General Office Billing Guidelines

- Maintain accurate patient data: Obtain accurate demographic and insurance information from each patient. Periodically recheck the information with the patient in case anything has changed.
- Make patients aware of your billing policies: Certain preventive exams and other office services are not covered by Medicare (e.g., annual physical examinations). Make sure that patients are aware of your billing policies and that they may be required to pay for the visit or specified services.
- Document: Be honest and thorough. Note time spent with the patient. Ensure that diagnosis codes substantiate the procedures performed, and that visit codes are supported by documentation in the visit note.
- Remember the payer: While Medicare is the most common payer for a geriatrics practice, it is not the only payer.
Coding may be affected by HIPAA, but payment and coverage rules are not. A common example is that most Medicare + Choice plans ("Medicare HMOs") cover preventive examinations. You cannot bill the patient in such a circumstance. Note: In this document, Medicare rules are used.

- **Know what you get paid:** Select the code that most closely matches your service, not the code that has a reimbursement that most closely matches your charge. Sometimes, more than one code can be appropriately used to code the same service. In addition, you will receive the lower of either the allowance or your charge, so make sure your charges keep up with the allowances.

- **Know the rules:** Invest some time and use resources such as basic AMA publications and the Web site of the Center for Medicare and Medicaid Services (CMS): [http://www.cms.hhs.gov](http://www.cms.hhs.gov)

### Coding and Billing

**Key Terms**

- **Current Procedural Terminology (CPT):** A system of procedure codes and descriptions published annually by the American Medical Association (AMA). It has been adopted by the Secretary of Health and Human Services as the standard system of reporting medical services. It is accepted by virtually all commercial health insurance carriers and required by Medicare and Medicaid.

- **Healthcare Common Procedural Coding System (HCPCS):** A two-level coding system that identifies healthcare procedures, equipment, and supplies for claim submission purposes. It has been selected for use in HIPAA transactions. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set. These codes are important to know so that you can properly bill for such services as medication injections. Medicare also requires use of these codes for selected services even when there is a CPT code, eg, administration of influenza vaccine.

- **International Classification of Diseases:** A diagnostic medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set is to classify causes of death. A US extension, maintained by the National Center for Health Statistics within the Centers for Disease Control (CDC), identifies morbidity factors, or diagnoses. The ICD-9 CM codes (International Classification of Diseases, 9th revision, Clinical Modification) have been selected for use in HIPAA transactions. Claims processing requires you to submit a diagnostic code with each procedure using this classification system.

- **Carrier:** A private company that has a contract with Medicare to pay your Medicare Part B bills. This is the company that pays your claims—they are a valuable resource for billing questions.

- **Documentation Guidelines:** The Center for Medicare and Medicaid Services (CMS) published guidelines in 1995 and 1997 that provide detailed criteria regarding the documentation required to support the selection of evaluation and management codes. These guidelines were created for use by CMS for audit purposes. CMS allows physicians to use either set of guidelines. The guidelines can also be used to improve your understanding of code selection. [http://www.cms.hhs.gov/medlearn/emdoc.asp](http://www.cms.hhs.gov/medlearn/emdoc.asp)

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Need more help? Many more definitions can be found at [http://www.cms.hhs.gov/glossary/](http://www.cms.hhs.gov/glossary/)

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### Coding and Billing

**Coding for Evaluation and Management Services**

- Most of the work performed by geriatricians falls into the billing category of Evaluation and Management (E&M) services. But, do not forget that there are many non-E&M services for which you can and should bill. "E&M" describes the encounter between the patient and the physician while the physician is performing the physical, taking the history, arriving at a diagnosis, and treating the problem. It also describes patient counseling and coordination of care.

- Geriatricians use the same basic codes as primary care physicians, but some codes are used more frequently in
this specialty. The following material explains **how to select the correct category and level of code and how to document key elements** of the visit. In addition, information is provided about secondary codes used in conjunction with E&M services.

- This is simply a guide, and does *not* present an exhaustive list of possible services. Policies on coding are constantly being updated, and reimbursement policies and actual payments vary by insurer and locality. Therefore, it is important to find out the policies of your local Medicare intermediary and other payers in your area.

- For more information on Medicare billing guidelines, a .pdf file can be found at [http://www.cms.hhs.gov/medlearn](http://www.cms.hhs.gov/medlearn) (Scroll down to Medicare Resources and select Documentation Guidelines.) The CPT manual is also an invaluable reference; coding is well described in the "E&M Services Guidelines" section and in the introduction to each code category.

### Coding and Billing

**Frequently Used Common Procedural Codes**

The tables below list the most frequently used codes for Evaluation & Management (E&M) services by category (type and location of patient).

Time is *not* the basis for code selection, but time guidelines are provided for relative comparison between the codes.

The CPT manual published by the American Medical Association describes each code in detail. CPT resources are not available for free, but may be ordered online. See [http://www.ama-assn.org/ama/pub/category/3113.html](http://www.ama-assn.org/ama/pub/category/3113.html)

Scroll down and select from the following:

- Office visits .................................................................Scroll to Page 4
- In-patient visits ............................................................Scroll to Page 4
- Nursing facility visits ......................................................Scroll to Page 5
- Home visits .......................................................................Scroll to Page 6
- Domiciliary, [residential/custodial facility, or home care plan oversight services](http://www.ama-assn.org/ama/pub/category/3113.html), Scroll to Page 6
- Consultations.....................................................................Scroll to Page 7

**TIP**

The Medicare physician fee schedule, by region, for these and other codes can be accessed at [http://www.cms.hhs.gov/physicians/mpfsapp/default.asp](http://www.cms.hhs.gov/physicians/mpfsapp/default.asp)

Accept the agreement, and scroll down to Start. Type in the code and your region to find your allowable.

### Office Visits

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time (min)</td>
<td>Code</td>
<td>Time (min)</td>
</tr>
</tbody>
</table>
Frequently Used Common Procedural Codes

In-patient Visits

<table>
<thead>
<tr>
<th>Admission Visit</th>
<th>Daily Visit</th>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time (min)</strong></td>
<td><strong>Code</strong></td>
<td><strong>Time (min)</strong></td>
</tr>
<tr>
<td>30</td>
<td>99221</td>
<td>15</td>
</tr>
<tr>
<td>50</td>
<td>99222</td>
<td>25</td>
</tr>
<tr>
<td>70</td>
<td>99223</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Observation Initial Day</th>
<th>Discharge Day Management</th>
<th>Admit/Discharge Same Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>99218</td>
<td>99238 for &lt;30 min</td>
<td>99234</td>
</tr>
<tr>
<td>99219</td>
<td>99239 for &gt;30 min</td>
<td>99235</td>
</tr>
<tr>
<td>99220</td>
<td>99217-observation discharge</td>
<td>99236</td>
</tr>
</tbody>
</table>

Nursing Facility Visits

The nursing facility codes have undergone significant changes to simplify coding and to capture the higher levels of work for both the initial and subsequent codes. Previously, these codes were confusing, and physicians were often unable to bill correctly for the services they provided. The new nursing facility codes are more in line with other code families. However, typical times have not yet been established for the following codes.

The two major subcategories of nursing facility services are Initial Nursing Facility Care and Subsequent Nursing Facility Care. Both of these subcategories can apply to new or established patients. The Initial Nursing Facility Care visits are still associated with the Resident Assessment (MDS, RAP, etc) and must be performed by a physician.

<table>
<thead>
<tr>
<th>Initial Nursing Facility Care</th>
<th>Required (all 3 listed for each code)</th>
<th>Usual Nature of Problem Requiring Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code* (per day)</td>
<td>Components for Patient Evaluation and Management</td>
<td>Complexity of Medical Decision Making</td>
</tr>
<tr>
<td>99304</td>
<td>Detailed History</td>
<td>Straightforward or low</td>
</tr>
<tr>
<td></td>
<td>Detailed Examination</td>
<td></td>
</tr>
<tr>
<td>99305</td>
<td>Comprehensive History</td>
<td>Moderate</td>
</tr>
</tbody>
</table>
In all cases, counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the needs of the patient and of his or her family.

### Subsequent Nursing Facility Care

<table>
<thead>
<tr>
<th>Code (per day)</th>
<th>Required (2 of the 3 listed for each code)</th>
<th>Components for Patient Evaluation and Management</th>
<th>Complexity of Medical Decision Making</th>
<th>Usual Patient Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99307</td>
<td>Problem-focused interval history</td>
<td>Problem-focused examination</td>
<td>Straightforward</td>
<td>Stable, recovering, or improving</td>
</tr>
<tr>
<td>99308</td>
<td>Expanded problem-focused interval history</td>
<td>Expanded problem-focused examination</td>
<td>Low</td>
<td>Response to treatment has been inadequate, or minor complication has developed</td>
</tr>
<tr>
<td>99309</td>
<td>Detailed interval history</td>
<td>Detailed examination</td>
<td>Moderate</td>
<td>Significant complication or significant new problem has developed</td>
</tr>
<tr>
<td>99310</td>
<td>Comprehensive interval history</td>
<td>Comprehensive examination</td>
<td>High</td>
<td>Unstable or significant new problem requiring immediate physician attention has developed</td>
</tr>
</tbody>
</table>

In all cases, counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the needs of the patient and of his or her family.

### Discharge Codes:

The discharge codes have remained the same:

- **99315**: Nursing facility discharge day management; 30 minutes or less
- **99316**: Nursing facility discharge day management; more than 30 minutes

The new Annual Assessment code is **99318**:

- **99318**: Evaluation and management of a patient that involves an annual nursing facility assessment and that requires these three key components:
  - a detailed interval history
  - a comprehensive examination
  - medical decision making that is of low to moderate complexity

**TIP**  
Do not use 99318 on the same date of service as 99304-99316.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the needs of the patient and of his or her family.

Usually, the patient is stable, recovering, or improving.
Frequently Used Common Procedural Codes

**Home Visits**

<table>
<thead>
<tr>
<th>Time (min)</th>
<th>Code</th>
<th>Time (min)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>99241</td>
<td>15</td>
<td>99347</td>
</tr>
<tr>
<td>30</td>
<td>99242</td>
<td>25</td>
<td>99348</td>
</tr>
<tr>
<td>40</td>
<td>99243</td>
<td>40</td>
<td>99349</td>
</tr>
<tr>
<td>60</td>
<td>99244</td>
<td>60</td>
<td>99350</td>
</tr>
<tr>
<td>80</td>
<td>99245</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Domiciliary, Residential/Custodial Facility, or Care Plan Oversight Services**

**Domiciliary Care Codes**

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99324</td>
<td>99334</td>
</tr>
<tr>
<td>99325</td>
<td>99335</td>
</tr>
<tr>
<td>99327</td>
<td>99336</td>
</tr>
<tr>
<td>99328</td>
<td>99337</td>
</tr>
</tbody>
</table>


Care Plan Oversight Codes for Hospice: **99377** and **99378**  
Care Plan Oversight Codes for Nursing Facility: **33379** and **99380**

The following Care Plan Oversight codes are used for patients who are not in nursing homes, in hospice, or under home care. Although the Relative Value Update Committee has assigned a relative value to these codes, final values will not be available until CMS publishes the ultimate decision/rule. Currently, CMS does not recognize care plan oversight codes in this setting, and it is unclear whether payment policy will change.

**99339:** Individual physician supervision of a patient who is **not located** in their home or in a domiciliary or residential/custodial facility requiring complex and multidisciplinary care modalities that involve regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, and communication (eg, telephone calls). Used for purposes of assessment or care decisions with health care professional(s), family member(s), legal guardians, and/or key caregiver(s) involved in a patient’s care and of integration of new information into the medical treatment plan, and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

**99340:** As above but 30 minutes or longer

**TIP**  
Do **not** use code 99339 or 99340 for patients who are under the care of a home health agency or a nursing facility, or enrolled in a hospice program. Use codes 99374 to 99375 for these purposes.
Consultations

Within Consultations, the codes for follow-up inpatient consultations and for confirmatory consultations have been deleted (ie, 99261—99263 and 99271—99275 have been deleted).

Confirmatory Consultations – If requested by the patient or a family member, use the office visit codes. (The AGS believes that in inpatient settings, a request initiated by the patient or a family still requires attending approval and thus is a professional request.) If the consultation is requested by a health professional, use outpatient or inpatient consultation codes as appropriate for the setting.

Follow-up Inpatient Consultations – Use the codes for Subsequent Hospital Care and for Subsequent Nursing Facility Care.

Frequently Used ICD9-CM Codes

How to Select the Correct Category and Level of Code

Selecting the correct category of code depends on the type and location of the patient.

Type of Patient

- **New patient:** a patient who has not been seen for 3 years by you or another member of your group in the same specialty
- **Established patient:** a patient who has been seen within the last 3 years by you or another member of your group in the same specialty
- **Consultation:** an opinion requested by another physician that requires a report back to the requesting physician. Coding for consultations is the same for new and established patients. However, if a patient is seen after the consultation in follow-up for ongoing care, the codes for established patient office visits or subsequent care hospital should be used.

TIP Make sure your specialty is correctly listed with CMS. Geriatric medicine is 38. See [http://www.upinregistry.com/](http://www.upinregistry.com/)
Location of Patient

The location of the patient is the location where the patient is seen. For example, if you see a resident of an assisted-living facility in your office, use the office visit code. If you see the same patient at the assisted-living facility, use the domiciliary care codes. In the emergency department, you are typically acting as a consultant to the emergency attending physician. While the place of service is the ED, it is an outpatient area, therefore you can use the office or other outpatient consultation codes when acting as a consultant on the care of your patient.

The most common sites of care are listed below. For complete definitions of all Place of Service (POS) codes, see http://www.cms.hhs.gov/states/posdata.pdf

- Office
- In-patient
- Emergency department
- Nursing facility
- Home
- Assisted-living, custodial care facility

Selecting the correct level of code depends on documenting the key elements of the visit.

Coding and Billing

How to Select the Correct Category and Level of Code

Selecting the correct level of code depends on documenting the key elements of the visit:

- History ................................................................. Scroll to Page 9
- Examination .......................................................... Scroll to Page 10
- Medical decision-making ........................................ Scroll to Page 11

Most E&M visits should be coded based on the extent of the documentation of these three key elements.

- New patient visits and consultations require all three key elements.
- Established patient visits require two of the three key elements.

In certain cases when the visit is dominated by counseling or coordination of care or is for prolonged services, time-based billing can be used.
How to Select the Correct Category and Level of Code

The history is the first of the three key elements that must be documented when selecting a code.

The history consists of all three of the following:

- **History of present illness (HPI):** Describe the present illness in detail, including severity, duration, location, context, and associated signs and symptoms.

- **Review of systems (ROS):** Review the body systems through questions that identify signs and symptoms of current or past problems. This is often an area of weakness in visit notes.

  According to the Documentation Guidelines (1997), 14 systems are recognized. A comprehensive ROS for new patients includes 10 systems.

- **Past, family, and social history (PFSH):** Note all three areas of review.

  Past history includes a summary of significant past illnesses, injuries, or treatments.

  Family history indicates any significant hereditary factors. State "family history not relevant" if appropriate.

  Social history indicates marital status, occupation, living situation, help needed for activities of daily living, alcohol, tobacco, etc.

In addition, the history should be categorized as one of the following:

- **Problem-focused:** chief complaint, brief history of present illness or problem

- **Expanded problem-focused:** chief complaint, brief history of present illness, system review relevant to patient’s problem(s)

- **Detailed:** chief complaint; extended history of present illness; system review relevant to patient’s problem(s) and extended to include review of limited number of additional systems; relevant past, family, or social history directly related to patient’s problem(s)

- **Comprehensive:** chief complaint; extended history of present illness; review of systems directly related to patient’s problem(s) extended to include review of all additional body systems; complete past, family, and social history

**TIP**

Patient questionnaires are an excellent tool for documenting review of systems and past, family, or social history. Sign the form and/or mention it in the record so that your review is documented. It is also acceptable documentation to refer to previously documented past, family, or social history information as being unchanged.

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**Coding and Billing**
How to Select the Correct Category and Level of Code

The examination is the second of the three key elements that must be documented when selecting a code.

The level of examination depends on the number of body areas and organ systems documented. Similar to the history, the examination should be categorized as one of the following:

- **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 other symptomatic or related organ system(s)
- **Detailed**: an extended examination of the affected body area(s) or organ system and other symptomatic or related organ system(s)
- **Comprehensive**: a general multi-system examination, or a complete examination of a single organ system

According to Documentation Guidelines (1997), a detailed examination should include at least six body areas or organ systems, and a comprehensive examination should include at least nine.

Preventive medicine E&M service is usually multi-system, but its extent is based on age and identified risk factors.

**TIP**
Documentation templates, either paper or electronic, are an effective tool for documenting the examination.
- physical exam template ........................................... Scroll to page 22
- review of systems template ...................................... Scroll to page 22

**Coding and Billing**

How to Select the Correct Category and Level of Code

**Medical decision-making** is the most complex and “seemingly” subjective of the three key elements that must be documented when selecting a code. (Reviewing the clinical examples in the appendix of the CPT manual can help you understand this subject.)

Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option based on the following factors:

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

However, co-morbidities, in and of themselves, are not considered in selecting a level of E&M service unless their presence significantly increases the complexity of the medical decision-making.

Four levels of the complexity of medical decision-making are recognized:

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

According to Documentation Guidelines (1997), to qualify for a certain level of complexity, two of the three elements in the table below must be met or exceeded.

<table>
<thead>
<tr>
<th>Number of Diagnoses or Management Options</th>
<th>Minimal</th>
<th>Limited</th>
<th>Multiple</th>
<th>Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount and/or Complexity of Data to be Reviewed</td>
<td>Minimal or none</td>
<td>Limited</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risk of Complications and/or Morbidity or Mortality</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Medical Decision-making</th>
<th>Straightforward</th>
<th>Low complexity</th>
<th>Moderate complexity</th>
<th>High complexity</th>
</tr>
</thead>
</table>

In the number of diagnoses or management options, coding reviewers look for “degree of complexity,” so consider and document the problem as:

- Self-limiting or minor
- Established, stable or improved
- Established, worsening
- New, no additional workup
- New, additional workup planned

For amount and/or complexity of data to be reviewed, consider tests such as the following that are ordered and reviewed:

- Clinical laboratory tests
- Radiology tests
- Other tests, eg, ECG, pulmonary function tests
Also consider the following activities:

- Discussing test results with the physician who performed the test(s)
- Deciding to obtain old records or additional history from someone other than the patient
- Reviewing old records or obtaining additional history from someone other than the patient. However, this does not count as time if you use time in determining the visit code.
- Presence of any family members or involvement of interpreter during visits. Difficulties with language, hearing, etc, are also accepted reasons for use of prolonged services codes. The key is that the patient is present.

For level of risk of complications and/or morbidity or mortality, consult the Documentation Guidelines (1997). In general, four levels of risk are recognized. The highest level is assigned based on the presenting problem, the diagnostic procedure(s) ordered, or the management option selected.

**Coding and Billing**

**How to Select the Correct Category and Level of Code**

*Time-based Billing*

- Although most codes are selected based on the three key elements of **history, examination, and medical decision-making**, in certain cases, **time-based billing** (ie, billing on the length of the visit) can be used.
- Visits must be dominated by counseling or coordination of care.
- Time is defined as **face-to-face** time for out-patients or floor/unit time for in-patients.
- Three things must be documented: the total duration of the visit, that at least 50% of the time was spent on counseling or coordination of care, and the issues that were discussed.

*Example*  A 40-minute visit with an established patient in which over half the time is spent discussing side effects of medication qualifies as a level 5 established patient visit.

**TIPS**

- For visits that are not dominated by counseling or coordination of care, billing cannot be based on time; however, time may still be a useful preliminary indicator of appropriate code selection.
- Some codes do not have reference times, so time cannot be used with them. Domiciliary care codes are an example.
The following table lists CPT coding examples for new and established patient office visits.

<table>
<thead>
<tr>
<th>Description of Office Visit</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Patient Visits</strong></td>
<td></td>
</tr>
<tr>
<td>Patient with small area of sunburn requiring first aid</td>
<td>99201</td>
</tr>
<tr>
<td>Patient with recurring episodes of herpes simplex who has developed a cluster of vesicles on the upper lip</td>
<td>99202</td>
</tr>
<tr>
<td>50-year-old woman with dyspepsia and nausea</td>
<td>99203</td>
</tr>
<tr>
<td>70-year-old patient with recent onset of episodic confusion</td>
<td>99204</td>
</tr>
<tr>
<td>65-year-old woman with exertional chest pain, intermittent claudication, syncope, and a murmur of aortic stenosis</td>
<td>99205</td>
</tr>
<tr>
<td><strong>Established Patient Visits</strong></td>
<td></td>
</tr>
<tr>
<td>82-year-old woman with documented vitamin B₁₂ deficiency; visit is for monthly B₁₂ injection</td>
<td>99211</td>
</tr>
<tr>
<td>65-year-old man with eruptions on both arms from exposure to poison oak</td>
<td>99212</td>
</tr>
<tr>
<td>55-year-old man for management of hypertension and mild fatigue; patient is on beta blocker/thiazide regimen</td>
<td>99213</td>
</tr>
<tr>
<td>68-year-old woman for routine review and follow-up of non-insulin-dependent diabetes, obesity, hypertension, and congestive heart failure; patient complains of vision difficulties and admits dietary noncompliance; patient is counseled concerning diet, and current medications are adjusted</td>
<td>99214</td>
</tr>
<tr>
<td>70-year-old woman with diabetes mellitus and hypertension, presenting with 2-month history of increasing confusion, agitation, and short-term memory loss</td>
<td>99215</td>
</tr>
</tbody>
</table>

*Source: CPT® 2004 Professional (pp 394-400). ©American Medical Association. All rights reserved.

### Preventive Medicine Visits

- Not all insurers pay for preventive medicine visits. For example, these visits are not covered by Medicare. If you suspect a patient does not have coverage, advise him or her of your billing policies.
- Insurers that do cover preventive medicine visits (eg, many HMOs) generally reimburse them at relatively high rates.
- Regardless of whether a preventive medicine visit is covered, the relevant codes can be used alone or in conjunction with a code for an E&M service (see below).

<table>
<thead>
<tr>
<th>Patient and Visit</th>
<th>Preventive Medicine Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New patient, initial visit</strong></td>
<td></td>
</tr>
<tr>
<td>Age 40 through 64 years</td>
<td>99386</td>
</tr>
</tbody>
</table>
Preventive Medicine Visits in Conjunction with an E&M Service

What should you do when you find a problem during an otherwise preventive medicine visit?

- Select the appropriate preventive medicine code and the E&M code that best represents the problems addressed.

Example

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>99397</td>
<td>$225</td>
</tr>
<tr>
<td>99214</td>
<td>$175</td>
</tr>
</tbody>
</table>

The patient will owe the difference if he or she has Medicare and a secondary insurance. $225 – $175 = $50

- Medicare allowable for a level 4 visit $87.78
- Medicare pays 80% $70.22
- Patient or secondary insurance pays remaining 20% $17.56

Patient total out-of-pocket may be up to $50 + $17.56 = $67.50

Note: Medigap will pay the secondary insurance amount but not the additional charge for the preventive medicine service that is not covered.

- Do not increase the level of the code for the E&M service to account for preventive medicine efforts.

Supervised Nurse Practitioner or Physician Assistant Visits: “Incident To”

- When a nurse practitioner or a physician assistant sees a patient “incident to” the physician, the physician can bill Medicare at the full physician allowance.
- The supervising physician must be on-site in the office suite.
- The nurse practitioner or physician assistant must be an employee of the physician or the physician’s group.
• A care plan must be pre-established by the physician, ie, new patient visits are not eligible.

• The physician may be required to co-sign the nurse practitioner’s note for certain payers. Signing all notes is probably a good idea.

• A licensed practical nurse (LPN), medical assistant (MA), or other nurse can see patients incident to the physician, but these visits are restricted to level one code (99211).

**TIP**  
Credentialed nurse practitioners and physician assistants can bill independently for both new and follow-up visits. While Medicare pays at 85% of the physician’s allowable, secondary insurers vary, so it is prudent to check with each one and enroll the mid-level practitioner as necessary. In fact, because payment on “incident to” billing situations is increasingly becoming more restricted, independent billing may be more appropriate for your circumstances.

### Coding and Billing

#### Supervised Resident Visits

• Physicians who are supervising residents must see the patient themselves.

• The bill is based on the combination of documented services of the attending physician and the resident.

• The attending physician must document that he or she performed or was present during the key portions.

• The attending physician must document his or her participation in the patient management.

• The attending physician does not need to copy the history. Acceptable language might be “I saw and evaluated the patient. I agree with the findings and the plan of care as documented by the resident.” or “I was present during the history and physical. I discussed the case with the resident and agree with the findings and plan as documented by the resident.”

• The modifier “GC” should be used with the selected CPT code to indicate involvement of a resident or fellow.

• Another option exists for primary care clinics. The physician does not have to actually see the patient, but he or she is then subject to different limitations. For example, the ratio of resident:physician visits may be set at 4:1, or billing over level 3 may not be allowed. For more detailed information, see [http://www.cms.hhs.gov/manuals/14_car/3b15000.asp#_15016_0](http://www.cms.hhs.gov/manuals/14_car/3b15000.asp#_15016_0) (the CMS Carriers Manual, Part 3, Chapter XV, Supervising Residents in Teaching Sessions).

#### Coding and Billing

#### Modifier 25

• The modifier “25” is used when a significant, separately identifiable E&M service is provided by the same physician on the same day of another procedure or service.
• A physician may perform a procedure or service, identified by a CPT code, on the same day that the patient’s condition requires a significant, separately identifiable E&M service above and beyond the "other" service provided, or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

• The E&M service may be prompted by the symptom or condition for which the procedure or service was provided. As such, different diagnoses are not required for reporting the E&M services on the same date. This circumstance should be reported by adding the modifier "25" to the appropriate level of E&M service.

Rules

• Certain services or procedures are considered part of another service or procedure.

• CMS uses Correct Coding Initiative (CCI) claims systems edits.

• Modifiers signal that CCI does not apply; using a modifier improperly may be considered fraud or abuse of the system.

• Modifier 25 does not override an edit, but indicates that you performed a service that was not part of the global or minor procedure.

Example

A person comes in with difficulty walking. After taking the history and performing an examination, you determine that the patient has osteoarthritis of the knee and would benefit from arthrocentesis and an intra-articular injection of a steroid.

You would bill the E&M with the modifier "25" because a separate E&M service was performed. You would also bill the arthrocentesis and medication codes.

Three months later, the patient calls and says the shot worked great and he would like another. You tell the staff to schedule the procedure. You ask the patient if he has had any problems and check to make sure the knee does not have an effusion, which would suggest a more serious condition. You perform the arthrocentesis and injection.

In this case, the plan was to perform the arthrocentesis and injection. Checking to be sure it was safe to perform the procedure before doing so is not a separately identifiable E&M service. Therefore, you should not bill for an E&M service, nor use the modifier. You should bill only the arthrocentesis and medication codes.

Coding and Billing

Prolonged Services

CPT Codes for Prolonged Services

<table>
<thead>
<tr>
<th>Description</th>
<th>Office</th>
<th>In-patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 30-74 minutes</td>
<td>99354</td>
<td>99356</td>
</tr>
<tr>
<td>minutes beyond the usual Estimated time for Code</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Time counted toward payment for prolonged E&M services includes only direct face-to-face contact between the physician and patient. It can include time that is spent with the family or caregiver so long as the patient is present.

• This code is used in addition to the primary code once the face-to-face time is 30 minutes longer than is typical. This is often the situation for complicated cases in which patients have extensive counseling needs or require unusual time due to communication or mobility limitations.

• Unlike for length of time (time-based billing), counseling or coordination of care do not need to dominate the use of this code. However, comments about time usage are still applicable. For example, the base code must have a time, the amount of time must be precisely documented, etc.

• Although the code for prolonged services can be added to any code, applying it to the higher level code is generally most appropriate.

**ESTIMATED TIMES FOR CODES AND THRESHOLD TO BILL FOR PROLONGED SERVICES**

<table>
<thead>
<tr>
<th>CODE</th>
<th>ESTIMATED TIME FOR CODE</th>
<th>THRESHOLD TIME FOR 99354</th>
<th>THRESHOLD TIME FOR 99354 AND 99355</th>
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<tr>
<td>99201</td>
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<td>50</td>
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<td>99205</td>
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</tr>
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<td>35</td>
<td>80</td>
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<td>99212</td>
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<td>99308</td>
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<td>115</td>
</tr>
<tr>
<td>99309</td>
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<td>90</td>
<td>135</td>
</tr>
</tbody>
</table>

**Rules**

• Billed in 30-minute increments

• Must be face-to-face
• Used in both office and in-patient settings
• Billed in addition to other services, including E&M at any level
• Must document the duration and content of the prolonged service personally rendered by the physician

**TIP**
• For more information on prolonged physician services visit [http://www.medicarenhic.com/providers/billing/prolongsrvs_0105.htm](http://www.medicarenhic.com/providers/billing/prolongsrvs_0105.htm)

## Coding and Billing

### Home Health Certification

CPT Codes for Home Health Certification (HCPCS II codes)

<table>
<thead>
<tr>
<th>Certification</th>
<th>G0180</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recertification</td>
<td>G0179</td>
</tr>
</tbody>
</table>

• Physician certification services for Medicare-covered services provided by a participating home health agency (patient not present), include (per certification period) review of initial or subsequent reports of patient status, review of patient’s responses to the OASIS* assessment instrument, contact with the home health agency to ascertain the initial implementation of the plan of care, and documentation in the patient’s office record.

• The patient must be homebound.

• See Care Plan Oversight Card for documentation and billing.

### Rules

• G0180 is billed only if the patient has not received Medicare Home Health services within last 60 days
• Recertifications can be done every 60 days from time of initial certification
• Rare situations for “new plan of care” can allow for recertification before 60 days

*For more information on OASIS (Outcome and Assessment Information Set), see [http://www.cms.hhs.gov/oasis](http://www.cms.hhs.gov/oasis)

## Coding and Billing

### Home Health Care Plan Oversight

CPT Codes for Home Health Care Plan Oversight (HCPCS II)

<table>
<thead>
<tr>
<th>Home</th>
<th>G0181</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>G0182</td>
</tr>
</tbody>
</table>

• Care plan oversight (CPO) is defined as physician supervision of a patient receiving Medicare-covered services that are provided by a participating home health agency/hospice. The physician is not in direct contact with the patient.

• This supervision requires complex and multidisciplinary care that involves regular 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 healthcare professionals involved in the patient’s care, integration of new information into the treatment plan, and/or adjustment of medical therapy, totaling 30 minutes or more within a calendar month.
**Rules**

- Requirement for a timesheet documenting over 30 minutes exclusive of certification and discussion with nonprofessionals (eg, family)
- No financial relationship with agency or hospice medical director
- Only one physician may bill. CPO is part of the postoperative global service and, therefore, the person who performed the surgical procedure may not bill CPO within the global. However, a primary care physician may bill CPO within the surgeon’s global.
- Prior face-to-face encounter (6 months) by the physician billing CPO must have occurred.
- 30 minutes/month minimum
- Box 23—agency number must be completed
- See Care Plan Oversight Card for documentation and billing

**Coding and Billing**

**Advanced Beneficiary Notice**

- Many insurance companies, including Medicare, are denying payments to physicians for office visits, procedures, tests, etc, which they think are routine or for screening purposes. Payments are also denied when the reason the physician is ordering or providing the service is not covered.
- By signing an Advanced Beneficiary Notice (ABN), the patient agrees to assume financial responsibility for services not covered by their insurance company.
- The ABN must be signed in advance, or you cannot bill the patient for the service.
- The ABN is not a routine form to have on file in the event of a denial. It is used when a denial is anticipated and this has been explained to the patient, who accepts responsibility for the service.
- Technically, an ABN is not required for services that are never covered (eg, preventive medicine visits for a Medicare beneficiary), but it is wise to have patients formally accept liability in all cases when a denial of coverage is likely.

**Psychiatry, Psychology, and Social Services**

- Psychiatrists, psychologists, or licensed clinical social workers who provide services for patients in a geriatrics practice use the CPT and ICD-9 codes specified for mental health. Psychiatrists can provide therapy and E&M services in the same visit using specified CPT codes for these services.
- Any physician may use the mental health ICD-9 codes that best describe the reason for the service, even if that service is an E&M service. However, different co-insurance amounts apply to mental health services in Medicare. The benefit amount is determined by the diagnosis, so an E&M service with a mental health diagnosis will trigger the mental health benefit level. For more detailed information, see [http://www.cms.hhs.gov/medlearn/mentalhealth.pdf](http://www.cms.hhs.gov/medlearn/mentalhealth.pdf)
TIPS

- Caregiver support services are not considered therapy and should be charged directly to the patient or caregiver. Such services include discussions about housing, transportation, daily care, etc.
- Family psychotherapy without the patient present (code 90846) is a Medicare-reimbursable service. However, reimbursement varies by insurance carriers. The time must be spent discussing the patient’s problem for which an ICD-9 code has already been assigned and that supports the medical necessity for use of this code. For example, Senile dementia, which has the code 290.0, and Senile dementia with delirium, which has the code 290.3, support use of the CPT code 90846. Check with your local carrier for their medical review policy.

Coding and Billing

Forms and Templates

- The following documents are sample templates and can be modified for your individual practice. The inpatient and care plan oversight documents must be printed locally and reformatted to create a convenient index sized card.

  - **Documentation Template - Physical Exam** ...........................................to be added in future
  - **Documentation Template - Review of Systems** ................................for the CPT code 90846. Check with your local carrier for their medical review policy.

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