiagnosed new problems)
2. Diagnostic procedure ordered (biopsy)
3. Prescription drug management

What's the Verdict?

1. The Documentation Matrix

    a. See the Documentation Matrix at the beginning of this handout

2. New Patient

    If this were a *new patient* the code would constitute a Level 1 office visit (i.e. CPT code 99201)

    a. You need to have all the criteria of history, exam and MDM met
    b. Failed to meet 99203 because of inadequate ROS
    c. 2 ROS are required for 99203 and the statement "denies other skin conditions" was not acceptable.
    d. If there was an adequate ROS either by use of a form of questions asked, this would be a 99203.

3. Established Patient

    a. If this were an established patient this would constitute a Level IV office visit (i.e., CPT 99214)

    b. Only two of the three key components need to be met (one can be ignored)
        - history and exam *or*
        - history and medical decision making *or*
        - exam and medical decision making

    c. You can ignore one of the three key components, but then the other two must be met in their entirety

    c. In this case, because we have a weak history (e.g., No ROS)
        - Let's use exam and medical decision making

    e. 99214 requires 12 body areas examined and moderate MDM. We've got that.