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Introduction

The California Academy of Family Physicians (CAFP) has produced the fourth edition of this valuable monograph to assist family physicians with an essential component of your day-to-day practice: coding and billing for the many services you provide. Coding appropriately and accurately is essential regardless of practice setting, size or payment model. We hope you find this to be a useful overview and an updated set of guidelines for use in your practice as we watch the payment landscape for medical services change in the United States, moving from a “volume-based” system to a “value-based” system.

How to Use this Guide

It is extremely important that everyone in a physician’s office understands that they play a part in effective payment management for the practice. In this guide, we will discuss the steps that should occur throughout the process and how to make sure everything is reported accurately.

This monograph is intended to be a guide for family physicians to illustrate the many benefits of the practice working as a team to optimize payment by coding and billing correctly, and to recover “lost” (previously un-billed) dollars.

The entire practice staff should review the chapters entitled “Tools & Resources” and “The Revenue Cycle Management Team.” Everyone should understand the role that he or she plays with payment and how each member of the team must communicate and work with the other members of the team. Clinical staff and physicians play an essential role in ensuring that all services are documented and coded. Encourage them to review this monograph as well, paying particular attention to Chapter 6 – “Don’t Forget to Bill for These Services.” The billing staff should use this monograph as a resource for training as well as a compliance check. For up-to-date listings of continuing medical education, including coding and billing education, log on to www.familydocs.org.

Learning Objectives

At the end of this monograph, readers should be able to:

1. Improve practice documentation of visits and procedures, whether documenting in a paper patient record or using an electronic health record.

2. Learn the language through which the physician can appropriately document and bill for a variety of services to third-party payers.

3. Enhance provider understanding of changes to Current Procedure Terminology (CPT) codes, including additions, deletions and edits.
4. Effectively use the ICD-10-CM code set to report the reason services were rendered and to support the quality of care provided to patients.

5. Understand the importance of reporting quality data to support the newly proposed payment models for paying health care providers for services provided to patients.

**Disclaimer, Acknowledgement, About the Author**

The material in this monograph was written by a practice management consultant and published by the California Academy of Family Physicians (CAFP). Any advice or information contained in this guide should not be construed as legal advice. When a legal question arises, consult your attorney for appropriate advice. The information presented in this guide is extracted from official government and industry sources. We make every attempt to assure that information is accurate; however, no warranty or guarantee is given that this information is error-free and neither the author nor CAFP accept responsibility or liability should an error occur. CPT codes used in this guide are excerpts from the current edition of the CPT book and are intended for instructional purposes only. They are not meant to substitute for up-to-date copies of the CPT that medical practices should keep on hand. CPT is copyrighted property of the American Medical Association.

The author, Mary Jean Sage, CMA-AC, has extensive experience in the health care field that spans more than 20 years. She is recognized nationally for her expertise in coding, billing and health care compliance. Her unique blend of administrative and clinical skills has earned her a reputation as an expert in managed care operations and payment management. She was instrumental in developing the Certified Medical Billing Associate program, which credentials medical billers and served as the initial Certification Director for the program. She currently serves as an advisor to a number of billing and coding publications, and is a regular contributor to CAFP’s monthly *Practice Management News* column. Ms. Sage declares no relevant financial interests in commercial entities that may support or be referenced in this publication.
Chapter One

Tools and Resources for Practice Success
Basic Tools for the Business of Medicine

Today’s physician has many options for completing the billing process in a family medicine practice. Many practices have transitioned from the basic Practice Management System that tracks practice accounts receivable and generates third party claims to an Electronic Health Record (EHR) that integrates the patient’s medical record with the patient’s financial record and allows claims generation as well as produces practice productivity and accounts receivable reports needed to manage the financial health of the practice. They encompass all the financial, clinical and operational elements for successfully running a practice. While these more sophisticated systems may be a major expense to acquire and implement, they can provide some relief from other practice expenses incurred by additional staff (billing, transcription, medical records), paper product inventory (forms), storage space and time (both physician and staff). In addition, because the systems can track and extract quality data, they eliminate the need to use additional resources such as staff time and/or registries.

Regardless of the type of billing system you are using or whether you are doing your billing in-house or using a service bureau or billing company, you need to make sure that your practice has the required tools and knowledge for effective billing and coding including:

- A thorough understanding of the billing process and billing terminology
- Good forms, documents and templates
- Current reference materials
- Written policies and procedures covering billing
- CPT and Healthcare Common Procedure Coding System (HCPCS) procedure coding expertise
- ICD-10-CM diagnosis coding expertise
- A fee schedule based on relative values
- A well designed patient information template (patient demographics)
- A well designed system for capturing charges
- A thorough understanding of the insurance claims process including both payment and appeals
- A thorough understanding of the practice’s third party payer contracts

Every practice is a little different, but each requires the same basic resources to be successful. Access to the right tools helps ensure your practice submits complete and accurate claims to insurance carriers the first time, which decreases days in accounts receivable (AR) and can increase practice viability. In an industry overloaded with coding, compliance and practice management how-to resources, how do you know which resources make sense for you?

Practices should take advantage of the wide array of commercial publications and other practice management products on the market today. While many of the resources we mention in this chapter are available free of charge, they can be cumbersome to use. Purchasing a superior product will improve accuracy and productivity, as these resources are often easier to use and understand and can be more valuable to the practice. It is important to consider the cost of these products and include them in your annual budget.

Consider three things before you purchase a resource:

1. Will it help improve accuracy?
2. Will it help you become more efficient as a business?

3. Will it help you minimize compliance risks while improving your bottom line?

**Important Coding and Billing Resources**

Every practice must have the most up-to-date coding and billing tools to make sure it collects every dollar owed while providing the highest quality of care possible to its patients. There are five core content sets that are considered critical to coding and billing success.


The [American Medical Association (AMA)](https://www.ama.org/) develops and maintains CPT codes. They are, in the words of the AMA, “a listing of descriptive terms and identifying codes for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians and other health care providers, patients, and third parties.” Physicians use CPT codes to report professional services to payers. Even though the ICD-10 code set contains a set of codes for procedures, physicians will continue to use CPT to report their professional services/fees. That is not expected to change any time in the near future.

AMA updates CPT codes annually every January 1 and it is critical that practices have access to the most current year CPT for reporting medical services. It is additionally imperative that your practice reference the CPT book that corresponds with the date of service because codes are annually added and deleted. It may be helpful to retain the past year’s version of CPT for a short time in the event you need to appeal a claim from a prior year.

**International Classification of Disease, 10th Revision (ICD-10-CM)**

ICD-10-CM (International Classification of Disease, 10th Revision – Clinical Modification) provides insurance carriers with the medical reason a patient visited a physician or other qualified non-physician practitioner. This code set is used to help providers establish medical necessity for billed services. The code set also allows providers to tell an insurance carrier about both past personal and family experiences with diseases and/or how a patient was injured. Additionally, the new code set allows the provider to report the status of a patient to reflect the care the provider is giving (i.e., BMI, wheel-chair bound, allergy status, drug under-dosing, presence of implants and devices).

As with CPT, the ICD-10 codes are annually updated (October 1), so it is critical that you are using the most current version for reporting medical services. Practices that do not stay on top of ICD-10 changes may receive unnecessary denials or requests for medical records due to inaccurate or incomplete diagnosis coding.

**Healthcare Common Procedure Coding System (HCPCS)**
HCPCS is Medicare’s system of National Level II codes and includes a listing of products, supplies and services not included in the CPT manual. HCPCS also “crosswalks” from CPT procedure codes to codes recognized for payment by Medicare and Medicaid or Med-Cal (G-Codes and Q-Codes). These include some codes for reporting quality data.

HCPCS is developed by the Centers for Medicare and Medicaid Services (CMS) and is updated annually (January 1). It is important to use the most current version of HCPCS for reporting injectable medications and supplies, as well as some physician professional services to Medicare, such as administration of some vaccines, some cancer screening services, annual wellness exams and some laboratory services commonly done in family medicine practices.

**The Correct Coding Initiative (CCI)**

Correct Coding Initiative edits, developed by and for Medicare, are also used, in some form, by many insurance carriers. CCI edits identify which physician services are not appropriately billed together – called mutually exclusive procedures – and which should be bundled or included in a more comprehensive service. Claims that stray from CCI edits are automatically denied by Medicare, unless the edit can be overridden with a modifier or proper documentation to support the exception. CCI edits are updated quarterly.

CCI edits can be located on the CMS website free of charge. There are also simplified, user-friendly versions available for purchase from for-profit entities. Additionally, many practice management software packages include some version of the CCI with their software. Whatever product you select, make sure you are receiving the quarterly updates!

**The Resource-Based Relative Value Scale (RBRVS)**

Resource-Based Relative Value Scale is Medicare’s physician fee schedule. Many private payers use some form of RBRVS to set their own fees as well. Some payers, for example, may contract with physicians based on a percentage of Medicare’s RBRVS fee schedule. Through this database, Medicare also provides guidance on how to correctly apply certain modifiers to services and indicates when a global concept applies to a service.

Medicare sets national fees for each service and adjusts that amount based on the Geographic Practice Cost Index (GPCI) for each Medicare locality. In other words, Medicare payment is adjusted based on your practice’s geographic location. This GPCI-adjusted fee is the amount that a physician will be paid by Medicare for an approved and correctly billed service. For example, a physician who performs a service in San Francisco, California will be paid more than a physician who performs the same service in Redding, California because of differences in the cost of practicing in each location.

The Medicare fee schedule is typically updated annually at the beginning of each calendar year, but can change at midyear or even quarterly. Updated information is always available through the CMS website or the website of any Medicare Administrative Contractor (MAC).

**Other Important Resources**
Compliance

Every practice should have a compliance program to satisfy state requirements and federal regulatory requirements of the Office of Inspector General (OIG). Compliance in this case refers to coding and billing, documentation standards, anti-kickback, antitrust and self-referral laws and a few other areas.

If you are not prepared, compliance problems can be costly. A small, upfront investment in good compliance resources can save you from future financial and legal woes. There are many off-the-shelf solutions for creating compliance programs and corrective action plans. Practices that need more complex plans or want plans tailored to their unique needs often hire a consultant to help them develop a plan.

At this point, adopting an OIG compliance plan is voluntary for physicians, but it shows a good faith effort to comply with standards set by public and private payers. An OIG fraud and abuse compliance plan has six elements:

1. Standards of Conduct
2. Training and Education
3. Appointment of a Compliance Officer
4. Open Lines of Communication
5. Monitoring
6. Enforcements

Other compliance areas to consider:

- OSHA (Occupational Safety and Health Administration) sets and enforces standards for employee and patient safety.
- HIPAA (Health Insurance Portability and Accountability Act) Privacy and Security sets standards for transactions between providers and payers, patient privacy and security for electronic data.

It is important to stay up-to-date on changes in laws and regulations just as much as it is to develop and maintain effective compliance programs. Print and electronic news sources can be helpful in alerting you to new rules and areas of enforcement. Be sure to share these with your staff.

Staff Development and Certification

Your staff is your greatest resource for maintaining payment and compliance. Professional certifications and credentials and the education and training required to achieve them can help ensure that your staff is competent, productive and up-to-date on the complex rules and regulations regarding payment and compliance for your practice.

Professional Association Membership
It is vitally important for you to be a member of your state and national professional associations (i.e., CAFP and AAFP). Together, they ensure physicians’ voices are heard by state and federal lawmakers, the for-profit health industry, government regulators and others attempting to interfere with your ability to care for your patients. Your state and local medical associations are also helpful in taking a stand on issues that impact the practice of medicine. They work as partners with your professional associations and you to develop and maintain a physician-led, patient-centered health system. Association membership often provides valuable discounts on many of the resources needed to run an effective practice.

Office Policies and Procedures Manual

Every business, regardless of the size, should have an office policies and procedures manual. The high staff turnover in medical practices today makes it more critical than ever to have these how-to resources at your fingertips. A policies and procedures manual ensures that institutional memory stays with the practice even if your office manager or other staff chooses to leave. Policies and procedures manuals are useful for training new staff or for cross-training purposes. Below is a partial list of items that should be included in such a manual:

- Job descriptions
- Financial (including billing) policies
- Appointment scheduling policies
- Triage policies

Sample policies are provided in Appendix B of this publication.

Internet Access

Major payers now post payment rules, their eligibility and medical policies online. They also allow claims submission and appeals through their websites—a huge time-saver. Practices may be required to register and create a username and password before gaining access to this information. Every practice should register with all major third party payers including both Medicare and Medicaid/Medi-Cal to receive email updates, and to access policy information.

Copies of All Third-Party Contracts

Practices frequently lose money because they do not understand the specifics of payer contract language. To be successful in billing and collections, you need access to current information about each payer’s contract requirements, including fee schedule by contracted product line, payment rules, authorization requirements, time frames for claims submission and billing procedures for physician services.

Form Letters

As medical practices are often required to repeatedly address the same issues, a good set of form letters minimizes redundancy, saves time and promotes consistency. A later chapter of this publication
provides some form letters for standard claims appeals. A word of caution, however, form letters are not an effective means of addressing medical necessity appeals and should not be used for that purpose.

**Other Resources and References**

Appendix A of this publication provides an extensive list of additional references and resources.
Chapter Two

The Revenue Cycle Management Team
Basic Steps of Medical Billing

Revenue cycle management starts the moment of the first patient contact and ends only when the account balance is zero. There are a series of important steps in between, each of which is critical for accurate billing and proper payment. To maximize payment you must be in control of each step of the payment process:

1. Initial patient contact made (usually by telephone, when the patient’s insurance status must be ascertained)
2. Patient registration completed or updated
3. Copayment collected (if applicable)
4. Charge document initiated (or EHR encounter initiated)
5. Services documented by the provider
6. Encounter form/document reviewed; payment collected
7. Billing system updated
8. Insurance claim prepared
9. Document filed for review and follow-up
10. Payment received from insurance carrier
11. Inquiry letter received from insurance carrier
12. Denial received from insurance carrier
13. Patient billed
14. Bill paid by patient
15. Accounts receivable reviewed
16. Collection efforts made
17. Account closed

Cultivating the Revenue Cycle Management Team

As a practicing physician and a business person, you must remember this maxim – your entire practice is the billing department. Billing for the services you, the physician, provide is not exclusive to the billing department. Every staff member plays a role in determining how well or how poorly the payment management process works in your practice. There are responsibilities that go along with each of these roles. The schematic below illustrates the various positions in a medical practice and how they all work together to assure efficient, effective payment management.
Let us discuss some of these positions and what role they play on the team.

Scheduler

The Practice Appointment Scheduler is often the point of first contact for the patient and practice. This is the person who makes the first decisions regarding office collections. They set patient expectations and convey practice expectations as they relate vital information about the practice and its billing operations and financial policies to the patient.

The information collected from the patient, as well as the information given to the patient often has a direct bearing on how successful the practice will be in collecting for the services to be rendered. Here are some areas of responsibility that bear review and monitoring:

- Can we see this patient? Are we a “Participating Provider” for the patient’s health plan? It is crucial that the appointment schedulers know the health insurance plans with which the practice contracts.

- Is pre-authorization required for the service the practice is to render? Does the scheduler know which of the services provided by the practice generally require pre-authorization from a third party carrier? If pre-authorization is required, who is responsible for obtaining that pre-authorization?

- Is the patient eligible for coverage (i.e., wellness services or preventive care)? Again, who will take responsibility for securing this eligibility information?

- Have you furnished financial responsibility information? Do patients know what they will be expected to pay at the time of service?

- Will you mail them a new patient information package or direct them to the practice website to complete the new patient registration package?
Receptionist

You depend on the receptionist to gather complete, up-to-date demographic and insurance information - the grist for claims:

- Do you regularly verify patient registration/information? You should verify patient information at least annually and more often if there are changes in such things as telephone numbers, emergency contacts and health insurance coverage.

- The position should be a check point for information previously conveyed or gathered by the scheduler:
  - Is eligibility for services checked/verified?
  - Is a pre-authorization received and recorded?

- Have you asked for the patient’s copay?

Clinical Staff

YES, the clinical staff has responsibilities for billing and collecting too! They must know the insurance plans with which you contract and the following things about those contracts:

- Which ancillary services your practice provides?

- If you do not perform lab/x-ray/PT, where do these services go (i.e., who has what contract)?

- Can you provide medical and surgical services on the same day for a particular plan (and get PAID)?

- Have you recorded any service provided “incident to” a physician’s service on the charge document (i.e., injections and immunizations, diagnostic studies such as ECG, or spirometry)?

Physician and Extenders

You provide the service and you, too, have some responsibilities to help the billing department operate more smoothly:

- Do you code your own services correctly?

- Do you understand the significance of assigning appropriate diagnosis codes to support the medical necessity of the services provided?

- Do you know what services might be “bundled” and/or not paid separately?
• Do you know which of your services may be denied for medical necessity because of diagnosis or frequency of service? Do you inform the patient and secure their consent for these services by having an advanced notice of consent and acceptance of financial responsibility signed before you provide the service?

**Cashier**

This is often the last stop for the patient before leaving the office. Do not miss the opportunity to make one last check for accuracy on a number of things:

- Have you collected the right co-pay/co-insurance?
- Have you collected for non-covered services if appropriate?
- Have you checked the superbill/encounter form for completeness? Did you verify the patient had all the services indicated/recorded; did the patient have any services not marked; and is there a diagnosis available for each service? Now is the time to check with the provider if the document is not complete.
- One last chance: have you verified the patient's insurance company is current and correct?

Practices differ in assigning responsibility for entering charges. If a paper encounter form is still used, some assign this job to a front office cashier (also known as a check-out clerk), while others batch up encounter forms for the business or billing office to process. No matter who the responsibility falls upon or the type of medical record, there should be a checks and balance system in place to verify all charges are captured for all patients.

**Insurance Biller**

Tasks and responsibilities for this position vary. Remember, the claim generation process starts when charges are posted for a service. Claims, however, must be reviewed for accuracy and completeness before they are actually generated or sent out.

Does the person in this position know:

- **All** the plans for which your practice is a provider?
- What is considered a “clean claim”?
- How to appeal for additional payment of denied or underpaid claims?
- Do you mail or transmit claims at least twice a week, if not daily?
- Is there a policy for handling the day-to-day correspondence from the insurance plans? Do you turn it around within 48 hours?
Collector

In some practices the collector position and the insurance biller are one and the same, while other times these duties are divided among several people. No matter the organization of your billing department, someone needs to be responsible for follow up after claims generation and must bring each patient account to a zero balance. The individual in this position must:

- Know how to comply with the rules and regulations of each contracted plan and how to read the remittance advice or explanation of benefits from each.

- Know what the expected payment is for each of your services from each of your insurance plans.

  Know how to determine what is billable to the patient or another third party and what needs to be written off for contractual adjustments.

- This position should also have the responsibility for:

  - Checking and monitoring your explanation of benefits - you may be losing money due to inaccurate payment processing.

  - Improving basic accounts receivable management:
    - Track percentage of accounts receivable over 90 days
    - Monitor percentage of charges written off to bad debt
    - Calculate days in accounts receivable
    - Implement critical financial management for diverse payer mix of managed care contracts

  - Using your Management Information System (MIS) for Payment and Financial Analysis
    - Reasons for payment denial by major carriers
    - Collection rates by individual payer
    - Payment timing trends
    - Contractual allowances and bad debt levels
    - Accounts Receivable (A/R) by third party payers
    - Payment by procedure - determine cost effectiveness

Something for All

The number of staff members you actually have in your billing department will vary depending upon practice size. However, as you can see there are many aspects contributing to effective revenue cycle management that occur outside the actual billing department. It is important that you build a team that not only shares work, but shares information as well.

A/R personnel need to communicate with the front office staff and charge entry personnel about what they see on the payment denials and requests for further information that flow through the billing office. A regularly scheduled meeting to discuss A/R and insurance payment issues will encourage this
form of communication and sharing of information. Cross training among the staff members can also be advantageous.

**Put Your Billing Policies and Procedures on Paper**

Most dysfunctional offices do not have a manual of billing policies and procedures. Instead, the staff depends on word-of-mouth to explain how things are done, allowing for a lot of bad habits to be passed on to new employees. Additionally, this system allows individuals to do things their own way, resulting in a number of different ways to do one task such as work a rejected claim. The absence of policies and procedures manuals also fosters individual standards and timelines for accomplishing or resolving issues. For example, if the standard for entering charges is “as soon as possible,” that could mean two weeks in a poorly run operation, while most experts will agree that no more than 24 hours should elapse before a charge is entered.

You can begin to develop a billing policies and procedures manual by simply putting to paper the steps required to get a claim out the door and paid. Follow the process displayed in the Payment Team schematic at the beginning of this chapter and ask yourself what happens from the time the patient calls to make an appointment until the service is provided and the patient’s account is brought to a zero balance.

You may purchase model policies and procedures from the [Medical Group Management Association](https://www.mgma.com) and the [American Medical Association](https://www.ama-assn.org). You will want to customize the policies for your specific practice, but the models are a good starting point.

If you need assistance in developing a billing policies and procedures manual, consider utilizing the services of a medical business or practice management consultant. You can access the names of consultants in your area by visiting the [Practice Resources](https://www.cafp.com/practice-resources) page on CAFP’s website or through AAFP’s [FP Assist Program](https://www.aafp.org/pcp/practice-management.html) (a clearinghouse of management consultants).

**In-House vs. Outsourced Billing – Evaluate Frequently**

Expect to pay between 9 percent and 12 percent of your collections for the associated costs of billing and collecting. It is critical to monitor your billing operations and monitor associated costs accordingly. The pros and cons of in-house versus outsourced billing should also be weighed. While in-house billing gives you better control of your collection operations, it requires dedicated space for activities that do not generate income.

When is it time to evaluate your billing department or company? It is always the right time! As a business owner, it is necessary to balance where your resources (time, money and staff) are spent. However, as a physician there is so little time in between seeing patients, that business management is often pushed aside.

Below are a few specific areas to evaluate and review with your billing manager or designated billing representative:
• **Billing Knowledge / Skill Set:** Are you often advised on billing codes and procedures based upon specific insurance? Do you know if your billing resource continues to allow you to code for something that is never paid? Having this information at your fingertips and ensuring that your billing resource has this knowledge, increases your overall collections success and reduces your write offs.

• **Communication:** Does your billing or billing service staff communicate well with other personnel and patients? Often you might hear patients grumble about “them not getting it right.” It is your responsibility to listen to your patients’ complaints and find out what is really happening. With the dynamic industry we are in, insurance companies are always changing the rules. It is very important that your billing staff is willing and able to explain these changes to your clients. Without proper communication, there is also a lot of opportunity for error when sending claims to insurance companies. If your billing resource does not have all the pertinent information, denials will result from incomplete claims. Your billing department or the company you hire to manage your accounts is a direct representation of your practice. Make sure you are happy with the billing staff’s communication process.

• **Accounts Receivable Follow-Up:** How often does your staff hear from your billing department or company for missing or additional information? Your accounts may not be receiving the proper attention if follow up is not done on at least a weekly basis. Make sure that requests for additional information, confirmation of basic information and any requests for medical records are fulfilled as soon as possible. A timeframe of one week is appropriate. Chances of payment are significantly reduced the longer one claim sits in your A/R.

Overall, you are responsible for your business. You should investigate and evaluate any billing company prior to contracting with them. Ensure that your billing company is able to keep up, follow-up and communicate as you grow or even pare down the size of your organization. This is a business relationship and should be treated as such.

The same evaluation should be done to determine if it is more feasible to = bill with an in-house billing department or if you should consider outsourcing your billing process.

A monthly meeting accompanied by extensive reports showcasing where your A/R is, is a must. This is your money and you should be very comfortable knowing where it is. Frequent meetings are a great opportunity to identify areas to improve in your business.

**Use Your Online Resources**

Get our staff off the phone and onto the Internet. Online is a far better way for your staff to communicate with referring practices, verify insurance eligibility and benefits, obtain authorizations, to check on claims status and to re-credential with health plans. In addition to the tasks just mentioned, here are some other suggestions on how your practice can become more effective by implementing technology solutions:

* **Instant Messaging**
Electronic communication saves an unbelievable amount of time and makes intra-office communication more efficient. Intra-office e-mail and instant messaging are great ways to transmit information in real time, with minimal steps. Here are two easy ways to use electronic messaging within the practice:

- The billing office can send a message to the receptionist when a slow-paying patient is spotted on the appointment schedule. The receptionist can then direct these slow-paying patients to the billing department before they leave the office. The schedule should be routinely examined ahead of time by the billing office, not just “if there’s time.”

- When Mrs. Brown arrives for her appointment she tells the receptionist she also needs to pick up a new prescription for her husband. The receptionist can send an instant message notifying the nurse that Mrs. Brown will be asking for this prescription. The nurse can then access Mr. Brown’s record and have the prescription ready by the time Mrs. Brown sees the physician.

Both of these are steps staff members can take at their desks to save time.

**On-Hold Messaging**

On-hold messaging is an inexpensive and efficient way to provide general information to your patients. It is better than subjecting the patient to silence (and wondering if they have been disconnected) or music they do not care for. Use this messaging for patient reminders (time for flu shots) and as a means of marketing any new services being offered by the practice. It is also a good opportunity to introduce any new providers or staff members of the practice. Make sure you are able to change the messages frequently and with ease.

**Use Your Practice Management System Effectively**

It is estimated that most medical practices only use about half the functionality in their practice management systems. Talk with your vendor to learn more about the standard reports your system creates as well as how to create custom reports. System reports are critical for measuring a practice’s progress toward goals and for identifying areas of opportunity. It is also important to talk with your vendor about other systems with which your system can connect to further enhance your system’s ability to be a “complete system.”

If you are not using Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA), now is the time to investigate the use of these more technically savvy systems. The benefits of shifting all health care payments to electronic transactions—reduced operating costs, efficient processing, enhanced reliability and strengthened security—are widely acknowledged, but unfortunately, are not widely used across the board with all payers. The costs associated with largely paper-based billing and insurance-related activities consume up to 12 percent of a provider’s revenue annually.

According to projections by HHS, EFT is projected to grow from 33 percent of all health care payments in 2010 to 84 percent by 2023, while ERA will increase from 35 percent to 82 percent of all payments over the same period. Being prepared for the age of electronic payments starts with understanding the options available. Providers need to work closely with their partners and health plans to get the support they need and to ensure that they are realizing all of the benefits of getting their money faster and with less hassle.
Chapter Three

Documentation of Services
Medical Record Documentation and Coding and Billing

Medical record documentation is required to record pertinent facts, findings and observations about an individual’s health history including past and present illnesses, examinations, tests, treatments and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

1. The ability of the physician and other health care professionals to evaluate and plan the patient’s immediate treatment and to monitor his/her health care over time.

2. Communication and continuity of care among physicians and other health care professionals involved in the patient’s care.

3. Accurate and timely claims review and payment.

4. Appropriate utilization review and quality of care evaluation.

5. Collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the “hassles” associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

What do Payers Want and Why?

1. The site of service.

2. The medical necessity and appropriateness of the diagnostic and/or therapeutic service provided.

3. Information that the services provided have been accurately reported.

General Principles of Medical Record Documentation

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:
   a. reason for encounter and relevant history, physical examination, findings and prior diagnostic test results
   b. assessment, clinical impression of diagnosis
   c. plan for care
   d. date and legible identity of the observer

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient’s progress, response to and changes in treatment and revision of diagnosis should be documented.

7. The CPT and ICD-10-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

**Documenting Evaluation and Management Services**

The documentation of a patient visit should be thorough in describing the medical elements within the encounter. By following the Evaluation and Management (E/M) component listing, an effective documentation outline can be developed for documenting E/M services. The key components of level of service selection are:

**HISTORY:** The patient’s history should be documented as personally taken or reviewed. Past, Family and Social History must be noted for detailed and comprehensive levels of service. Physicians may note that the details were reviewed and considered non-contributory.

- **Chief Complaint:** A concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient’s words.

- **History of Present Illness (HPI):** A chronological description of the development of the patient’s present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, duration, context, modifying factors and associated signs and symptoms significantly related to the presenting problem(s).

- **Location:** Where is the problem located?

- **Duration:** How long have the symptoms been present?

- **Severity:** How bad is the problem, pain or symptom? For example, “on a scale of one to 10, how bad is the pain if one is minimal and 10 is extreme?”

- **Quality:** Description of the problem in terms such as sharp, throbbing, persistent, dull, etc.

- **Context:** What were the circumstances that surrounded the start of the problem?

- **Timing:** When does the problem occur (e.g., only at night)?

- **Modifying Factors:** Does anything make the problem better or worse, such as, “When I turn on my side, it does not hurt as much.”
**Associated Signs and Symptoms:** Are there any other problems or symptoms associated with this problem?

**Review of System (ROS):** An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. For the purpose of CPT, the following elements of a system review have been identified:

a. Constitutional symptoms (fever, weight loss, etc.)  
b. Eyes  
c. Ears, Nose, Mouth, Throat  
d. Cardiovascular  
e. Respiratory  
f. Gastrointestinal  
g. Genitourinary  
h. Musculoskeletal  
i. Integumentary (skin and/or breast)  
j. Neurological  
k. Psychiatric  
l. Endocrine  
m. Hematologic/Lymphatic  
n. Allergic/Immunologic

**Past History:** A review of the patient’s past experience with illnesses, injuries and treatments that include significant information about:

a. Prior major illnesses and injuries  
b. Prior operations  
c. Prior hospitalizations  
d. Current medications  
e. Allergies (e.g., drug, food)  
f. Age appropriate immunization status  
g. Age appropriate feeding/dietary status

**Family History:** A review of medical events in the patient’s family that includes significant information about:

a. The health status or cause of death of parents, siblings and children  
b. Specific diseases related to problems identified in the Chief Complaint  
c. History of the Present Illness and/or System Review  
d. Diseases of family members which may be hereditary or place the patient at risk

**Social History:** An age appropriate review of past and current activities that includes significant information about:

a. Marital status and/or living arrangements  
b. Current employment  
c. Occupational history
d. Military history  
e. Use of drugs, alcohol and tobacco  
f. Level of education  
g. Sexual history  
h. Other relevant social factors

**EXAMINATION:** Details of the physical exam should include complaints, symptoms considered, observations and areas examined.

**MEDICAL DECISION MAKING:** This critical component should clearly describe the complexity of the process by detailing all diagnoses or presenting problems, elements of data reviewed, patient risk and treatment options. Data reviewed may be documented by listing evaluated laboratory values or date ranges for review of past complications.

Contributory Factors for selecting levels of service are:

**COUNSELING:** Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

a. Diagnostic results, impressions, and/or recommended diagnostic studies  
b. Prognosis  
c. Risks and benefits of management (treatment) options  
d. Instructions for management (treatment) and/or follow-up  
e. Importance of compliance with chosen management (treatment) option  
f. Risk factor reduction  
g. Patient and family education

**COORDINATION OF CARE:** Appropriate for the problems/needs of patient and family.

**NATURE OF PRESENTING PROBLEM:**

Minimal: May not require the presence of a physician, but is provided under physician supervision.

Self-limited or minor: A problem that runs a definite and prescribed course, is transient, is not likely to permanently alter health status or has a good prognosis.

Low severity: Risk or morbidity without treatment is low, little to no risk of mortality without treatment and full recovery without functional impairment is expected.

Moderate severity: Risk of morbidity without treatment is moderate, moderate risk of mortality without treatment, uncertain prognosis or increased probability of prolonged functional impairment.

High severity: Risk of morbidity without treatment is high, moderate to high risk of mortality without treatment or high probability of severe, prolonged functional impairment.
TIME = MORE THAN 50 PERCENT OF THE SERVICE: When counseling or coordinating care equals more than 50 percent of the physician/patient encounter, then time is one of the key factors in qualifying for a particular level of service. The extent of counseling and/or coordination of care must be documented.

The Consequences of Abbreviated Documentation

The *Documentation Guidelines*, as developed by CMS, declare that, when documented in the medical record, non-specific global statements such as “ROS noncontributory” or “remainder of exam normal” are insufficient to document the performance of a significant amount of care. Since there is no specific medical content, such documentation is treated as if no significant care has been performed. This position also reflects a quality of care perspective, because such general statements do not report any questions that were actually asked or any patient responses; physicians cannot use this imprecise information to make critical medical judgments.

Medical records with abbreviated documentation result in significant down-coding when subjected to E/M coding audits. Per *Documentation Guidelines* and also per US Social Security law, reviewers are required to interpret lack of documentation as non-performance of care.

Documenting the Different Levels of Service (E/M)

The levels of E/M services are based on four types of history, four types of examination and four levels of complexity of medical decision making. It is the documentation in the medical record that supports the levels of history, exam and medical decisions that are then incorporated in to selecting the appropriate overall level of E/M Service.

HISTORY

The levels of history are:

- **Problem Focused**: Chief complaint, brief history of present illness or problem.
- **Expanded Problem Focused**: Chief complaint, brief history of present illness, problem pertinent system review.
- **Detailed**: Chief complaint, extended history of present illness, problem pertinent system review extended to include a review of a limited number of additional systems, and pertinent past, family and social history directly related to the patient’s problems.
- **Comprehensive**: Chief complaint, extended history of present illness, review of systems that are directly related to the problems identified in the history of present illness plus a review of all additional body systems and complete past, family and social history.

Each type or level of history includes some or all of the following elements:

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
• Past, Family and/or Social History (PFSH)

A chief complaint is indicated for all levels of service.

The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

Documentation for history includes the following guidelines:

• 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 the present illness.

• An ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. The review and update may be documented by:
  o Describing any new ROS and/or PFSH information, noting there has been no change in the information; and
  o Noting the date and location of the earlier ROS and/or PFSH.

• The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient (i.e., health history form). To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

• If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance that precludes obtaining a history.

<table>
<thead>
<tr>
<th>HPI (history of present illness) elements:</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location □</td>
<td>Severity □</td>
<td>Timing □</td>
<td>Modifying factors □</td>
<td>Brief (1-3)</td>
</tr>
<tr>
<td>Quality symptoms □</td>
<td>Duration □</td>
<td>Context □</td>
<td>Associated signs and symptoms □</td>
<td></td>
</tr>
<tr>
<td>ROS (review of systems):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constitutional (wt loss, etc) □</td>
<td>Ears, nose □</td>
<td>GI □</td>
<td>Integumentary □</td>
<td>Endo □ (skin, breast ) □</td>
</tr>
<tr>
<td>Hem/hyphen □</td>
<td>Respiratory □</td>
<td>Psych □</td>
<td>“All others neg.” □</td>
<td></td>
</tr>
<tr>
<td>Pertinent to Problem (1 system)</td>
<td>Extended (2-9 systems)</td>
<td>Complete (10 or more systems or some systems with statement “all other neg.”)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFSH (past medical, family, social history) areas:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Past history (the pt.’s experiences with illnesses, operations, injuries &amp; treatments) □</td>
<td>None □</td>
<td>None □</td>
<td>Pertinent (1 history area) □</td>
<td>Complete (2 or 3 history area)</td>
</tr>
<tr>
<td>Family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk) □</td>
<td>None □</td>
<td>None □</td>
<td></td>
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<tr>
<td>Social history (an age appropriate review of past and current activities) □</td>
<td>None □</td>
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</tbody>
</table>

Determine a level of history using the table above. a) If a column has three elements circled, draw a line up that column to the top row and circle the type or level of history. b) If no column has all of the elements circled, find the circle(s) farthest to the left. Draw a line up that column to the top row and circle the type or level of history.
EXAMINATION

The levels of examination are:

- **Problem Focused**: A limited examination of the affected body area or organ system.

- **Expanded Problem Focused**: A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).

- **Detailed**: An extended examination of the affected body areas(s) or organ system(s) and any other symptomatic or related body areas(s) or organ system(s).

- **Comprehensive**: A general multi-system examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

For purposes of a multi-system examination, the following organ systems are recognized:

1. Eyes
2. Ears, nose, mouth and throat
3. Cardiovascular
4. Respiratory
5. Gastrointestinal
6. Genitourinary
7. Musculoskeletal
8. Skin
9. Neurologic
10. Psychiatric
11. Hematologic/Lymphatic/Immunologic
12. Constitutional (vital signs, general appearance)
The 1997 Documentation Guidelines developed by CMS, also define levels of examination and documentation guidelines for the following single organ system exams:

1. Cardiovascular
2. Ears, Nose, Mouth and Throat
3. Eyes
4. Genitourinary (Female)
5. Genitourinary (Male)
6. Musculoskeletal
7. Skin
8. Neurologic
9. Psychiatric
10. Hematologic / Lymphatic / Immunologic

A general multi-system examination or a single organ system examination may be performed by any physician regardless of specialty. The type (general multi-system or single organ system) and content of examination are selected by the examining physician and are based upon the clinical judgment, the patient’s history and the nature of the presenting problem(s).

There are three guidelines for documenting a physical examination:

1. Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.

2. Abnormal or unexpected findings of the examination of any asymptomatic body areas(s) or organ system(s) should be described.

3. A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

### 1995 Guidelines

<table>
<thead>
<tr>
<th></th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body areas:</strong></td>
<td>1 body area/system</td>
<td>2-4 areas or systems</td>
<td>5-7 areas or systems</td>
<td>8+ systems</td>
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<tr>
<td>Head, including face</td>
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<td>Chest, including</td>
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<td>Abdomen</td>
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<td>Back, including spine</td>
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<td>Neck</td>
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<tr>
<td>Breast and axillae</td>
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<td>Genitalia, groin, buttocks</td>
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<tr>
<td><strong>Organ system:</strong></td>
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<td>Cardiac</td>
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<td>Ears, nose</td>
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<td>Resp</td>
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<td>Musculo</td>
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<td>Psych</td>
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<td>Eyes</td>
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<td>Mouth, throat</td>
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<td>GI</td>
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<td>Skin</td>
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<td>Hem/lymph/immun.</td>
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<tr>
<td>Cardiovascular</td>
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<td>GU</td>
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<td>Neuro</td>
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</table>
1997 Guidelines

<table>
<thead>
<tr>
<th>Multi-System Exam:</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>1-5 bullets/elements</td>
<td>6 bullets/elements</td>
<td>12 bullets/elements</td>
<td>18 bullets</td>
</tr>
<tr>
<td>Ears, nose</td>
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<td>Resp</td>
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<td>Musculo</td>
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<td>Psych</td>
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<td>mouth, throat</td>
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<td>GI</td>
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<td>Cardiovascular</td>
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<td>Neuro</td>
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<td>Single Organ system:</td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Ears, Nose, Throat, Mouth</td>
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<td>Musculoskeletal</td>
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<td>Skin</td>
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<td>Eyes</td>
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<tr>
<td>Genitourinary (female)</td>
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<td>Genitourinary (male)</td>
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<td>Neurological</td>
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<td>Hematologic/Lymphatic/Immunologic</td>
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<td>Psychiatric</td>
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<tr>
<td>Respiratory</td>
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</table>

**COMPLEXITY OF DECISION MAKING**

Medical Decision Making is made up of three elements and four types. Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by **three elements** - data, risk and diagnostic and/or management options.

Medical Decision Making is:

- The number of possible diagnoses and/or management options.
- The amount and/or complexity of medical records, diagnostic tests and/or other information that must be obtained, reviewed and analyzed.
- The risk of significant complications, morbidity and or mortality, as well as co-morbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making “complexity” are recognized:

1. Straight-forward
2. Low Complexity
3. Moderate Complexity
4. High Complexity

To qualify for a given type of decision making, **two of the three elements must be met or exceeded**.

<table>
<thead>
<tr>
<th># of Dx(s) -or- Mgmt Options</th>
<th>Amount and/or Complexity of Data Reviewed</th>
<th>Risks of Complication, Morbidity or Mortality</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td><strong>High Complexity</strong></td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td><strong>Moderate Complexity</strong></td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td><strong>Low Complexity</strong></td>
</tr>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td><strong>Straightforward</strong></td>
</tr>
<tr>
<td>Number of Diagnosis or Treatment Options</td>
<td>Amount and/or Complexity of Data Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Limited or Minor</td>
<td>Clinical Lab Tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Established Problem, Stable</td>
<td>Radiology Studies</td>
<td></td>
<td></td>
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<tr>
<td>Established Problem, Worse</td>
<td>Medicine Studies</td>
<td></td>
<td></td>
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<tr>
<td>New Problem, No Further Work-Up</td>
<td>Discussion with Performing MD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Problem, Further Work-Up</td>
<td>Review Old Records, Discuss with Other MD</td>
<td></td>
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<tr>
<td></td>
<td>Independent visualization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| Minimal       | • One self-limited or minor problem, eg., cold, insect bite, tinea corporis | • Laboratory tests requiring venipuncture  
• Chest x-rays  
• EKG/EEG  
• Urinalysis  
• Ultrasound, eg. Echocardiography  
• KOH prep | • Rest  
• Gargles  
• Elastic bandages  
• Superficial dressings |
| Low           | • Two or more self-limited or minor problems  
• One stable chronic illness eg, well controlled hypertension or non-insulin dependent diabetes, cataract, BPH  
• Acute uncomplicated illness or injury, eg. cystitis, allergic rhinitis, simple sprain | • Physiologic tests not under stress, eg. pulmonary function tests  
• Non-cardiovascular imaging studies with contrast eg, barium enema  
• Superficial needle biopsies  
• Clinical laboratory tests requiring arterial puncture  
• Skin biopsies | • Over-the counter drugs  
• Minor surgery with no identified risk factors  
• Physical therapy  
• Occupational therapy  
• IV fluids without additives |
| Moderate      | • 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, eg. lump in breast  
• Acute illness with systemic symptoms, eg. pyelonephritis, pneumonitis, colitis  
• Acute complicated injury, eg. head injury with brief loss of consciousness | • Physiologic tests under stress, eg. cardiac stress test, fetal contraction stress test  
• Diagnostic endoscopies with no identified risk factors  
• Deep needle or incisional biopsy  
• Cardiovascular imaging studies with contrast and no identified risk factors, eg. arteriogram, cardiac catheterization  
• Obtain fluid from body cavity, eg. lumbar puncture, thoracentesis, culdocentesis | • Minor surgery with identified risk factors  
• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors  
• Prescription drug management  
• Therapeutic nuclear medicine  
• IV fluids with additives  
• Closed treatment of fracture or dislocation without manipulation |
| High          | • 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, eg. multiple trauma, acute MI | • Cardiovascular imaging studies with contrast with identified risk factors  
• Cardiac electrophysiological tests  
• Diagnostic endoscopies with identified risk factors  
• Discography | • Elective major surgery (open percutaneous or endoscopic) with identified risk factors  
• Emergency major surgery (open, percutaneous or endoscopic)  
• Parenteral controlled substances |
The highest level of risk in any one category determines the overall risk!

Documenting Surgical or Procedural Services

When documenting surgical or procedure services it is preferable to always follow the elements of a good operative report:

1. Site
2. Size and number for lesions, defect, incisions, etc.
3. Diagnosis
4. Complications, if any
5. Anesthesia, if any and what type
6. Disposition of patient

Economic Consequences of Noncompliant Coding and Documentation

From an economic perspective for the family physician, one cannot overemphasize the importance of appropriate and compliant E/M coding and documentation. Potential financial ramifications can result from either overcoding or undercoding.

Overcoding occurs in one of two circumstances:

1. Documentation in the medical record for the three key components is not sufficient to support the submitted E/M code.

2. The Nature of Presenting Problem is not of sufficient severity to warrant the level of care indicted by the submitted E/M code.

The negative financial consequences of overcoding begin with audits that reclaim “overpayments.” A more severe economic penalty may occur if a Medicare audit imposes additional penalties for “fraud” in cases where the reviewer determines that the physician has a consistent pattern of excessive overcoding. There is an additional danger that Medicare or private insurers may extrapolate a finite financial penalty from a limited audit and apply it to the entire populations of E/M claims that have been filed over a prolonged time period. All of these penalties have the potential to be financially devastating to a family medicine practice.
Under-coding generally occurs among physicians who fear financial penalties from potential audits and simply have no confidence in the accuracy of their documentation and coding. These physicians therefore code all E/M services at low levels out of fear of being audited or investigated for fraud, even when they have performed and documented more comprehensive levels of care. The negative financial consequences of under-coding are that it results in insufficient payment for the services physicians have rendered and documented.

**Analyzing the Financial Impact of Undercoding**

Using the Medicare fee schedule as a fee base, and dependent upon geographic location, undercoding outpatient initial visits by one code level costs the physician between $30 and $40 per visit. Under-coding outpatient established visits by one code level costs the physician between $15 and $37 per visit. Applying these values, if a physician were to care for 5000 office patients per year, under-coding by one level per visit would translate to a loss of between $150,000 and $200,000 per year of gross income.

There are similar negative financial consequences for under-coding other E/M services, such as inpatient and emergency department services.

The goal for all family physicians should be to select all of their E/M codes appropriately, according to the Nature of the Presenting Problem for each patient encounter and to ensure that they generate medical records that demonstrate they have provided the level of care indicated by these codes.

Not thoroughly documenting non-evaluation and management services, such as injection administration, blood draws, joint injections and nebulizer treatments also have the potential of lost revenue:

1. If services are not documented in the record, they may be lost in the charge capture system.
2. If services are not completely documented (e.g., what medication is used and how much, what local anesthesia was used, how large was the wound repair, exactly how was the lesion removed), the potential of services being denied payment for lack of documentation to support the performance of that service coded and/or billed is great.

Remember, a procedure done in the office should be documented, just as it would be required to be documented if the service was performed in the hospital or an outpatient surgical center.
Chapter Four

Coding Evaluation and Management Services
The Evaluation and Management (E/M) Services codes were introduced into CPT nomenclature in 1992. These codes describe services provided by physicians and non-physician providers to “evaluate” patients and “manage” their care. The E/M codes replaced “visit” codes that described services generally as a “brief visit,” “intermediate” or “comprehensive.” These codes are widely used by physicians of all specialties and describe a very large portion of the medical care provided to patients of all ages.

PRIMARY TYPES OF E/M SERVICES

Outpatient - Office visits for new and established patients (99201-99205) and (99211-99215)
These codes are used to report E/M services provided in the physician’s office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

NEW PATIENT OFFICE VISIT: Three of Three Components Must Be Met or Exceeded

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Physical Exam</th>
<th>Medical Decision Making</th>
<th>Average Time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>P</td>
<td>P</td>
<td>S</td>
<td>10</td>
</tr>
<tr>
<td>99202</td>
<td>E</td>
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<td>S</td>
<td>20</td>
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<td>99203</td>
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<td>L</td>
<td>30</td>
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<tr>
<td>99204</td>
<td>C</td>
<td>C</td>
<td>M</td>
<td>45</td>
</tr>
<tr>
<td>99205</td>
<td>C</td>
<td>C</td>
<td>H</td>
<td>60</td>
</tr>
</tbody>
</table>

A patient is considered “new” to a practice if he/she has not received any professional services (face-to-face) from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

ESTABLISHED PATIENT OFFICE VISIT: Two of Three Components Must Be Met or Exceeded

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Physical Exam</th>
<th>Medical Decision Making</th>
<th>Average Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>5</td>
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<tr>
<td>99212</td>
<td>P</td>
<td>P</td>
<td>S</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>E</td>
<td>E</td>
<td>L</td>
<td>15</td>
</tr>
<tr>
<td>99214</td>
<td>D</td>
<td>D</td>
<td>M</td>
<td>25</td>
</tr>
<tr>
<td>99215</td>
<td>C</td>
<td>C</td>
<td>H</td>
<td>40</td>
</tr>
</tbody>
</table>

Key: History and Physical Exam
- P – Problem Focused
- E – Expanded Problem Focused
- D – Detailed
- C – Comprehensive

Key: Medical Decision Making
- S – Straightforward
- L – Low Complexity
- M – Moderate Complexity
- H – High Complexity
Hospital Observation Service (99218-99220)

Hospital Observation Service codes are used to report E/M services provided to patients admitted as “observation status” in a hospital. It is not necessary that the patient be located in a hospital designated “under observation” by the hospital, but rather the status of the patient is designated as “under observation” by the physician.

To report services to a patient designated as “under observation status,” who is discharged on the same date, use the services codes for Admission and Discharge on the same date (99234-99236).

Hospital Observation Service requires all three key components of E/M service be provided.

Subsequent Observation Care (99224 – 99226)

These codes were introduced into CPT in 2011 to address the needs of reporting physician services to those patients who remain under observation care for more than two days (one day for initial care and one day for discharge care). These patients are those who are housed in the hospital, but have not yet been admitted as an inpatient.

These codes have structure and value that are similar to subsequent hospital inpatient service codes and typical times have been established for the codes. Two of the three key components of any E/M service must be met.

Observation Care Discharge Service (99217)

Observation care discharge of a patient from “observation status” includes final examination of the patient, discussion of the hospital stay, instructions for continuing care and preparation of discharge records.

HOSPITAL INPATIENT SERVICES

According to one study done, based on 125 audits, 80 percent of hospital visits were miscoded. A likely reason for this is that the documentation for these visits is not in the doctor’s office, but in the hospital and is most often not reviewed before code selection is made. This makes it difficult to monitor coding and documentation compliance.

A Critical Tip - Remember that if the patient is stable, you cannot code higher than a level one service. A level two service patient requires that the patient be responding inadequately, or some indication of a need for change in therapy or medication is documented. Level three service should reflect increasing degrees of instability or significant new problems having occurred (there are only three levels of hospital visit).

Initial Hospital Care (99221-99223)

By CPT definition, Initial Hospital Care codes are used to report the first hospital inpatient encounter with the patient by the admitting physician. For initial inpatient encounters by physicians other than the admitting physician, see initial consultation codes or subsequent hospital care codes as appropriate.
Because Medicare no longer recognizes the consultation codes as payable services, it is possible for the Medicare patient to receive initial hospital care (99221 – 99223) by more than one physician on the same day.

To eliminate the confusion as to who is the admitting physician or “physician of record” for a Medicare patient, a modifier AI has been developed to identify the admitting physician or “physician of record.” It is a modifier developed by CMS (HCPCS Level II) and may be used with either a hospital (acute care) patient or a nursing facility patient.

When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service all E/M services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in other site of service as well as in the inpatient setting. E/M services on the same day provided in sites other than the hospital that are related to the admission should NOT be reported separately.

Initial Inpatient Hospital Care codes require three key components. Minimally, a detailed history and a detailed physical examination are required, regardless of the level of medical decision making.

**Subsequent Hospital Care (99231 - 99233)**

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient’s status, since the last assessment by the physician. Subsequent Hospital Care codes require two of three key components and “patient status” must be considered when making the correct code selection.

A patient may receive care from more than one physician on any given day, as long as it is for different diagnosis. Family physicians that have admitted a patient and requested a consultation and care by a consultant should remember to diagnostically code only the reason(s) they, the family physician, are following the patient. Insurers typically deny services provided to patients by multiple physicians on the same day, for the same diagnosis.

**Hospital Discharge Services (99238-99239)**

The hospital discharge management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. The physician that admitted the patient and did the initial work up is not required to be the physician that does the discharge summary and bills for discharge day services. These codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the physician on that date is not continuous. Instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms are also part of this service.

**Observation or Inpatient Service – Admit/Discharge Same Day (99234 – 99236)**
To report services to a patient who is either placed on observation or admitted as an inpatient and discharged on the same date, use CPT codes 99234 – 99236. This set of codes mirrors the initial hospital care code guidelines and documentation requirements.

**CONSULTATION**

In 2010 Medicare discontinued recognizing the consultation codes as payable services for Medicare recipients. To date, most other carriers have continued to recognize the consultation services as payable services, although some payers have dramatically decreased the allowed payment value for these services. The discussion of the consultation service that follows is valid for all non-Medicare patients. When providing a consultation service to a Medicare patient, however, refer to the discussion of consulting on a Medicare patient that follows the general discussion of consultations.

A consultation is defined as a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

A consulting physician may initiate diagnostic and/or therapeutic services.

The request for a consultation from the attending physician or other appropriate source and the need for a consultation must be documented in the patient’s medical record. The consultant’s opinion and any services that were ordered or rendered must also be documented in the patient’s medical record and communicated to the requesting physician or other appropriate source.

Any specifically identifiable procedure (i.e., identified with a specific CPT code) performed on or subsequent to the date of the initial consultation should be reported separately.

If a consultant subsequently assumes responsibility for the management of a portion or all of the patient’s condition(s), the consultation codes should not be used. In the hospital setting, the physician receiving the patient for partial or complete transfer of care should use the appropriate subsequent hospital care codes. In the office setting, the appropriate established patient code should be used.

There are now only two subcategories of consultations:

1. Office of Other Outpatient
2. Initial Inpatient

See each subcategory for specific reporting instructions. There are no longer CPT codes for follow up inpatient consultation services or confirmatory consultation services. Services subsequent to an initial inpatient consultation should be coded as subsequent hospital care. Confirmatory consultations should be billed as initial consultations if they were appropriately requested.

*Family Physicians are often requested by surgeons to provide a consultation on their patients for surgical clearance. See our discussion of billing for surgical clearance services in Chapter Six.*
Office or Other Outpatient Consultations (99241-99245)

Office or Other Outpatient Consultation codes are used to report consultations provided in the physician’s office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, custodial care or emergency department.

Following the initial consultation, if an additional request for an opinion or advice is received regarding the same or a new problem from the attending physician and documented in the medical record, the office consultation codes may be used again. However, if the patient is only returning as a follow-up at the consulting physician’s request, the visit would be coded as an established patient visit.

Office or Other Outpatient Consultation codes require all three key components.

Consultations on Medicare Patients

If a family physician is asked to consult on a Medicare patient in the outpatient environment, those services must be reported using either a new patient visit code or an established patient visit. A realistic crosswalk between consultation codes and new and established patient codes looks like this:

<table>
<thead>
<tr>
<th>Consult</th>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>99201</td>
<td>99212</td>
</tr>
<tr>
<td>99242</td>
<td>99202</td>
<td>99213</td>
</tr>
<tr>
<td>99243</td>
<td>99203</td>
<td>99214</td>
</tr>
<tr>
<td>99244</td>
<td>99204</td>
<td>99215</td>
</tr>
<tr>
<td>99245</td>
<td>99205</td>
<td>99215 + 99354</td>
</tr>
</tbody>
</table>

Preoperative consultations: Physicians (primary care or specialists) performing preoperative and postoperative consultations for their established patients at the request of the surgeons may bill the appropriate HCPCS/CPT consultation code as long as all of the following five criteria are met and the medical record is documented as such:

1. The surgeon must request the consulting physician’s opinion or advice regarding evaluation and/or management of a specific problem (e.g. preoperative clearance).

2. The surgeon’s request for a consultation and the need for consultation must be documented in the patient’s medical record. In an inpatient setting, the request may be documented as part of a plan written in the requesting surgeon’s progress note, an order in a hospital record or a specific written request for the consultation. In an office or other outpatient setting, the request may be documented by a specific written request for the consultation from the requesting surgeon or the physician’s records may show a specific reference to the request.
3. The consulting physician’s opinion and any services ordered or performed must be documented in the patient’s medical records and must be communicated to the surgeon. The medical record should identify the specific problem which was the reason for the consultation, describe the extent of the history, physical and medical decision making that supports the level of consultation code billed and include the consultant’s findings and recommendations to the requesting surgeon.

4. The consulting physician must provide all of the services necessary to meet the description of the level of CPT code billed.

5. If the consultation is performed postoperatively, the same consulting physician cannot have already performed a consultation preoperatively. If a preoperative consultation was performed by a physician, the postoperative services of that same physician must be reported via the appropriate subsequent hospital, office or other E/M procedure code.

**Initial inpatient consultations (99251-99255)**

Initial Inpatient Consultation codes are used to report physician consultations provided to the hospital inpatient, residents of nursing facilities or patients in a partial hospital setting.

Only one initial consultation should be reported by a consultant per admission. Initial Inpatient Consultation codes require all three key components.

Consultation services provided to the Medicare patient in the inpatient environment must be coded and billed using either an initial hospital care service code or a subsequent hospital care service. A realistic crosswalk between initial consultation codes and initial hospital care looks like this:

<table>
<thead>
<tr>
<th>Inpatient Consult Codes</th>
<th>Hospital Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>99255</td>
<td>99223 + 99356</td>
</tr>
<tr>
<td>99254</td>
<td>99222 + 99356</td>
</tr>
<tr>
<td>99253</td>
<td>99221 or 99233</td>
</tr>
<tr>
<td>99252</td>
<td>99232</td>
</tr>
<tr>
<td>99251</td>
<td>99231</td>
</tr>
</tbody>
</table>
OTHER E/M SERVICES

EMERGENCY DEPARTMENT SERVICES
- New and Established Patients 99281 – 99288
  - All Physicians May Use
  - Critical Care Codes Should be Used if Appropriate
  - New/Established Patients Coded Similarly (3/3 Components)
  - Specialist Referral by ER Physician not Considered Consults

PATIENT TRANSPORT SERVICES 99289 - 99288

CRITICAL CARE SERVICES
- First 60 Minutes 99291
- Additional 30 Minutes (each) 99292
  - Not Necessarily "Continuous" Time
  - 15 Minutes is the Critical "Cut-Off"
  - (1/2 hour - 1 hour, 14 min. = 99291)
  - 99291 Used Once Per Day Only
  - "Status" (diagnosis) Not “Unit” is Deciding Factor

NURSING FACILITY SERVICES (SNF, ICF, LTCF)
- Initial Care (per day), new or established 99304 - 99306
- Subsequent Care 99307 - 99310
- Discharge Services (based on time) 99315 – 99316

OTHER NURSING FACILITY SERVICES
- Annual Nursing Facility Assessment 99318

DOMICILIARY, REST HOME, CUSTODIAL CARE SERVICES
- New Patient 99324 - 99328
- Established Patient 99334 – 99337
- Includes Assisted Living

DOMICILIARY, REST HOME (e.g., ASSISTED LIVING FACILITY), or HOME CARE PLAN OVERSIGHT SERVICES
- 15-29 Minutes 99339
- 30 minutes or more 99340
  - Per Month Services
  - Patient need not be present
  - Place of Service is Office

HOME SERVICES
- New Patients 99341 - 99345
- Established Patient 99347 - 99350

PROLONGED SERVICES
- Direct Patient Contact -Outpatient
  - 1st hour 99354
Each Add’l 30 minutes 99355

- Direct Patient Contact – Inpatient
  - 1st hour 99356
  - Each Add’l 30 minutes 99357

- Without Direct Patient Contact - 1st hour 99358
  - Each Add’l 30 minutes 99359

- Prolonged Clinical Staff Services with Physician or other QHP Supervision
  - 1st hour 99415
  - Each Add’l 30 minutes 99416

CASE MANAGEMENT SERVICES

- Anticoagulant Management
  - Initial 90 days of therapy 99363
    - Minimum 8 INR measurements
  - Each subsequent 90 days 99364
    - Minimum 3 INR measurements

- Medical Team Conferences (30 minutes or more)
  - Direct Contact (face-to-face) 99366
  - Without Direct Contact
    - Physician 99367
    - Non Physician Professional 99368

CARE PLAN OVERSIGHT SERVICES (Per 30 day periods)

- Patient Under Home Health Care Agency Care
  - 15-29 Minutes 99374
  - 30 Minutes or more 99375

- Hospice Patient
  - 15-29 Minutes 99377
  - 30 Minutes or more 99378

- Nursing Home Patient
  - 15-29 Minutes 99379
  - 30 Minutes or more 99380

Family Physicians often provide this type of service. Medicare does not recognize the above CPT codes, but does pay for some of these services utilizing HCPCS Level II codes. Please see our discussion of this topic in Chapter Six – Remember to Bill for These Services.

PREVENTIVE MEDICINE SERVICES (WELL EXAMS) – by age

- New Patients 99381 - 99387
- Established Patient 99391 – 99397

COUNSELING RISK FACTOR REDUCTION AND BEHAVIOR CHANGE INTERVENTION – New or Established Patient

- Individual Counseling 99401 – 99404
  - Time based by 15 minute units

- Behavior Change Interventions – Individual
  - Smoking and Tobacco Use Cessation
    - Intermediate three to 10 min. 99406
- Intensive - > 10 min. 99407
  - Alcohol and/or Substance Abuse
    - Brief 15-30 min. 99408
    - Greater than 30 min. 99409
- Group Counseling
  - 30 minutes 99411
  - 60 minutes 99412
- Other Preventive Medicine
  - Health Hazard Appraisal 99420
  - Unlisted 99429

NON-FACE-TO-FACE PHYSICIAN SERVICES
- Telephone Services
  - Established patient
  - No E/M service within the previous seven days
  - Cannot lead to E/M or procedure service in next 24 hours
    - 5-10 minutes of discussion 99441
    - 11-20 minutes of discussion 99442
    - 21-30 minutes of discussion 99443
- On-Line Medical Evaluation 99444
  - Response to patient inquiry
  - Established patient
  - No E/M service by internet or other electronic communication within previous 7 days

SPECIAL EVALUATION AND MANAGEMENT SERVICES
- Basic Life and/or Disability Evaluation 99450
- Work Related or Medical Disability 99455 – 99456
  - Evaluation Services

NORMAL NEWBORN CARE
- Initial Care
  - Hospital or Birthing Center – per day 99460
  - Other than Hospital or birthing Center 99461
- Subsequent Hospital Care, per day 99462
- Initial Hospital or Birthing Center, per day
  - Admitted/discharge same day 99463
- Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn 99464
- Delivery/birth room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output 99465
- 99465 may be reported in conjunction with 99460, 99468, 99477
- 99464 and 99465 cannot be reported together
- Report procedures performed as a necessary part of the resuscitation (intubation, vascular lines) in addition to 99465

**NEONATAL INTENSIVE CARE SERVICES AND PEDIATRIC AND NEONATAL CRITICAL CARE SERVICES**

- Pediatric Critical Care Patient Transport 99466 – 99467
- Inpatient Neonatal and Pediatric Critical Care 99468 – 99476
- Initial and Continuing Intensive Care Services 99477 – 99480
  - Patient not critically ill, but requires intensive observation, frequent interventions and other intensive care services
  - Intensive care of low birth weight patient

**CARE MANAGEMENT SERVICES**

- Chronic Care Management Services – 20 min/month 99490
- Complex Chronic Care Management Services
  - First 69 minutes per month 99487
  - Each additional 30 minutes per month 99489

| Total Duration of Staff Care Management Services | Complex Chronic Care Management |
|-------------------------------------------------|---------------------------------
| Less than 60 minutes                            | Not reported separately        |
| 60-89 minutes (1 hr. – 1 hr. 29 min.)           | 99487                          |
| 90-119 minutes (1 hr. 30 min – 1 hr. 59 min.)   | 99487 and 99489 x1             |
| 120 minutes or more (2 hours or more)           | 99487 and 99489 x 2 and 99489 for each additional 30 minutes |

**TRANSITIONAL CARE MANAGEMENT SERVICES**

- Moderate Complexity Medical Decision Making 99495
  - Face-to-face visit within 14 days of discharge
- High Complexity Medical Decision Making 99496
  - Face-to-face visit within 7 days of discharge
- Advance Care Planning
  - First 30 minutes 99497
  - Each additional 30 minutes 99498

**OTHER E/M SERVICES**

- Unlisted E/M Service 99499
INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE

When selecting a level of E/M service, it is important to remember that it is ultimately the responsibility of the physician providing the E/M service to determine the level of service provided. Physician documentation in the patient’s medical record is of utmost importance; it must support the level of service reported.

Specific steps must be taken to select the appropriate level of E/M service. These steps are:

1. Identify the category and subcategory of service

Refer to the table of categories and subcategories of E/M services in your CPT manual to identify the appropriate category and subcategory of service provided (e.g., office or other outpatient new patient, established patient, in patient – initial admission, subsequent care).

2. Review the reporting instructions for the selected category or subcategory

Most of the categories and many of the subcategories of E/M services have special guidelines or instructions unique to that category or subcategory. It is important to read and be guided by those special instructions.

3. Review the E/M service code descriptors in the selected category or subcategory

The descriptors for the levels of E/M services recognize even components (history exam, medical decision making, counseling, coordination of care, nature of presenting problem and time). The first six are used in determining the level of service. Review the descriptors in the category or subcategory selected.

4. Determine the extent of history obtained

The medical history provides essential information for diagnosis and management and varies based on the clinical judgment of the physician and each individual patient and problem(s). Obtaining the history includes:  Chief Complaint, History of Present Illness, Review of Systems, Past, Family and/or Social History. There are four levels (extent) of history: Problem Focused, Expanded Problem Focused, Detailed and Comprehensive. Use the components of history obtained to determine the overall extent (level) of history.

5. Determine the extent of the examination performed

The extent of the examination performed depends on the clinical judgment of the physician and the nature of the patient’s presenting problems. Depending upon the number of systems examined, choose a level (extent) of exam from the following choices: Problem Focused, Expanded Problem Focused, Detailed and Comprehensive.
6. Determine the complexity of medical decision making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the three elements: data, risk and number of diagnostic and/or management options. Two of the three elements must be met or exceeded to select a level of complexity of medical decision making. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M service, unless their presence significantly increases the complexity of medical decision making.

7. Select the appropriate level of E/M services

The selection of the appropriate level of E/M service is based on the key components performed by the physician and the number of key components required for the particular category/subcategory identified.

Some of the categories/subcategories of E/M service require all of the key components to meet or exceed requirements stated in the code descriptor to qualify for a level of E/M service. Other categories/subcategories of E/M services require only two of the three key components to meet or exceed the stated requirements to qualify for a particular level of service.
Chapter Five

Using Modifiers Effectively

Getting Paid for What You Do!
Using Modifiers Effectively - Getting Paid for What You Do

The use of modifiers is an important part of coding and billing for health care services. Modifiers are designed to give insurance carriers, including Medicare, additional information needed to process a claim. This includes HCPCS Level I (CPT) and HCPCS Level II codes. There is a complete list of CPT modifiers in Appendix A of your current year’s CPT book. The complete list of HCPCS Level II modifiers can be found in the HCPCS Level II publication. It is often found on the inside of the front and back covers, as well as in an Appendix within the book.

Both sets of modifiers are updated annually and should be checked for accuracy and current validity. Correct modifier use is an important part of avoiding fraud and abuse or noncompliance issues, especially in coding and billing processes involving the federal and state governments. Incorrect modifier usage is identified as one of the top 10 billing errors determined by federal, state and private payers.

A modifier provides the means by which a physician can indicate or “flag” a service provided to the patient that has been altered by some special circumstance(s), but for which the basic code description itself has not changed. A modifier is used to indicate:

- A service or procedure has both a professional and technical component, but both components are not applicable
- A service or procedure was performed by more than one physician and/or in more than one location
- A service or procedure has been increased or reduced
- Only part of a service was performed
- An adjunctive service was performed
- A bilateral procedure was performed
- A service or procedure was performed more than once
- Unusual events occurred during a procedure or service

Placement of a modifier after either a CPT or HCPCS code does not ensure payment. A special report may be necessary if the service is rarely provided, unusual, variable or new. The special report should contain pertinent information and an adequate definition or description of the nature, extent and need for the procedure/service.

Some modifiers are information only (e.g., -24 and -25) and do not affect the amount of payment. They can, however, determine if the service will be paid or denied.

Other modifiers such as modifier -22 (unusual procedural services) will increase the payment under the protocol for many third-party payers if documentation supports the use of this modifier. Modifier -52 (reduced services) will usually equate to a reduction in payment.

Determining correct modifier assignment can be very frustrating at times. If the medical record document does not support the use of the specific modifier, physicians risks the denial of the claim based on lack of medical necessity and possible fraud and/or abuse penalties should the medical record documentation be reviewed by federal, state and other third-party payers.
A Review of Modifiers Commonly Used by Family Physicians:

**Modifier -22** is used to report an unusual procedural service. The key here is that the service is procedural in nature, and not an E/M service. When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier -22 to the usual procedure CPT code. A report may be required by the third-party payer to support the unusual nature of the service.

*Example:* A family physician excises a lesion located in the abdominal folds of a very obese person. The obesity makes the excision more difficult. The physician indicates the complexity of the removal of the lesion by appending the -22 modifier to the code used to report the removal of the lesion. A copy of the physician’s operative note is attached to the claim when the third-party is billed.

**Modifier -24** is used when a physician provides a surgical service related to one problem and then, during the period of follow-up care for the surgery, provides an E/M service unrelated to the problem. The -24 modifier is appended to the E/M service that follows the surgical service.

*Example:* The family physician repairs a minor laceration on an elderly gentleman who fell on his back stairs and cut his forearm. Five days later, the patient comes back in to the office to have his blood pressure checked because he is having what he considers to be a severe headache. Because the wound repair has 10 days of postoperative care included in its global period, the -24 modifier must be appended to the office visit service for evaluation of the headache. Additionally, a separate diagnosis, not related to the laceration, should be used as the primary diagnosis for the office visit service.

**Modifier -25** is used 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. 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. However, a different diagnosis may be reported if present. The physician must remember that the -25 modifier is reported on the E/M, not the procedure or other service.

*Example:* A patient presents to the family physician’s office suffering from shoulder pain. Upon examination of the patient, the physician determines the patient has bursitis and would benefit from an injection of cortisone into the shoulder joint. In addition to documenting the elements of the E/M visit, the physician documents an operative note describing the joint injection, identifying the medication and amount injected into the shoulder.

The E/M visit is billed, appending the -25 modifier to the code. The appropriate code for the joint injection is billed, with no modifier, and the appropriate code is billed to identify the name and amount of the medication injected.

In this scenario, because the patient came in to the office with shoulder pain, that should be the primary diagnosis used for the E/M service. The bursitis diagnosis would be used for the injection and medication.
Third party payers sometimes deny E/M services and procedural services billed on the same day, even when the physician appends the -25 modifier. These services should be appealed for appropriate payment.

**Modifier -26** is used to report only the physician (professional) component of a service that is a combination of a physician component and technical component. Before using this modifier one must make sure there is not a separate CPT code that describes the professional component of the service.

**Example:** A family physician is evaluating a patient with shortness of breath and orders a chest x-ray. The x-ray equipment in the office is currently being serviced and will not be available until the next day. The physician sends the patient upstairs to another office to have the x-ray taken and asks the patient to return to his office with the x-ray films so he may read and interpret the films. The family physician reads the chest x-ray, documents his interpretation and makes a decision as to how best to treat the patient’s problem. The other office will bill for the technical component of the x-ray while the family physician will append the -26 modifier to the CPT code for the chest x-ray to indicate he/she performed the professional component or interpretation.

**Modifier -33** is used when the primary purpose of the service is to deliver an evidence based service in accordance with the US Preventive Services Task Force’s current A or B ratings or other preventive services identified in legislative or regulatory preventive service mandates. For separately reported services specifically identified as preventive, the modifier should not be used.

The application of modifier -33 is primarily used to indicate the impact on a patient’s co-pay, deductible, etc., and has less relevance to the coding itself. To a significant degree, this modifier is a commercial payer’s replacement to Medicare’s –PT modifier. The –PT is only applicable when a planned screening colonoscopy, for example, turns out to be a therapeutic one, while modifier -33 is used for any such procedure/service that was planned to be “preventive” and did not turn out so.

**Example:** Patient is seen for follow-up for hypertension, the provider does a cholesterol screening (preventative service) in an in-office lab. Modifier -33 is attached to the lab CPT code for the cholesterol study because it is being done for a screening purpose. ICD-10-CM code Z13.220 (screening for lipoid disorders) is coded as an additional diagnosis. Modifier -33 is not required on services that are inherent to screening services (i.e., screening mammography).

**Modifier -50** is used to report bilateral procedures that are performed at the same operative session. The use of this modifier is only applicable to services/procedures performed on identical anatomic sites, aspects or organs. Some CPT codes, by definition, are bilateral in nature, and it would not be appropriate to add the bilateral modifier to those services (e.g., removal of impacted cerumen).

**Example:** A patient comes in to the family physician’s office to have joint injections in both the right and left elbows. Because the physician does the exact same procedure twice, once on the right and once on the left, the service is reported as a bilateral service appending the -50 modifier to the CPT code for intermediate joint injection.

Diagnostic and therapeutic procedures may require the use of the bilateral modifier if the anatomic structures are found bilaterally and an identical procedure is performed on both sides.
**Modifier -51** is used to report multiple procedures, other than E/M services, that are performed at the same session by the same provider. The primary procedure or service should be reported as listed. The additional procedure(s) or service(s) should be identified by attaching the -51 modifier to the additional procedure or service.

*Example:* A patient goes to her family physician’s office complaining of a four-week history of pain in her right lateral epicondyle and right deltoid region. She has been caring for her grandchildren ages two and seven years of age and finds it difficult to lift them because of the pain in her arm and shoulder. She receives Kenalog injections in the right elbow and shoulder.

This service is billed as multiple procedures rather than bilateral procedures, because the injections were given in different sites, and they are two different procedure codes. The shoulder injection is billed as the primary procedure using the appropriate CPT code for a joint injection of a major joint. There is no modifier appended to that procedure. The elbow injection is billed as the additional procedure, using the CPT code for intermediate joint injection and the -51 modifier is appended to that CPT code.

It is customary for third-party payers to discount the payment for the additional procedure(s). For this reason, it is important that the physician list the most comprehensive procedure/service first on the claim form with no modifier attached and apply the modifier (-51) to the additional or less comprehensive service.

**Modifier -52** is used to report a service that has been partially reduced or eliminated at the physician’s discretion. The service provided can be identified by its usual procedure number and appended with the modifier -52 to indicate that the service is reduced. This modifier provides a means of reporting reduced services without disturbing the identification of the basic service.

Documentation should be present in the medical record explaining the circumstances surrounding the reduction in the service. Some third-party payers may require the submission of this documentation with the claim to allow the payer to access the correct payment.

*Example:* A patient presents to the physician’s office with the chief complaint of wrist pain after falling from a chair at home. Anteroposterior (AP) and lateral x-ray views of the wrist revealed a Colles’ fracture of the right wrist. The family physician performed a closed treatment with manipulation. Following the treatment, the physician ordered a post-reduction x-ray.

The closed treatment of the fracture would be reported with the CPT code for that service, along with the appropriate codes for both x-rays. The first x-ray code would not be appended with a modifier. However, the second x-ray code would require the -52 modifier to indicate it was a limited comparative radiographic study.

**Modifier -55** is used when one physician performs the postoperative management for another physician who previously performed the surgical procedure. The modifier is used to identify the postoperative
management service. The physician who performs the postoperative management reports the operative procedure code with the -55 modifier appended.

**Example:** A cardiothoracic surgeon performed a percutaneous balloon valvuloplasty on the patient’s pulmonary valve due to pulmonary value insufficiency. The surgeon followed this patient in the hospital, but upon discharge wrote a transfer of care order to the patient’s family physician in a community near the patient’s home, to follow up with postoperative care.

The family physician who assumes the postoperative care for this patient would report the CPT code for the valvuloplasty appended with the -55 modifier after the first post-discharge visit with the patient.

**Modifier -79** is used to report the performance of an unrelated procedure or service during the postoperative period of another procedure or service. This modifier is used only to indicate that the unrelated procedure was performed by the same physician during the postoperative period of the original procedure.

A different diagnosis code should be reported, linked to the unrelated procedure. Failure to use this modifier when appropriate may result in denial of the subsequent surgery or procedure claim.

**Example:** A patient who is currently being treated for a non-displaced right Colles fracture comes to the family physician’s office complaining of pain and swelling of the left knee. Upon examination the physician determines there is fluid under the knee cap and subsequently does an aspiration of fluid from that knee. The arthrocentesis of the left knee would be billed with the appropriate CPT code appended with the -79 modifier.

**Modifier -80** is used to report surgical assistant services. From a CPT coding perspective, this modifier is intended to be used to report physician services. Many users, however, report these modifiers for a variety of non-physician surgical assistant services.

**Example:** The family physician’s patient is undergoing a balloon angioplasty by the cardiac surgeon. Because the family physician has a special interest in his cardiac patients, and has had the appropriate training, the surgeon asks the family physician to be the assistant surgeon for this patient. The family physician will bill exactly the same CPT code for the angioplasty that the surgeon bills, but will append the -80 modifier to his service.

The most common misinterpretation of the assistant surgeon modifier(s) is to report physician assistant (PA) or nurse practitioner (NP) assistant surgical services. Some third-party payers do consider this an acceptable means of reporting non-physician assistants during surgery. Many have established their own guidelines for reporting assistant surgeon services. Each practice should check with the various third-party payers with whom they contract to review their guidelines for billing for surgical assistance.

Payment for surgical assistant services also varies by third-party payer. While Medicare traditionally allows 16 percent of a surgeon’s fee for the surgical assistant, other payers sometimes allow between 16 and 22 percent.
A Listing of HCPCS Level II Modifiers:

The following list is not an exclusive listing of HCPCS Level II modifiers, but are some of the modifiers more commonly used by family physicians. We list them here as a reminder to consider their use when appropriate. Please refer to the current edition of HCPCS Level II National Codes for the appropriate use of each modifier.

<table>
<thead>
<tr>
<th>HCPCS Level II Modifiers – Partial List</th>
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<tbody>
<tr>
<td>AG – Primary physician</td>
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<tr>
<td>AQ – Physician service HPSA area</td>
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<tr>
<td>AR – Physician scarcity area</td>
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<tr>
<td>AS – Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery</td>
</tr>
<tr>
<td>E1 – Upper left, eyelid</td>
</tr>
<tr>
<td>E2 – Lower left, eyelid</td>
</tr>
<tr>
<td>E3 – Upper right, eyelid</td>
</tr>
<tr>
<td>E4 – Lower right, eyelid</td>
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<tr>
<td>F1 – Left hand, second digit</td>
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<tr>
<td>F2 – Left hand, third digit</td>
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<tr>
<td>F3 – Left hand, fourth digit</td>
</tr>
<tr>
<td>F4 – Left hand, fifth digit</td>
</tr>
<tr>
<td>F5 – Right hand, thumb</td>
</tr>
<tr>
<td>F6 – Right hand, second digit</td>
</tr>
<tr>
<td>F7 – Right hand, third digit</td>
</tr>
<tr>
<td>F8 – Right hand, fourth digit</td>
</tr>
<tr>
<td>F9 – Right hand, fifth digit</td>
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<tr>
<td>FA – Left hand, thumb</td>
</tr>
<tr>
<td>GA – Waiver of liability statement on file (ABN - Medicare patients)</td>
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<tr>
<td>GC – this service has been performed in part by a resident under the direction of a teaching physician</td>
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<tr>
<td>GE – this service has been performed by a resident without the presence of a teaching physician under the primary care exception</td>
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<tr>
<td>GP – services delivered as part of an outpatient physical therapy plan of care</td>
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<tr>
<td>GV – attending physician, not hospice</td>
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<tr>
<td>GW – service not related to the hospice patient’s terminal illness</td>
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<tr>
<td>GY – item or service statutorily excluded or does not meet the definition of any Medicare benefit</td>
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<tr>
<td>LT – left side</td>
</tr>
<tr>
<td>PT – Colorectal cancer screening test; converted to diagnostic test or other procedure.</td>
</tr>
<tr>
<td>Q5 – service furnished by a substitute physician under a reciprocal billing arrangement</td>
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<tr>
<td>Q6 – services furnished by a locum tenens physician</td>
</tr>
<tr>
<td>QW – CLIA waived test</td>
</tr>
<tr>
<td>SA – Nurse practitioner rendering service in collaboration with a physician</td>
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<tr>
<td>T1 – Left foot, second digit</td>
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<tr>
<td>T2 – Left foot, third digit</td>
</tr>
<tr>
<td>T3 – Left foot, fourth digit</td>
</tr>
<tr>
<td>T4 – Left foot, fifth digit</td>
</tr>
<tr>
<td>T5 – Right foot, great toe component</td>
</tr>
<tr>
<td>T6 – Right foot, second digit</td>
</tr>
<tr>
<td>T7 – Right foot, third digit</td>
</tr>
<tr>
<td>T8 – Right foot, fourth digit</td>
</tr>
<tr>
<td>T9 – Right foot, fifth digit</td>
</tr>
<tr>
<td>TA – Left foot, great toe TC – technical</td>
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</tbody>
</table>

There are many more HCPCS Level II modifiers available. Check your current HCPCS Level II manual for appropriate selection.
Chapter Six

Do Not Forget to Bill for These Services Which Family Physicians Typically Provide
The Visit for Surgical Clearance

Family physicians are frequently asked to perform “surgical clearance” on an existing patient before the patient undergoes a surgical procedure by a surgeon. The question is then asked - is this a new patient visit, established patient visit or a consultation?

Often, this service is a consultation if all the parameters of a consultation are met:

1. There is a request from a physician for the family physician’s opinion and/or advice (can this patient withstand the operation?);

2. There is a reason for the consultation (what does the surgeon need to know about the patient’s underlying illnesses or condition during this operative period?); and

3. A report goes back to the requesting source (your report of clearance or clearance with modifications). The service should then be billed at the appropriate level of either outpatient or inpatient consultation for all non-Medicare patients.

Even if you are treating the patient or managing the problem in question, as long as the three criteria for consultation are met, that would be the appropriate service to bill. If it is a Medicare patient, then a new patient visit or an established patient visit should be billed. If it is an established patient, then a higher level of service (99214 or 99215) would most likely be appropriate as the history would be expected to be complete, as well as the examination, even if the medical decision making was not as complex.

The preventive medicine services codes (99385-99387 and/or 99394-99397) would not be appropriate to use for pre-operative consultation services, since the patient is coming in to be seen for a specific reason – pre-operative clearance – and this service would not be considered preventive medicine.

Remember, when it is a surgical clearance, the primary diagnosis for the service would be an ICD-10-CM code that begins with a Z and indicates the service is a pre-procedural examination:

- Z01.810  Encounter for pre-procedural cardiovascular examination
- Z01.811  Encounter for pre-procedural respiratory examination
- Z01.812  Encounter for pre-procedural laboratory examination (blood and/or urine)
- Z01.818  Encounter for other pre-procedural examination

The secondary diagnosis would then be the underlying illness for which they are being treated by the family physician. An additional secondary diagnosis would be the reason for the surgery. You will most likely need to report the Type 1 NPI of the requesting physician on the claim as well.

Family physicians sometimes lose payment to which they are entitled because these services are billed incorrectly.
PREVENTIVE MEDICINE SERVICES - Well Exams/Checks

Preventive Medicine services are often referred to as “well checks” or “annual exams.” The extent and focus of these services is largely dependent on the age of the patient. The CPT codes are differentiated by new patient (99381 – 99387) versus established patient (99391 – 99397) and are age sensitive.

The “comprehensive” nature of Preventive Medicine services reflects an age and gender appropriate history and exam and is NOT synonymous with the “comprehensive” history and examination required in other E/M services (99201 – 9350).

The comprehensive history for Preventive Medicine services:
- Is not problem oriented
- Does not include a Chief Complaint or Present Illness
- Does include a comprehensive Systems Review
- Does include a comprehensive or interval Past, Family and Social History
- Does include a comprehensive history of pertinent Risk Factors

The comprehensive examination is multi-system, but the extent of the exam is based on the age of the patient and risk factors identified.

There is no medical decision making required for Preventive Medicine services.

Third party payers have varying payment policies governing the payment for these services. With the passage of the ACA (Affordable Care Act), however, payers allow the services at least annually for children, adolescents, teens and adults with no cost sharing for the patient (no co-payment, co-insurance or deductible). Services for newborns and infants are often allowed more frequently.

The service codes do include counseling, anticipatory guidance or risk factor reduction interventions provided at the time of the preventive medicine service. If those services are provided at a separate encounter or visit, then the services should be billed using one of the counseling codes identified by either individual counseling or group counseling. These counseling services might include such things as weight reduction, smoking cessation or general nutrition counseling (non-illness related).

It is preferable for the physician practice to ask the patient to verify coverage with his/her insurance company before the physician provides a preventive medicine service.
ANNUAL/ SCREENING/PREVENTIVE SERVICES

“Annual Physical” is a commonly used term by patients and physicians. However, there is no CPT code for such a service. Some may limit the term to mean exam, others may include various screening and diagnostic studies. Some physicians may also perform problem oriented services at the same time at such a visit. There are, however, Preventive Visit codes that are used to describe this service.

Preventive Medicine is an important part of any family practice and it is important that family physicians understand how to accurately use these codes to receive appropriate payment for the services provided to their patients.

Preventive Services and the Non-Medicare Patient

Remember the codes (CPT 99381 – 99387 and 99391 – 99397) are divided into services provided to new patients and services provided to established patients, and each code is assigned a patient age range. Each service requires an age and gender appropriate history and exam. There is no medical decision making element required for these services.

The appropriate diagnosis code for preventive services should be something in the Z00.1 (newborn, infant and child health exams) category for infants and children and a code in the Z00.0 category for adults (adult medical exam). If special screening studies or vaccinations are given in the course of the preventive service, then an appropriate diagnosis code (Z23 – encounter for immunization) should be used for that service.

Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory and/or radiology and other procedures, or screening tests, such as vision, hearing and developmental tests, that can be identified with a specific CPT code are reported separately in addition to the code for the preventive visit.

The Affordable Care Act (ACA) provides, that effective September 23, 2010, on renewal, all commercial health plans, including self-insured ERISA plans, must cover certain preventive services. There is no cost sharing allowed for these preventive services meaning the patient should not incur any out-of-pocket expense. It is important, however, to understand that there are guidelines associated with what may be considered preventive. The basics of this provision of the ACA are spelled out in Federal Register Volume 75, No. 137 July 19, 2010.

Some payers will pay for such preventive services, but only if they are provided in one of the insurance company’s designated “Centers of Excellence.” Check with your payers for their current policies and guidelines.

Preventive/Screening Services and the Medicare Patient

In recent years, Congress has added important screening services to Medicare’s benefit package. These services include:

- Initial Preventive Physical Exam (IPPE) – also known as the “Welcome to Medicare Visit”
- Annual Wellness Visit (AWV) – both initial and subsequent
- Abdominal Aortic Aneurysm (AAA) Screening
- Cardiovascular Disease Screening
- Diabetes Screening Tests
- Diabetes Self-Management Training (DSMT)
- Medical Nutrition Therapy (MNT)
- Screening Pap Tests
- Screening Pelvic Exam
- Screening Mammography
- Bone Mass Measurements
- Colorectal Cancer Screening
- Prostate Cancer Screening
- Glaucoma Screening
- Seasonal Influenza Virus Vaccine
- Pneumococcal Vaccine
- Hepatitis B (HBV) Vaccine
- Counseling to Prevent Tobacco Use
- Human Immunodeficiency Virus (HIB) Screening

Make sure you use the appropriate diagnosis when billing Medicare for these services. Some of the above services may be subject to frequency and payment limitations. Check the most current information available in Medicare’s Quick Reference Chart to confirm the appropriate HCPCS/CPT codes, and ICD-10-CM codes to use, as well as who is covered, the frequency and payment guidelines.

The Annual Wellness Visit – Medicare Patients

In 2011, Medicare patients became eligible to receive an Annual Wellness Visit (AWV) with a Personalized Prevention Plan (PPPS). Both the deductible and copayment/coinsurance are waived for this service. Two HCPCS Level II codes were established to report the initial AWV and all subsequent visits.

The visits are focused on initiating and updating the patient’s personal prevention plan, as opposed to an actual physical exam. To manage patient expectations of the type of visit an AWV is, and the fact that it is not intended to be a visit where new or existing health problems are dealt with, a simple one-page explanation of the AWV and what will be covered is a good proactive tool to use. An example of such a letter can be found in the July/August 2011 issue of Family Practice Management.

The payment for these services roughly equals a level four visit and can present an opportunity for some increased revenue to any family practice if administered effectively and efficiently. For example, if a family physician does an average of five subsequent AWVs for Medicare patients per week, annually that would be additional revenue of approximately $30,000 for the physician.

The requirements for an Initial AWV (G0438) are different than the requirements for the subsequent visits. Included in the Initial AWV with PPPS are:
• Establishment of an individual’s medical/family history – using a health history questionnaire is accepted.

• Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual – establish this list so that providers may be added and deleted as needed.

• Measurement of an individual’s height, weight, BMI (or waist circumference, if appropriate), BP and other routine measurements as deemed appropriate, based on the beneficiary’s medical/family history.

• Detection of any cognitive impairment that the individual may have as defined in the ACA.

• Review of the individual’s potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.

• Review of the individual’s functional ability and level of safety based on direct observation, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

• Establishment of a written screening schedule for the individual, such as a checklist for the next five to ten years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual’s health status, screening history and age-appropriate preventive services covered by Medicare.

• Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risk and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention and nutrition.

• Any other element(s) determined appropriate by the Secretary of Health and Human Services through the National Coverage Determination (NCD) process.

The services provided in the subsequent AWV (G0439) are a somewhat different, but for the most part, are an update of those things required for the initial AWV:

• An update of the individual’s medical/family history - provide a mechanism on the initial health history the patient completes, for multiple year updates or require the patient to complete a new questionnaire annually, as many practices do.
• An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing PPPS.

• Measurement of an individual’s weight (or waist circumference), BP and other routine measurements as deemed appropriate, based on the individual’s medical/family history.

• Detection of any cognitive impairment that the individual may have, as defined in ACA.

• An update to the written screening schedule for the individual as defined in the ACA and developed in the first AWV.

• An update to the list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are under way for the individual, as developed at the first AWV.

• Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.

• Any other element(s) determined by the Secretary through the National Coverage Determination (NCD) process.

Here are some tips for efficiently and effectively providing these new services to the Medicare patients in your practice:

1. Non-physician practitioners – NPs, Pas and CNS – can provide these services. If you have those professionals in your practice, have them provide these services.

2. Use your ancillary staff effectively – they can take histories, administer questionnaires, update lists and provide resources.

3. Put your Medicare patients on the practice recall system for this service. It not only reminds the patient to make an appointment for the service, it should also spread the delivery of this service out so that the practice is not bombarded at the beginning of each year with requests for the service.

4. Be cognizant of the time sensitivity of providing these services to the patient. For those patients that become eligible for Medicare throughout the year, remember these AWVs are subsequent to the patient’s IPPE (initial preventive physical exam). The Medicare patient should receive the IPPE during his/her first twelve months of eligibility for Medicare and the initial AWV needs to be at least 12 months after the effective date of the patient’s Medicare coverage. If a claim for an AWV is submitted within the first 12 months after the effective date of the beneficiary’s first Medicare Part B coverage, it will be denied as that beneficiary is eligible for the IPPE or “Welcome to Medicare” physical.
The initial AWV is a “once in a lifetime” service. If a patient has had that service elsewhere and a second claim for the service is billed, it will be denied with a remark code indicating the lifetime benefit maximum has been reached for the benefit.

5. Be aware that the AWV service can be provided on the same day as another E/M service. To report that both services are separate and payable, append the -25 modifier to any other illness-related E/M service done on the same date. **Do not put the modifier on the G0438 or G0439 that is used to report the AWV.**

To access visit templates that will help document the elements of the AWV on visit the AAFP’s popular *Medicare Preventive Physical Exam (‘Annual Wellness Visit’)* Tool.
PHYSICAL EXAMS THAT DO NOT HAVE CPT CODES (Sports, Camp, DMV) – Make Sure You Get Paid for These Services

Millions of students take part in community and school sports activities each year. Students are likely required to provide proof that they are healthy enough to participate.

Family physicians also provide physicals for camp, pre-employment, DMV, adoption agencies and other types of administratively requested exams. Insurance plans, often, do not pay for these types of physicals, even though they are important for the patient to have.

Because CPT does not have a code to report any of these types of physicals, family physicians are often uncertain about how to bill for them. You have a couple of options, but each requires a proactive effort to determine what the patient’s health plan covers and how best to report the services.

Perform a full preventive service and bill the health plan. Most payers pay for one preventive exam annually. Where this is the case, using the benefit for a limited sports physical is not advantageous to the physician’s practice or the patient. If the patient has not had a full preventive service in the last year, the practice’s scheduler should inform the parent or patient when he or she calls for an appointment that a full preventive service is recommended and that the requested physical form can be filled out in conjunction with the preventive visit.

Perform the physical and bill the patient. For cases where the patient’s preventive service benefit has been exhausted by a full preventive exam in the last year or the patient’s health plan will not pay for the service under any circumstances, you should set a fee and instruct your scheduling staff to inform anyone wishing to schedule a physical for any of these purposes, that it must be paid for at the time of service.

Most practice management (billing) systems allow you to set up codes for services that are not billed to insurance. These are often alphabetical codes, which avoids confusion with CPT codes – e.g. “sport,” “DMV,” “camp,” “adoption.” This enables the practice to track utilization data and to generate itemized statements. You should ensure that the statement provides a detailed description of the service for the benefit of parents and patients with health care savings accounts (HSA) and those who track health care expenses for tax purposes.

Use the Appropriate ICD-10-CM Code for the service. You will want to insure that the correct diagnosis code is used to report these types of exams. Some examples are:

- Z02.0 Encounter for examination for admission to educational institution (school exam)
- Z02.1 Encounter for pre-employment examination
- Z02.2 Encounter for examination for admission to residential institution
- Z02.3 Encounter for examination for recruitment to armed forces
- Z02.4 Encounter for examination for driving license (DMV)
- Z02.5 Encounter for examination for participation in sport (sports physical)
- Z02.6 Encounter for examination for insurance purposes
- Z02.71 Encounter for disability determination
- Z02.82 Encounter for adoption services
CARE PLAN OVERSIGHT

Care Plan Oversight (CPO) is physician supervision of patients under either a home health or hospice agency where the patient requires complex or multi-disciplinary care modalities involving:

- Regular physician development and/or revision of care plans;
- Review of subsequent reports of patient status;
- Review of laboratory and other studies;
- Communication with other health professionals not employed in the same practice who are involved in the patient’s care;
- Integration of new information into the care plan, and/or;
- Adjustment of medical therapy

Effective January 1, 1995, CMS extended Medicare coverage for CPO services and allowed separate payment for CPO services exceeding 30 minutes per month only for those patients who are receiving Medicare covered home health or hospice benefits.

**REMINDER: Medicare does not pay for care plan oversight services for nursing facility or skilled nursing facility patients.**

Under the provisions of the Balanced Budget Act of 1997, nurse practitioners, physician assistants and clinical nurse specialists, practicing within the scope of State law, may also bill for care plan oversight. These non-physician practitioners must be providing ongoing care for the beneficiary through E/M services, but not if they are involved only in the delivery of the Medicare covered home health or hospice service.

**CPT Codes**

Effective for claims submitted January 1, 1998 and after, three new CPT codes for CPO services differentiate among patients receiving home health, hospice and nursing facility services. Physicians must use CPT code 99375 to bill CPO services for beneficiaries receiving Medicare covered home health services and CPT code 99378 to bill CPO services for beneficiaries receiving Medicare covered hospice services. The last code, CPT code 99380, is a bundled status code and does not allow a separate payment since payment for care planning for nursing home patients is bundled into the physician’s payment for E/M services.¹ The CPT descriptions follow:

<table>
<thead>
<tr>
<th>99375</th>
<th>Physician supervision of a patient under care of home health agency</th>
<th>30 minutes or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician supervision of a patient under care of home health agency <strong>G0181</strong> (patient not present) requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient’s care, integration of new information into the medical treatment plan and/or adjustment of the medical therapy, within a calendar month.</td>
<td>30 minutes or more</td>
</tr>
</tbody>
</table>

¹ The CPT descriptions follow:
| 99378 | **Physician supervision** of a hospice patient (patient not present) requiring **G0182** complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone) with other health care professionals involved in patient’s care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month. | 30 minutes or more |
| 99380 | **Physician supervision** of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone) with other health care professionals involved in patient’s care integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month. | 30 minutes or more |

**Conditions of Coverage**

The physician cannot bill CPO services with other services on the same claim. **CPO services must be billed separately.** Physicians must bill care planning only once per calendar month and must bill only one month’s services per line item. The claim must not be submitted until after the end of the month in which the service was performed.

**Other conditions of coverage:**

- The beneficiary must require complex or multi-disciplinary care modalities requiring ongoing physician involvement in the patient’s plan of care;
- The beneficiary must be receiving Medicare covered home health care or hospice services during the period in which the care plan oversight services were furnished;
- The physician who bills CPO must be the same physician who signed the home health or hospice plan of care;
- The physician must furnish at least 30 minutes of care plan oversight (see countable services) within the calendar month for which payment is claimed and no other physician has been paid for care plan oversight within that calendar month;
- The physician must have provided a covered physician service that required a face-to-face encounter with the beneficiary within the six months immediately preceding the provision of the first care plan oversight service (face-to-face encounter does not include EKG, lab services or surgery);
The care plan oversight billed must not be routine post-operative care provided in the global surgical period of a surgical procedure billed by the physician;

- For beneficiaries receiving Medicare covered home health services, the physician must not have a significant financial or contractual interest in the home health agency as defined in 42 CFR 424.22 (d);
- For beneficiaries receiving Medicare covered hospice services, the physician must not be the Medical Director or an employee of the hospice or providing services under arrangements with the hospice;
- The care plan oversight services must be personally furnished by the physician who bills them;
- Services furnished “incident to” a physician’s service do not qualify as CPO and do not count toward the 30-minute requirement;
- The physician may not bill CPO during the same calendar month in which he/she bills the Medicare monthly capitation payment ESRD benefit) for the same beneficiary; and
- The physician billing for care plan oversight must document in the patient’s record, which services were furnished and the date and length of time associated with those services.

**Countable Services**

The following activities are countable services toward the 30-minute minimum requirement for care plan oversight:

- Review of charts, reports, treatment plans or lab or study results, except for the initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.
- Telephone calls with other health care professionals (not employed in the same practice) involved in the care of the patient.
- Team conference (time spent per individual patient must be documented).
- Telephone or face-to-face discussions with a pharmacist about pharmaceutical therapies.
- Medical decision making.
- Activities to coordinate services are countable if the coordination activities require the skills of a physician.

**Non-Countable Services**

The following activities are services not countable toward the 30-minute requirement:

- Services furnished by nurse practitioners, physician assistants, clinical nurse specialists (except services described above) and other non-physicians cannot be billed under the care plan oversight service. This includes the time spent by staff getting or filing charts, calling HHAs, patients, etc.
- The physician’s telephone call to patient or family, even to adjust medication or treatment and the physician’s time spent telephoning prescriptions to the pharmacist are not countable since these activities do not require physician work or meaningfully contribute to the treatment of the illness or injury.
• Travel time, time spent preparing claims and for claims processing
• Initial interpretation or review of lab or study results that were ordered during or are associated with a face-to-face encounter.
• Low intensity services included as part of other E/M services.
• Informal consults with health professionals not involved in the patient’s care.
• The physician’s time spent discussing with his/her nurse and conversations the nurse had with the HHA do not count toward this 30-minute requirement. However, the time spent by the physician working on the care plan after the nurse had conveyed the pertinent information to the physician is countable toward the 30-minutes.
• Only one physician per month will be paid for CPO for a patient. Other physicians working with the physician who signed the plan of care are not permitted to bill for these services.
• The work included in hospital discharge day management (99239-99239) and discharge from observation (99217) is not countable toward the 30 minutes per month required for the billing of care plan oversight. Physicians may bill for work on the same day as discharge, but only for those services separately documented as occurring after the patient is actually physically discharged from the hospital.

Documentation Requirements

A review of CPO claims by Medicare carriers has shown that several home health agencies and hospices have provided the documentation to support a physician’s CPO claim. Moreover, they are also providing physicians with standardized activity summaries to document the time spent with the patient. Per Medicare, this policy is not consisted with their policy guidelines.

Medicare tells us a signed treatment plan is NOT sufficient documentation that significant complex medical management requiring the integration of new information into the plan of care or the adjustments in the medical therapy was furnished by the physician.

1. Documentation to support a physician claim that 30-minutes or more of CPO services have been provided during the calendar month for a certain patient must be prepared and signed by the physician who provided the CPO services. Two documentation log examples are provided in the following pages.

   a. The physician must document which services were furnished and the date and length of time associated with those services.

   b. CPO documentation without the billing physician’s signature will result in the denial of the service.

   c. Only a handwritten signature of the physician is acceptable for the CMS form 485 (Home Health Certification and Plan of Care). Medicare will not cover home health CPO services when the billing physician uses stamp signatures on the CMS form 485.

2. Documentation prepared by home health agencies (HHAs) or hospice may not be used in lieu of a physician’s documentation.

3. Documentation must support the necessity and reasonableness of the CPO service.
Claim Submission Requirements

Care plan oversight services are billed separately from E/M codes for office/outpatient, hospital, home, nursing facility or domiciliary services.

The physician is responsible for obtaining the Medicare provider number of the HHA or hospice that is responsible for the plan of care he/she has signed for the beneficiary and which is rendering Medicare covered services to the beneficiary. CMS has temporarily waived the requirement to include the HHA or Hospice provider number on a CPO claim, but once (and if) that requirement is re-instated physicians must submit the 6-character Medicare provider number of the HHA or hospice rendering the covered Medicare service during the period in which the CPO was furnished.

The date of service entered on the claim form must be the first and last dates for the month that care planning services were actually provided and documented, not the calendar month that the claim is being submitted. Submit claims after the end of the month in which services were rendered.

- The HHA or hospice plan must be signed before CPO services are billed. The physician who bills for CPO services must be the same physician who signed the home health or hospice plan of care.

Claims for CPO services will be denied when a review of beneficiary claim history files fails to identify a covered physician service requiring face-to-face encounter by the same physician during the six-month period preceding the provision of the first CPO service. E/M codes in the ranges of 99201-99263 or 99281-99357 are considered evidence that a face-to-face encounter occurred.

Patient Awareness

Typically, care plan oversight services do not involve a face-to-face encounter between the patient and the physician. Therefore, the patient may not be aware that the services were provided. Physicians can help by informing their patients that Medicare will pay for these services when the specified conditions are met. Medicare Summary Notice (MSN) statements will notify beneficiaries of the allowed care plan oversight services.

1,2,3 As of January 1, 2001, Medicare will no longer pay for services billed with codes 99375 and 99378. CPT 2001 definition of CPO includes medical professionals’ telephone calls to “others involved in the patients’ care,” including family members. Medicare allows payment for phone calls only to other “medical professionals.”

Two HCPCS (Level II) codes have been established that retain the 2000 CPT definitions and allow payment:

G0181 – Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care.

G0182 – Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary.
CARE PLAN OVERSIGHT LOG SHEET

Patient: ___________________________ DOB: __/__/__

Month of Service: _________________ Home Health Agency/Hospice Name: ___________

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Total Daily Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certification (15 min)</td>
<td></td>
</tr>
<tr>
<td>Re-Certification (10 min)</td>
<td></td>
</tr>
<tr>
<td>Review Pt. Reports (3-4 min)</td>
<td></td>
</tr>
<tr>
<td>Lab Reviews (3-4 min)</td>
<td></td>
</tr>
<tr>
<td>Imaging Reports (5-6 min)</td>
<td></td>
</tr>
<tr>
<td>Phys. Therapy Orders (4-5 min)</td>
<td></td>
</tr>
<tr>
<td>Signature (2 min)</td>
<td></td>
</tr>
<tr>
<td>Medicine Changes (7-10 min)</td>
<td></td>
</tr>
<tr>
<td>Orders (4-5 min)</td>
<td></td>
</tr>
<tr>
<td>Phone Call (15-20 min)</td>
<td></td>
</tr>
<tr>
<td>“FYI” Notices (2 min)</td>
<td></td>
</tr>
<tr>
<td>Medical Supply Rx (2-3 min)</td>
<td></td>
</tr>
<tr>
<td>Other (explain)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total of ALL Time:</strong></td>
</tr>
</tbody>
</table>

Billing Code (check one):  [ ] G0179 RE-CERTIFICATION  G0180 [ ] CERTIFICATION
[ ] G0181 Physician supervision of a patient receiving Medicare-covered services provided by a participating HOME HEALTH AGENCY (patient not present) requiring complex and multidisciplinary care (30 minute or more)
[ ] G0182 Physician supervision of a patient under Medicare-approved HOSPICE (patient not present) requiring complex and multidisciplinary care (30 minutes or more)

DX:

Physician Signature:  Form MUST be signed by Physician to verify billing
# CARE PLAN OVERSIGHT LOG SHEET

Patient Name:__________________________ Agency Name:__________________________

<table>
<thead>
<tr>
<th>Date (mo/day/yr)</th>
<th>Development of Care</th>
<th>Revision of Care Plan</th>
<th>Review of Patient Reports</th>
<th>Lab Reviews</th>
<th>Diagnostic Test Reviews</th>
<th>Communication with Other Healthcare Professionals</th>
<th>Integration of New Info into Treatment Plan</th>
<th>Adjustment of Medical Therapy</th>
<th>Other (Define)</th>
<th>Total Time</th>
</tr>
</thead>
</table>

Physician Signature:__________________________ Total Time: __________

(Form Must Be Signed By Physician Before Billing)
Physician Certification and Recertification of Home Health Plans of Care

Many family physicians sign Home Health Plans of Care on a routine basis and fail to bill for this service to many payers (including Medicare). Use HCPCS code G0180 for the certification and HCPCS G0179 for the recertification and development of plans of care for Medicare-covered home health services. The home health agency certification code (G0180) can only be billed when the patient has not received Medicare-covered home health services for at least 60 days.

The home health agency recertification code (G0179) is used after a patient has received services for at least 60 days (or one certification period) when the physician signs the certification after the initial certification period. Code G0179 will be reported only once every 60 days, except in the rare situation when the patient starts a new episode before 60 days elapses and requires a new plan of care to start a new episode.
TRANSITIONAL CARE MANAGEMENT (TCM)

Transitional Care Management Services is the transition in care of a patient:
   From: Health care facilities → To: The patient’s community setting:
   • Inpatient Hospital
   • Partial Hospital
   • Observation Status
   • Skilled Nursing Facility / Nursing Facility
   • Home
   • Domiciliary
   • Rest Home
   • Assisted Living

Transitional Care Management Services require:
   • A face-to-face visit within the specified time frames.
   • Interactive contact with the patient or caregiver within two business days of discharge and may be direct (face-to-face), telephonic or by electronic means.
   • Medication reconciliation and management no later than the date of the face-to-face visit.

These codes are:
   • Reported once per patient within 30 days of discharge.
   • Are selected based on medical decision making and the date of the first face-to-face visit.
   • May be reported by only one individual.

The codes used to report these services are:

99495     Transitional Care Management Services with the following required elements:
   • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge.
     o This will require good coordination with the hospital about the discharge date.
   • Medical decision making of at least moderate complexity during the service period.
   • Face-to-face visit, within 14 calendar days of discharge.

99496     Transitional Care Management Services with the following required elements:
   • Communication (direct contact, telephonic, electronic) with the patient and/or caregiver within two business days of discharge.
   • Medical decision making of high complexity during the service period.
   • Face-to-face visit, within seven calendar days of discharge.

Some specifics about these codes and this service:
   • Additional E/M services reported separately should be on subsequent dates after the first face-to-face visit.
   • The physician must specify that the discharge service may not constitute the required face-to-face visit. Instead, the day of discharge counts as day one of the 30-day period; the two business days for contacting the patient begin after the discharge.
   • TCM is not reportable in the postoperative period of a service by the same individual who reported the operative service.

Access AAFP’s 30-day worksheet to document TCM services appropriately.
CHRONIC CARE MANAGEMENT AND COMPLEX CHRONIC CARE MANAGEMENT SERVICES (CCMS)

CMS (Medicare) now pays for Chronic Care Management Services. CMS expects this service to be most frequently billed by primary care physicians, though specialists who meet the requirements may also bill for the service. Further, the California Medical Association (CMA) believes that non-physician providers that may furnish the full range of these services include nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwives. They recognize that many CCMS will be furnished “incident to” a physician’s services. If provided in compliance with applicable state law, time spent by a clinical staff person furnishing aspects of CCMS outside the practice’s normal business hours during which there is no direct physician supervision would count toward the time requirement to bill for the service, even though the services do not meet the direct supervision requirement for “incident to” services.

Other requirements:

1. Before a practitioner can furnish or bill for CCMS, eligible beneficiaries must be informed about the availability of these services, how they are accessed, how the patient’s information will be shared with other providers in the care team and that cost-sharing applies to CCMS even when they are not delivered face-to-face (i.e., the Medicare patient has some financial responsibility).

2. A written or electronic copy of the care plan is required to be provided to the beneficiary and must be documented in the patient’s EHR. Further, CMS recommends that a practitioner furnishes an annual wellness visit (AWV) or initial preventative physical examination (IPPE) prior to furnishing CCMS.

3. Beneficiaries must provide consent at the outset to receive CCMS and document in the medical record that the CCMS were explained and offered to the patient. While revocation of the agreement to provide CCMS is not effective until the end of a current 30-days period, a beneficiary may do so at any time. Subsequent to revocation, a beneficiary may choose to seek CCMS from a different practitioner, who would then need to fulfill all the requirements for billing this service.

In addition to the required CCMS components, CMS requires that providers have to meet certain standards that will require additional investments in staff training and technology, such as a certified EHR that meets the most recent regulatory standard for meaningful use that practitioners would need to be able to access 24 hours a day, seven days a week.

As clarified by CPT, care coordination activities performed by clinical staff typically include:

- Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers and/or other professionals regarding aspects of care;
- Communication with home health agencies and other community services utilized by the patient;
- Collection of health outcomes data and registry documentation;
- Patient and/or family/caretaker education to support self-management, independent living and activities of daily living;
- Assessment and support of treatment regimen adherence and medication management;
- Identification of available community and health resources;
- Facilitating access to care and services needed by the patient and/or family; and
- Development, communication and maintenance of a comprehensive care plan.

CPT further identifies that the care coordination office/practice must have the following capabilities:
- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff;
- Use a standardized methodology to identify patients who require chronic complex care coordination services;
- Have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner;
- Use a standardized form and format in the medical record; and
- Be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

The CPT codes used to report Chronic Care Management Services and Complex Chronic Care Management Services are as follows:

**99490** Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following required elements:
- Multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient.
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation or functional decline.
- Comprehensive care plan established, implemented, revised or monitored.

*Chronic care management services of less than 20-minutes duration in a calendar month, cannot be reported separately.*

**99487** Complex chronic care management services, with the following required elements:
- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation or functional decline.
- Establishment or substantial revision of a comprehensive care plan.
- Moderate or high complexity medical decision making.
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

**99489** Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary service).

For a further discussion of CCMS and a description of its general components, access both the 2013 and 2014 *Update of Strategies for Coding, Billing and Getting Paid Appropriately.*
**ADVANCE CARE PLANNING**

Advance Care Planning has been recognized as a separately payable service and two CPT codes have been developed to report the service. For the first time, in 2016 Medicare will begin paying for the service. This service requires three basic elements:

1. A face-to-face meeting between physician/Qualified Health Professional (QHP) and patient, family, surrogate;
2. Counseling and discussing advance directives – the document which appoints an agent and/or records the wishes of patients pertaining to their medical treatment at a future time should they lack decisional capability at that time;
3. Completion of relevant legal forms. Note that it may be appropriate to complete the forms at the time of this visit, however, if the patient needs additional time and planning, the forms could be completed at a later date.

No active management of problems is undertaken during the time period reported for Advanced Care Planning. An E/M can be reported separately on the same day as this service except for the following services:

- Critical Care (99291 – 99292)
- Inpatient Neonatal and Pediatric Critical Care (99468 – 99476)
- Initial and Continuing Intensive Care of Neonate (99477 – 99480)

The CPT codes used to report advance care planning, which includes the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed) by the physician or other qualified health care professional are:

- **99497** First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- **99498** Each additional 30 minutes (list separately in addition to code for primary service)

CMS reminds us that these codes will be separately payable, beginning January 1, 2016 under these conditions:

1. When reasonable and necessary for the diagnosis or treatment of injury or illness.
   a. Deductible/Coinsurance applies.
2. As a voluntary, separately payable part of an annual wellness visits (AWV).
   a. Add the modifier -33 to the service when billed at the same times as the AWV because the AWV is considered a preventive service.
   b. No deductible/coinsurance applies.

The service can be billed
- On the same day as another E/M service – add modifier -25 to the other E/M service code.
- During a period covered by TCM, CCM or global surgery – make sure you appended an appropriate modifier.
At this time CMS has not applied any limitation on frequency of the planning service — it can be provided as needed, but it is not expected to be provided excessively. The 2016 National payment rates are $85.99 for CPT 99497 and $74.88 for CPT 99498.

PROLONGED SERVICES — CLINICAL STAFF

Prior to 2016 codes 99354 and 99355 were the only codes that could be reported for prolonged services provided face-to-face with the patient. These services, however, implied that the physician or qualified health care professional was providing the service. The development of new codes allows a method for reporting face-to-face services that are not provided by the physician/QHP of things that only require face-to-face observation by clinical staff under the supervision of a physician/QHP. Development of new codes allow for such reporting under specifically noted circumstances.

These things should be remembered when billing the new codes for this service (CPT 99415 for the first hour and CPT 99416 for each additional 30 minutes):

- The typical face-to-face time for the primary service is used in defining when prolonged services time begins.
- Less than 45 minutes is not reported separately.
- When face-to-face time is noncontiguous, use only the face-to-face time provided to the patient by the clinical staff.
- Use once per date of service.

CERUMEN REMOVAL

Removing impacted cerumen from the ear is something frequently done in the family medicine office. Sometimes it requires the use of instrumentation which must be done by the physician or other QHP and sometimes it can be removed with simple ear lavage performed by clinical staff. There are no CPT codes to differentiate the two types of removal. The cerumen, however, must be impacted, and documented as such, to utilize either of these codes. An E/M code should be reported when non-impacted cerumen is removed:

69209 Removal impacted cerumen using irrigation/lavage, unilateral

- Can be done by clinical staff.
- Medicare does not recognize service as unilateral.
- Only practice expense value has been assigned this service (no physician work).

69210 Removal impacted cerumen requiring instrumentation, unilateral

- Must be done by a physician or other QHP.
- Medicare does not recognize service as unilateral.
Using and Billing for Non-Physician Medical Providers

Many Family Physicians find it beneficial to employ non-physician medical providers to help care for their patient base. Those non-physician providers commonly used in a family practice setting are nurse practitioners (NP), clinical nurse specialists (CNS) and/or physician assistants (PA).

Patients seen by the non-physician medical providers vary by practice setting and practice needs. It is up to each individual practice to decide how to use the non-physician provider and set protocol for the practice. Here are a few things to keep in mind when employing a non-physician provider:

1. Verify the license and scope of practice allowed by the license for each non-physician provider. Scope of practice allowed by each license varies. Medicare is currently very concerned that some non-physician providers are practicing outside the scope of their licensure so it is important to verify the scope of licensure very closely and make sure that provider is only providing those services that are currently within their scope of licensure.

2. Check with third-party payers to verify how they require services of non-physician providers to be reported and how they pay claims for these providers. Payment policies vary widely by insurance carriers and payers. Your billing staff will need to know the ins and outs of billing for these providers.

Medicare currently allows NPs, CNSs and PAs to practice either independently as part of a family practice or provide services “incident to” a physician’s service. Make sure you are familiar with the guidelines for each type of practice arrangement.

If the services are provided “incident to” those services of a physician, review Medicare’s definition of incident to services. They are services and supplies that are:
- An integral, although incidental, part of the physician’s professional service.
- Commonly rendered without charge or generally not itemized separately in the physician’s bill.
- Of a type that are commonly furnished in physicians’ offices or clinics.
- Furnished by the physician or by auxiliary personnel under the physician’s direct supervision (physician is physically present in the office suite when the services are provided).

3. Enroll non-physician providers correctly with each of your payers. Again, enrollment requirements will vary widely and each practice will need to maintain compliance with their third-party payers.
Chapter Seven

Improving Efficiency and Cash Flow
Easy Steps for Improving Efficiency and Cash Flow

You can avoid revenue problems with up-to-date policies, statistical reports, claims appeal processes and proper coding.

Update Policies and Procedures

Most employees hate the process of collecting unpaid bills. If policies and procedures for claims processing are not up-to-date, employees may be tempted to let collections slide. In addition to putting policies and procedures in writing, your practice should observe a formal procedure for verifying that they are followed, ensuring that all charges are entered into your system, insurance claims are filed quickly and accurately and insurance claims are examined carefully and challenged, if necessary.

Sample billing policies can be found in Appendix B of this publication.

Monitor Performance

To prevent revenue problems, you should review your financial data with daily, weekly and monthly statistical reports. These brief reports should highlight key data, such as monthly, year-to-date and prior year charges, payments and adjustments, monthly and yearly accounts receivable balances and several ratios to help you monitor cash flow:

\[
\text{Net collection rate} = \frac{\text{Total Collections}}{\text{Total Charges - Adjustments}}
\]

Net collection rate monitors the effectiveness of billing. If this ratio begins to decrease, it may either be the result of increased contractual write-offs, or it may mean that your procedures need attention or that staff members are writing off payment denials instead of appealing them. You should strive for a net (sometimes called adjusted) collection rate of 94 percent or higher.

\[
\text{Gross collection rate} = \frac{\text{Total Collections}}{\text{Total Charges}}
\]

Gross collection rate measures the discounts or adjustments of third-party payers. This rate can be affected by the practice fee schedule and how it is developed in relationship to your payment from third-party plans. The average gross fee-for-service collection rate for family practices varies, but you should expect the rate to be between 64 and 74 percent. If your rate is less, remember that physician charges vary. If you are not satisfied with your percentages, you may want to consider renegotiating some of the practice’s contracts.

\[
\text{Number of Days in Accounts Receivable} = \frac{\text{Total Collections}}{\text{Total Charges}}
\]

Number of Days in Accounts Receivable should be monitored monthly along with balances owed by your top four or five payers. If the number of days in accounts receivable begins to increase, the practice needs to quickly assess the problem. California’s prompt payment laws foster quick claim turnaround and payment from payers, keeping the number of days
in A/R for family practices to between 55 and 70 days. If your days in A/R are higher you need to investigate to see if claims are going out timely and cleanly, if correspondence from insurance companies are addressed and resolved quickly and if patient balances are being brought down quickly.

| Accounts Receivable | Average Daily Charges |

**Appeal Rejected Claims**

Some practices hesitate to formally appeal insurance claim denials because they are often unfamiliar with the appeals process. Every insurance carrier has a unique appeals process and generally posts their process on their website or in their Claims Processing or Provider Manual. The billing staff should review the appeals process of each insurer with whom you have contracted. Claims that are either not paid, not paid in a timely manner, are paid inappropriately or are not paid for medical necessity should be considered for appeal.

Appeal letters should always be:

- Brief
- To the Point
- Clear

To develop an effective appeal letter, remember to incorporate all of these things into your process:

1. Restate all identification number from the Explanation of Benefits (EOB).

2. Get to the point in the first sentence: “This is to appeal the amount allowed for (date of service).”

3. Make it easy to read and understand.
   - Bullets or numbered paragraphs
   - **Boldface type** to focus attention
   - Layman’s terms
   - Keep to one page if possible

4. Be Nice.
   - Thank them for their help
   - Keep a sense of humor
   - Accept the responsibility for confusing them

5. Only discuss their basis for the denial, underpayment or cutback. Stay away from other issues like:
   - “We are board certified”
   - “This is the fourth time this patient has had this procedure”
   - “You have been mistreating us since 1990”
6. Copy the patient.

7. Follow Up.

Sample appeal letters addressing these issues immediately follow this chapter.

**Know Your Coding**

Make sure you or any other providers in your group and your coding staff are well trained in coding and documentation. Insurance companies will reject claims with the wrong codes or with codes that are not supported by documentation. An audit from an insurance company can result in fines and prosecution. Your staff, or an external source, should conduct regular chart audits to ensure the quality of your coding practices. Not only can chart audits help spot and correct coding errors that may be leading to rejected claims, they can identify a pattern of undercoding, which could also be hurting your bottom line.

A sample coding audit worksheet follows.
### Coding Audit Worksheet

Client: ____________________________________________  Dr. ____________________________
Signature: □ Yes □ No  D.O.S_______________________  Match: □ Yes □ No
Patient #: __________________________
Primary DX Billed: ______  □ Agree □ Disagree  2nd Dx: ______  □ Agree □ Disagree
Chief Complaint: __________________________________________

#### HISTORY

<table>
<thead>
<tr>
<th>Problem Focused</th>
<th>Extended Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI (history of present illness) elements:</td>
<td>□ Brief (1-3)</td>
<td>□ Brief (1-3)</td>
<td>□ Extended (4+ or status of 3+ chronic/inactive cond.)</td>
</tr>
<tr>
<td>□ Location  □ Severity  □ Timing  □ Modifying factors  □ Quality  □ Duration  □ Context  □ Associated signs and symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| ROS (review of systems): | □ None | □ Pertinent to Problem (1 system) | □ Extended (2-9 systems) | □ Complete (10+ more systems or some systems with statement -all other neg.) |
| □ Constitutional (wt loss, etc)  □ Ears, nose  □ GI  □ Integumentary  □ Endo  □ Eyes  □ Cardiovascular  □ Musculo  □ Neuro  □ Hem/lymph  □ Respiratory  □ Psych  □ “All others neg.” | | | | |

| PFH (past medical, family, social history) areas: | □ None | □ None | □ Pertinent (1 history area) | □ Complete (2 or 3 history area) |
| □ Past history (the pt.’s experiences with illnesses, operations, injuries & treatments) | | | | |
| □ Family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk) | | | | |
| □ Social history (an age appropriate review of past and current activities) | | | | |

Circle an entry for history in the table above.  a) If a column has 3 elements circled, draw a line up that column to the top row and circle the type of history. b) If no column has all of the elements circled, find the circle(s) farthest to the left. Draw a line up that column to the top row and circle the type of history.

#### EXAM

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Head, including face  □ Chest, including □ Abdomen  □ Back, including spine  □ Neck  □ breast and axillae  □ Genitalia, groin, buttocks  □ Ea.ex.</td>
<td>□ 1 body area/system</td>
<td>□ 2-4 areas / systems</td>
<td>□ 5-7 areas / systems</td>
<td>□ 8 + systems</td>
</tr>
<tr>
<td>□ Constitutional (e.g. vitals, gen app)  □ Eyes  □ Cardiovascular  □ GU  □ Neuro  □ Hem/lymph/imm.</td>
<td>1-5 bullets / elements</td>
<td>6 bullets / elements</td>
<td>12 bullets / elements</td>
<td>18 bullets - see exam sheets</td>
</tr>
</tbody>
</table>

#### COMPLEXITY

H: __________________________  E: __________________________

MD: __________________________________________
E/M Billed: __________________________  □ Agree □ Disagree  Auditor
CPT: __________________________________________  □ Agree □ Disagree  Modifiers: __________________________

Number of Diagnoses or Treatment Options

<table>
<thead>
<tr>
<th>Problem to Exam Physician</th>
<th>No. x Points = Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max. = 2 1</td>
</tr>
<tr>
<td>Established problem(to examiner); stable, improved</td>
<td>1</td>
</tr>
<tr>
<td>Established problem(to examiner) worsening</td>
<td>2</td>
</tr>
<tr>
<td>New problem(to examiner); no additional work-up planned</td>
<td>Max. = 2 3</td>
</tr>
<tr>
<td>New prob. (to examiner); add, work-up planned</td>
<td>4</td>
</tr>
</tbody>
</table>

**TOTAL**

Bring total to line A in Final Result for Complexity
### Amount and/or Complexity of Data to be Reviewed

<table>
<thead>
<tr>
<th>Data to be Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology sections of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine sections of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

Bring total to **C** in Final Result for Complexity

### FINAL RESULT FOR COMPLEXITY

<table>
<thead>
<tr>
<th></th>
<th>Number of diagnoses or management options</th>
<th>&lt;1 Min.</th>
<th>2 Limit</th>
<th>3 Multi</th>
<th>4 Exten</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Highest risk</td>
<td>Min.</td>
<td>Low</td>
<td>Mod</td>
<td>High</td>
</tr>
<tr>
<td>C</td>
<td>Amount and complexity of data</td>
<td>&lt;1 Min. or none</td>
<td>2 Limited</td>
<td>3 Mod.</td>
<td>&gt;4 Exten.</td>
</tr>
</tbody>
</table>

**Type of decision making**

<table>
<thead>
<tr>
<th></th>
<th>Straight Forward</th>
<th>Low Comp</th>
<th>Mod. Comp</th>
<th>High Comp</th>
</tr>
</thead>
</table>

Draw a line down any column with 2 or 3 circles and circle the level of decision-making in that column. Otherwise, draw a line down the column with the 2nd circle from the left.
### TIME

If the physician documents total time and suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

| Does documentation reveal total time – Time: Face-to-face in outpatient setting. Unit/floor in inpatient setting | ☐ Yes ☐ No |
| Does documentation describe the content of counseling or coordinating care | ☐ Yes ☐ No |
| Does documentation reveal that more than half of time was counseling or coordinating care | ☐ Yes ☐ No |

### Risk of Complications and/or Morbidity or Mortality

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| MINIMAL       | • One self-limited or minor problem, e.g. cold, insect bite, tinea corporis | • Laboratory tests requiring venipuncture  
• Chest x-ray  
• EKG/EEG  
• Urinalysis  
• Ultrasound, e.g. echo  
• KOH prep | • Rest  
• Gargles  
• Elastic bandages  
• Superficial dressing |
| LOW           | • Two or more self-limited or minor problems  
• One stable chronic illness, e.g. well controlled hypertension or non-insulin dependent diabetes, cataract, BPH  
• Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain | • Physiologic tests not under stress, e.g. pulmonary function tests  
• Non-cardiovascular imaging studies with contrast e.g. barium enema  
• Clinical laboratory tests requiring Arterial puncture.  
• Skin biopsies | • Over the counter drugs  
• Minor surgery with no identified risk factors  
• Physical therapy  
• Occupational therapy  
• IV fluids without additives |
| MODERATE      | • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment  
• Undiagnosed new problem with uncertain prognosis, e.g. lump in breast  
• Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis  
• Acute complicated injury, e.g. head injury with brief loss of consciousness | • Physiologic tests under stress, e.g. cardiac stress test, fetal contraction stress test  
• Diagnostic endoscopies with no identified risk factor  
• Deep needle or incisional biopsy  
• Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram, cardiac cath.  
• Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis | • Minor surgery with identified risk factors  
• Elective major surgery (open percutaneous or endoscopic) with no identified risk factors  
• Prescription drug management  
• Therapeutic nuclear medicine  
• IV fluids with additives  
• Closed treatment of fracture or dislocation without manipulation |
| HIGH          | • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
• Acute or chronic illnesses or injuries that may pose a threat to life or bodily function e.g. multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive | • Cardiovascular imaging studies with contrast with identified risk factors  
• Cardiac electrophysiological tests  
• Diagnostic endoscopies with identified risk factors  
• Discography | • Elective major surgery (open percutaneous or endoscopic) with identified risk factors  
• Emergency major surgery (open percutaneous or endoscopic) with identified risk factors  
• Parenteral controlled substances  
• Drug therapy requiring intensive monitoring for |
<table>
<thead>
<tr>
<th>Severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure</th>
<th>Toxicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• An abrupt change in neurologic status, e.g. seizure, TIA, weakness, or sensory loss</td>
<td>• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>

Result - circle nearest to the bottom. Bring result to Line B in Final Result for Complexity.
Appeal Letters
Enforce Contract Rates

ABC Medical Practice
123 Hometown Road
Your Town, CA 90000

Healthcare Insurance Company
Claims Review Section
P.O. Box 1111
Moneyplace, CA 90000

Re: Edna Jones
Patient ID: 12351234
Claim: 231ER 45678HCI
Employer Name: Your Phone Company

Dear Claims Supervisor:

This is to appeal the amount allowed for surgery (Colles Fracture Care) on 12/17/0x.

Our current contract with you (dated 4/1/0x) calls for $50 per RBRVS unit according to your fee schedule dated 12/1/0x.

1. The claim was paid at $38.60 per unit
2. The services rendered total 6.945 units
3. The correct payment is $347.25.
4. Additional due $79.17

<table>
<thead>
<tr>
<th>Code</th>
<th>Billed</th>
<th>RVUs</th>
<th>Contracted Amount</th>
<th>You Paid</th>
<th>Balance Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>11111</td>
<td>6.945</td>
<td>$347.25</td>
<td>$268.08</td>
<td>$79.17</td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your assistance in reprocessing this claim for the correct payment.

Sincerely,

Susie Sharp, Billing Manager
Non-timely Payment of Claim

ABC Medical Practice
123 Hometown Road
Your Town, CA 90000

Healthcare Insurance Company
Claims Review Section
P.O. Box 1111
Moneyplace, CA 90000

Re: Edna Jones
   Patient ID: 12351234
   Claim: 231ER 45678HCI
   Employer Name: Your Phone Company

Dear Claims Supervisor:

Attached is a copy of your claim for service for your insured. As of this date, we have not received payment for ____________ days since we submitted the claim to you. We have not received any notice that the claim was not complete or any indication that the service was not properly authorized. Therefore, you appear to be in violation of California Health & Safety Code Sec. 1371 (see language below). We expect full payment due for these services to be remitted to us at once, along with the applicable interest due under the statute. Continuing violation of this statute will be reported to the California Department of Insurance or Department of Managed Health Care as applies to your plan.

HSC Sec. 1371 A health care service plan...shall reimburse claims or any portion of a claim, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the health care service plan, or, if the health care service plan is a health maintenance organization, 45 working days after the receipt of the claim....If an uncontested claim is not reimbursed within the respective 30 to 45 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30 or 45 working day period.
Non-timely Payment of Claim After Further Information Sent

ABC Medical Practice  
123 Hometown Road  
Your Town, CA 90000

Healthcare Insurance Company  
Claims Review Section  
P.O. Box 1111  
Moneyplace, CA 90000

Re: Edna Jones  
Patient ID: 12351234  
Claim: 231ER 45678HCI  
Employer Name: Your Phone Company

Dear Claims Supervisor:

Attached is a copy of our claim for services for your insured. As of this date, we have not received payment for ______ days since we submitted to you the additional information you requested about this claim. We have not received any notice that the claim was being further contested or questioned or any indication that the service was not appropriately authorized. Therefore, you appear to be in violation of California Health & Safety Code Sec. 1371 (see language below). We expect full payment due for these services to be remitted to us at once, along with applicable interest due under the statute. Continuing violation of this statute will be reported to the California Department of Insurance or Department of Corporation as applies to your plan.

HSC Sec 1371 A health care service plan...shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the health maintenance organization, 45 working days after receipt of the claim....If an uncontested claim is not reimbursed by delivery to the claimant’s address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30 or 45 working day period....If a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, then the plan shall have 30 working days, or if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim.
Denial of Service of Alleged Failure to Meet Medical Necessity After Prior Authorization Received

ABC Medical Practice
123 Hometown Road
Your Town, CA 90000

Healthcare Insurance Company
Claims Review Section
P.O. Box 1111
Moneyplace, CA 90000

Re: Edna Jones
Patient ID: 12351234
Claim: 231ER 45678HCI
Employer Name: Your Phone Company

Dear Claims Supervisor:

Attached is a copy of our claim for services for your insured and copy of prior authorization we received from you. Your denial of the claim appears both inappropriate and also appears to be a per se violation of California Health & Safety Code Sec. 1371.8 (see language below).

We expect prompt payment of this claim. If we fail to receive payment within the next 10 working days, we will be forced to refer this issue to the California Department of Managed Health Care or Department of Insurance, as applies to your plan.

HSC Sec.1371.8 A health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization.
Denial of Service for Alleged Failure to Meet Medical Necessity

ABC Medical Practice
123 Hometown Road
Your Town, CA 90000

Healthcare Insurance Company
Claims Review Section
P.O. Box 1111
Moneyplace, CA 90000

Re: Edna Jones
Patient ID: 12351234
Claim: 231ER 45678HCI
Employer Name: Your Phone Company

Dear Claims Supervisor:

Attached is a copy of our claim for services for your insured, for which you have denied payment, alleging lack of medical necessity. We urge immediate reconsideration of this action. The denial of services appears to be a per se violation of California Health & Safety Code Section 1370.2 (see language below).

In order to determine if this violation requires us to report this incident to the California Department of Insurance or Department of Managed Health Care, as applies to your health plan, please advise us of the name, qualifications, training, background and relevant expertise of the reviewer that denied the claim in question. If you consider the reviewer’s identity to be confidential, then provision of the other information about the reviewer is still required pursuant to HSC Sec. 1370.2

We expect reconsideration of this claim or provision of this required information to be provided within the time frames specified by HSC 1371. Thank you for your consideration.

HSC 1370.2 Upon an appeal to the plan of a contested claim, the plan shall refer the claim to the medical director or other appropriately licensed health care provider...If...he or she is not competent to evaluate the specific clinical issues of the appealed claim, prior to making a determination, he or she shall consult with an appropriately licensed health care provider who is competent to evaluate the specific clinical issues presented in the claim...(which) means that the reviewer has education, training, and relevant expertise that is pertinent for evaluating the specific clinical issues that serve as the basis of the contested claim. The requirements of this section shall apply to claims that are contested on the basis of a clinical issue, the necessity for treatment or the type of treatment proposed or utilized.
Dear Claims Supervisor:

Attached is a copy of our claim for services for your insured, for which you have denied payment alleging lack of medical necessity. We urge your immediate reconsideration of this action. A copy of all referable chart notes, supporting reports and other explanatory material is attached.

In our view, your denial of this service is not consistent with professionally accepted standards for judging medical necessity. For example, be aware that the American Society of Internal Medicine has established as official policy the following definition of medical necessity:

‘A test, procedure or investigation is medically appropriate if documentation supports that the results of the test, procedure or investigation would alter or influence the diagnosis, course of treatment or prognosis of the patient’s illness, disease or disability.’

All of the tests and treatments which were performed in connection with this claim clearly meet the requirements of this policy statement. Furthermore:

‘Appropriateness cannot be fairly judged by third parties except against standards based on scientifically acceptable data or professional consensus, as described in published documents. Such data and standards should be publicly available, explicitly referenced by the reviewer and rationale provided.'
for denying a procedure if the practitioner’s judgment is contradicted in post-payment review or in medical necessity determination prior to payment.’

Should any of the services performed referenced in the claim be declared by your reviewer to not be medically necessary, please be advised that I fully expect the reviewer to comply with these policies, with disclosure of the reviewer’s appropriate training and background in this clinical area, and with appropriate references which support the reviewer’s position in this clinical case.
Chapter Eight

Value-Based Payment

Make Sure You Are Ready to Participate Effectively!
In April 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA) into law. Under MACRA, the shift towards value-based payment will start in 2019, based on measurement year 2017. CMS will pay bonuses to providers who participate in the newly formed Merit-Based Incentive Payment System (MIPS) or to those who participate in a Qualified Alternate Payment Model (APM). In California, this will include Patient Centered Medical Homes (PCMH) under the 1115 waiver, any model under the Center for Medicare and Medicaid Innovation Program, Accountable Care Organizations and select Medicare demonstrations. MIPS will effectively pull elements from each of the existing value based programs including Physician Quality Reporting System (PQRS), Value Based Payment Modifier (VBFM) and Meaningful Use of Electronic Health Records (EHR MU) and consolidate into one overall, value based program. The separate payment implications associated with each current program will then sunset at the end of 2018.

While reading the discussion below about current value-based programs, it is important that family physicians are aware of the approaching shift. With Medicare taking the lead, commercial payers are highly motivated to move towards value-based payment as well. CMS hopes to finalize rules governing the MIPS program in 2016 and CAFP will provide educational programming on these rules.

**Value-Based Payment**

The shift toward value-based payment brings a change in the business and clinical practices of every medical practice in the United States. Instead of basing compensation on the volume of patients you treat, this new system will reward you for achieving certain quality objectives and penalize you for not achieving them. This means that increasing your revenue stream will soon rely on the quality of care your practice provides, not on the quantity of care you provide. The ultimate goal of the new system is to reduce costs for care while improving patient outcomes—an important goal of all physicians.

For most family physicians, the shift’s largest challenge is not the actual quality of the care they provide, but rather the system and tools needed to quantify quality in a cost-and time-effective way. Many practices will need to implement new data tracking systems.

By taking action now, you will be prepared to be eligible for incentives, avoid penalties, improve patient outcomes in your practice and be well positioned to collaborate with commercial payers as they develop their own value-based initiatives. Most importantly, by taking action now, you will position your practice to thrive as these changes are enacted, instead of being overwhelmed by them.

**Why are Systems Changing?**

Under the present fee-for-services system, the inevitable way to increase revenue has been to increase both the number of patients seen per physician and the number of medical services provided. This has not served the interests of patients or physicians as:

- Patients spend less time with their treating physicians.
- Practices are forced to stretch their administrative and staff resources, making errors more likely to occur.
• Coordination of care and management of patient conditions outside face-to-face visits are not given enough attention.
• Cost/benefit analysis is rarely considered.

**Medicare’s Value-Based Systems**

To combat the negative factors and their effects on quality of care of the current system, CMS rolled out systems where compensation is linked to the quality of care providers provide their patients rather than to the sheer volume of patients they treat. These programs and systems include the PQRS and the VBPM program.

CMS implemented PQRS to provide bonus payments to physicians and non-physician providers to incentivize the reporting of certain quality measures in caring for their Medicare patients. The VBPM ties performance, health outcomes and other measures to government-based payment for both hospitals and providers.

In addition, commercial payers are already following suit and are implementing their own quality-based payment programs.

To make the transition from fee-for-service to value-based payment (VBP), medical practices should consider whether they need to begin aggregating and analyzing patient health information and other statistical information. Each VBP program will have its own specific factors that may need to be tracked by providers. Physicians can begin to prepare their practices by putting the systems and processes in place to consistently track patient care, outcomes and satisfaction. No matter the specifics of each program, having the correct systems and processes will be central to participating in it.

**Medicare’s Value-Based Payment Modifier Program**

The Medicare VBPM program evaluates a provider’s performance based on the quality and cost of care they provide to their fee-for-service Medicare patients. The program rewards high-performing providers with increased payments and reduces payments to low-performing providers. The program uses PQRS quality data and Medicare cost data to determine a provider’s value score. Failure to report PQRS will result in automatic percentage reductions to the provider’s Medicare Physician Fee Schedule payments.

The VBPM applies only to physician and non-physician practitioner payments made under the Medicare Physician Fee Schedule. In 2015, participating and non-participating physicians in groups of 100 or more eligible practitioners who submitted claims to Medicare under a single tax identification number are subject to the modifier, based on their performance in calendar year 2013. The program’s requirements will be applied to groups of 10 or more in 2016 and to solo providers and groups of two or more in 2017, barring any changes necessary as a result of MACRA.

Upward, downward and neutral adjustments to physician payments under the Medicare Physician Fee Schedule will be based on performance from two years prior. Hence, Medicare payments in
2017 will be adjusted based on practitioners’ performance in 2015 and payments in 2018 will be adjusted based on practitioners’ performance in 2016.

**Making the Transition**

The logic is simple: tracking patient data, analyzing that data and presenting your analyses are swiftly becoming integral parts of modern medicine. By not putting these systems in place now, solo and small group practices also risk allowing medicine to evolve and leave them behind.

Preparing your practice for the shift to VBP systems isn’t just a technical issue; it’s a mindset issue. Staff and physicians need time to adjust to the new data collection software, systems, and processes. If you do not begin the process soon, you risk irrevocably crippling your practice as these programs begin rolling out.

**Five Steps to Get Ready to Participate in Medicare Value-Based Payment Modifier Program**

**Step One: Individual or Group Participation**
Providers and provider groups must decide if they will participate in the program as individuals or as a group.

Individual Eligible Providers (EPs) are identified by their individual National Provider Identifier (NPI) and Tax Identification Number (TINs).

A **group practice** is defined as a single TIN with two or more individual eligible professionals who have reassigned their billing rights to that TIN. Group practices can register to participate in PQRS via the group practice reporting option (GPRO) to be analyzed at the group (TIN) level.

**Step Two: Choose a Reporting Mechanism**
The VBPM program’s quality measurement component is aligned with the reporting requirements under PQRS.

Individual practitioners may report their PQRS quality measures or measure groups to CMS using one of the following:

- Medicare Part B claims (keep in mind that not all measures and no measure groups can be reported via claims)
- Qualified PQRS registry
- Direct electronic health record (EHR) using certified EHR technology (CEHRT)
- CEHRT via a data submission vendor
- Qualified clinical data registry (QCDR)

Group practices may report their PQRS quality measures to CMS using one of the following:

- Qualified PQRS registry
- GPRO Web Interface (for groups of 25+ only)
- Direct EHR using CEHRT
- CEHRT via data submission vendor
• The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS via CMS-certified survey vendor (for group practices of two or more) to supplement PQRS group practice reporting

**Step Three: Choose Quality Measures**
Individual EPs and PQRS group practices should choose at least nine individual measures across three National Quality Strategy (NQS) domains or one measures group as an option to report on measures to CMS (with the exception of GPRO Web Interface). Individual EPs or PQRS group practices must also report one cross-cutting measure if they have at least one Medicare patient with a face-to-face encounter.

The individual measures and the measures groups for the current reporting year can be found on the [CMS website](https://www.cms.gov).

**Step Four: Review PQRS Payment Adjustment Information**
If you do not satisfactorily report data on quality measures for covered professional services, you will be subject to a negative payment adjustment under PQRS. The percentage of the payment adjustment increases each year and applies to all of the EP’s or group practice’s Part B covered professional services under the Medicare Physician Fee Schedule. This could be costly to any practice.

**Step Five: Measure, report and Iterate**
Report the quality measure’s data you collect through your chosen mode.

The most important step you and your practice will take is to evaluate what worked, what did not work and what needs improvement. Use the information you collect to improve weak areas in your patient care. Work with staff to identify how to improve your data collection process during the next cycle.

Above all, remain up-to-date on the changes in reporting and quality measures for the programs in which you participate. Regularly research their standards and seek out new programs for which your practice may qualify.

Configuring your practice to accommodate value-based payment systems is an unavoidable step you will have to take to avoid severe financial problems in the next five to 10 years. While implementing these systems may take years of planning, training and execution, it will be worth the overall improvements to quality of care they will bring. Taking action now will set you up to take advantage of future incentives and avoid future penalties.
Appendix A

Reference Materials
Reference Materials

Every practice needs current reference materials. The references include procedure and diagnostic codes, relative value scales, workers’ compensation fee schedules and other basic references. The following materials are considered fundamental and essential to medical billing. It is important to have the most current version/edition of each of these references:

- **Current Procedure Terminology (CPT)**
- **Healthcare Common Procedure Coding Systems (HCPCS) Level II Codes**
- **International Classification of Diseases (ICD-10-CM)**

These may all be purchased online from the AMA or your favorite medical publishing firm: [American Medical Association](https://www.ama-assn.org) [Alpha II](https://www.alphaii.com) [Optum](https://www.optum.com) [PMIC Coding & Compliance](https://www.pmic.com)

- **Workers’ Comp Fee Schedule**
  Call your [State Department of Labor or Department of Workers’ Comp](https://www.dol.gov) for other sources.

- **Medicare Fee Schedule**
  Your Medicare Administrative Contractor (MAC) publishes the fee schedule annually, but no longer mails it out to each participating provider. It can be accessed on your local Medicare carrier website, such as [Norian's](https://www.norian.com).

- There are several different fee schedules you may wish to access:
  1. Physicians Fee Schedule (for your locality)
  2. Medicare Part B Drug Allowances (injections)
  3. Clinical Laboratory Fee Schedule
  4. DME, Orthotics and Prosthetics Fee Schedule

- **Medicare Billing Guide**
  There are a number of billing guides that will be helpful for family physicians. Some examples are:
  - 1500 Claim Form Instructions (even if you are submitting electronically)
  - Evaluation and Management Services
  - Introduction to Medicare Billing Guide (for new physicians and billers)
  - Medicare Secondary Payer – MSP
  - Non-Physician Practitioners Billing Guide
  - Preventive Services Billing Guide
  - Medicare and the Resident Physician (for teaching programs and clinics)

Noridian Healthcare Solutions makes these manuals available to the public through their [website](https://www.norian.com). Medicare also has a calendar of Web based programs (Webinars) and Ask the Contractor Teleconferences (ACT) that is published on the contractor’s website. Most of these presentations
are between 60 and 90 minutes in length and can be helpful for physicians and billing staff members. Questions are allowed.

- **Medicare Newsletters**

  A Medicare newsletter called the Medicare Advisory is periodically published by each Medicare carrier. These newsletters detail Medicare billing issues and guidelines and discuss billing parameters for Medicare. Most carriers publish a bulletin at least quarterly, while some publish more often as needed. Most of the carriers no longer mail the newsletters to providers, but they are available online at the carrier's website. Each practice should join the email list of your Medicare carrier to receive notification when these newsletters are available.

- **Correct Coding Initiative (CCI)**

  CMS implemented [National CCI edits](https://www.cms.gov) in 1996 for the purpose of identifying and eliminating the incorrect coding of medical services. To purchase the CCI Edits, call the National Technical Information Service:
  
  - To receive the information by fax call (703) 605-6880
  - To order subscriptions call (703) 605-6060 or (800) 363-2068

- **Medicaid/Medi-Cal Provider Manual**

  Medicaid/Medi-Cal manuals are published by the state Medicaid contractor and are mailed to all participating providers. Since these manuals are periodically updated, someone in the practice should be responsible for making sure they are current. The manuals are an excellent resource that details billing parameters for all of the Medicaid/Medi-Cal special programs.

  Many contractors have put the manuals online and this is a more up-to-date means of accessing the current information. You may wish to “opt out” of receiving the paper manuals if you are able to access the online manuals.

- **Provider Manuals for all Contracted Payers**

  Provider Manuals are available for all of your contracted payers, such as Anthem Blue Cross, Blue Shield, Tricare, Aetna, Cigna etc. The manuals can usually be obtained by contracting your local provider relations representative. Many of the payers make their manual available online as well. You may need a user identification and password to access the manual, so check with each payer. Online examples are:

- **Payment Articles from Family Practice Management**

  Each issue of Family Practice Management published by the American Academy of Family Physicians offers payment advice. These articles should be circulated throughout the billing department of each practice.

- **Practice Management News**
The California Academy of Family Physicians publishes a monthly online newsletter – *Practice Management News*. There are periodic articles relating to billing and coding issues, as well as other practice management issues.
Appendix B

Sample Billing Policies
**ABC FAMILY PRACTICE**

**Category:** Billing Office  
**Policy #:**  
**Title:** Office Encounter Form

**POLICY:** A patient encounter form shall be completed for each patient scheduled for services at the clinic site or department.

**Procedures:**

1. Each patient will be requested to complete a patient information sheet to collect current demographic information for the purpose of creating a new account for the patient or updating established patient’s information.

2. A patient encounter form will be generated from the computer for each patient seen in the clinic or department.

3. Place the encounter form on the front of the patient’s chart prior to the appointment to provide easy access for the providers.

4. Physicians and other providers will complete the encounter form by entering the appropriate charge code and diagnosis code and will sign each form.

5. The duplicate copies will be distributed as follows: pink goes to the patient, white is sent to the Billing Office with the bath report containing the charge. The yellow copy is retained at the clinic for 90 days after which the copies will be disposed.
POLICY: Offsite encounter forms will be documented, collected and posted on the same day they are generated.

Procedures:
1. Offsite charges are defined as follows:
   a) Nursing home charges
   b) Inpatient charges
   c) Emergency department
   d) Request for medical record copies
   e) Legal/attorney activities

2. Charges generated in 1a and 1b above will be documented on the appropriate hospital ticket, indicating the following information:
   1. Patient name
   2. Date of birth
   3. Place of service
   4. Date of service(s)
   5. Diagnosis code(s)
   6. Procedure code(s)

3. Charges generated in 1a, 1b, and 1c above will be documented and collected daily based on patient discharge.

4. The physician should obtain a copy of the patient’s information from the admitting department at the hospital. The physician should mark the appropriate level of service provided and include the dates of service for each level. Indicate admit and discharge date. The physician will write down the diagnosis and sign the encounter form.

5. The encounter forms will be turned in to the Billing Office. The Billing Office should review the encounter form for completeness. The information system should be referenced for the patient’s account number, which should be recorded on the encounter form.

6. Record the proper CPT and ICD-10-CM codes based on the physician’s level of service and diagnosis. Batch the encounter forms and route to charge entry personnel for keying. These charges will be posted within forty-eight (48) hours of receipt.

7. All charges will be posted in control groups assigned to a unique user.

8. An audit journal will be generated and used to balance the Control Group.

9. All out-of-balance situations will be resolved immediately.
10. Any incomplete encounter forms will be returned to the appropriate physician for completion. Completion is required on the same day as ticket is returned.

**ABC FAMILY PRACTICE**  
*Category:* Billing Office  
*Policy #:*  
*Title:* Coding

**POLICY:** Coding: The provider will complete and accurately code charge documents at the time of service.

**Procedures:**

1. The provider will complete charge documents at the time the service is rendered.

2. Diagnosis “rule outs” will not be permitted. A diagnosis must be made and coded based on information available and symptoms presented. If a charge ticket is received in the Billing Office containing a rule out, it will be re-submitted to the provider for correct coding.

3. Providers will match CPT codes to the appropriate diagnosis code using a numeric method.

4. Incorrect or incomplete charge documents will be returned to the provider for correction on the day of service, so that timely charge entry can be performed.

5. The accuracy of charge coding and medical record documentation will be regularly reviewed. Providers with a coding error rate of greater than 10 percent will be subject to training at the direction of the Medical Director.
POLICY: Charge entry: Charges for professional services will be accurately posted in the billing system at the point of service and balanced at the end of the day on the same day services are rendered. This will ensure that revenue is credited to the correct accounting period.

Procedures:

1. Charges will be posted to unique batch control groups at the time and point of service. Account representatives in each practice location will be assigned individual control groups. They will be responsible for posting the financial transactions.

2. Providers will document charges and corresponding procedure and diagnosis codes on preprinted encounter forms. These encounter forms will be created for each unique patient visit.

3. All charges will be posted to a batch control group assigned to each account representative.

4. Charges will be posted to the patient account and a receipt printed for the patient.

5. The account representative to whom the batch is assigned will balance each individual batch control group at the end of each day.

6. An audit report will be generated and cash totals will be used to balance the batch control group.

7. All batches with conflicting balances will be resolved immediately.

8. Encounter forms with incomplete charge data will be returned to the originating provider for completion to assure expedient billing and collection. This process must occur on the same day as the service.
POLICY: Accurate and timely data entry: All demographic, clinical and financial data entry will occur in a timely and accurate manner.

Procedures:

1. Types of data will be entered according to the following:
   - Registration and patient demographic data will be entered at the time the patient schedules the appointment
   - Medical clinical data and all medical chart documentation will be recorded on the date of service
   - Billing and all charges, adjustments and payments will be entered into the computer within 24 hours of the date of service.

2. Data entry must achieve a 98 percent accuracy rate. Staff not achieving this goal will spend a day of training at the Billing Office. If accuracy is not achieved during this additional training, the employee will be considered for transfer to another area.
POLICY: Billing third-party payers: Third-party payers will be billed in a timely manner to receive expedient payment for claims generated.

Procedures:

1. Third-party payers will be billed via electronic claims service when available.

2. Claims sent via electronic media will be billed as accepting assignment.

3. Third-party claims that cannot be billed electronically due to the need for attachments, or for other reasons, will be billed using the standard CMS 1500 claim form.

4. Third-party claims will be generated and forwarded to payers on a daily basis to expedite payment.

5. Every effort will be made to eliminate errors in registration, charge coding and charge entry to ensure timely payment.
ABC FAMILY PRACTICE
Category: Billing Office
Policy #: 
Title: Billing commercial carriers

**POLICY:** Billing commercial carriers: Commercial payers will be billed within one business day of the date of service.

**Procedures:**

1. Commercial insurers are payers that do not have a contractual relationship with the practice.

2. The Billing Office will submit all commercial claims to the appropriate payer.

3. The monthly billing statement to patients will indicate the patient due and insurance due balance.

4. After 60 days, if the balance has not been paid by the payer, the patient will be billed directly and the balance will become the responsibility of the patient.

5. Payment follow-up will occur according to the clinic third-party payer policy and procedure.
POLICY: Claim denials: The Billing Office will monitor and research claims denied by insurance carriers to determine the cause of the rejection and if appropriate, the claim will be resubmitted or appealed for payment.

Procedures:

1. A monthly claims denial report will be generated from the computer system. It will be analyzed to determine the specific claims that have been denied, the cause of the denial and any necessary information required for closing the claim.

2. Upon resolution of the issues causing the claim to be denied, a new claim will be submitted or appealed.

3. Causes of errors will be reported to the appropriate clinic or department managers to assure resolution of the policy or procedures causing the denial.

4. Errors will be tracked as a method of determining training needs.
POLICY: Insurance Follow Up: The Billing Office will be responsible for timely follow-up on monies owed to the Practice pending insurance.

Procedures:
Reports will be generated from the billing system to ensure expedient payment.

1. For denied or pending claims - the following actions will be taken based on the denial code indicated on the EOB or remittance:
   
   a. If the patient is not eligible for benefits, or the service is not a covered benefit, the balance will be transferred to self-pay;
   b. If additional information is required, the claim will be resent with the appropriate information or attachments; or
   c. If demographic information or policy numbers are incomplete or inaccurate, the patient will be called to obtain valid data. This updated information will be immediately entered into the computer and rebill will be requested.

2. For follow-up – Follow the schedule below to ensure consistency:
   
   a. 30 days after date of service
      1. Confirm receipt of payment
      2. If no payment, contact the insurer to determine claim status
      3. Determine the following:
         1) Expected date of payment
         2) Reason for denial or claim hold
      4. Assemble any documentation requested to adjudicate the claim and rebill if necessary.
   b. 45 days after date of service:
      1. Confirm receipt of payment
      2. Re-file claim if no payment has been received
   c. 60 days after date of service
      1. Confirm receipt of payment
      2. If no payment, contact provider relations and determine claim status
      3. Determine the following:
         1) Expected date of payment
         2) Reason for continued denial or claim hold
         3) Assemble any documentation requested to facilitate payment
         4) Re-file claim
         5) Notify patient of claim status and solicit his/her assistance with the carrier
         6) Notify patient that the balance due will be changed to patient due in 30 days
d. 90 days after date of service:
   1. Confirm receipt of payment
   2. If no payment, change balance due to patient responsibility
   3. Bill patient for balance due

e. 120 days after date of service:
   1. Confirm payment
   2. If no payment, re-contact the patient and request payment. It may be necessary
to set up financial arrangements with the patient according to the Practice
financial policy

f. 135 days after date of service:
   1. Confirm payment
   2. If no payment, submit collection letter advising of 15 days to pay balance in full

g. 150 days after date of service:
   1. Check for payment
   2. Submit collection letter according to Practice collection policy
POLICY: Financial Policy: All patients will be provided a copy of the practice’s financial policy.

Procedures:

The financial policy will include information regarding the practice’s policy as it relates to the following:

1. Insurance companies – participation and billing
2. Time of service payment
3. Patient’s responsibility
4. Workers’ compensation
5. Auto accidents
6. Collections
7. Contact information for billing office

The financial policy will be presented to patients upon their registration at the Practice. Once the patient has read the financial policy, ask him/her if there are any questions. If there are any, answer them to clear up any misunderstanding. If there are no questions, verbally reinforce the patient’s responsibility to clear the balance in full.