Handout for coding

Evaluation and management

CHIEF COMPLAINT (CC)
The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.
The medical record should clearly reflect the chief complaint. If not, the service is either preventive service or unbillable.

Evaluation and Management Category

New Patient is one that have not received any professional service from the physician or other qualified health professional of the **exact** the same specialty or sub-specialty, who belong to the same group practice.

Established Patient is one that have received any professional service from the physician or other qualified health professional of the **exact** the same specialty or sub-specialty, who belong to the same group practice.

Can established patient become a new patient?
The answer is **yes,** the rule of thumb is 3 years after last seen by the provider.

E/M services recognize seven components.
These components are:

- **History**
- **Examination**
- **Medical decision making**
- Counseling
- Coordination of care
- Nature of presenting problem; and
- Time

3 Key components

- History (HPI) a record of patient's medica history, including current symptom, past illnesses, and family history
- Examination a physical examination of the patient's body to assess their health.
- Medical Decision Making (MDM) the process of evaluating patient present condition and determining the appropriate course of treatment.

E/M service is dependent on two or three key components.
Performance and documentation of one component (e.g, exam) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

New guidelines - Evaluation and Management

- On **Jan. 1, 2021**, the CMS and AMA implemented revised guidelines and code descriptors for office and other outpatient services E/M codes 99202-99215.

The coding guidelines were overhauled to change the code selection requirements to be based on medical decision making (MDM) or total time of the E/M service.

- Eliminated the requirement to meet a certain level of history and exam, instead requiring a medically appropriate history and/or physical exam.
- The goals to reduce administrative burden and better align coding with how patient care is delivered today. Patient care should be driven by the need to treat patients, not the need to satisfy a coding requirement.

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option. The level of complexity was reduced from 5 to 4 levels for office outpatient.

Factors to consider in determined MDM level

- The number of possible diagnoses and/or the number of 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 comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management option.

TIME

- Is the explicit factor in choosing the most appropriate level of E/M services.
- It is the time spent by a physician or other qualified health care professional assessing and managing a patient on the date of the encounter.
- Should the time spend face-to-face with the patient is 15-20 minutes and using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
- Time spent reviewing records, tests, arranging services, and communicating with other professionals and the patient through written reports and telephone contacts is considered non-face-to-face time and cannot be included in the time when billing based on time.
- Does not apply to all E/M codes. you should not consider time to be a component for emergency department (ED) E/M services. Most ED services are provided in a setting where multiple patients are seen during the same time. It would be difficult to calculate time for any one patient.

Coding

Screening for TB

- **Procedure/service code**

- ✓ New Patient 99202 and 99203
- ✓ Establish Patient 99211,99212 and 99213

- **Other procedure/service code**
  - ✓ Screening and other laboratory codes
  - ✓ Skin Test
  - ✓ IGRA Quantiferon
  - ✓ Sputum Aero induce technique.

- **Diagnosis code**
  - ✓ Encounter for screening for TB
  - ✓ Contact with and (suspected) exposure to TB

  Other diagnosis (if applicable)
  - ✓ HIV disease (confirm)
  - ✓ Screening for HIV
  - ✓ Kidney transplant status (write in)
  - ✓ Liver transplant status (write in)
  - ✓ All pre-existing condition, symptom and factor influencing health status

  Code Symptoms
  - ✓ Cough
  - ✓ Night sweats
  - ✓ Abnormal weight loss (assign BMI)
  - ✓ Abnormal sputum
  - ✓ Low grade Fever
  - ✓ Fatigue
  - ✓ Hemoptysis

  Other diagnosis (if exist)
  - ✓ Alcohol abuse and dependence
  - ✓ COPD
  - ✓ Diabetes
  - ✓ ESRD
  - ✓ Nicotine dependence
  - ✓ Hep C
  - ✓ Hypertension
  - ✓ Obesity
  - ✓ Adverse effect of medications

Active TB – Initial and recurring treatment for active TB

- **Procedure code**
  - ✓ New Patient 99203 and 99204
  - ✓ Established Patient 99213 and 99214

- **Other procedure code**

  All required test to confirm active TB

- **Diagnosis code**

- ✓ Respiratory Tuberculosis A15.0 – A19.9

Other diagnosis code

- ✓ Code all pre-existing condition (related and non-related)
- ✓ Code all other factors influencing health.

Diagnosis code for MDR

- ✓ Z16.20 Resistance to unspecified antibiotics
- ✓ Z16.24 Resistance to multiple antibiotics
- ✓ Z16.341 Resistance to single antimycobacterial drugs
- ✓ Z16.342 Resistance to multiple antimycobacterial drugs

Initial and recurring treatment of Latent TB Infection (LTBI)

- **Procedure/service codes**
  - ✓ New Patient 99203 and 99204
  - ✓ Establish Patient 99213 and 99214

- **Other procedure/service code**
  - ✓ Screening and all other laboratory service codes including x-ray (if applicable)

**Note* *LTBI is not eligible to bill using CODE H0033.*

Eligible dx code for DOT are A15.0 to A19.9

- **Diagnosis code**
  - ✓ Latent tuberculosis Z22.7 *(use for confirmed dx only, otherwise use codes for abnormal findings)*

Other diagnosis codes

- ✓ Long-term current use of medicine
  - Z79.2 Long-term (current) use of antibiotics
  - Z79.899 Other long-term (current) drug therapy
- ✓ All pre-existing condition, symptom and factor influencing health status.
- ✓ All other abnormal test result

Daily encounter – **DOT** (on UB04 or CMS 1450)

- **Procedure** - H0033
- **Diagnosis** – A15 to A19.9

Telehealth (last updated, January 2023)
Telehealth" means the mode of delivering health care services and public health via information and communication technologies.

Documentation Requirements

- Practitioners must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT® or HCPCS codes.
- Benefits or services delivered via telehealth should be the same as for a comparable in-person service.

- The distant site provider can bill benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier.
- Responsible for maintaining appropriate supporting documentation and should be on patient medical record/chart.
- Consent

Providers should also note the following:

- Medi-Cal service or benefit being delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code(s) as well as any other requirements described in this section of the Medi-Cal provider manual.
  e.g., H0033 – Oral medication administration- direct observation
- For billing purposes, providers must ensure that the documentation, typically images, sent via store and forward be specific to the patient's condition and adequate for meeting the procedural definition and components of the CPT or HCPCS code that is billed.
- Claims are subject to all existing Medi-Cal coverage and reimbursement policies.

Consent

- Health care providers must inform the patient prior to the initial delivery of telehealth services about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services.
- Required to report the most applicable place of service.

Reimbursable Telehealth Service

- Telehealth modalities are reimbursable when billed
  - ✓ **Modifier 95** Provided via synchronous, inter- active audio and visual telecommunications systems.
  - ✓ **Modifier 93** Provided via synchronous telephone or other real-time interactive **audio-only** telecommunications systems.
  - ✓ **Modifier GQ** Provided via asynchronous store and forward telecommunications systems.

*Modifier should be attached to Evaluation and Management codes

Final thoughts

Create a culture of compliance.

"Just because your competitor is doing something doesn't mean you can or should."

When in doubt, ask question or help.

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