MEDICAL BILLING 101

prepared by Medwave Billing & Credentialing

EVALUATION AND MANAGEMENT

- Initial Patient Visit

- What information is being collected?
  - Demographics
  - Insurance
  - Authorizations
  - HIPAA compliance paperwork, Release of Information

PREPARING A CLEAN CLAIM

- 1) **Demographics** that must be collected
  - Subscribers health insurance **Policy Number (Box 1a.)**
  - Patients **First and Last Name** as presented on their health insurance card **(Box 2 & 4)**
  - Patients **Date of Birth and Sex** (DOB) **(Box 3)**
  - Patients **Address (Box 5 & 7)**
  - Patients Relationship to the ensured **(Box 6)**

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )		ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

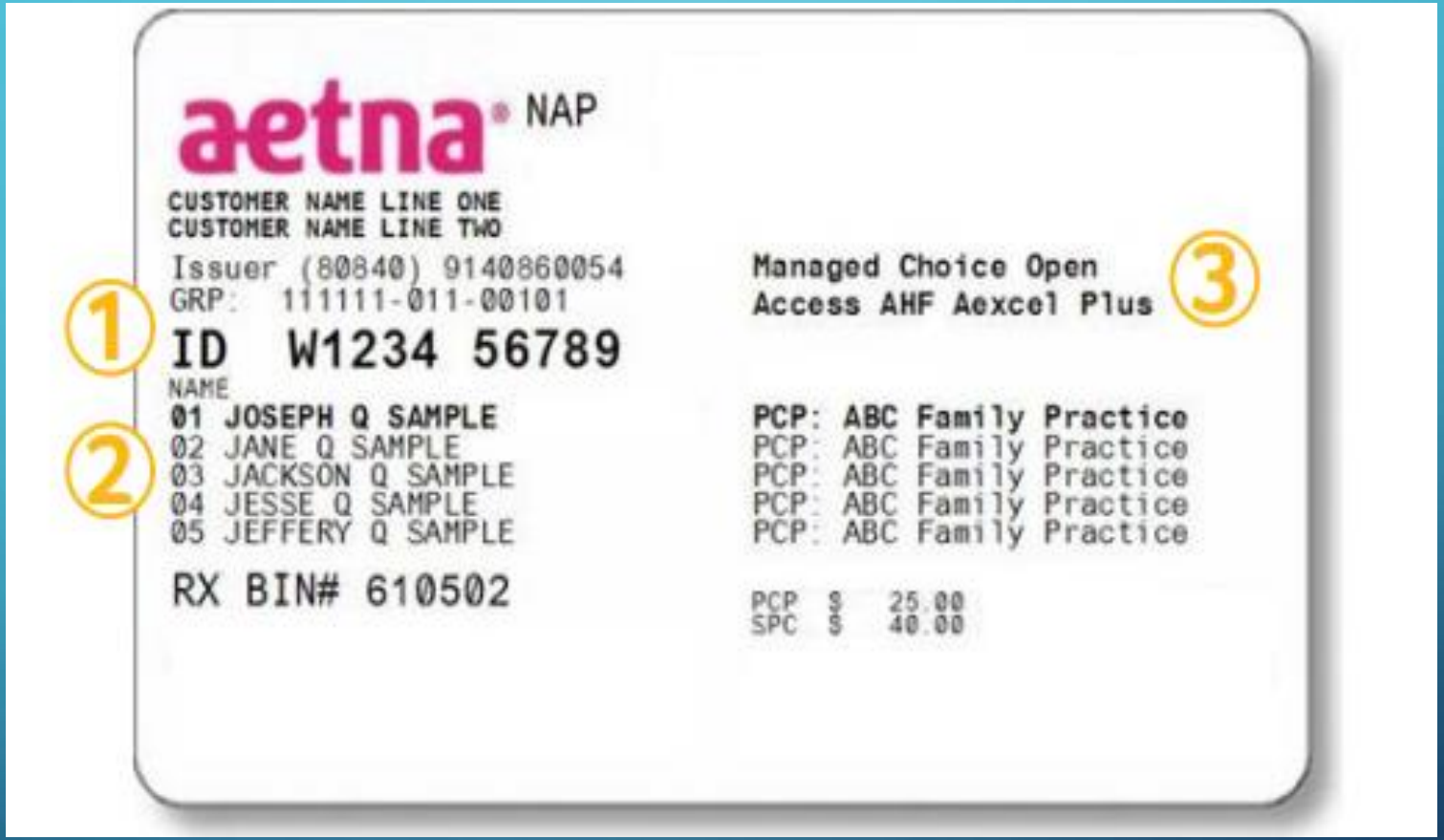
SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

PATIENT ELIGIBILITY AND VERIFICATION

- 1) The patient's insurance can change at any point in time. It must be checked every time the patient comes in to the office.
- How can we verify eligibility?
  - Billing software can verify the patient's eligibility in real time (Athena)
  - Using the insurance companies' online portals (Should be set up at time of credentialing)
  - Calling the insurance company directly (Provider Phone is located on the back of card)

EXAMPLE INSURANCE CARDS



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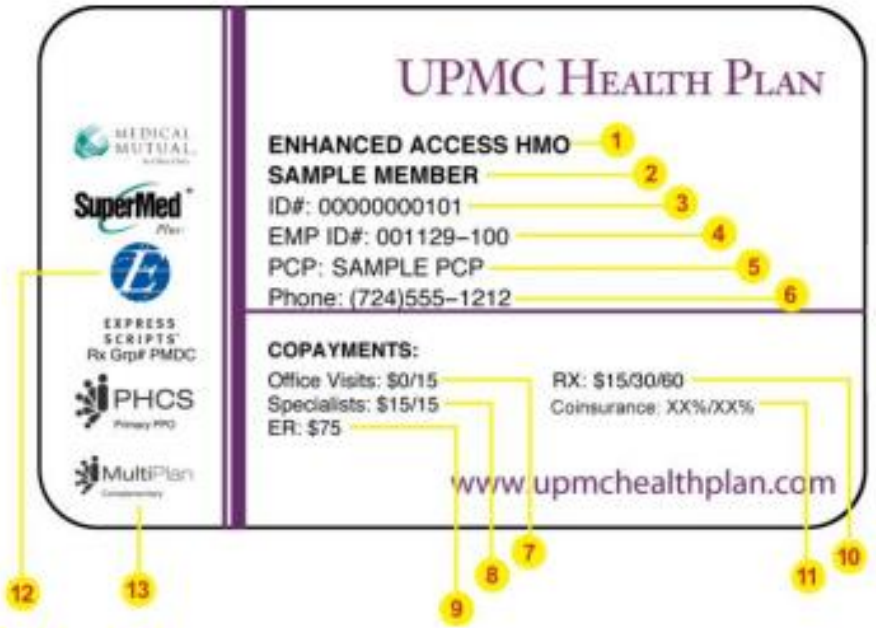

1. Plan name
2. Member name
3. Member identification number
4. Employer identification or group number
5. Primary care provider
6. Primary care provider's telephone number
7. Copayment for office visits to member's primary provider
8. Copayment for office visits other than to member's primary provider
9. Copayment for non-admitted treatment in a hospital emergency department
10. Prescription drug copayments
11. Coinsurance for services provided by network providers/coinsurance for out-of-network providers
12. Express Scripts logo indicates the member has prescription drug coverage
13. Logos indicate the member's coverage with other vendors

NOTE: If a member has a deductible, the information will be listed below the coinsurance information.

DUAL MEDICARE / MEDICAID PLAN

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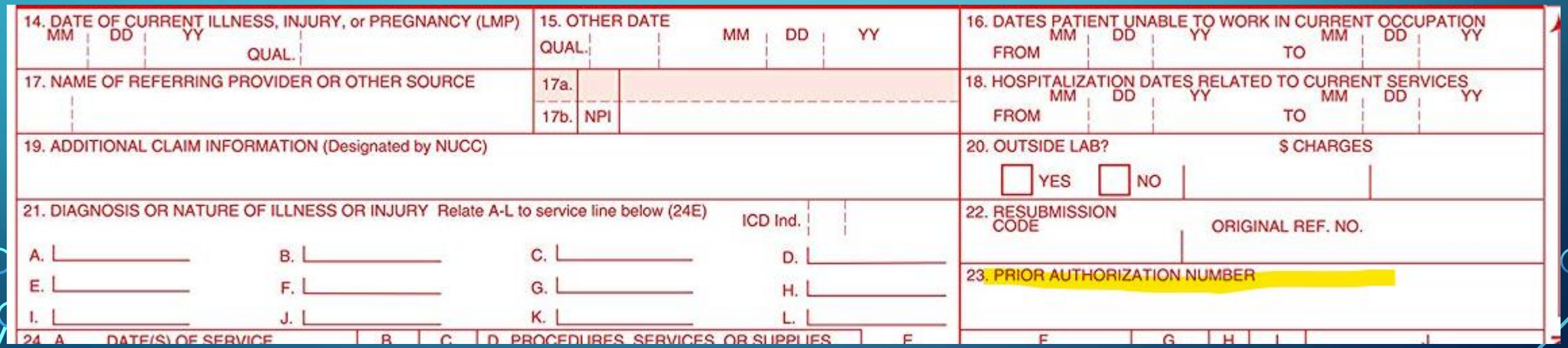
AUTHORIZATION FOR SERVICES

- Our patient needed an authorization. Where does it go now?
  - 1) It should be recorded in the billing software's Utilization Management tab.
  - 2) It is added to the claim for the date of service authorized. (Box 23)
  - 3) It should be part of the patients Electronic Health Record (EHR)



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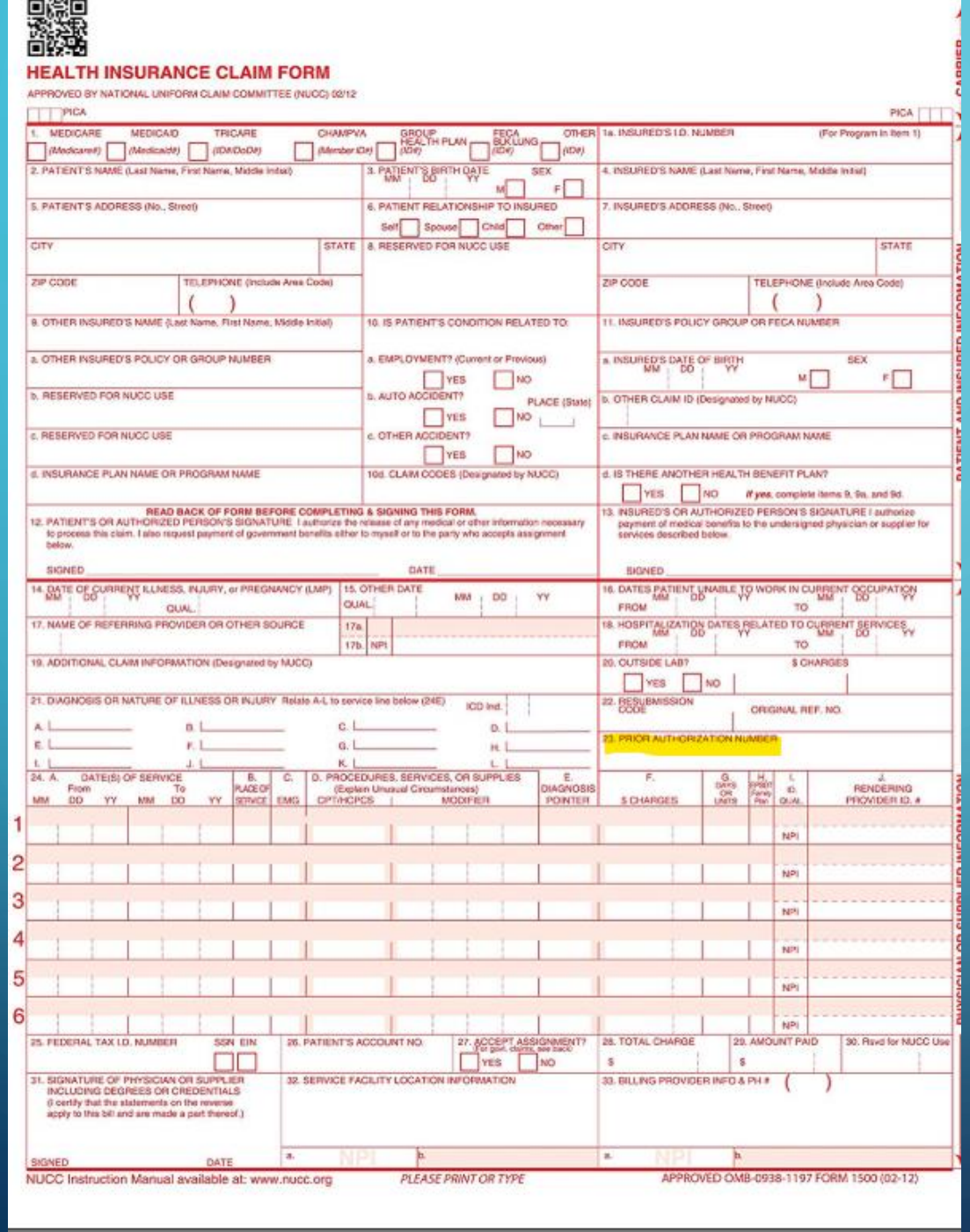

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

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SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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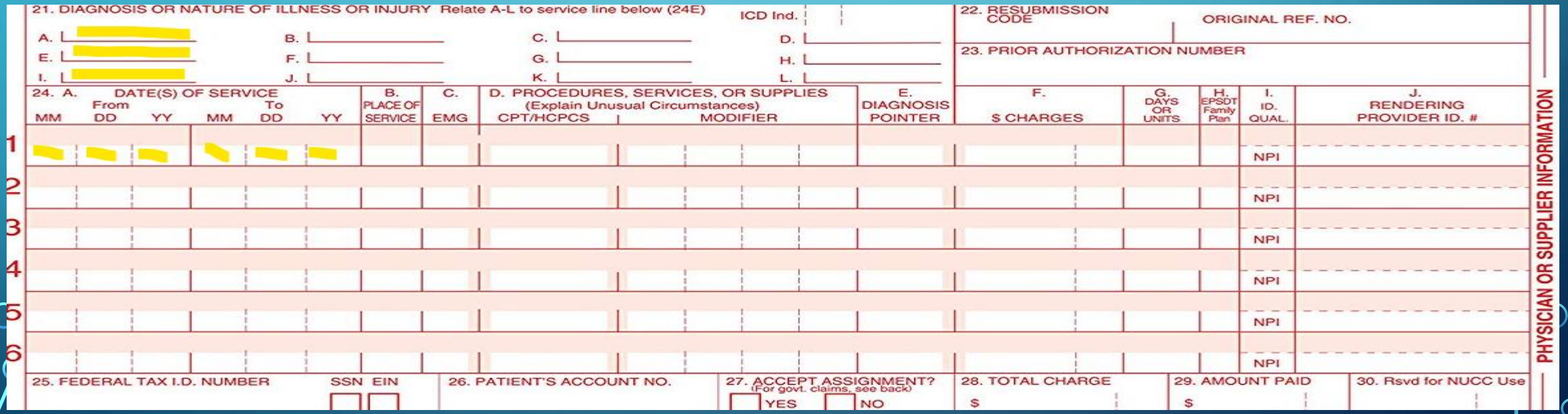
CHARGE ENTRY

- 1) Add the charge for the procedure done
- 2) Add the corresponding CPT code from the Coder
- 3) Add modifiers if needed



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CREATING A UNIFORM FEE SCHEDULE

HOW TO IDENTIFY FEE SCHEDULES THAT ARE REASONABLE VS. ALLOWABLE FEE'S?

CHARGED AMOUNT

- The fee schedule that you use to bill with
- Fee schedule for Self Pay Patients

ACTUAL AMOUNT RECEIVED

- What the practice is actually receiving back from the insurance company

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CLAIM SUBMISSION

- Claims can be submitted electronically, paper, payer portal
  - The **Payer ID** is needed to submit claims electronically. They are usually located on the back of the patient's insurance card. They can also be found on the payer's provider manual.
    - Payer ID's may vary depending on the product (EX: Medicare vs Medicaid)
  - Address for payers are located on the back of the patient's card
    - These addresses will vary depending on the product
    - Workman's Comp (WC) and Auto claims have designated addresses for claims
  - Most Payer portals have Direct Data Entry (DDD) to enter a claim

POSTING ERA'S / EOB'S

- Electronic Remittance advice (ERA)
- Explanation of benefits (EOB)
  - Both contain the information needed to post payment to the patients account
  - Both contain the reason codes as to why the claim was paid or denied

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EXPLANATION OF BENEFITS
DEPOSIT NOTICE ONLY

SEPTEMBER 15, 2017

PROVIDER SUMMARY

Provider: ABC FAMILY PRACTICE

Provider Number: 0987654321

DIRECT DEPOSIT SUMMARY

FUNDS AVAILABLE DATE 09/25/2017 EFT PAYMENT NUMBER 99XXXXXXX

ACCOUNT TYPE CHECKING

TOTAL EFT PROVIDER DEPOSIT	$847.57
TOTAL INTEREST CALCULATED	$0.00
TOTAL MEMBER PAYMENTS	$0.00

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Camp Hill, PA 17089

ABC FAMILY PRACTICE
321 MAIN STREET
ANY TOWN, USA 12345-6789

DATE(S) OF SVC	NUM OF SVCS	REVENUE/ PROCEDURE CODE	PAY-MENT CODE	PROVIDER CHARGE	OUR ALLOWANCE	NON-CHARGEABLE AMOUNT	NON-CHG CODE	MEMBER LIABILITY AMOUNT	MEM LIAB CODE	OTHER AMOUNT	AMOUNT(S) PAID (* = MEMBER)	MESSAGE CODES
PATIENT ACCT #: 123456 MEMBER ID: XXXXXXXXXXXX						PATIENT: JACK PUBLIC MEMBER: JACK PUBLIC					CLAIM NUMBER: 20XXXXXXXXX	
09/07/2017	1	99392-00	026	150.00	77.52	72.48	25				77.52	J0080
09/07/2017	1	90633-00	026	50.00	40.93	9.07	25				40.93	J0080
09/07/2017	1	90657-00	026	32.00	19.05	12.95	25				19.05	J0080
09/07/2017	1	G0008-00	026	25.00	20.77	4.23	25				20.77	J0080
			CLAIM TOTALS			98.73					158.27	
PATIENT ACCT #: 123457 MEMBER ID: XXXXXXXXXXXX						PATIENT: JANE PUBLIC MEMBER: JACK PUBLIC					CLAIM NUMBER: 20XXXXXXXXX	
09/07/2017	1	99385-00	023	203.00	98.83	104.17	25				98.83	J9040
09/07/2017	1	90658-00	023	32.00	22.29	9.71	25				22.29	J9040
			CLAIM TOTALS			113.88					121.12	

CLAIM SPECIFIC MESSAGE(S):
We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.

PATIENT ACCT #: 12345R MEMBER ID: XXXXXXXXXXXX						PATIENT: JIM PUBLIC MEMBER: JACK PUBLIC					CLAIM NUMBER: 20XXXXXXXXX	
09/07/2017	1	99204-00	026	241.00	166.00	75.00	25	20.00	D1		146.00	J0080
09/07/2017	1	81025-00	026	13.00	6.00	7.00	25	6.00	A1			X5018,J0080
			CLAIM TOTALS			82.00		26.00			146.00	
PATIENT ACCT #: 123459 MEMBER ID: XXXXXXXXXXXX						PATIENT: JOHN Q PUBLIC MEMBER: JOHN Q PUBLIC					CLAIM NUMBER: 20XXXXXXXXX	
09/07/2017	1	99385-00	033	203.00	98.83	104.17	25				98.83	J9040
09/07/2017	1	81025-00		13.00				13.00	H1			U5006,J9040
			CLAIM TOTALS			104.17		13.00			98.83	

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An Independent Licensee of the Blue Cross and Blue Shield Association

PFXXXXXX

MESSAGE(S):

J0080	If you have questions, please call 1-866-731-8080.
J1163	If the member receives Medicaid or Medical Assistance, they may be eligible for assistance with cost shares. Contact the local County Assistance Office for any questions regarding coverage provided by a Medicare Assistance Plan.
J1223	If you have any questions, please call 1-888-234-5374.
J9040	If you have any questions, call 1-866-731-8080 or the Western District Office 1-800-547-3627 or the Eastern District Office (215) 564-2131 or write to Customer Service, P.O. Box 890035, Camp Hill PA 17089-0035.
U5006	The patient's coverage does not provide for this service or diagnostic study as part of their preventive schedule. Therefore, no payment can be made for this service.
X5018	The allowance for this service has been applied to the dollar deductible amount required under the patient's coverage.

PAYMENT CODES:
- 023 = PREMIERBLUE SHIELD
- 026 = CONTRACTED ALLOWANCE
- 033 = COMMUNITY BLUE PPO
- 038 = MEDICARE ADVANTAGE

NON-CHARGEABLE AMOUNT CODES:
- 25 = Differential
- 35 = Medicare Advantage Sequestration

MEMBER LIABILITY CODES:
- A1 = Deductible
- D1 = Copay
- H1 = Rejected Billable Non-Covered Service

REJECTED OR DENIED CLAIMS

- Review the EOB / ERA for Reason codes
- Resubmit the claim
  - Correct the claim in Athena
  - Correct the claim in the payer portal
  - If it is a clerical error then the billing staff should be advised for future reference.

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CORRECTING A DENIED / REJECTED CLAIM

FIXING AN ERROR ON CLAIM

- Resubmission Code 7 (BOX 22)
- Original Claim Number (BOX 22)
  - Alerts the payer that this is a replacement claim and not a duplicate

VOIDING THE CLAIM COMPLETELY

- Resubmission Code 8 (BOX 22)
- Original Claim Number (BOX 22)
  - Alerts the payer that this claims is to be voided. A new claim could now be submitted.

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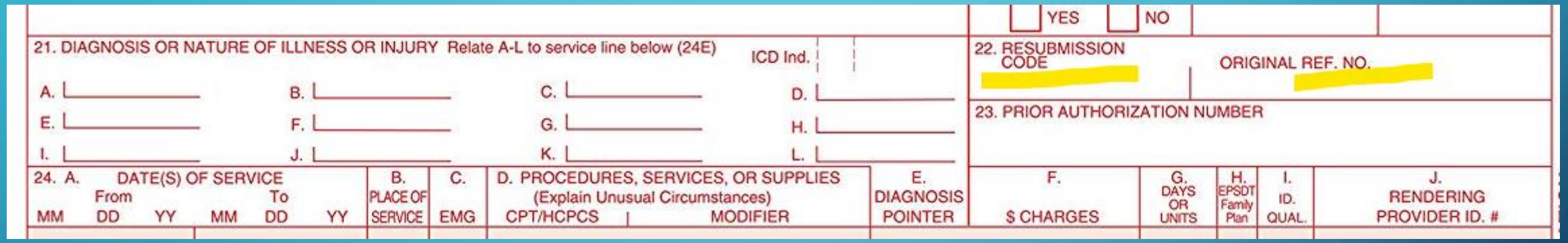
CORRECTING A DENIED / REJECTED CLAIM



										YES NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE	ORIGINAL REF. NO.		
A.	B.	C.	D.							23. PRIOR AUTHORIZATION NUMBER			
E.	F.	G.	H.										
I.	J.	K.	L.										
24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #		

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WRITE OFF'S VS. CONTRACTUAL RATES

IS IT BETTER TO WRITE OFF AS CONTRACTUAL RATES? HOW TO AVOID WRITE OFFS?

CONTRACTUAL WRITE OFF

- Reimbursement rates are calculated when you sign your contract with the insurance company.
- Rates can change and can be periodically renegotiated
- These are the write offs you are not allowed to collect from the patient

WRITE OFF FOR CHARGES

- These are the charges you bill out for the patient expecting to get back the contracted rate.
- These are the charges you are allowed to collect

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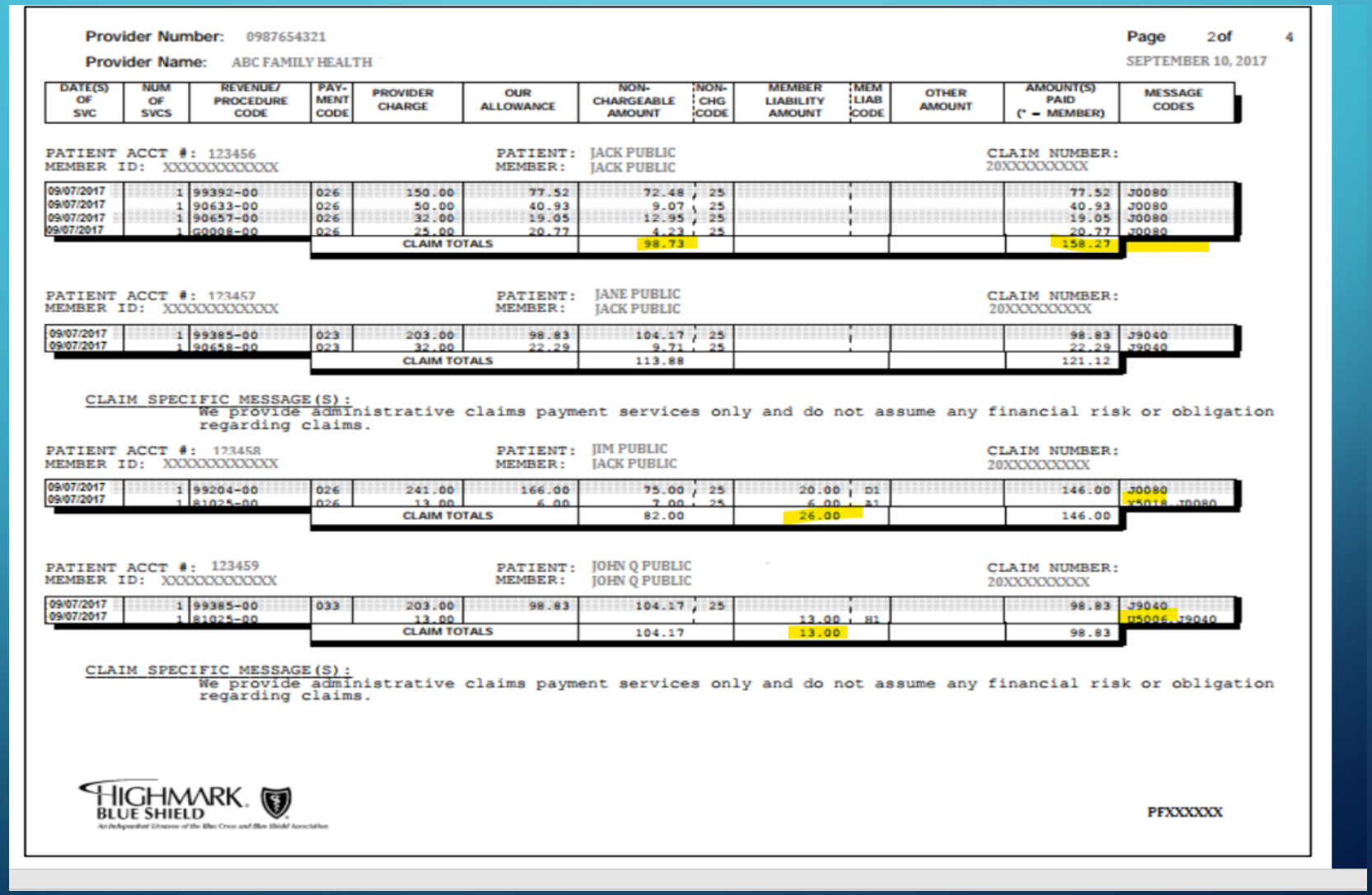
HOW TO DECIPHER CONTRACTUAL FROM AN ACTUAL WRITE OFF?



Provider Number: 0987654321 Page 2of 4

Provider Name: ABC FAMILY HEALTH SEPTEMBER 10, 2017

DATE(S) OF SVC	NUM OF SVCS	REVENUE/ PROCEDURE CODE	PAY-MENT CODE	PROVIDER CHARGE	OUR ALLOWANCE	NON-CHARGEABLE AMOUNT	NON-CHG CODE	MEMBER LIABILITY AMOUNT	MEM LIAB CODE	OTHER AMOUNT	AMOUNT(S) PAID (* = MEMBER)	MESSAGE CODES
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				CLAIM TOTALS		113.88					121.12	

CLAIM SPECIFIC MESSAGE(S):
We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.

PATIENT ACCT #: 123458 MEMBER ID: XXXXXXXXXXXX						PATIENT: JIM PUBLIC MEMBER: JACK PUBLIC					CLAIM NUMBER: 20XXXXXXXXX	
09/07/2017	1	99204-00	026	241.00	166.00	75.00	25	20.00	D1		146.00	J0080
09/07/2017	1	81025-00	026	13.00	6.00	7.00	25	6.00	A1			Y5018, J0080
				CLAIM TOTALS		82.00		26.00			146.00	
PATIENT ACCT #: 123459 MEMBER ID: XXXXXXXXXXXX						PATIENT: JOHN Q PUBLIC MEMBER: JOHN Q PUBLIC					CLAIM NUMBER: 20XXXXXXXXX	
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09/07/2017	1	81025-00		13.00				13.00	H1			U5006, J9040
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SECONDARY CLAIMS

PRIMARY CLAIM

- Build you initial claim and submit

SECONDARY CLAIM

- Post your primary payment
- Convert your primary claim to reflect the secondary insurance

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CYCLE OF A CLAIM

1. Check Eligibility and Benefits
2. Collect copay
3. Patient is seen by provider and visit is documented
4. Coder reviews patient's documentation and assigns CPT codes
5. Biller enters the charges, CPT codes, modifiers, DX codes
6. Claim is submitted electronically or on paper.
7. Claim is processed by payer
8. Electronic Remittance Advice (EOB) is received and posted to patient account

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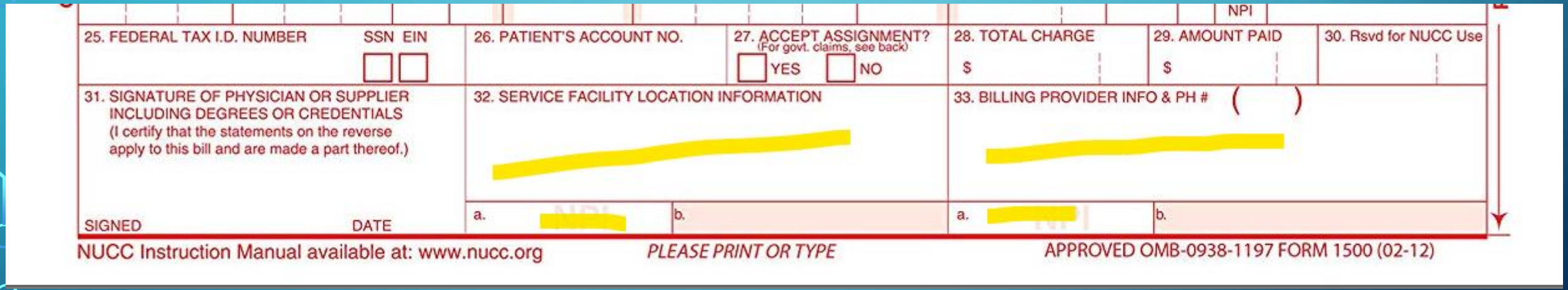
PROVIDER INFORMATION NEEDED ON CLAIM

- Rendering Provider
  - Individual NPI (Box 24J)
  - Signature of Provider (Box 31)

- Billing Provider
  - Group Type II NPI (Box 32 & 33 a.)
  - Address where Services were Rendered (Box 32)
  - Address where Billing and Correspondence is sent (Box 33)

PROVIDER INFORMATION NEEDED ON CLAIM



NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.		

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

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Evaluation and Management: Coding Evaluations

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Evaluation and Management Services

Overview

- Office and Outpatient Services
- Consultations
- Critical Care Services
- Prolonged Services
- Case Management Services
- Care Plan Oversight Services
- Preventive Medicine Services
- Non Face-to-Face Services
- Special E/M Services
- Complex Chronic Care
- Psychiatric Collaborative Care Management
- Medicare Evaluation and Management
- Medicaid Evaluation and Management
- Rectal Exam Codes
- Vaccine Codes

CPT 99201-99205 - Office and Outpatient Evaluation and Management

99201-99205

- For **NEW** Office or Outpatient patients only
- Only used once per start of care with Doctor
- These codes can be used for Urgent Care Visits

NEW PATIENT VISIT

CPT Code	99201	99202	99203	99204	99205
Required Key Components *(3/3 required)					
History and Exam					
• *Problem-Focused*	X				
• *Expanded Problem-Focused*		X			
• *Detailed*			X		
• *Comprehensive*				X	X
Medical Decision Making (complexity)					
• *Straightforward*	X	X			
• *Low*			X		
• *Moderate*				X	
• *High*					X
Contributory Factors					
Presenting Problem (Severity)					
• *Self-Limited or Minor*	X				
• *Low to Moderate*		X			
• *Moderate*			X		
• *Moderate to High*				X	X
Counseling					
Coordination of Care					
Typical Face-to-Face Time (Minutes)	10	20	30	45	60

CPT 99211-99215 - Office and Outpatient Evaluation and Management

99211-99215

- For **ESTABLISHED** Office or Outpatient patients only
- Used for all subsequent visits within a 12-month year
- These codes can be used for Urgent Care Visits

ESTABLISHED PATIENT VISIT

CPT Code	99211	99212	99213	99214	99215
Required Key Components **(2/3 required)					
History and Exam					
• *Problem-Focused*	N/A	X			
• *Expanded Problem-Focused*			X		
• *Detailed*				X	
• *Comprehensive*					X
Medical Decision Making (complexity)					
• *Straightforward*	N/A	X			
• *Low*			X		
• *Moderate*				X	
• *High*					X
Contributory Factors					
Presenting Problem (Severity)					
• *Minimal*	X				
• *Self-Limited or Minor*		X			
• *Low to Moderate*			X		
• *Moderate to High*				X	X
Counseling					
Coordination of Care					
Typical Face-to-Face Time (Minutes)	5	10	15	25	40

CODING SPECIALTY VISITS

- Append the correct E/M code for the level of service
- Apply the most descriptive DX code for the services being rendered
    - EXAMPLE:

Cheat Sheet ICD 10: Family Planning

ICD-10	Description
Z30.09	Counseling and **advice on contraception**
Z30.011	Encounter for **initial prescription of contraceptive pills**
Z30.013	Encounter for **initial prescription of injectable contraceptive**
Z30.014	Encounter for **initial prescription of intrauterine contraceptive device**
Z30.012	Encounter for **prescription of emergency contraception**
Z30.430	Encounter for **insertion of intrauterine contraceptive device**
Z30.432	Encounter for **removal and re-intrauterine contraceptive device**
Z30.433	Encounter for **removal and reinsertion of intrauterine contraceptive device**
Z30.40	Encounter for **surveillance of contraceptives, unspecified**
Z30.41	Encounter for **surveillance of contraceptive pills**
Z30.431	Encounter for **routine checking of intrauterine contraceptive device**
Z30.42	Encounter for **surveillance of injectable contraceptive**
Z30.49	Encounter for **surveillance of contraceptive**

CPT 99241-99255 - Consultation Evaluation Codes

99241-99255

- 99241-99245- Office or Outpatient Consultation
- 99251-99255- Initial Inpatient Consultation Services

CPT 99291-99292 - Critical Care Services Evaluation Codes

99291-99292- for use with one or more vital organ failure (Life Threatening Condition)

- 99291- Critical Care Evaluation first 30-74 minutes
- 99292- Critica Care Evaluation, each addition 30 minutes you add one more unit.

CPT 99354-99416 - Prolonged Services Evaluation Codes

99354-99357

- 99354-99357- Prolonged Services with direct patient contact
- 99358-99359- Prolonged Services without patient contact
- 99360- Prolonged Standby Services
- 99415-99416- Prolonged Clinical Staff Services with Physician or other Qualified Healthcare Professional Supervision

When can you use Prolonged Evaluation Services?

- Prolonged Service Codes are used in conjunction with another Evaluation and Management codes
    - Used when the service goes above and beyond a TIMED E/M code for longer than 30 minutes. This is usually used when the coordination of care / counseling services exceed more than 50% of the visit
        - This does not include the time with clinical staff, just the provider
    - EXAMPLE: A patient is seen for 99213 office visit (E/M), but the patient was counseled for greater than 30 minutes, above the normal 15-29 minutes allotted for this level visit.
        - The claim would need to be billed with CPT codes:
            - 99213
            - 99354- first 60 minutes
            - 99355- every subsequent 30 minutes

Table 1 - Some Outpatient E/M Codes with Their Listed "Typical Times"

Code	Time	Code	Time	Code	Time
99201	10 min	99211	5 min	99241	15 min
99202	20 min	99212	10 min	99242	30 min
99203	30 min	99213	15 min	99243	40 min
99204	45 min	99214	25 min	99244	60 min
99205	60 min	99215	40 min	99245	80 min

Total Duration of Prolonged Services	Outpatient Code(s)*	Inpatient/Observation Code(s)*
less than 30 min	Not reported separately	Not reported separately
30-74 min (30 min - 1 hr 14 min)	99354 X 1	99356 X 1
75-104 min (1 hr 15 min - 1 hr 44 min)	99354 X 1 AND 99355 X 1	99356 X 1 AND 99357 X 1
105 -134 min (1 hr 45 min – 2hr 14 min)	99354 X 1 AND 99355 X 2	99356 X 1 AND 99357 X 2
135-164 (2hr 15 min – 2 hr 44 min)	99354 X 1 AND 99355 X 3	99356 X 1 AND 99357 X 3

CPT 99366-99368 - Case Management Services Evaluation Codes

99366-99368

- 99366- Medical Team Conference with Direct Face-to-Face contact with patient or family (30 Min. Or More)
- 99367- Medical Team Conference by a **Physician** without Direct Face-to-Face contact with patient or family (30 Min. or More)
- 99368-Medical Team Conference **Non-Physician** without Direct Face-to-Face contact with patient or family (30 Min. or More)

CPT 99374-99380 - Care Plan Oversight Evaluation Codes

99374-99380

- 99374- 15-29 min.
- 99375- 30 min. Or more
- 99377- 15-29 Hospice Care
- 99378- 30 min. Or more Hospice Care
- 99379- 15-29 min. Nursing Facility Care
- 99380- 30 min. Or More Nursing Facility Care

G0181-G0182 (Medicare)

- **G0181 - Physician Supervision of Medicare Patient. (Home Health)**
- **G0182 - Physician Supervision of Medicare Patient. (Hospice)**

CPT 99381-99429 - Preventive Medicine Evaluation Codes

99381-99429

- 99381-99387- New Patient Preventive Services (Levels Based on Age)
- 99391-99397- Established Patient Preventive Services
- 99401-99412- Counseling Risk Factor Reduction and Behavior Change Intervention
- 99429- Other Preventive Services

Coding for Annual Wellness Visit

Visit Includes: Age and gender appropriate History, Exam, Counseling/Risk Factors/Intervention, Ordering of Labs / Procedures

- New Patient- Initial wellness visit
  - 99381- Younger than 1 year
  - 99382- 1-4 years old
  - 99383- 5-11 years old
  - 99384- 12-17 years old
  - 99385- 18-39 Years old
  - 99386- 40-64 Years old
  - 99387- 65 years and older
- Established Patient- Yearly Wellness visit
  - 99391- Younger than 1 year
  - 99392- 1-4 Years old
  - 99393- 5-11 Years old
  - 99394- 12-17 Years old
  - 99395- 18-39 Years old
  - 99396- 40-64 Years old
  - 99397- 65 Years and older

CPT 99401-99404- Preventive Counseling Visits

99401-99404- Counseling Risk Factor Reduction and Behavior Change Intervention

99401- Preventive Medicine Counseling 15 min.

99402- Preventive Medicine Counseling 30 min.

99403- Preventive Medicine Counseling 45 min.

99404- Preventive Medicine Counseling 60 min.

These codes are coded based on time and risk factor

DX CODES FOR PREVENTATIVE COUNSELING

Dietary Counseling	Z71.3
Exercise Counseling	Z71.89
Injury Prevention Counseling	Z71.89
HIV Counseling	Z71.7
STD Counseling	Z71.89
Contraception Counseling	Z30.8, Z30.9
Counseling concerning Lifestyle	Z72.3, Z72.4, Z72.51, Z72.6, Z72.820, Z72.89, Z72.9
	Z71.0
Advice or Treatment for a non-attending 3rd party Counseling	Z76.81
Pediatric Pre-Birth Visit for an Expectant parent Counseling	Z71.89
Parental Concerns for a child Counseling	Z71.89
Marital and Partner Problem Counseling	Z87.891
Smoking Cessation Counseling	Z71.51
Substance use and abuse Counseling	Z71.41
Alcohol use and abuse Counseling	

COUNSELING REQUIRING ADDITIONAL CPT CODES

- SMOKING CESSATION
  - 99406- Intermediate Counseling
    - 3-10 Minutes
    - 25 Modifier on E/M Visit
    - 2 attempts a year, 4 sessions per attempt, 8 total sessions allowed per year
  - 99407- Intensive Counseling
    - 10 Minutes or greater
    - 25 Modifier on E/M visit
    - 2 attempts a year, 4 sessions per attempt, 8 total sessions allowed per year
- DRUG USE AND ABUSE
  - 99408- Brief Intervention and screening
    - 15-30 Minutes
    - 25 Modifier on E/M visit
  - 99409- Brief Intervention and Screening
    - 30 Minutes or more
    - 25 Modifier on E/M visit

PAYER	CODE	DESCRIPTION
Commercial insurance, Medicaid	99408	Alcohol and/or substance abuse structured screening and brief intervention services, 15–30 minutes.
Commercial insurance, Medicaid	99409	Alcohol and/or substance abuse structured screening and brief intervention services, greater than 30 minutes.
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services, 15–30 minutes.
Medicare	G0397	Alcohol and/or substance abuse structured screening and brief intervention services, greater than 30 minutes.
Medicare	G0442	Screening for alcohol misuse in adults, 15 minutes. No coinsurance; no deductible for patient.
Medicare	G0443	Brief face-to-face behavioral counseling for alcohol abuse, 15 minutes. Up to four per year for individuals who screen positive for alcohol misuse. No coinsurance; no deductible for patient.
Medicaid	H0049	Alcohol and/or drug screening (code not widely used).
Medicaid	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes (code not widely used).

CPT 99441-99452 - Non Face-to-Face Services Evaluation Codes

99441-99452

- 99441-99443- Non-Face-to-Face Telephone Services
- 99444-99444- Non-Face-to-Face On-Line Medical Evaluation
- 99446-99452- Interprofessional Telephone/Internet/ Electronic Health Record Consultations

CPT 99450-99457 - Special Evaluation/Management Services Codes

99452-99457

- 99450-99454- Basic Life and or Disability Evaluation
- 99455-99457- Work Related Disability Evaluation

CPT 99483-99484 - Complex Chronic Care Services Codes

99483-99484

- 99483- Comprehensive Evaluation for patient with Cognitive Impairment
- 99484- BHI Care Management

CPT 99492-99494 - Psychiatric Collaborative Care Management

99492-99494

- 99492- Initial Psychiatric Collaborative Care Management (First 70 Min. in first month)
- 99493-Subsequent Psychiatric Collaborative Care Management (First 60 Min. in subsequent month)
- 99494-Initial or Subsequent Psychiatric Collaborative Care Management (Each Additional 30 Min.)

Medicare Evaluation and Management Codes

Welcome to Medicare Visit

- G0402: Medicare Preventive visit (Welcome to Medicare)
- Frequency: One time in first 12 months, upon enrolling in Medicare
- DX: Z00.00, Z00.01

Subsequent Yearly Visits

- G0438- Yearly Wellness Exam, 12 months after Welcome Visit
- G0439- Subsequent Exams 12 mo. after G0438

Medicaid Evaluation and Management Codes

Yearly Exams- 99385-99397

- 99385-99387- New Patient Yearly Exam (Only Used Once)
- 99395-99397- Established Patient Yearly Exam (Every 12 Months)
- DX: Z00.00, Z00.01

99201-99205

- New Patient Exam(Only Used Once)
- Not Considered a Yearly Exam

99211-99215

- Established Patient Subsequent Exam

RECTAL EXAM CODES- Women

- S0601- Screening Protoscopy
- S0610- Annual Gynecological Exam- New Patient
- S0612- Annual Gynecological Exam- Established Patient

*When these codes are used as a screening per the patients benefits then the price is included in the E/M service. If not, it can be reimbursed separately by **appending Modifier “25” to the E/M service.**

RECTAL EXAM CODES- Men

- S0605- Digital Rectal Exam, Male, Annual
- 84153- Prostate Cancer Screening; (PSA) Prostate Specific Antigen Test (Test ordered with signs and symptoms)
- G0102- Prostate Cancer Screening (Medicare Code)
- G0103- Prostate Cancer Screening; (PSA) Prostate Specific Antigen Test (Medicare Code)
    - DX code Z12.5- Encounter for Screening for Malignant Neoplasm of Prostate
    - DX code R97.20- Rectal Exam Screening
    - When these codes are used as a screening per the patients benefits then the price is included in the E/M service. If not, it can be reimbursed separately by **appending Modifier “25” to the E/M service.**

VACCINES for Out of Network or Non- PC Provider

- 1) Most insurance companies will want the patient to be seen by an IN-NETWORK provider. (Varies by plan, there are some exceptions)
- 2) You do NOT have to be the PCP to administer Vaccines.
    - Preventative Vaccines- To ensure they are paid; they should be billed with a DX code that says it is a primary reason for the visit.

Evaluation and Management: Basic Components

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Medical Decision Making

- Straightforward
- Low Complexity
- Moderate Complexity
- High Complexity

How do I know what level to use?

1. Number of DX and Management Options
2. Amount and Complexity of Data
3. Risk

Straightforward

Patient History: Problem Focused

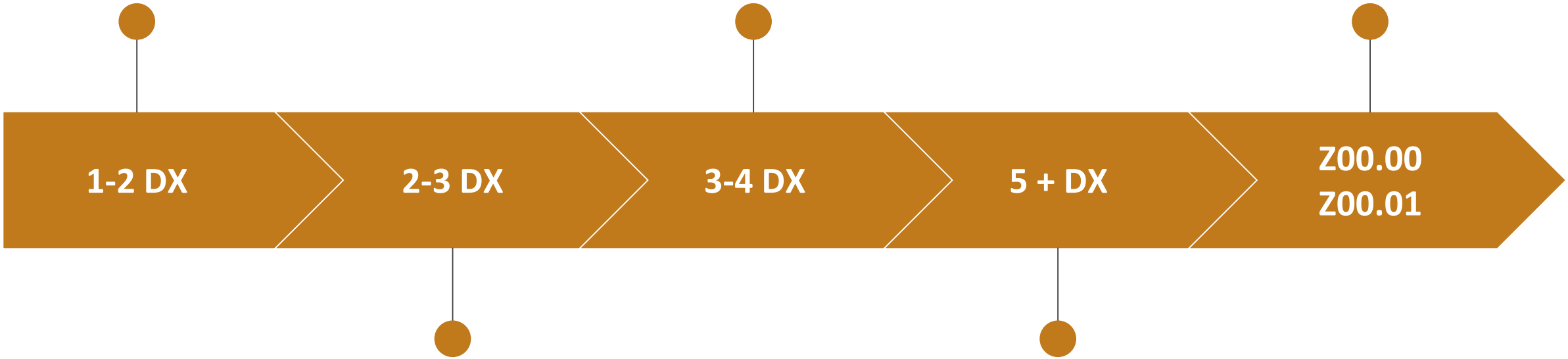
10-20 Min.

Moderate Complexity

Patient History: Comprehensive

45 Min.

Yearly Visit: Once every 12 months



Low Complexity

Patient History: Expanded Problem

30 Min.

High Complexity

Patient History: Comprehensive

60 Min.

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Elements for Each Level of Medical Decision Making

TYPE OF DECISION MAKING	NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED	RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Patient History

The Elements Required for Each Type of History:

- **CC**-Chief Complaint,
- **HPI**-History of Present Illness
- **ROS**-Review of Systems
- **PFSH**- Pertinant, Past, Family, Social History

- To qualify for a given type of history, all four elements indicated in the row must be met. (Note that as the type of history becomes more intensive, the elements required to perform that type of history also increase in intensity.)

EXAMPLE:

1. A problem focused history requires:

    - documentation of the chief complaint (CC)
    - a brief history of present illness (HPI),

2. A detailed history requires:
    - the documentation of a CC,
    - an extended HPI,
    - an extended review of systems (ROS),
    - past, family, and/or social history (PFSH).

Elements Required for Each Type of History

TYPE OF HISTORY	CC	HPI	ROS	PFSH
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

While documentation of the CC is required for all levels, the extent of information gathered for the remaining elements related to a patient's history depends on clinical judgment and the nature of the presenting problem.

The Assessment of Risk

- Presenting problem(s)
- Diagnostic procedure(s)
- Possible management options

The level of risk of significant complications, morbidity, and/or mortality can be:

1. Minimal
2. Low
3. Moderate
4. High

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	• One self-limited or minor problem (for example, cold, insect bite, tinea corporis)	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound (for example, echocardiography) • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness (for example, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH) • Acute uncomplicated illness or injury (for example, cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress (for example, pulmonary function tests) • Non-cardiovascular imaging studies with contrast (for example, barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives

Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (for example, lump in breast) • Acute illness with systemic symptoms (for example, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (for example, head injury with brief loss of consciousness)	• Physiologic tests under stress (for example, cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors (for example, arteriogram, cardiac catheterization) • Obtain fluid from body cavity (for example, lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function (for example, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) • An abrupt change in neurologic status (for example, seizure, TIA, weakness, sensory loss)	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Side-by-Side Comparison of Medicare Wellness and Care Coordination Services

Providing the Medicare wellness and care coordination services described below allows a practice to optimize fee-for-service revenue, while improving quality and decreasing total cost of care. These services will also help financially support other population health management initiatives.

	Annual Wellness Visits (AWV)	Chronic Care Management** (CCM)	Advanced Care Planning (ACP)	Transitional Care Management (TCM)
Financial Importance	Initial Preventive Physical Exam (IPPE) G0402 $169* Initial AWV G0438 $174* Subsequent AWV G0439 $118* Supports patient assessment, patient-directed goal setting, and development of a comprehensive care plan. The AWV is 100% covered—no copay nor deductible for eligible beneficiaries.	**Monthly payment opportunity** CPT code 99490 $42* Non-complex CCM 20-minute timed service provided by clinical staff to coordinate care across providers and support patient accountability. CPT code 99491 $83* 30 minutes of CCM provided by a physician or other qualified health care professional per calendar month and must account for all care management work for the month. CPT code 99491 cannot be reported in the same calendar month as CPT code 99487, 99489, and 99490. CPT Code 99487 $92* Complex CCM 60-minute timed services provided by clinical staff to substantially revise or establish moderate to high-complexity decision-making. G0506 (Add on code to be reported with another patient encounter code during which the physician or NP/PA initiates CCM with a patient.) $63* Initiating chronic care by a comprehensive assessment and development of a care plan by physician or NP/PA during an office visit in which CCM is initiated. May only be billed once.	CPT code 99497 $86* First 30 minutes (minimum 16) CPT code 99498 $76* Add-on for additional 30 minutes Opportunity to discuss patient and caregiver's wishes concerning end-of-life care. No copay for Medicare beneficiaries if done during AWV.	CPT code 99495 $166* Moderate-to-high complexity CPT code 99496 $234* High complexity Sets up a safe and successful patient transition from a hospital or other health care facility to a community setting.
Operational Advantages	AWV helps with empanelment and attribution of Medicare beneficiaries. Establishes or strengthens rapport with the patient and/or caregiver. Chance to introduce TCM, CCM, and ACP to the patient.	Reduces telephone calls to the practice by developing a regular communication channel for CCM patients. Regular monthly payment will support additional clinical staff hours or positions. Time for staff to provide patient education and answer medical questions.	No limit on the number of times ACP can be billed for a given beneficiary during a given time period. Opportunity for patient to communicate and/or document wishes for family. Increased patient engagement and satisfaction in their care.	Increases patient satisfaction by reducing risk of readmission by improving care and meeting patient's needs. Service requires face-to-face visits with primary care provider and team in 14 days for moderate complexity (99495) or seven days for high complexity (99496). Prompt follow-up decreases unnecessary readmissions and reduces total cost.
Clinical Outcomes	Improves quality of care by identifying and closing care gaps and developing a care plan. Provides overall assessment and plans personalized preventive needs and early interventions. Opportunity to update the clinical record to reflect current problem list and diagnosis coding for hierarchal condition category (HCC) risk scoring and risk stratification. Planning access to needed care will decrease emergency room visits and hospitalizations and drive down cost.	Decreased hospitalizations/emergency room (ER) visits will decrease cost of care through prevention and early intervention. Improved follow through and implementation of personalized care plan; increasing dedicated staff time will close care gaps. Improves communication and care coordination across health care professionals and settings. Improves patient engagement and accountability with regular communication with care team.	Decisions on end-of-life care are documented in the medical record. Likelihood patient and/or caregiver's wishes for end-of-life care will be upheld. May decrease total cost of care since patients may opt for palliative care options in a home setting instead of costly invasive, aggressive, or health facility choices.	Improved continuity of care through: Medicine reconciliation and answering beneficiary/caregiver questions to support safe and successful transitions. Review of hospital and pending diagnostic tests/treatments ordered. Improved coordination across the medical community. Establishing or reestablishing referrals with community providers/services to support patient's behavioral health or health-related social needs.

* Medicare and Medicare Advantage payment varies by geographical location. Check with your local Medicare Administrative Contractor (MAC) or plan for local/contracted rates. Values from Medicare Physician Fee Schedule 2019.
** Medicare Advantage plans may or may not pay for Chronic Care Management separately, as monthly care management support includes this service. You will need to verify the benefit with the specific plan.