Billing and Coding Pearls for Primary Care

Stephanie M. Benson, MD, FAAFP

Faculty and Associate Program Director

Southern NM Family Medicine Residency Program

Disclosures

- I have nothing to disclose.

Objectives

- Review billing pearls for common primary care services.
- Discuss the use of add on codes, such as the advance care planning code, to capture billing for services you already provide.
- Demonstrate how to incorporate additional billable services, such as annual wellness visits, into your daily routine.
- Discuss changes to CMS billing and coding rules.

Pearls

- Procedures and same day visits, remember to use the 25 modifier
- Correct units for immunizations
- Correct units for medications administered
- In office labs, EKG interpretation, nebulizer treatments

Nicoletti, B. Chart Audit: Is Your Practice Billing What It Should?
Fam Pract Manag. 2009 Mar-Apr;16(2):15-19.

Perform Chart Audits

1. Select a day to audit from three months ago.
2. Print a patient list from that day's appointment schedule.
3. Pull the superbills for that day.
4. Print out the patient account detail for *only* the date of service you're auditing.
5. Pull the patient charts for that day.
6. Use an audit tool, record the pertinent data in each field.
7. If all or part of the claim was denied or if the amount of payment seems lower than the fee schedule amount, consult the explanation of benefits for more information.
8. Compare the diagnosis codes from the superbill, patient account and medical record and note any differences or discrepancies.
9. Summarize discrepancies on a separate page, noting the dollar amounts of unbilled charges or others that should have been paid.
10. Act on what you find.

Nicoletti, B. Chart Audit: Is Your Practice Billing What It Should?
Fam Pract Manag. 2009 Mar-Apr;16(2):15-19.

Add on codes

- Screening and assessment codes
- Counseling codes
- Transitional Care Management
- Chronic Disease Management

Screening and assessment codes

CODE	PAYER	REQUIREMENTS	ADDITIONAL INFO
G0442	Medicare	Screening for alcohol misuse in adults, 15 minutes	Annual. Does not need assoc. signs and sx of illness. No intervention needed
G0444	Medicare	Screening for depression in adults, 15 minutes	Annual screening
96110	Commercial insurance, Medicaid	Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	Developmental and autism screening. Developmental surveillance w/o structured screening instrument included in WCC
96127	Commercial insurance, Medicaid	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder scale), with scoring and documentation, per standardized instrument	Use for both screening and follow-up of emotional and behavioral health conditions
99160	Commercial insurance, Medicaid	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument	Alcohol screening without intervention, Concussion evaluations, Nutrition Assessments
99161	Commercial insurance, Medicaid	Administration of caregiver-focused health risk assessment instrument for the benefit of the patient, with scoring and documentation, per standardized instrument	Postpartum depression screening during WCC, Caregiver Strain Index

Hughs, C. Getting Paid for Screening and Assessment Services.
Fam Pract Manag. 2017 Nov-Dec;24(6):25-29.

Screening and assessment codes

CODE	PAYER	REQUIREMENTS	ADDITIONAL INFO
G0101	Medicare	A screening pelvic and clinical breast exam for all female beneficiaries every 2 years.	Pelvic and breast exam required, 7 of 11 elements required. Can be billed with E/M with 25 modifier
Q0091	Medicare	Collection of pap smear, can be billed every 2 years	Screening not diagnostic. Can be billed with E/M with 25 modifier
G0102	Medicare	Annual DRE for men over age 50	Can only be billed independently. Screening not diagnostic.
G0103	Medicare	Annual prostate cancer screening test for men over age 50	PSA. Screening not diagnostic. No modifier needed.

Mills, T., Six Payment Opportunities You May Have Overlooked.
Fam Pract Manag. 2008 Nov-Dec;15(9):27-32.

Counseling Codes-Tobacco

CODE	PAYER	REQUIREMENTS	ADDITIONAL INFO
99406	All	Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	Submit with diagnosis code for the patient's condition affected by the use of tobacco. Use with E/M for office visit and 25 modifier
99407	All	Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes	Submit with diagnosis code for the patient's condition affected by the use of tobacco. Use with E/M for office visit and 25 modifier

Mills, T. Six Payment Opportunities You May Have Overlooked.
Fam Pract Manag. 2008 Nov-Dec;15(9):27-32.

Counseling Codes-Advance Care Planning

CODE	PAYER	REQUIREMENTS	ADDITIONAL INFO
99497	ALL	Explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes (minimum of 16 minutes), face-to-face with the patient, family member(s), and/or surrogate	Use with E/M for office visit. Document minutes spent, who was present and what was discussed. Completion of advance directive not required. Can be billed as stand alone. Can be billed with AWV
+99498	ALL	Each additional 30 minutes of advance care planning	Bill with 99497

Nicoletti, B. Four Coding and Payment Opportunities You Might Be Missing. Fam Pract Manag. 2016 May-June;23(3):30-35

Counseling Codes-Alcohol

CODE	PAYER	REQUIREMENTS	ADDITIONAL INFO
99408	Commercial insurance, Medicaid	Alcohol and/or substance abuse structured screening and brief intervention, 15–30 mins.	Use with other evaluation and management (E/M) codes by using modifier 25
99409	Commercial insurance, Medicaid	Alcohol and/or substance abuse structured screening and brief intervention, > 30 mins.	Use with other evaluation and management (E/M) codes by using modifier 25
G0396	Medicare	Alcohol and/or substance abuse structured screening and brief intervention, 15–30 mins.	"to evaluate and/or treat patients with signs/symptoms of illness or injury“, Use the five A’s (Ask, Assess, Advise, Assist, and Arrange)
G0397	Medicare	Alcohol and/or substance abuse structured screening and brief intervention, > 30 mins.	"to evaluate and/or treat patients with signs/symptoms of illness or injury“, Use the five A’s.
G0443	Medicare	Brief face-to-face behavioral counseling for alcohol abuse, 15 minutes.	Up to four per year for individuals who screen positive for alcohol misuse. Can bill with G0442

Zoorob, RJ, Grubb J, Gonzalez SJ, Kowalchuk AA. Using Alcohol Screening and Brief Intervention to Address Patients' Risky Drinking. Fam Pract Manag. 2017 May-June;24(3):12-16.

Transitional Care Management

CODE	PAYER	REQUIREMENTS	ADDITIONAL INFO
99495	Medicare	• Communication (direct contact, telephone, or electronic) with the patient or caregiver within two business days of discharge • Medical decision making of *at least moderate complexity* during the service period • A face-to-face visit within *14 days* of discharge	First communication can be from staff member. Pays more than standard E/M code. Billed independently.
99496	Medicare	• Communication (direct contact, telephone, or electronic) with the patient or caregiver within two business days of discharge • Medical decision making of *high complexity* during the service period • A face-to-face visit within *7 days* of discharge	First communication can be from staff member. Pays more than standard E/M code. Billed independently.

Nicoletti, B. Four Coding and Payment Opportunities You Might Be Missing. Fam Pract Manag. 2016 May-June;23(3):30-35

Chronic Disease Management

CODE	PAYER	REQUIREMENTS	ADDITIONAL INFO
99490	Medicare	At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month • 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	Time spent directly by the billing practitioner or clinical staff counts. Assumes 15 minutes of work by the billing practitioner per month.
99491	Medicare	At least 30 minutes of physician or other qualified health care professional time, per calendar month • 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	Only time that is spent personally by the billing practitioner

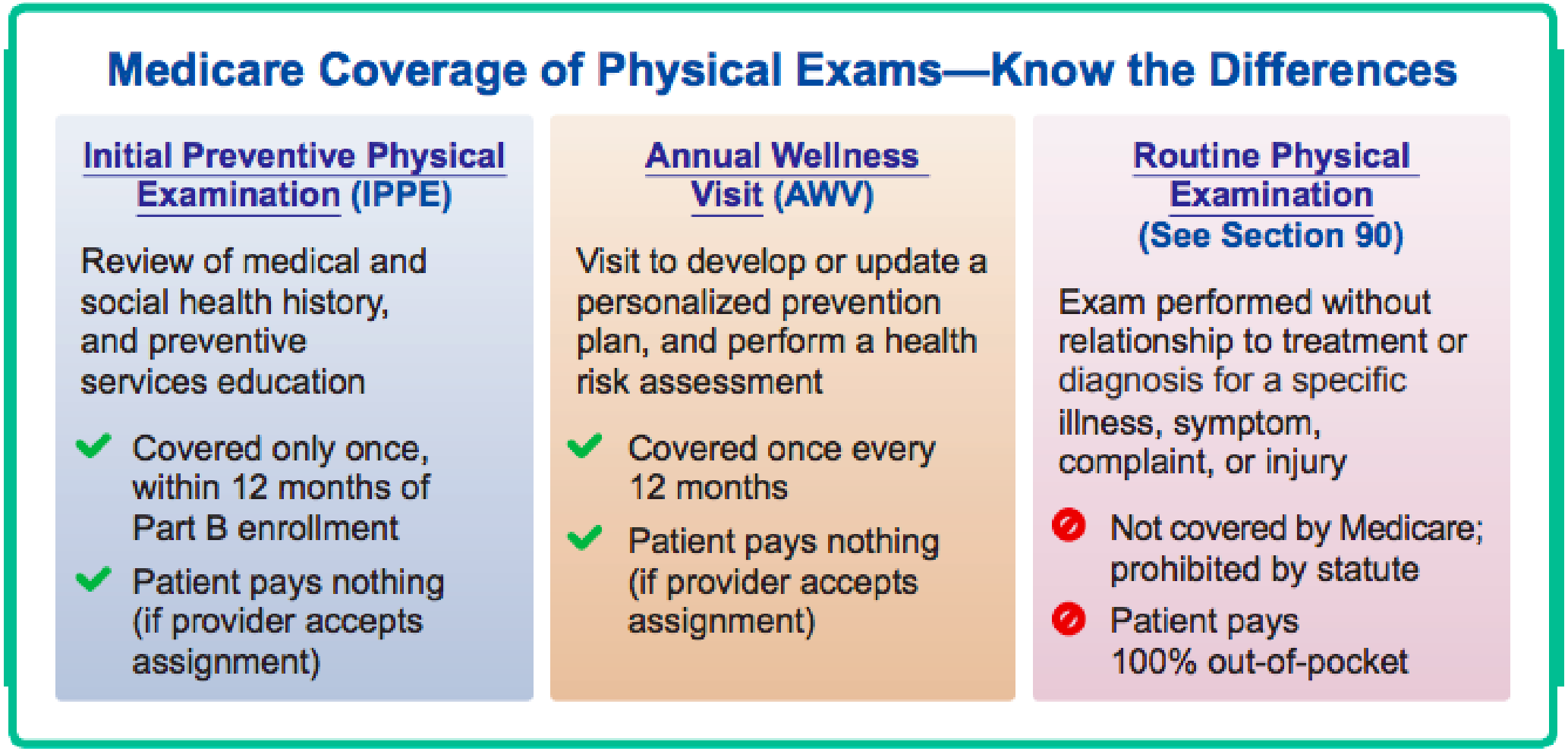
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Chronic Disease Management

99487	Medicare	At least 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month • 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	Time spent directly by the billing practitioner or clinical staff counts
99489	Medicare	Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	Billed with 99487

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Medicare Preventative Visits



Welcome to Medicare Exam (IPPE)

- Within first year of enrollment only regardless of age
- One time benefit
- Specific requirements
- EKG is covered
- Does not cover labs

Welcome to Medicare Exam (IPPE)

1. Review the beneficiary's medical and social history	At a minimum, collect information about: • Past medical and surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments) • Current medications and supplements (including calcium and vitamins) • Family history (review of medical events in the beneficiary's family, including conditions that may be hereditary or place the beneficiary at risk) • History of alcohol, tobacco, and illicit drug use • Diet • Physical activities • We encourage providers to pay close attention to opioid use during this part of the IPPE, which includes opioid use disorders (OUD). If a patient is using opioids, assess the benefit for other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk. Refer to the CMS Roadmap to Address the Opioid Epidemic fact sheet for more information on combating opioid misuse. For more information about Medicare Coverage of Substance Abuse Services and mental health services, refer to the MLN's Screening, Brief Intervention, and Referral to Treatment (SBIRT) booklet.

Welcome to Medicare Exam (IPPE)

2. Review the beneficiary's potential risk factors for depression and other mood disorders	Use any appropriate screening instrument. You may select from various available standardized screening tests designed for this purpose. For more information, refer to the Depression section on the Substance Abuse and Mental Health Services Administration–Health Resources and Services Administration's Screening Tools website.
3. Review the beneficiary's functional ability and level of safety	Use appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas: • Activities of daily living • Fall risk • Hearing impairment • Home safety
4. Exam	Obtain the following: • Height, weight, body mass index, and blood pressure • Visual acuity screen • Other factors deemed appropriate based on the beneficiary's medical and social history and current clinical standards

Welcome to Medicare Exam (IPPE)

5. End-of-life planning, on beneficiary agreement	End-of-life planning is verbal or written information provided to the beneficiary about: • The beneficiary's ability to prepare an advance directive in case an injury or illness causes them to be unable to make health care decisions • If you are willing to follow the beneficiary's wishes expressed in an advance directive
6. Educate, counsel, and refer based on the previous five components	Based on the results of the review and evaluation services in the previous components, provide appropriate education, counseling, and referral.
7. Educate, counsel, and refer for other preventive services	Includes a brief written plan, such as a checklist, for the beneficiary to obtain: • A once-in-a-lifetime screening electrocardiogram (EKG/ECG), as appropriate • The appropriate screenings and other preventive services Medicare covers including the Annual Wellness Visit

Welcome to Medicare Exam (IPPE)

IPPE CODES	DESCRIPTION
G0402	Face-to-face initial preventative visit, one time benefit within the first 12 months of enrollment
G0403	Electrocardiogram (ECG) performed as a screening for the IPPE (with interpretation and report)
G0404	ECG performed as a screening for the IPPE (tracing only without interpretation and report)
G0405	ECG performed as a screening for the IPPE (interpretation and report only)
G0468	Federally qualified health center (fqhc) visit, ippe or awv; a fqhc visit that includes an initial preventive physical examination (ippe) or annual wellness visit (awv) and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving an ippe or awv

https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/preventive-physical-examination.html

Medicare Annual Wellness Visits

- Face-to-face visit
- Every 12 months
- Annual Health Status Review with required components
- Review all chronic conditions
  - Update a patient's problem list
- Plan for needed health services for the upcoming year
  - Review a patient's quality measures
- Counsel the patient
  - Ensure the patient is taking advantage of all free services and screenings available

Medicare Annual Wellness Visits

- Perform a Health Risk Assessment (HRA)-standardized questionnaire completed by the patient
  - Demographic data
  - Health status self-assessment
  - Psychosocial risks
  - Behavioral risks
  - Activities of Daily Living (ADLs) and Functional status

Medicare Annual Wellness Visits

- Review patient's medical and family history
  - Medical events of the patient's parents, siblings, and children including hereditary conditions that place them at increased risk
  - Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments
  - Use of, or exposure to, medications and supplements, including calcium and vitamins
- Establish list of current providers and suppliers

Medicare Annual Wellness Visits

- Measure height, weight, Body Mass Index (BMI) (or waist circumference, if appropriate), and blood pressure
- Assess cognitive function- use a brief tool such as the Mini-Cog
- Depression screening-PHQ-2/PHQ-9
- Review functional ability and level of safety
  - Ability to perform Activities of Daily Living (ADLs)
  - Fall risk
  - Hearing impairment
  - Home safety

Medicare Annual Wellness Visits

- Establish a written screening schedule for the individual, such as a checklist for the next 5 to 10 years based on appropriate recommendations, personalized prevention plan of service (PPS)
- Establish a list of risk factors and conditions for primary, secondary, or tertiary intervention.
- Provide personalized health advice to the patient, as appropriate, including referrals to health education or preventive counseling services and programs.
- At the patient's discretion, furnish advance care planning services.

Medicare Annual Wellness Visits

- If applicable, review current opioid prescriptions
  - Review their potential Opioid Use Disorder (OUD) risk factors
  - Evaluate their pain severity and current treatment plan
  - Provide information on non-opioid treatment options
  - Refer to a specialist, as appropriate
- Screen for potential Substance Use Disorders (SUDs)

Medicare Annual Wellness Visits

AWV CODES	DESCRIPTOR
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
G0468	Federally qualified health center (fqhc) visit, ippe or awv; a fqhc visit that includes an initial preventive physical examination (ippe) or annual wellness visit (awv) and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving an ippe or awv

*Don’t forget you can also bill ACP code with 33 modifier

Medicare Annual Wellness Visits

- A problem-oriented evaluation and management (E/M) service can be covered at the time of AWV (99201 – 99205; 99211 – 99215).
- The problem-oriented portion of the visit must be separately identifiable and medically necessary to either treat the patient's illness or injury.
- Ensure the documentation is complete and requirements for both types of visits are met and documented.
- Use modifier -25 on the problem-oriented E/M service code.

2021 Coding Changes

- Developed by AMA and CMS
- From the Patients over Paperwork initiative
- Meant to decrease documentation burden and improve reimbursement
- Coding based on either time OR medical decision making
- History and PE documentation requirements are gone
- For new and established outpatient visits

2021 Coding Changes

E/M CODING CHANGES SUMMARY

Coding for outpatient and office visit evaluation and management services will change starting Jan. 1, 2021. Here's a brief summary of how the new guidelines will differ from the current guidelines.

Year	Coding with medical decision making (MDM)			Coding with time	History and exam
2020	Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Typical time face-to-face; only when counseling and/or coordination of care dominate encounter	Key elements in selection of level of service
2021	Number and complexity of problem(s) addressed	Amount and/or complexity of data to be reviewed and analyzed	Risk of complications and/or morbidity or mortality	Total time (including non-face-to-face) on date of visit; can code any visit based on time	Only required as medically appropriate and not part of code level selection

For more details on the new medical decision making guidelines, visit https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

2021 Coding Changes-Time

- Based on total face-to-face AND non face-to-face time spent by the qualified health provider (QHP)
- Does not include staff time
- MUST be on the date of service
- Not dependent on 50% time spent on counseling
- Does not have be itemized but should reflect performed activities

Time Activities

Total Time Activities per encounter includes **PROVIDER TIME**:

- Preparing to see the patient (review labs on that day)
- Obtaining and/or reviewing history
- Examination
- Counseling
- Education
- Ordering
  - tests
  - medications
  - Procedures, etc.
- Charting
- Independent interpretation (*except if billing CPT code*)
- Communication of results
- Care coordination

I personally spent 35 minutes in patient care on this date.

Total time spent with the patient today was 20 minutes with an additional 10 minutes sending scripts and documenting in the record.

2021 Coding Changes-Time

New Patient		Established Patient	
Code	Time (minutes)	Code	Time (minutes)
99202	15 – 29	99212	10 – 19
99203	30 – 44	99213	20 – 29
99204	45 – 59	99214	30 – 39
99205	60 – 74	99215	40 – 54
If <15 min, no code based on Time		If <10 min, no code based on Time	

2021 Coding Changes-Time

Total Duration of NEW Patient Office/ Other Outpatient Established Patient	
Time	**Code Reporting**
Less than 75 minutes	Not reported separately
75 – 89 minutes	99205, 99417 x 1
90 – 104 minutes	99205, 99417 x 2
105 minutes or more	99205, 99417 x3 or > for ea addtl 15 minutes
Total Duration of ESTABLISHED Patient Office/Other Outpatient Services	
Less than 55 minutes	Not reported separately
55 – 69 minutes	99215, 99417 x 1
70 – 84 minutes	99215, 99417 x 2
85 minutes or more	99215, 99417 x 3 or > for ea addtl 15 minutes

2021 Coding Changes-Time Examples

- “Thirty minutes was spent with the patient reviewing imaging, conducting a physical examination and discussing the treatment plan.”
  - Would be a 99203 or 99214
- “I spent a total of 92 minutes for record review, exam, communication with other providers, and documentation of this encounter.”
  - Would be 99205 plus 99217 x2 or 99215 plus 99217 x3

2021 Coding Changes-Medical Decision Making

- Based on 3 factors:
  - Number and complexity of problems addressed
  - Data reviewed and analyzed
  - Risk of complications and/or morbidity or mortality
- Must meet the level for two out the three
- Does not differ for new or established patients

MDM Overall – Detailed View

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 **99212**	Straight forward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 **99213**	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (Must meet requirements of at least 1 of 2 categories) **Category 1a**: Tests and documents • Any combination of 2 from the following: • Review prior external note(s), ea unique source* • Review of the result(s) of each unique test*; • Ordering of each unique test* **or** **Category 1b**: Assessment requiring an independent historian(s)	Low risk of morbidity from additional diagnostic testing or treatment

MDM Overall – Detailed View

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99211	N/A	N/A	N/A	N/A
99202 **99212**	Straight forward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 **99213**	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (Must meet requirements of at least 1 of 2 categories) **Category 1a**: Tests and documents • Any combination of 2 from the following: • Review prior external note(s), ea unique source* • Review of the result(s) of each unique test*; • Ordering of each unique test* **or** **Category 1b**: Assessment requiring an independent historian(s)	Low risk of morbidity from additional diagnostic testing or treatment

MDM Overall – Detailed View

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99211	N/A	N/A	N/A	N/A
99202 **99212**	Straight forward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 **99213**	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (Must meet requirements of at least 1 of 2 categories) **Category 1a**: Tests and documents • Any combination of 2 from the following: • Review prior external note(s), ea unique source* • Review of the result(s) of each unique test*; • Ordering of each unique test* **or** **Category 1b**: Assessment requiring an independent historian(s)	Low risk of morbidity from additional diagnostic testing or treatment

MDM Overall – Detailed View

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 **99212**	Straight forward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 **99213**	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (Must meet requirements of at least 1 of 2 categories) **Category 1a**: Tests and documents • Any combination of 2 from the following: • Review prior external note(s), ea unique source* • Review of the result(s) of each unique test*; • Ordering of each unique test* **or** **Category 1b**: Assessment requiring an independent historian(s)	Low risk of morbidity from additional diagnostic testing or treatment

MDM Overall – Detailed View

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate (Must meet requirements of at least 1 out of 3 categories) **Category 1**: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review prior external note(s) from ea unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2**: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3**: Discussion of management or test interp • Discussion of management or test interpretation with external physician/other qualified health care professional\ appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

MDM Overall – Detailed View

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate (Must meet requirements of at least 1 out of 3 categories) **Category 1**: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review prior external note(s) from ea unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2**: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3**: Discussion of management or test interp • Discussion of management or test interpretation with external physician/other qualified health care professional\ appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

MDM Overall – Detailed View

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate (Must meet requirements of at least 1 out of 3 categories) **Category 1**: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review prior external note(s) from ea unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2**: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3**: Discussion of management or test interp • Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

MDM Overall – Detailed View

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99205 99215	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet requirements of at least 2 out of 3 categories) **Category 1:** Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review prior external note(s) from ea unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2:** Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3:** Discussion of management or test interp • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

MDM Overall – Detailed View

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99205 99215	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet requirements of at least 2 out of 3 categories) **Category 1:** Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review prior external note(s) from ea unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2:** Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3:** Discussion of management or test interp • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Level 4 Problems

- One unstable chronic illness
- Two stable chronic illnesses
- One acute illness with systemic symptoms (e.g., pyelonephritis or pneumonia),
- One acute complicated injury (e.g., concussion),
- One new problem with uncertain prognosis (e.g., breast lump).

Millette, K. Coding Level 4 Office Visits Using the New E/M Guidelines. Fam Pract Manag. 2021 Jan-Feb;28(1):27-33.

Level 4 Data

- One x-ray or electrocardiogram (ECG) interpreted by you
- Discussion of the patient's management or test results with an external physician
- A total of three points, earned as follows
  - 1 point for each unique test ordered or reviewed (panels count as one point each; you cannot count labs you order and perform in-office yourself)
  - 1 point for reviewing note(s) from each external source
  - 1 point for using an independent historian.

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Level 4 Risk

- Prescription drug management, which includes ordering, changing, stopping, refilling, or deciding to continue a prescription medication
- The presence of social determinants of health (lack of money, food, or housing) that significantly limit a patient's diagnosis or treatment
- Decision about major elective surgery without identified risk factors for patient or procedure
- Decision about minor surgery with identified risk factors for patient or procedure.

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Level 4 Questions

- Was your total time between 30 and 39 minutes for an established patient, or between 45 and 59 minutes for a new patient? If so, then you're done. Code it as a level 4 using total time.
- Did you see the patient for a level 4 problem and either prescribe a medication, interpret an x-ray (or ECG), or order/review three tests?
- Did you prescribe a medication and either interpret an x-ray (or ECG) or order/review three tests?

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2021 Coding Changes-Other points

- 99201 has been deleted
- 99211 is unchanged
- Residents MUST precept all level 4 and 5 visits (99214, 99215, 99204, 99205) and preceptors must se them
- Documentation should still support what you do
- New primary care code G2211 is on hold
  - Was meant to be used for all primary care as an add on to improve reimbursement to primary care
  - Suspended through December 2023 as part of the CARES act
  - Would add an additional $3 billion to primary care

Self, C., Moore, K., Church, S. The 2021 Office Visit Coding Changes: Putting the Pieces Together. Fam Pract Manag. 2020 Nov-Dec;27(6):6-11.

Conclusions

- Remember billing and coding pearls.
- Use add on codes, such as the advance care planning code, to capture billing for services you already provide.
- Incorporate additional billable services, such as annual wellness visits, into your daily routine.
- Familiarize yourself with the changes to CMS billing and coding rules and bill accordingly.

Resources

- FPM Billing, Coding, and Claims Processing Toolbox
- CMS Chronic Care Management Booklet
- AAFP Medical Billing and Coding Resources
- AAFP 2021 Coding Changes Vignettes
- CMS Medicare Wellness Visits Educational Tool
- AMA E/M Level of Medical Decision Making Table