Coding Challenges in Internal Medicine

Presented by:
Brenda Edwards, CPC, CPMA, CPC-I, CEMC
AAPCCA Board of Directors

Topics to Discuss

- Medical necessity
- Bulletproof E/M documentation
- Cerumen removal
- Skin procedures
- Joint injections
- Drug administration
- Carve out visits
- Incident to
- Grey Areas

AAPC
Credentialing the Business Side of Medicine

E/M Code Selection & Medical Necessity

- Is equal to the sum of:
  1. History

     Plus

  2. Exam

     Plus

  3. <u>Medical Decision Making (MDM)</u>

Together equal

<u>The E/M Code Selection</u>

E/M Code Selection

- Medical necessity
  - "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code"
- Volume
  - Should not be the primary factor to select the level of service billed
- Documentation
  - Accurately support the level of service reported

http://www.cms.gov/manuals/downloads/clm104c12.pdf

E/M Code Selection

History	Problem Focused	Expanded	Detailed	Comprehensive
Exam	Problem Focused	Expanded	Detailed	Comprehensive
MDM	Straight Forward	Low	Moderate	High

99222 **Initial hospital care,** per day, for the evaluation and management of a patient, which requires these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making of moderate complexity.**

E/M Code Selection

History	Problem Focused	Expanded	Detailed	Comprehensive
Exam	Problem Focused	Expanded	Detailed	Comprehensive
MDM	Straight Forward	Low	Moderate	High

99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- **A detailed history;**
- **A detailed examination;**
- **Medical decision making of moderate complexity.**

Bulletproofing E/M Documentation

Questions to Ponder

- How do we achieve “bulletproof E/M documentation?
- Would another provider be able to step in?
- Would documentation be specific and legible?
- Would another provider understand the rationale for treatment?
- In the worst case scenario, if a provider is in a court of law, would they be able to defend their documentation?

AAPC
Credentialing the Business Side of Medicine

Bulletproofing E/M Documentation

- Make the Chief Complaint a *real* complaint
  - Chief complaint is not
    - 3 month follow up
    - Here for check up
    - Doing well
    - Ankle

Answer the Questions

- Who- is the patient?
- What – is the problem?
- When – did it begin?
  (Set date or chronic?)
- Where – is the location of the problem?
- Why – is the patient here?
- How –are you going to treat them

AAPC
Credentialing the Business Side of Medicine

Don’t ignore the ROS

- Avoid pitfalls in ROS
  - Providers should identify each system reviewed
  - Avoid vague language
  - ROS as above
  - ROS within normal limits
  - ROS negative
- All others negative

  (We’ll address this in grey areas)

Use the Exam Guidelines Which Work Best for Your Provider

- You CAN use either 95 or 97 guidelines just don't combine them on one visit
- Physician's are not limited by specialty on the 97 exam templates

AAPC
Credentialing the Business Side of Medicine

Incorporate the Language of MDM into the Documentation

- Use language that paints the picture, give rich details of the encounter

Cerumen Removal

- Considerations
  - Visual-exam impaired?
  - Qualitative-causing symptoms?
  - Inflammatory-foul odor or infection?
  - Quantitative-obstructive, copious?

- Additional Considerations
  - Simply removing wax is not 69210
    - Instead use appropriate level evaluation and management (E/M) code regardless of how it is removed
  - Only the provider can bill 69210 for removal if truly impacted
    - Using at minimum an otoscope and instruments such as wax curettes and suction plus specific ear instruments (eg, cup forceps, right angles)
    - Indicate the time, effort, and equipment required

AAPC
Credentialing the Business Side of Medicine

Cerumen Removal

- Separate E/M with modifier 25 to identify significant and separately identifiable problem was addressed during visit
- 69210 Removal impacted **CERUMEN** (separate procedure), 1 or both ears
- G0268 Removal of impacted **CERUMEN** (one or both ears) by physician on same date of service as audiologic function testing
  - Add on code stating both the removal of **CERUMEN** and function testing were performed.
  - Used for Medicare services

Cerumen Removal

Which scenario(s) are reported with 69210?

1) The removal is performed by the nurse via irrigation or lavage. **NO!**
2) The removal is performed by the primary care physician via irrigation or lavage. **NO!**
3) The “ear wax” is described as impacted cerumen because it completely covers the eardrum and the patient has hearing loss. The impacted cerumen is removed by the primary care physician or otolaryngologist with magnification provided by an otoscope or operating microscope and instruments such as wax curettes, forceps, and suction. **YES!**

AAPC
Credentialing the Business Side of Medicine

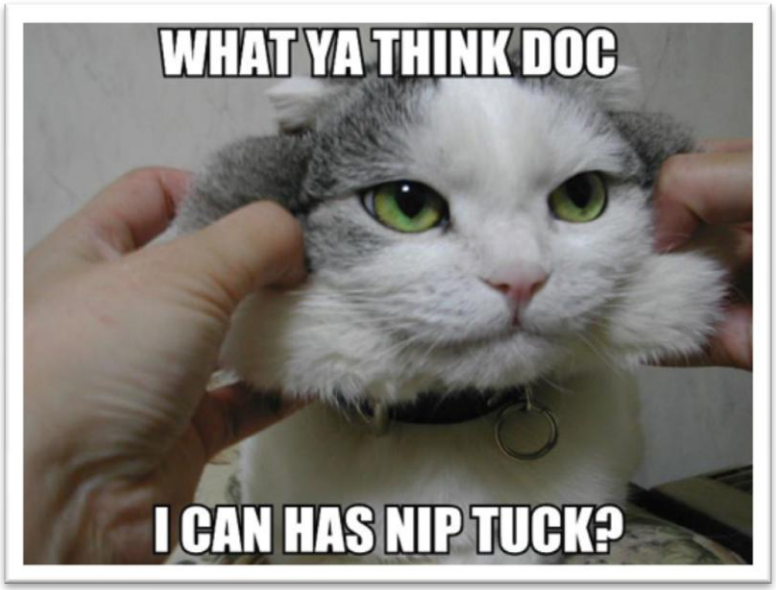
Cerumen Removal Example

- A 43-year-old female presents with flu and respiratory symptoms, including nasal drainage and ear congestion as well as a cough. On exam, the physician finds impacted cerumen obstructing the left eardrum. Impacted cerumen is removed and prescriptions given for cough and congestion.

COMPARED WITH

- On exam, the physician finds impacted cerumen completely covering the left eardrum resulting in hearing loss. The impacted cerumen is removed by the primary care physician with magnification provided by an otoscope, forceps and suction.

AAPC
Credentialing the Business Side of Medicine



Skin Procedures

The physician documents an excisional shave biopsy of the forearm

HOW DO YOU CODE THAT???

AAPC
Credentialing the Business Side of Medicine

Skin Procedures

- Paring or Cutting 11055-11057 (0 global days)
  - Removal by peeling or shaving
  - Used for corns or calluses
- Biopsy 11100-11101 (0 global days)
  - Removal or entire or partial lesion to confirm a diagnosis
  - Biopsy is content when done on same lesion/same day
- Removal 11200-11201 (10 day global)
  - Removal by sharp method or destruction
  - Small flesh-colored/pigmented lesions around neck, upper chest, axilla, groin
- Shave 11300-11313 (10 day global)
  - Sharp removal of dermal or epidermal lesions without full-thickness excision
  - Does not require suture closure

Skin Procedures-Excision

- Benign 11400-11446 (10 day global)
- Malignant 11600-11646 (10 day global)
  - Documentation must include
    - Diameter of lesion, *including* margins required for complete excision
      - Should be done PRIOR to removal-don't rely on path report
      - Specimen may shrink or become fragmented during excision
    - Location and quantity of lesions removed
  - Sutures
    - Simple (non layered) closure is included in excision
    - Intermediate or complex is separately reportable
  - Wait for pathology report to assign correct CPT code

Skin Procedures-Destruction

- Benign 17000-17004 (10 day global)
  - 17110-17111 (common/plantar warts)
  - Code selection by number of lesions, not method
  - Does not require sutures
  - Method
    - Electrosurgery, cryosurgery, laser, chemical treatment
- Malignant 17260-17286 (10 day global)
  - Code based on location AND size of each lesion
  - Does not require sutures
  - Method
    - Electrosurgery, cryosurgery, laser, chemical treatment

Skin Procedures

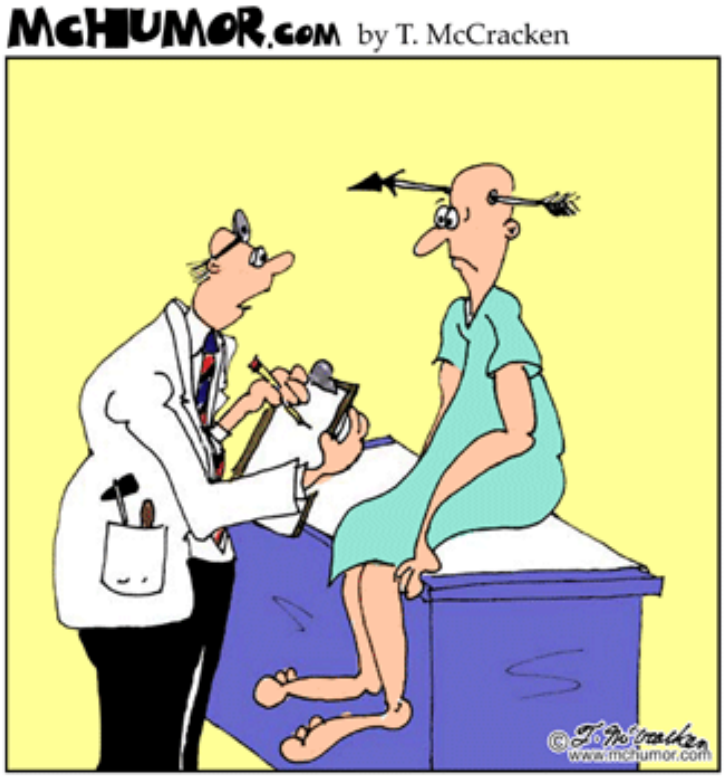
- Before assigning the lowest code in a range
  - –Query physician
  - –Look at CPT®, CDR and any other resources together
    - "CPT® descriptions are not the same as what you are telling me"
    - "Help me to understand what you did or what you meant"

Example

- The patient is a 39-year-old male with history of a suspicious mole on the left upper arm which was recently biopsied and indicated actinic keratosis. Today we are excising the remainder of the lesion (in ASC setting). After injecting 15 cc of 1% Lidocaine around the area of the keratosis, the skin was incised in a 1.5 cm elliptical fashion and down through the subcutaneous tissue. The subcutaneous tissue was then closed with 3-0 absorbable suture. The skin was closed with three sutures and dressing applied. The specimen was submitted to Pathology. The patient will return in two weeks for suture removal.

11402
12031 (51 not applicable in ASC or hospital setting)

Superficial Incision and Drainage



"Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests."

- Location
- Size
- Global period

AAPC
Credentialing the Business Side of Medicine

Superficial Incision and Drainage

- 10060/10061 Incision through the skin to allow abscess contents to drain
  - Superficial and not deeper structures.
- “Complicated“
  - Indicates site was difficult to access
  - Required prolonged physician work
  - Drain may be placed with closure at a later date
  - Document the complicating factor
- 10 day global

Example

- 54-year-old female is seen with a complaint of a painful lump on the middle of her back. It has been warm recently and in the past has drained (like a pimple) when pressure was applied. It has come back twice now after being popped. **Examination reveals a quite raised, red area in the bra line area of her back. This appears to be a sebaceous cyst which has drained in the past. An incision is made and the cyst is allowed to drain. We will take a look at it in 10 days to see how it is healing**

OR

10060 for single cyst

Example

- 54-year-old female is seen with a complaint of a painful lump on the middle of her back. It has been warm recently and in the past has drained (like a pimple) when pressure was applied. It has come back twice now after being popped. **Examination reveals a quite raised, red area in the bra line area of her back. This appears to be a sebaceous cyst which has drained in the past. I recommended we remove it to avoid problems in the future. An incision is made and the cyst and capsule are removed intact. A simple closure was performed. Patient to follow up in 10 days for suture removal.**

Need size of the defect created to determine the excision code (11400-11443)
Simple closure is included

Joint Injections

- Size of joint (0 global days)
  - 20600 small (finger, toe)
  - 20605 medium (wrist, elbow, ankle)
  - 20610 major (shoulder, hip, knee joint)
- Injected or aspirated?
  - What if the same joint is injected and aspirated?
  - What if the plan is to aspirate and inject but no fluid is removed?
- Drugs injected
  - Name(s) and dosage(s) (multiply out units)
- Office visit only when significant *and* separately identifiable
- Modifiers

  - 25 - 50 - 51 - 59

Example

- Established patient presents with ten day history of painful right knee. She fell playing softball and slid on both knees. No open wounds noted on either knee. Vitals 128/78, pulse 80. Upon examination of the right knee, a fluid collection is felt on the inner aspect of the knee. The plan is to aspirate the fluid and inject Depo Medrol. This should relieve the swelling and pain in the knee.

Does documentation support a separate visit?

20610, in addition a HCPCS code for depo medrol
Is there a problem with the note? No dosage!

Drug Administration

- Allergy injections 95115-95199
  - John comes in weekly for his allergy shot
- Immunization Administration 90465-90474
  - Bill in addition to the vaccine and toxoid codes 90476-90749
- Therapeutic/diagnostic or antibiotic type of injection 96360-96379
  - Name of drug being injected
  - Route of administration (i.e., subcutaneous, intramuscular, intra-arterial or intravenous)
  - Dosage

AAPC
Credentialing the Business Side of Medicine

Drug Administration

- Office visit may be separately billable only if "other identifiable services are provided at that time”
- Medicare will not allow CPT code 99211 on the same day as a drug administration code that has a work relative value unit"
  - Only allowed with modifier 25 indicating that a separately identifiable evaluation and management service was provided

www.cms.hhs.gov/transmittals/downloads/R34OTN.pdf

Medicare Pub. 100-20 transmittal 34

Carve Out

- Is it possible? SURE!
  - A physician can provide both a preventive and a problem-focused "sick visit" services at the same time
- Why do it?
- The intent
- The “Oh By The Way” list
- Significant separate service
  - Document what the provider actually did to treat chronic conditions
    - If purely med check/refill, it is preventive
    - Medication modifications due to symptoms may warrant separate service
- Patient complaints

AAPC
Credentialing the Business Side of Medicine

Medicare Claims Processing Manual

"When a physician furnishes a Medicare beneficiary a covered visit at the same place and on the same occasion as a noncovered preventive medicine service (CPT codes 99381-99397), consider the covered visit to be provided in lieu of a part of the preventive medicine service of equal value to the visit"

AAPC
Credentialing the Business Side of Medicine

Carve Out-CPT-4

- Documentation requirements
  - If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine 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 should also be reported… The appropriate preventive medicine service is additionally reported.
  - An insignificant or trivial problem that is encountered in the process of performing the preventive medicine service and which does not require additional work and the performance of the key components of a problem-oriented E/M service, *should not be reported*.

Carve Out

- What part of the visit is preventive, which part was illness/injury related?
  - Not required to have two separate notes but may be helpful documentation is separated in the visit
  - "Sick" visit will need the history, exam, medical decision-making for the problem documented
    - Append modifier 25 to "sick" visit
  - Treatment of insignificant problems is included in preventive service

Carve Out-Medicare

- Preventive visit must be reported and “carved out” even though it is a non-covered service
- Medicare-covered screening services during the visit
  - Colon/rectal cancer screening (G0104-G0106, G0120-G0122, 82270)
  - Prostate cancer screening (G0102, G0103)
  - Screening breast cancer mammography (77057, G0202)
  - Glaucoma screening exam (G0117, G0118)
  - Pap smear (Q0091)
  - Pelvic and breast exam (G0101)
  - Flu, pneumonia and hepatitis B vaccines (G0008, G0009 and G0010)

http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

Carve Out-Medicare

99397	Preventive medicine (non covered)	$100.00
99214-25	”Sick visit” E/M (covered by Medicare)	-40.00
	Total charges	140.00
	Patient responsibility	**60.00**

- Patient can only be billed the difference between the standard fee for the preventive service(s) and the amount that Medicare will cover
- Patient is responsible for co-insurance based on the Medicare allowable
- Patient is responsible for deductible

 The fees are for example only and do not correspond with the Medicare Fee Schedule

Example of Carve Out

- Physician sees an established patient for a scheduled annual exam (preventive medicine)
- During the course of the encounter breast lumps are palpated. An order is written for a mammogram ASAP (problem focused visit)

Incident To

- What is this?
- Established
- Where can this be billed?
- Who does this pertain to?
- Who is the supervising MD?
- Documentation
- Know your state laws
- Payment

AAPC
Credentialing the Business Side of Medicine

Incident To

- Employee of the physician
- Patient, problem and plan of care are all established
  - Physician must initiate course of treatment, provide subsequent services on a frequency to show active participation and management
- Provided in the office setting under direct personal supervision of physician(in the office suite and immediately available)
  - Cannot be billed in the hospital setting
- Documentation must link the NPP (NPs, CNSs and PAs) with the supervising physician
  - Legible co-signature of practitioner providing care and the supervising physician
  - Notation of supervising physician's involvement
- NPP service is paid at 100% of the physician fee

Example

- A physician employed NP works in a satellite office. The physician is ***never*** present.

- The physician evaluates a patient with diagnosis of hypertension. The physician initiates treatment and sees the patient every third visit. The NP conducts follow-up visits with the patient, monitoring and treating the hypertension over weeks, months, or years.

AAPC
Credentialing the Business Side of Medicine

AAPC
Credentialing the Business Side of Medicine

Using Same Elements for HPI and ROS

"You would expect there to be some further development in the ROS," a senior CMS official says. "What you may *not* do is use the same piece of information to score twice within the HPI, he adds".

Q6. Can a physician count a single history item in both the HPI and ROS? For example, could we count "shortness of breath" as an associated sign and symptom in the HPI and respiratory system in the ROS?

A 6. A clearly documented medical record would prevent the need to "double-dip" for HPI and ROS, but WPS Medicare, in rare circumstances, could accept counting one statement in both areas if necessary.

 http://www.wpsmedicare.com/j5macpartb/training/resources/provider_types/2009_0526_emqahistory.shtml

Counting CC and HPI Elements

Q 22. Can the History of Present Illness (HPI) elements be counted for both the Chief Complaint (CC) and the associated signs/symptoms? For instance, a patient presents with chest (location) pain (CC) that she has had for 3 days (duration). She also experiences shortness of breath (associated signs/symptoms) when walking up the stairs (context).

A 22. Yes. According to the E/M 1995 and 1997 DG, "The CC, ROS, and PFSH may be listed as separate elements of history or they may be included in the description of the history of present illness

 http://www.wpsmedicare.com/j5macpartb/training/resources/provider_types/2009_0526_emqahistory.shtml

Review of Systems-“All Systems Negative”

At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.

PFSH

- When Past, Family and/or Social History documentation has the terms "Non-contributory" or "negative," these are not considered appropriate documentation. Documentation of PFSH must include social and/or family history information, such as alcohol consumption, smoking history, occupation, or familial hereditary conditions.
- When the terms "non-contributory" or "negative" are used in PFSH documentation, the documentation might indicate "Past medical history is non-contributory" or "Social history is non-contributory." Such documentation would not indicate the provider had actually addressed the issues. It must be clear that the PFSH was discussed with the patient. To use the term "non-contributory" alone does not clearly indicate PFSH was addressed.

http://www.wpsmedicare.com/part_b/publications/em_history.shtml

Use of 3 Chronic Conditions as HPI

Q 7. Where can I get CMS' documentation stating three chronic or inactive conditions apply to both 95 and 97 guidelines?
A 7. The 1997 DG state an extended HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. The 1995 DG do not have this statement. However, WPS Medicare received clarification from CMS indicating this statement applies to both 1995 and 1997.

http://www.wpsmedicare.com/j5macpartb/training/resources/provider_types/2009_0526_emqahistory.shtml

Use of 3 Chronic Conditions as HPI

- In 1997 the Evaluation and Management (E/M) Guidelines were enhanced under the History of Present Illness (HPI) section of the 1995 score sheet to include patient's chronic conditions in which an exacerbation may have occurred resulting in the chief complaint and the reason for the patient encounter. The documentation in the patient's medical record must state a status of the chronic condition in order to meet the requirement under the History: HPI Status of 1, 2, or 3 Chronic Conditions on the 1995 score sheet. An example could be: hypertension - stable on Atenolol.

https://www.highmarkmedicareservices.com/faq/partb/pet/lpet-evaluation_management_services.html

Thank you!

AAPC
Credentialing the Business Side of Medicine