Resident Billing Training

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Coding and Billing Compliance

Agenda

- Documentation
- New Patient E/M 2021 Guidelines
- Established Patient E/M 2021 Guidelines
- Medical Decision Making explained
- Data categories new in 2021
- Categories and Codes
- Billing according to Time
- Prolonged time
- History and exam
- Diagnosis coding
- Modifiers

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Documentation

- Anatomy of a chart note- Items required to have in your documentation in order to bill for the service
  - Chief complaint
  - History of present illness
  - Review of systems
  - Physical exam
  - Assessment
  - Plan
  - Some items that carry forward from one note to another
    - PFSH

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Documentation

- History of present illness (HPI)
  - A Brief description of the patients current illness or a review of their chronic conditions that the patient may have that you are reviewing during this encounter
- Review of systems(ROS)
  - Interview between provider and patient about signs and symptoms relating to the chief complaint
- PFSH
  - Past personal
  - Past family
  - Past social

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Documentation

- Physical exam
  - This is the part where you will document all of your findings during the physical exam
  - Keep in mind that it is always better to be more specific than vague
  - Specialists can have a more detailed exam that pertains to their specialty

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Documentation

- Medical Decision Making
  - Assessment
    - The diagnoses the patient has that you are personally treating- these must be documented throughout the note
      - Example: the patient has cancer and is being treated by oncology team, you are treating their other ailments. You will not document the cancer as a diagnosis unless you are caring for the cancer or the cancer diagnosis is affecting the diagnosis you are managing
  - Plan
    - What do you plan to do for the patients diagnosis? This is where you document lab work, Rx meds, diagnostic testing, surgical treatment plans...

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New versus Established patients

- A new patient is someone who is new to you or your specialty
  - Someone who has not been seen by you or someone in your specialty in the past 3 years
    - You will not consider a new patient just because you have personally never seen the patient, if the patient has seen someone in your specialty/ group in the past 3 years
- An established patient is someone who is established with you as their patient
  - The patient has been seen by you or someone in your specialty/ group in the past three years

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Coding and Billing

- Coding E/M services(office visits)
  - Levels
    - You get to a level either by
      - Documenting everything that happens in the encounter specifically and you decide if you wish to bill according to
        - Time
        - Medical Decision making

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Medical Decision Making explained

- Straightforward
  - 1 self limited or minor problem
  - Minimal or not data to review
  - Minimal risk of morbidity
- Low
  - 2+ self limited or minor problem or 1 stable chronic illness or 1 acute uncomplicated illness
  - Limited data to review (see categories next slide)
  - Low risk of morbidity

Medical Decision Making explained cont.

- Moderate
  - 1+ chronic illness with exacerbation or 1 undiagnosed new problem with uncertain prognosis or 1 acute illness or 1 acute complicated injury
  - Moderate data to review(see next slide for categories)
  - Moderate risk of morbidity
- High
  - 1+ Chronic illness with severe exacerbation or 1 acute/chronic illness/injury that poses a threat to life
  - Much data to review(see next slide for categories)
  - High risk of morbidity

Data categories as part of MDM 2021

- New to the table of risk in 2021 are data categories

Category	Included in category
Category 1	**tests and documents** *Any combination of 2 from following* • Review of prior external note from each unique source • Review of the result(s) of each unique test • Ordering of each unique test
Category 2	**Assessment requiring and independent historian (moderate or high)** • Independent interpretation of a test performed by another physician/ other qualified health care professional (not separately reported)
Category 3	**Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/ or other qualified health care professional\ appropriate source(not separately reported)

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Time based coding

- In 2021 the provider may choose whether to bill according to time or according to MDM
- How to bill according to time
  - Document everything that happens in the encounter to substantiate medical necessity
  - Document the start time and end time for the encounter
  - Document how time was spent in the encounter

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Time based coding

- In 2021 we can now count both face-to-face time as well as non-face to face time What does this mean?
  - Time spent with the patient during the encounter (face-to-face time)
  - Any time spent reviewing labs/tests prior to encounter(non face-to-face time)
  - Any time spent getting prepared for the encounter(non face-to-face time)
  - Any time spent documenting or finishing up the encounter after the patient leaves(non face-to-face time)
- Total time counted during the Date of Service only

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Prolonged time

- When billing according to time and the time exceeds the level 5 time you can add on a code for prolonged time spent
- **99XXX** *Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)*

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New Patient E/M 2021 Guidelines

Code	Medical Decision Making	Time
99202	Straightforward	15-29 minutes
99203	Low	30-44 minutes
99204	Moderate	45-59 minutes
99205	High	60-74 minutes

*For encounters lasting longer than 74 minutes there is a prolonged services code

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Established Patient E/M 2021 Guidelines

Code	Medical Decision Making	Time
99212	Straightforward	10-19 minutes
99213	Low	20-29 minutes
99214	Moderate	30-39 minutes
99215	High	40-54 minutes

*For encounters lasting longer than 54 minutes there is a prolonged services code

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History and Exam

- In 2021 The History and Exam elements are not being used to calculate the level of E/M service provided
- What does this mean?
  - The History and exam component should still be documented
  - The history and exam helps to prove the medical necessity of the E/M level chosen
  - 2021 guidelines state that ancillary staff may collect information from patient/ family(from portal or questionnaire) and the provider must review the information collected

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Diagnosis coding

- Specific documentation
  - Being specific in your documentation is imperative to get the proper and correct reimbursement
    - Insurance payers are NOT paying for unspecified codes, try to refrain from using them
      - There will be instances when an unspecified code is your only option
    - Specify **Laterality**
      - Is it the right? Is it the left?- There should not be a time when you would ever have unspecified laterality
    - Specify the **size**
      - Sizes of lesions are important specify the sizes
    - Specify the **location**
      - Location of a lesion or another sign/symptom
    - Specify the **detail** of a disease
      - The stage of a disease is important to note

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Modifiers

- GC- under the direction of a teaching physician
- GE- without the presence of a teaching physician
- In power chart when selecting your codes scroll down and be sure you select the code with these modifiers attached

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Thank You!

If you have any questions please feel free to email Anastacia Chapman at chapman114@marshall.edu

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