Charting Smarter not Longer: Advanced Concepts in Outpatient Coding

Workshop WB01
SGIM 33rd Annual Meeting
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Sponsored by the SGIM
Clinical Practice Committee

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Learning Objectives: To Understand

- Effective and efficient documentation strategies for coding common E&M services
- How to code for simultaneous E&M services AND procedures
- How to code for simultaneous E&M services AND preventive services.
- E&M codes for case management services that are common in academic GIM
- How to code for outpatient consultations
- How to apply Medicare specific G codes for preventive and other services

- NOT A SUBSTITUTE FOR YOUR LOCAL COMPLIANCE OFFICE!
Workshop Overview

• Introduction
• Didactic Segment (~15 minutes)
  – The CPT coding system
  – How to choose a CPT code and Efficient Documentation
• Small Group Segment (~23 minutes each)
  – E&M Vignettes: level 4 vs. level 5 visits
  – Preventive services and case management
  – Dual visits: E&M with preventive or procedure codes AND consultation coding
• Evaluations (5 minutes)

- Developed by AMA
- Endorsed by CMS
  - CMS has a supplemental system, “HCPCS” for services specifically covered by Medicare
    - Preventive services (stool occult blood, PAP, etc)
    - Medications such as influenza vaccine
    - Home health care plan certification, and others
CPT System for Coding, cont’d

• All (almost) CPT codes have relative value units that determine payment for that service
• Total RVUs
  – Work, practice expense, and malpractice expense RVUs
• Conversion factor
• Geographic price correction index (GPCI)
On Line Resources

- E&M guidelines: Medicare Learning Network
  www.cms.hhs.gov/MLNGenInfo

- ACP Center for Practice Innovation:
  http://www.acponline.org/pmc/coding.htm?info
Evaluation and Management

• Medical Necessity
• Documentation
  – History
  – Examination
  – Medical Decision Making
Medical Necessity

• Payment of a claim is driven by medical necessity or the “why” of a claim
• Generally speaking, most payer definitions consider:
  – Providing services which are “reasonable and necessary” to resolve a problem, or
  – Improve the patient’s health, functioning, or well being, and
Conceptual Model

- Medical necessity **DRIVES** Medical Decision Making
- Medical Decision Making **DRIVES** the history and exam you do
- These in turn **DRIVE** the codes you choose
### Established Outpatient Visit

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Evaluation and Management

History

- Chief Complaint
- HPI
- ROS
- Past Medical/Family/Social History (PFSH)
E&M: History

Chief Complaint: why the patient presented

- Symptom or diagnosis
- Physician recommended return
- Other factor that is reason for encounter
E&M: History

HPI  (4 elements for service code 4/5: “extended HPI”)

• location
• quality
• severity
• duration
• timing
• context
• modifying factors
• associated signs and symptoms
E&M: History

ROS (14)

- Constitutional (fever, weight loss)
- Eyes
- Ear, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- GI
- GU
- Musculoskeletal
- Skin/Breast
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymph
- Allergic/Immunologic
E&M: History

- Past Medical History
  (for example, med list)
- Family History
- Social History

- service code 4/5 new patients require all 3
- service code 4 return patients require 1 of 3
- service code 5 return patients require 2 of 3
- if unable to obtain, document why
- can link to PFSH in a prior note with changes noted
Evaluation and Management

Physical Examination (12)

- Constitutional
  - VS or general
- Eyes
- ENT, Mouth
- Cardiovascular
- Respiratory
- GI
- GU
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic
E&M: Examination

Notations such as “negative” or “normal” are sufficient to document normal findings related to unaffected body areas or asymptomatic organ systems.
Evaluation and Management

Medical Decision Making

- # of diagnoses or management options
- amount/complexity of reviewed information
- risk and morbidity/mortality
Evaluation and Management

Coding Based on Time

- Time is the “controlling factor” for visits in which the majority of face to face time is spent counseling
- An “opt out” if hx, exam, MDM do not support as high a code as time does
E&M

Coding Based on Time, cont’d

- Counseling is discussions of:
  - diagnostic results or plans
  - prognosis
  - risk/benefits of management options
  - treatment instructions
E&M

Coding Based on Time, cont’d

– Document (99214):
  • This visit lasted 25 minutes face to face time over half of which was counseling about....
  • For example: “our diagnostic and management plans...”
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Minimal MDM Requirements-
Service code 4 Problem Oriented Return (99214)

• Moderately Complex MDM (2/3 needed)
  – Moderate Risk (1/3 needed)
    • Mild exacerbation of a chronic problem
    • Two stable chronic problems
    • Prescription drug management or medication side effect
  – Multiple diagnoses/management options
    • Undiagnosed new problem without workup
  – Moderate complexity of data
Minimal Requirements - Service code 4
Chronic Disease Mgmt Return (99214)

2 of 3 needed (Hx, exam, MDM)

- Detailed History
  - Chief Complaint
  - HPI: Status of 3 chronic or inactive conditions or 4 elements (both are “extended HPI”)
  - 1 PFSH
  - ROS: 2 systems—OK to “reuse” systems but not symptoms.
    - Consider separate ROS section if HPI = 3 chronic conditions
Minimal Requirements- Service code 4
Chronic Disease Mgmt Return (99214)

- Detailed Exam
  - If HPI = 3 chronic conditions defer to Medical Decision Making
    - 1997 Detailed Exam = 12 elements in 2 or more systems
  - If HPI = 4 elements, see problem focused return

- Moderately Complex Decision Making
  - See problem focused return
  - Moderate risk includes (among other things):
    - Two or more stable or chronic conditions
Documentation Requirements for Other Visits

• Return service code 5 (99215)
  – If the visit complexity is high, either perform a comprehensive (8+ system) exam or document 10+ ROS and 2 PFSH

• New service code 4/5 (99204/5)
  – Consider new patient history form for efficient 10+ ROS. Document 3 PFSH. 8+ system exam.
Tools to systematize history and documentation process

• Patient Questionnaire
  – Update PMH/FH/SH
  – Complete ROS

• Documentation Templates and Habits
  – “PMH/FH/SH reviewed and updated on profile page”
  – “10+ system ROS otherwise negative”
Determinants of 99215

- **History**: common (4 HPI, 10+ ROS, 2 PFSH)
- **Exam**: 8 system (not extraordinary, for example: gen, EENT, pulm, CV, GI, skin, psych)
- **MDM** (Need 2 of 3):
  - **Dx**: (common) “New problem to examiner, further w/u”
  - **Risk**: (seldom) “life threatening”
  - **Data (4 points)**: lab = 1 pt; x-ray = 1 pt; med test = 1 pt

- **Key points for documentation**:
  - Obtain and summarize part of history from family member = 2 points
  - Review x-ray = 2 points
  - Review and summarize old records = 2 points
99215 (vs. 99214)

• Need to have 2 of comprehensive hx or exam, or high complexity MDM
  – Management of 3 chronic problems is usually 99214
  – Management of problem new to examiner with additional workup (or worsening of established problem and 2 stable chronic problems) is extensive # of diagnoses, but to reach 99215, need:
    • High risk (severe exacerbation of acute or chronic problem or drug therapy with intensive monitoring) OR
    • Extensive complexity of data (e.g., lab, ECG, and independent visualization of x-ray [or other additive criteria]) AND EITHER
      – 8 system exam performed OR
      – Comprehensive history, including 10+ROS and 2+PFSH
Problem Oriented Return, Case #1

• CC: 55 yo woman w/ back pain

• Level 3, 4, or 5?

• Depends on:
  – what is done (and medical necessity for it)
  – what is documented
Problem Oriented Return, Case #1, cont’d

- CC: 55 yo woman w/ back pain
- HPI
  - pt awoke 1 week ago with constant, aching, moderately-severe LBP
  - associated with intermittent spasms
  - improves with ibuprofen
  - no trauma, fevers, weakness, bowel or bladder sx
Problem Oriented Return, Case #1, cont’d

• Exam
  – Gen: BP 110/60
  – Back: lumbar paraspinous tenderness

• Assessment
  – LBP, probably muscular

• Plan
  – Continue ibuprofen
  – Begin cyclobenzaprine 10mg TID prn
  – RTC 2 weeks if not better, sooner prn
Problem Oriented Return, Case #1: analysis

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Problem Oriented Return, Case #1: detailed analysis

- History:
  - HPI extended

- Exam:
  - Expanded problem focused (2 systems)

- MDM:
  - Dx
  - Data
  - Risk
Problem Oriented Return, Case #1:
Analysis with: added history:
“medications reviewed, see summary page”

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Problem Oriented Return, Case #1: Analysis with added history and complexity

ROS: complete ROS o/w neg; PFSH: Non-smoker; Exam: T=102; MDM: W/U: CBC, MRI, discuss with spine surgeon

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Problem Oriented Return, Case #2:

S: 72 yo smoker whose daughter calls “20 lb wt loss in 2 mo”, fatigue. Sleeping a lot, some diarrhea, epigastric pain with eating. No hematochezia, no fever, 10+ system ROS o/w negative. Wife died 6 mo ago; PMH: CAD, pos. PPD
(4 HPI: severity, duration, context, assoc s/s; 2 PFSH)

O: 8 organ system exam

A: wt loss in elderly pt, very broad DDx

P: order and review CXR and ECG; order CBC, TSH, CPK, CMP; stool hemoccult
(7 Data: 1 lab, 1 x-ray, 1 medical test, 2 for other history source, 2 review CXR; note: some experts would only give 2 points for ordering x-ray and independent review of same)
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Chronic Disease Return #1

- CC/ID: 65 yo woman with several concerns
- Problem List/Med List- See 1/10/10 note; reviewed, no changes
- HPI
  1) Cerebrovascular Disease. No TIA symptoms.
  2) HTN. She is tolerating her HCTZ well.
  3) Hyperlipidemia. Her 12/09 lipid panel showed an LDL of 120.
- ROS
  - No exertional chest pain. Notes reflux symptoms every 1-2 weeks, controlled with Tums.
Chronic Disease Return #1 (Cont’d)

- Exam. BP 124/82. Weight 190 lbs. Appears well
- A/P
  1) Cerebrovascular disease. Continue aspirin. Repeat duplex in 1 year.
  2) HTN. Stable. Continue HCTZ.
  3) Hyperlipidemia. Above her target LDL given her cerebrovascular disease. Increase lovastatin to 40 mg/day. Lipid panel and ALT at her follow up visit in 3 months.
# Chronic Disease Return, Case #1

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<tr>
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Chronic Disease Return #2

• CC
  – 55 yo man with several concerns

• Problem List/Medication List
  – See 10/21/09 clinic note, with the adjustment that bupropion is being discontinued

• HPI
  1) HTN. His BP is usually around 120/80 when checked at work. He has no side effects from HCTZ.
  2) Depression. Mood is much better after 8 months of treatment. He would like to discontinue bupropion.
  3) Asthma. No recent exacerbations.
Chronic Disease Return #2 (Cont’d)

- ROS. No edema or cough
- PE. BP 130/80. P 70. Chest-Clear
- A/P
  1) HTN. Adequately controlled. Continue HCTZ
  2) Depression. Resolved. Bupropion 150 mg/day for 10 days then D/C. If his mood worsens significantly, he will restart it. Recheck in 3 months.
  3) Asthma. Continue prn albuterol
# Chronic Disease Return, Case #2

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Chronic Disease Return #3

- CC/ID: 63 yo man with several concerns
- Problem List/Medication List- See 1/9/10 note, except metformin is now 1 gm bid.
- HPI:
  1) Diabetes. Denies hypoglycemic episodes.
  2) Hyperlipidemia. Trying to follow a low fat diet.
  3) DJD. Knee pain adequately controlled with salsalate.
Chronic Disease Return #3 (Cont’d)

- ROS: No GI upset or skin lesions on feet
- Exam: BP 124/70  P 62  Weight 199 lb
- Lab: 12/09 HbA1c 7.5%, LDL 120
- A/P
  2) Hyperlipidemia. Risks and benefits of diet/exercise vs statins discussed. Continue diet and exercise. Repeat lipid panel in 3 months.
  3) DJD. Continue salsalate; script written for 3 months.
# Chronic Disease Return, Case #3

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Consults

• 3 Rs
  – Request
    • Must be in written record of requesting provider, even if request is verbal (CMS requirement effective January, 2006)
  – Render opinion
    • Premise is that the consultant has expertise beyond that of requestor for a specific area
  – Report to requesting physician
    • Must be written
    • May be part of shared medical record (“CC” in EMR OK)

• Referral is a transfer of care, not a consult
  • Occurs when an MD/NPP requests that another MD/NPP take over the responsibility for managing a patient’s complete care for a condition and does not expect to continue treating or caring for that condition: intent of request is key

» NPP = non physician provider
Consults

• When documenting a consult state:
  – “I was requested by Dr. Smith to evaluate Mr. Patient for ______________”
  – “Dear Dr. Smith, I saw Mr. Patient per your request in consultation for___________”
  – Report must include recommendations
Consults

A 59 year old clinic patient of yours is scheduled for elective prostatectomy. He has well controlled hypertension, type 2 diabetes and DJD. Current medications include ASA, HCTZ, and metformin. His surgeon asks you to do a preoperative evaluation to help plan his medication use during surgery.

You do:
- a detailed history (status of chronic disease, cardiac and pulmonary ROS, med review)
- a detailed exam that includes 5 systems: constitutional, pulmonary, cardiac, GI, musculoskeletal
- moderate complexity decision making

How do you code this encounter?
## New Outpatient Visit and Outpatient Consult

(need 3 of 3 elements)
(required elements are the same for new visit or consult, the only difference is when coding by time)

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### History (need all)
- **HPI**: 1
- **ROS**: 1
- **PFSH**: 1

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<td><strong>or 2 stable prob</strong></td>
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### Exam
- **Exam**: 1, 2, 5, 8

### Complexity (2/3)
- **#Dx**: 1, 0
- **Data**: No meds, No meds
- **Risk**: 1, 2

#### No meds
- **Prescription med**: 1 new no w/u or 2 stable prob
- **Life threaten**: 1 new w w/u or 2 worse

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• If this were a return office visit, it would be a level 4 return visit: 99214 (1.50 wRVU)
• However, since he was referred to you for consultation for a specific problem, it can be coded as a level 3 outpt consult: 99243 (1.88 wRVU)
  – Your note must indicate the reason for the referral, and a copy must go to the surgeon
• The coded diagnoses should include the reason he was referred (HTN, DM), and the procedure that is planned (prostatectomy)
• If you help with postop management, code with subsequent visit codes, not consult codes
Procedural Services

- Identified by CPT code
- Covers the spectrum from minor office based procedures to inpatient based surgery
- Global surgical period: physician services for a period of time around procedure
  - Example: Postop care of cholecystectomy
Procedural Services, cont’d

Common office procedures for internists:

- Destruction of premalignant lesion (CPT 17000, 0.65 wRVU)
- Cryotherapy of warts (CPT 17110, 0.70 wRVU)
- Subdeltoid bursa injection (CPT 20610, 0.79 wRVU)
- Paracentesis (CPT 49080, 1.35 wRVU)
Procedural Services, cont’d

- Mindset of CPT is that procedures occur as a separate service, on a scheduled basis
- For general internists, this is often not the case
- You can bill (and get paid) for simultaneous E and M and procedural services
A 60 year old woman presents for routine follow-up of hypertension. She takes HCTZ and enalapril. She feels well. Her BP today is 130/80.

She asks you to examine some red spots on her forehead. You identify 3 actinic keratoses and freeze them.

How do you code this visit?
Procedural Services, case 1 cont’d

- Management of hypertension: 99213 (wRVU 0.97)
- Destruction of skin lesion
  - For first lesion: 17000 (0.65 wRVU)
  - For second: 17003 (0.07 wRVU)
  - For third: 17003 (0.07 wRVU)
- Attach 25 modifier to the E&M service
- Total wRVU 1.77 (between level 4 and 5)
Procedural Services, case 2

- A 60 year old woman presents for follow-up of knee pain. At her last visit, you suspected osteoarthritis, and recommended NSAIDs.
- Your history today is EPF (brief HPI, single system ROS)
- Your exam today is EPF (vitals, musculoskeletal)
- You do an x-ray, which confirms OA, and decide to do an intra-articular injection

...How do you code this visit?
Procedural Services, case 2 cont’d

- E&M for knee OA: 99213 (wRVU 0.97)
- Intra-articular injection of knee
  - 20610 (0.79 wRVU)
  - Bill separately for drug injected (triamcinolone)
- Attach 25 modifier to the E/M service
- If you injected both knees, bill 20610 twice, add 50 modifier (“bilateral procedure”) to second procedure code
Preventive Services

- Mindset of CPT is that NO symptom or disease evaluation and management is done (*no CC, no HPI*)

- The CPT version requires the following:
  - Comprehensive history
  - Comprehensive pt-appropriate exam
  - Appropriate counseling

- Insurance coverage varies greatly
Preventive Services, cont’d

• For patients desiring preventive service, report using CPT codes
  - Determined by age and new vs. established (9938x, 9939x)
  - Established patient age 40-64, CPT 99396 (1.53 wRVU; 99214 1.50, 99215 2.11)

• For commercially insured patients, often paid without deductibles, so patients are motivated to have this reported correctly

• Not covered by Medicare
Preventive Services, cont’d

- Medicare DOES cover a group of preventive services
  - Breast and pelvic exam (G0101)
  - Obtaining screening PAP (Q0091)
  - Digital rectal exam (G0102 “bundled” unless only service performed)
  - Colon cancer screening (multiple codes)
  - Vaccines: influenza, pneumococcal, hepatitis B (high risk only)
Preventive Services, cont’d: G101 “Breast & Pelvic Exam”

- Requires at least 7 of the following:
  - Inspection & palpation of breasts
  - Digital rectal examination
  - External genitalia
  - Urethral meatus
  - Urethra
  - Bladder
  - Vagina
  - Cervix
  - Uterus
  - Adnexa
  - Anus and perineum

Preventive Services, cont’d: Smoking Cessation

- Two attempts per 12 month period, 4 counseling sessions per attempt
- Sessions can be “intermediate” (>3, ≤10 min) or “intensive” (>10 min)
- Services may be performed “incident to” services by a “qualified provider”

Preventive Services, cont’d:
Tests

- Screening PAP
- Screening FOB and others
- PSA testing
- Bone mineral density testing
- AAA testing
- Others determined by statute

Initial Preventive Physical Exam

- “Welcome to Medicare” visit (G0402; wRVU = 2.30)
- Must be done within 12 months of part B eligibility
- Can be done with other E&M service
- Must include
  - Comprehensive medical and social history review; brief physical exam (height, weight, BMI, BP, visual acuity); risk assessment for depression
  - Functional ability (hearing, ADLs, fall risk) and home safety assessment
  - End of life planning
  - ECG NO LONGER REQUIRED (though may be done)
  - Written plan for other preventive services

Preventive Services, cont’d

• A 50 year old man presents for his “annual checkup”. He is healthy except for stable, well controlled HTN, treated with HCTZ 25 mg q day. As you talk to him, it is clear that he expects age appropriate preventive services, as well as assessment and management of his disease.

• How do you proceed?
Preventive Services, cont’d

• You tell the patient that you have time to do both preventive services and assessment of his HTN today, but that you need to bill him for both

• You could offer to do 1 service today, and the other service on a different day
Preventive Services, cont’d

• You do a comprehensive history and exam, with extra attention paid to cardiovascular system, neurologic system, and potential side effects of HCTZ
• You order appropriate testing and counsel about his medication
• You document the preventive service and disease management service (note must demonstrate the extra work: safest is to document services separately)
• How should you code this encounter?
Preventive Services, cont’d

• You can use the following codes:
  • For the preventive service, CPT 99396 (1.53 wRVU)
  • For the disease management service, CPT 99213 (0.97 wRVU)
  • Attach a 25 modifier to the E/M code (99213)
  • Be sure to link ICD-9 codes to each CPT code:
    – V70.0 for 99396 (preventive service)
    – 401.1 for 99213 (disease management)
Preventive Services, cont’d: Elements needed

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*Based on age & risk factors; not synonymous with 8+ PE in 99215
Case Management

- A 70 year old patient of yours is hospitalized with pneumonia.
  - Medical history includes diabetes and osteoarthritis.
- The hospitalization goes well, except she develops a grade 2 pressure sore on her right heel.
- She is discharged to home with home health nursing visits to manage her pressure sore. You receive the home health agency care plan.
- What do you do with it?
Home Health Care Plan Certification

- Certification of home health care plan
- CMS covered service: use HCPCS code
- Done for 60 day period
- Initial certification: HCPCS G0179 (0.67 wRVU—between level 2 and 3 return visit)
- Recertification: HCPCS G0180 (0.45 wRVU—about same as level 2 return visit)
- Does **NOT** require a face to face visit
Care Plan Oversight

• A 52 year old C7 quadriparetic man receives daily home health nursing for his bowel and bladder program, as well as skin assessment and medication oversight. He works full time, and his quadriparesis resulted from an on-the-job injury.

• You spend 20 minutes reviewing his care plan for the next 60 days, then return it to his home health agency
Care Plan Oversight, cont’d

- Applies to a broad range of services
- Can only be done by 1 physician for any given time period
- You must have seen the patient within previous 6 months
- Report total time per 30 day period
- Time is either 15-29 min \( \text{OR} \geq 30 \text{ min} \)
- Our patient is 20 minutes, CPT 99374 (1.1 wRVU, between level 3 and 4 return visit)
- There are other codes for patients in hospice or nursing home
  - http://www.acponline.org/journals/news/jan-feb06/codes.htm
Care Plan Oversight, cont’d

• For Medicare patients, rules are slightly different
  – Use G0181 to report this service (1.73 wRVU, between level 4 and 5 return visit); use G0182 if for hospice care
  – Can only be used if time for 30 day period is ≥ 30 min
  – Time less than 30 min is considered a “bundled service”
Case Management, cont’d

• You notice Mr. X, a long time patient on your schedule
• He is a 78 year old patient who lives at home, but suffers from dementia
• The patient has a spouse-caretaker, a home health nurse, and a department of aging case manager
• When you go into the exam room, you are surprised to see them all there, but not Mr. X. They want to discuss behavioral problems he has been having
• Can you bill for this service?
  – Interdisciplinary care conference: not currently covered by CMS
  – You can bill the patient or the family member for this service
  – CPT 99367; (1.10 wRVU)
Case Management, Phone calls

- Ms. Y is a 53 year old female patient of yours with diabetes and hypertension.
- You last saw her 4 weeks ago. At that time, her BP was 150/95 on HCTZ, and you asked her to start enalapril 10 mg per day, take her BP 3 times a week, and either return for a visit or phone you with results. In addition, she had a BMP done 10 days after starting enalapril.
- She has called you to report she has had no side effects of enalapril. Her BPs have been 140-150/85-90. You review her overall medication regimen with her, the normal lab tests, and recommend she increase enalapril to 20 mg per day.
- Can you bill for this service?
Case Management, Phone calls, cont’d

- This phone call is a billable service
  - You are on the firmest ground for billing this if you told the patient at her last visit that you think a f/u phone call is OK, but you will need to bill her for it, and she must check with her health plan to see if any portion of her bill will be “covered”
- This service will be reimbursed by some private insurance carriers and Medicaid, but not Medicare
- CPT codes are: 99441-99443
  - 99444 is for a similar service done by electronic communication such as email
- “Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment”
  - 99441: 5-10 min of “medical discussion” (0.25 wRVU, 0.34 tRVU)
  - 99442: 11-20 min of “medical discussion” (0.5 wRVU, 0.64 tRVU)
  - 99443: 21-30 min of “medical discussion” (0.75 wRVU, 0.95 tRVU)
  - 99444: time not specified (0 wRVU)

- Should you provide or bill for this service?
EVALUATIONS!!
## Audit Tool

### HISTORY

<table>
<thead>
<tr>
<th>Category</th>
<th>Presenting Problems</th>
<th>Relevant Past History</th>
<th>Relevant Physical Examination</th>
<th>Treatment and Medication</th>
<th>Overall Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HISTORY</strong></td>
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### CHIEF COMPLAINT

<table>
<thead>
<tr>
<th>System</th>
<th>Complaint</th>
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### PHYSICAL EXAMINATION:

**Problem Focused:** Limited exam of affected body area or organ system
**Expanded Problem Focused:** Limited exam of affected body area or organ system & other symptoms or organ system
**Comprehensive:** General multi-system exam has organ system complete exam of a single organ system

### MEDICAL DECISION-MAKING

<table>
<thead>
<tr>
<th>Problem</th>
<th>Diagnostic Procedures/Tests</th>
<th>Management Options Selected</th>
<th>Number of Diagnoses or Treatment Options</th>
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<tbody>
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### OVERALL LEVEL OF SERVICE

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<th>Requirement</th>
<th>Level</th>
<th>Points</th>
<th>Percent</th>
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### GENERAL CONSIDERATIONS

- Audit Tool
- Comprehensive examination
- Medical decision-making
- Overall level of service

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### HICPAC

- **HICPAC**: Health Informational Containment Program
- **Comp**: Comprehensive Examination
- **Def**: Definitive Examination

---

### MEDICAL DECISION-MAKING

- **Dx**
- **Pr**
- **Therapy**

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### HISTORICAL SUMMARY

<table>
<thead>
<tr>
<th>System</th>
<th>History</th>
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