Inpatient Coding and Billing

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MedNet21
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Objectives

- Discuss Inpatient Billing Changes From 2023
- Show How to Document for the Appropriate CPT codes
- Discuss Relative Value Units (RVUs) for Inpatient CPT codes
- Discuss What Affects the Diagnosis Related Group (DRG) For a Patient's Hospital Stay

What Happened in 2023?

- Observation Current Procedural Terminology (CPT) codes largely replaced with codes used for Inpatient
  - Exception: Same Day Admit/Discharge (99234 - 99236)
- Billing now in-line with Outpatient Billing changes from 2021
  - History and Exam just need to be medically appropriate
  - Medical Decision Making (MDM) requirements changed

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Considerations for Inpatient Billing in the USA:

- Billing for Physician Services is typically based on Current Procedural Terminology (CPT) Codes
- CPTs are maintained by the AMA
- Medicare and Medicaid (CMS) determine the RVU compensation they provide for CPTs
- Private Insurances determine their own RVU Compensation

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Considerations for Inpatient Billing by CMS:

Time Based
- Date of service
- Must document total time spent
- Can supersede MDM
- Includes time non-face-to-face with patient
  - Reviewing records
  - Documenting in EMR
  - Communicating with other Health care professionals
  - Discussions with family and care-givers.

Medical Decision Making
- Number and complexity of problems addressed
- Data reviewed and tests ordered
- Complexity of management

Considerations for Inpatient Billing:

Inpatient Visit Code	History/Exam	Medical Decision Making	Time (min)	wRVU
99221 *99231*	Medically required history and/or exam ONLY	Low	*40 min* *25 min*	1.63 *1.00*
99222 *99232*		Moderate	50 min *35 min*	2.60 1.59
99223 *99233*		High	75 min *50 min*	3.50 *2.40*

Considerations for Inpatient Billing:

Time Based
- Date of service
- Must document total time spent
- Can supersede MDM
- Includes time non-face-to-face with patient
  - Reviewing records
  - Documenting in EMR
  - Communicating with other Health care professionals
  - Discussions with family and care-givers.

Medical Decision Making
- Number and complexity of problems addressed
- Data reviewed and tests ordered
- Complexity of management

Low MDM CPT Codes (Initial 99221, Subsequent Day 99231)

Elements of MDM

Number and Complexity of problems	Amount/Complexity of Data Reviewed/Analyzed* **Each unique test, order, document contributes to the combination of 2 or 3 in Category 1 below*	Risk of Complications/morbidity/ mortality of management
• Low Complexity or Number of Problems	Low level of Analyzed Data	Low risk

Moderate MDM CPT Code (99222, 99232)		
Elements of MDM (must meet 2 of these 3)		
Number and Complexity of problems	Amount/Complexity of Data Reviewed/Analyzed *Each unique test, order, document contributes to the combination of 2 or 3 in Category 1 below	Risk of complications/ morbidity/mortality of management

Moderate
• 1/+ chronic illness uncontrolled/ progressing/ side effects
• 2/+ stable chronic
• 1 undiagnosed new problem with uncertain prognosis
• 1 acute illness with systemic symptoms
• 1 acute complicated injury
	Moderate *(meet 1 of 3 categories)*
	Category 1:
	• *Any combination of 3 of below:*
	  • Review prior note from each unique source
	  • Review of the results of each unique test
	  • Ordering of each unique test
	  • Assessment requiring independent historian
	Category 2:
	• Independent interpretation of test performed by another physician/qualified healthcare provider
	Category 3:
	• Discussion of management or test with external provider/appropriate source
		Moderate Risk
		
		Non-exhaustive Examples:
		
		• Rx management
		• Diagnosis or treatment limited by Social Determinants of Health
		• Discussion of risks/benefits of surgery

High MDM CPT Codes (99223, 99233)		
Elements of MDM (must meet 2 of 3)		
Number and Complexity of problems	Amount/Complexity of Data Reviewed/Analyzed *Each unique test, order, document contributes to the combination of 2 or 3 in Category 1 below	Risk of complications/morbidity/ mortality of management

High
 	
• 1/+ chronic illness with severe exacerbation/ progression/ or side effect of treatment
 	
• 1/+ acute or chronic illness or injury which poses a threat to life or bodily function
	Extensive *(meet 2 of 3 categories)*
	Category 1:
	• *Any combination of 3 of below:*
	  • Review prior note from each unique source
	  • Review of the results of each unique test
	  • Ordering of each unique test
	  • Assessment requiring independent historian
	Category 2:
	• Independent interpretation of test performed by another physician/qualified healthcare provide
	Category 3:
	• Discussion of management or test with external provider/appropriate source
		High Risk
		
		Non-exhaustive Examples:
		
		• Rx management requiring intensive monitoring for toxicity
		• Decision regarding escalation of care
		• Decision to de-escalate care or change to DNR because of poor prognosis
		• Discussion of elective major surgery with identified risks of patient/procedure
		• Decision about emergency major surgery

Moderate vs High MDM CPT Code

- What makes something **a severe exacerbation, a threat to life or bodily function, a drug requiring intensive monitoring?**
  - Determined by the patient's condition, **the documentation**, and the individual insurance.

When Billing for High MDM, be Explicit

- Documenting these factors justifies the CPT level for that day
  - The severity of the problem, how it puts the patient or organ function at risk
  - Documenting review of records or results, ordering tests, discussions with other Health Care Professionals
  - Interpreting images, ECGs, PFTs, etc.
  - Obtaining external history from caregivers or outside sources

When Billing for High MDM, be Explicit

- Documenting these factors justifies the CPT level for that day
  - The risk and monitoring required with medications
    - IV vancomycin, heparin, insulin, diltiazem, nicardipine, amphotericin
    - Consider high risk oral medications, e.g. warfarin or tacrolimus
  - High risk decisions and high-risk management

Vignette 1: What MDM Level Should you Bill?

Case: 72 y/o Male with Parkinson's disease, Hypertension, DM, and falls who was admitted with pneumonia and hypoxia.

- It is Hospital Day #5. He was weaned to room air and changed to oral antibiotics two days ago and is feeling improved though still weaker than baseline.
- He has been medically ready for discharge for a day, but he is waiting for pre-certification from insurance for a skilled nursing facility.

- What level of MDM should you bill?

Vignette 1: What MDM Level Should you Bill?

- Maybe 99231 (Low MDM subsequent day CPT).
- Patient was previously changed to oral antibiotics and is doing well.

Vignette 1: Was There More?

- We note the patient needed adjustment of insulin for hyperglycemia and anti-hypertensives for lower blood pressures (Problems, Management Complexity) that day. You note his glucoses in the A/P (Data).

Or

- We note detailed discussion of discharge plan with Case Manager and Social Worker (Data Review) and we note how the patient is progressing and tolerating the antibiotics (Problems, Management Complexity)

With either it should qualify for a Moderate MDM CPT (99232)

Moderate MDM CPT Code (99222, 99232)		
Elements of MDM (must meet 2 of these 3)		
Number and Complexity of problems	Amount/Complexity of Data Reviewed/Analyzed *"Each unique test, order, document contributes to the combination of 2 or 3 in Category 1 below*	Risk of complications/ morbidity/mortality of management
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Vignette 2

You admit a 74 y/o Female with DM type 2, HTN, COPD, and chronic diastolic CHF presenting with 10 lb weight gain, dyspnea, orthopnea, and palpitations.

- EMS found her at an SaO2 of 78% with RR of 30.
- She was put on CPAP and was converted to 6 LPM supplemental O2 in the ED.

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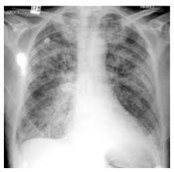
Vignette 2

- HR is 130s, BP 110/70, RR 18 with SaO2 90% on 6 LPM supplemental oxygen.
- She has signs of hypervolemic CHF and irregularly irregular rhythm.
- ECG shows A Fib with RVR. CXR shows pulmonary edema.
- Chem: Cr 2.2 from 1.2, BNP 900.
- You give IV lasix and diltiazem, oxygen and prn CPAP



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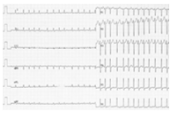

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A/P: Moderate or High MDM H&P CPT?

73 y/o F with DM type 2, HTN, and chronic diastolic CHF presents with acute on chronic diastolic CHF exacerbation and new A fib with RVR

- Acute on chronic diastolic CHF: Hypervolemic and perfusing
  - IV Lasix, I/O, chem monitoring.
  - TTE ordered, has been 14 months since prior echo.
  - Cardiac diet, fluid restriction.
- Newly Discovered A fib with RVR
  - Rate control with IV diltiazem
  - CHADS2VASC is 4, starting apixaban
- Hypoxia: due to above, provide CPAP and oxygen as needed. Wean as able
- AKI: due to CHF and A Fib with RVR. Monitoring.

Probably 99222 with the documentation

- Problem Complexity
  - Severity of the CHF exacerbation and A fib with RVR and risk to the patient were not documented.
  - Acute hypoxic respiratory failure not documented.
- Data Analysis
  - Review of CXR images and actual ECG not reported (best to include this in A/P)
  - Review of notes, outside historians, not noted.
- High risk of Management, Morbidity, Mortality
  - Discussion of close monitoring needed with diuresis or IV diltiazem?
  - Decision about level of hospitalization? Step-down unit

Let's say this is the A/P

73 y/o F with DM type 2, HTN, and chronic diastolic CHF presents with acute on chronic diastolic CHF exacerbation, Acute hypoxic respiratory failure, and new A fib with RVR

- Acute on chronic diastolic CHF: Severe CHF exacerbation with compromised renal function and hypoxic respiratory failure.
  - IV Lasix, will need close monitoring of UOP, renal function, and hemodynamics for patient and renal safety.
  - Cardiac diet, fluid restriction.

Let's say this is the A/P

- Newly Discovered A fib with RVR, management complicated with AKI. ECG reviewed and c/w A fib
  - Rate control with IV diltiazem. Monitoring hemodynamics carefully while on this IV medication. Titrate to control HR
  - CHADS2VASC is 4, starting apixaban
- Acute hypoxic respiratory failure: due to CHF and A fib, provide CPAP and oxygen as needed. Reviewed CXR images with likely pulmonary edema. Wean oxygen and CPAP as able. Monitoring closely as patient was tenuous in the ED. Admit to Step-down unit
- AKI: Cr 2.2 from 1.2 baseline. complicated with CHF and A Fib with RVR. Monitoring UOP, renal function and hemodynamics carefully with potential cardiorenal syndrome and worsening renal function

High MDM CPT Codes (99223, 99233)

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Inpatient Relative Value Units (RVUs)

- Compensation for a Hospitalization is often paid by the Diagnosis-Related Group (DRG) for Medicare, Medicaid, and many private insurances
- **Compensation for physicians typically comes from CPT codes which are tied to RVUs**
  - **Compensation per RVU is $32.74 by Medicare**

Inpatient Work RVUs

Code Type	Low MDM CPT: RVU	Moderate MDM CPT: RVU	High MDM CPT: RVU
Initial Day	99221: 1.63	99222: 2.6	99223: 3.5
Subsequent Day	99231: 1.0	99232: 1.59	99233: 2.4
Discharge		99238 (≤ 30 min): 1.5	99239 (> 30 min): 2.15
Same Day Admit/DC	99234: 2.0	99235: 3.24	99236: 4.3

CMS uses Initial Day CPT codes for New Consults, Private Insurances may use other codes such as 99252-99255

Inpatient Work RVUs

Code Type	CPT: RVU	CPT: RVU
Critical Care Time	99291 (30-74 min): 4.5	99292 (each 30+ min) : 2.25
Prolonged Time	99418 (15 min): 0.81	CMS Code (15 min): HCPCS G0316: 0.61*
Advanced Care Planning	99497 (first 16-30 min): 1.5	99498 (16-30 min+) : 1.4

**For some services CMS uses a different Code than the AMA managed CPT codes, such as for prolonged time*

Critical Care Time

- Requires 3 criteria
  - Clinical Condition:
    - High probability of **sudden, clinically significant, or life-threatening deterioration**
  - Treatment Criterion:
    - Requires direct management by physician for **life and organ-supporting interventions**
  - Time: at least 30 minutes. Document time

Critical Care Time

- 99291: 30-74 min
- 99292, each additional 30 min
  - Must be 30 min to count, may be repeated
  - E.g. 140 min of critical care time is 99291 + 99292 + 99292

Critical Care Time

- Examples which may appropriate for Billing Critical Care
  - Acute Respiratory Failure
  - Septic Shock or Severe Sepsis
  - Cardiac Arrest
  - Myocardial Infarction
  - Acute Stroke
  - Drug Overdose
  - Severe Bleeding

Prolonged Care

- The AMA Controls CPT codes
  - Inpatient Prolonged Time is CPT 99418.
- Medicare has its own Prolonged Time code
  - HCPCS G0316

You spent 80 minutes in medically necessary care of a patient on hospital day #2

- What CPT codes can you bill?

Designed by Wannapik

What Counts for Prolonged Care?

- Criteria same as billing for visits for time
- Includes time face-to-face with patient and non-face-to-face with patient

Designed by Wannapik

Case: What CPTs Can We Bill?

- You can bill 15 min after the time for your other encounter is over
  - Can be repeated for each additional 15 min
- For this case, you spent 80 min with patient
  - Bill subsequent day 99233 (50 min) + 99418 + 99418
  - RVUs: 2.4 + 0.81 + 0.81

Designed by Wannapik

Advanced Care Planning

- CPT codes for Advanced Care Planning (ACP)
  - For time spent with patient, family, surrogate, or caregiver on ACP.
  - Compensates for advance directives and goals of care conversations.
- CPT 99497 is for Initial 16 - 30 minutes
- CPT 99498 is for additional 16 - 30 min

Advanced Care Planning

- You admit a sick patient. During the admission visit, you have a lengthy 35-minute meeting with a patient and family over goals of care

What CPT codes can you bill?

35-minute Advanced Care Planning Meeting

- What CPT codes can you bill?
  - Initial Admission CPT code 99222 or 99223
  - And Advanced Care Planning CPT codes 99497 (RVU 1.5)
  - Unable to bill for subsequent ACP time as you didn't reach 16 minutes
- Documentation should include the necessity of conversation and time of ACP, ideally with start and end time.

Inpatient billing of Insurance

- Physician billing is typically based on CPT codes
- **Compensation for the hospital is based on the Diagnosis-Related Group (DRG) for Medicare, Medicaid, and many private insurances**
  - **Meant to standardize reimbursement**

What determines DRG for Medicare?

- Principal Diagnosis
- Secondary Diagnoses, particularly those which represent increased resource use
- Procedures performed
- Age, Sex
- Discharge Status
- Complication or Comorbidities (CCs) or Major Complications or Comorbidities (MCCs)

What determines DRG for Medicare?

How is the DRG Determined from these factors?

- Accurate Documentation which reflects the complexity of care
- Accurate Diagnoses and Problems associated with hospital stay and CPT codes.

What are MCCs? AKA what I get coding and billing queries about

- MCCs are Clinically Severe and Resource-Intensive Diagnoses
- **The context of the hospitalization, documentation, and insurance determine if a diagnosis is a MCC, CC, or neither.**
- **Your documentation is critical to capturing the complexity of the patient**

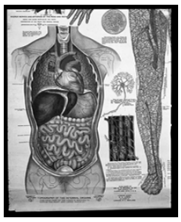
Relevant Diagnoses, CCs, MCCs

Case: 45 year old patient with T10-level paraplegia, chronic wounds, and chronic sacral osteomyelitis who was admitted with fevers suspected to be from a urinary tract infection

- On presentation the patient has hypotension with mAP 60 and AKI with a creatinine rise from 1.0 to 1.8. These both improve with IVFs.
- What relevant diagnoses are present? Which may be MCCs or CCs?

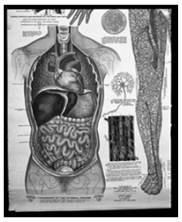
What are MCCs? AKA what I get coding and billing queries about

- Possible examples of MCCs, though it depends on individual insurance
  - Sepsis, DIC, Necrotizing Fasciitis
  - Shock, Acute MI, PE, Pulmonary Hypertension
  - AKI, particularly if severe or requiring HD or with rhabdomyolysis. ESRD
  - Cirrhosis with ascites or HE, Acute Liver Failure



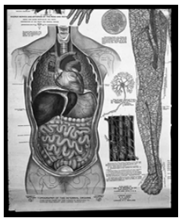
Examples of MCCs?

- Severe Pancreatitis, especially with pseudocysts, abscess or necrosis
- Malignant Neoplasms
- Extensive burns
- Severe Encephalopathy
- Intra-cranial Hemorrhage, Anoxic Brain Injury, Severe TBI
- Spinal cord compression, Acute paralysis
- Stage IV Pressure Ulcers, Severe Protein Calorie Malnutrition



Examples of MCCs?

- Complicated Peptic Ulcer Disease, e.g. with bleed or perforation
- Severe withdrawal from Substance
- Severe Electrolyte Issues, e.g. severe hyperkalemia or hyponatremia
- DM with HHS or DKA
- Severe Mental Health disorder
- Severe Immunosuppression



What are CCs?

- Comorbidities and Complications may add to the complexity and DRG to a lesser degree.
- Possible examples:
  - DM with complications
  - COPD
  - CHF
  - A Fib
  - Severe Substance Use Disorder, Withdrawal

Clinical Vignette: MCCs

- All below may be MCCs
  - UTI
  - Sepsis (Sofa rise ≥ 2)
  - Chronic paraplegia
  - Stage IV pressure ulcer
  - AKI? In association with sepsis
  - Chronic osteomyelitis?

Ambulatory Coding and Billing

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Objectives

- Understand ambulatory coding updates
- Document less
- Big wins for primary care!
- Get paid for the work you (already) do

2021 E/M updates: Let's dive in!

- Increased wRVUS associated with codes
- Decrease documentation burden
- Document only what is needed
- Focus on MDM

Considerations:

Time Based
- Date of service
- Includes info collected by staff
- Must document total time spent
- Can supersede MDM

Medical Decision Making
- Number and complexity of problems addressed
- Includes tests considered but not ordered
- Includes speaking with outside providers/care team members

Established Patient Visit Code	History/Exam	Medical Decision Making	Time (min)	wRVU
99202 *99212*	Medically required history and/or exam ONLY	Straightforward	15-29 *10-19*	0.93 *0.70*
99203 *99213*		Low	30-44 *20-29*	1.60 *1.30*
99204 *99214*		Moderate	45-49 *30-39*	2.60 *1.92*
99205 *99215*		High	60-74 *40-54*	3.50 *2.80*

Considerations:

Time Based
- Date of service
- Includes info collected by staff
- Must document total time spent

Medical Decision Making
- Number and complexity of problems addressed
- Includes tests considered but not ordered
- Includes speaking with outside providers/care team members

Code	Level of MDM	Elements of MDM		
		Number and Complexity of problems	Amount/Complexity of Data Reviewed/Analyzed* **Each unique test, order, document contributes to the combination of 2 or 3 in Category 1 below*	Risk of Complications/morbidity/ mortality of management
99202 99212	Straightforward	1 self limited/minor problem	None	Minimal risk

99203
99213
	Low	• 2 self limited/minor
		• 1 stable chronic
		• 1 acute uncomplicated
		• 1 stable acute problem
			Limited *(meet 1 of 2 categories)*
			• *Category 1:*
			  • *Any combination of 2 of below:*
			  • Review prior note from each unique source
			  • Review of the results of each unique test
			  • Ordering of each unique test
			OR
			• *Category 2:*
			  • Assessment requiring independent historian
				Low risk

Code	Level of MDM	Elements of MDM		
		Number and Complexity of problems	Amount/Complexity of Data Reviewed/Analyzed **Each unique test, order, document contributes to the combination of 2 or 3 in Category 1 below*	Risk of Complications/morbidity /mortality of management

99204
99214
	Moderate	Moderate
		• 1/+ chronic illness uncontrolled/progressing /side effects
		• 2/+ stable chronic
		• 1 undiagnosed new uncertain prognosis
		• 1 acute illness systemic
		• 1 acute complicated injury
			Moderate *(meet 1 of 3 categories)*
			• *Category 1:*
			  • *Any combination of 3 of below:*
			  • Review prior note from each unique source
			  • Review of the results of each unique test
			  • Ordering of each unique test
			  • Assessment requiring independent historian
			OR
			• *Category 2:*
			  • Independent interpretation of test performed by another physician/qualified healthcare provider
			OR
			• *Category 3:*
			  • Discussion of management or test with external provider/appropriate source
				Moderate Risk
				• Rx management
				• Diagnosis or treatment limited by SDOH
				• Discussion of risks/benefits of surgery
				• Discussion of risks/benefits of management of medications without starting treatment

Code	Level of MDM	Elements of MDM		
		Number and Complexity of problems	Amount/Complexity of Data Reviewed/Analyzed **Each unique test, order, document contributes to the combination of 2 or 3 in Category 1 below*	Risk of Complications/morbidity/mortality of management

99205
99215
	High	High
		• 1/+ chronic illness uncontrolled/progressing /side effects
		• 2/+ stable chronic
		• 1 undiagnosed new uncertain prognosis
		• 1 acute illness systemic
		• 1 acute complicated injury
			Extensive *(meet 2 of 3 categories)*
			• *Category 1:*
			  • *Any combination of 3 of below:*
			  • Review prior note from each unique source
			  • Review of the results of each unique test
			  • Ordering of each unique test
			  • Assessment requiring independent historian
			OR
			• *Category 2:*
			  • Independent interpretation of test performed by another physician/qualified healthcare provider
			OR
			• *Category 3:*
			  • Discussion of management or test with external provider/appropriate source
				High Risk
				• Rx management requiring intensive monitoring for toxicity
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de escalate care because of poor prognosis
				• Discussion of elective major surgery with identified risks of patient/procedure

Case #1:

- 25 yo female with no significant pmhx presents with cough, runny nose, and no fever of 3 days duration. She denies shortness of breath, body aches or chills. Multiple family members have been ill with the same symptoms. She is up to date on COVID19 and Flu vaccines. In office POC testing is negative for flu and COVID19. Supportive care is recommended with over the counter medications.

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99203
99213
	Low	• 2 self limited/minor
		• 1 stable chronic
		• 1 acute uncomplicated illness
			Limited *(meet 1 of 2 categories)*
			• *Category 1:*
			  • *Any combination of 2 of below:*
			  • Review prior note from each unique source
			  • Review of the results of each unique test
			  • Ordering of each unique test
			OR
			• *Category 2:*
			  • Assessment requiring independent historian
				Low risk

Case #2

- 75 yo with DM, HTN, and MCI presents to clinic with URI symptoms including fever, cough and myalgia for 2 days. He is a patient of your colleague's, and you review their last note. He appears mildly ill, but vitals are stable. On POC testing, he is negative for Flu, but positive for COVID19. On chart review, you note mild renal insufficiency on last chem panel. He is not up to date on his covid shots. You decide to prescribe renally dosed nirmaltrevir-ritonavir based on his medical history and discuss side effects and risks and benefits of treatment vs supportive care with over-the-counter medications.

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			OR
			• *Category 2:*
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			OR
			• *Category 3:*
			  • Discussion of management or test with external provider/appropriate source
				Moderate Risk
				• Rx management
				• Diagnosis or treatment limited by SDOH
				• Discussion of risks/benefits of surgery
				• Discussion of risks/benefits of management of medications without starting treatment

Case #3

- 55 yo female with OSA, a. fib, DM and HTN returns for regular follow up. You review her chart. She has seen cardiology and sleep medicine since her last visit with you. No changes were made to therapy. The labs you had ordered to be completed prior to her visit are stable. Her a1c is 6.4, and chemistry is stable. BP is 124/68 today. She is tolerating her medications well and reports no complaints during her visit today. You make no changes to her current medication regimen, document them in your assessment and plan, and refill her prescriptions.

Code	Level of MDM	Elements of MDM		
		Number and Complexity of problems	Amount/Complexity of Data Reviewed/Analyzed **Each unique test, order, document contributes to the combination of 2 or 3 in Category 1 below*	Risk of Complications/morbidity/mortality of management

99204
99214
	Moderate	Moderate
		• 1/+ chronic illness uncontrolled/progressing /side effects
		• 2/+ stable chronic
		• 1 undiagnosed new uncertain prognosis
		• 1 acute illness systemic
		• 1 acute complicated injury
			Moderate *(meet 1 of 3 categories)*
			• *Category 1:*
			  • *Any combination of 3 of below:*
			  • Review prior note from each unique source
			  • Review of the results of each unique test
			  • Ordering of each unique test
			  • Assessment requiring independent historian
			OR
			• *Category 2:*
			  • Independent interpretation of test performed by another physician/qualified healthcare provider
			OR
			• *Category 3:*
			  • Discussion of management or test with external provider/appropriate source
				Moderate Risk
				• Rx management
				• Diagnosis or treatment limited by SDOH
				• Discussion of risks/benefits of surgery
				• Discussion of risks/benefits of management of medications without starting treatment

Prolonged Services:

- 99417 and G2212

Same Date of Service → Non face to face time → Added in 15-minute increments

Prolonged Services:

- G2212
  - Medicare
  - Add to MAXIMUM time

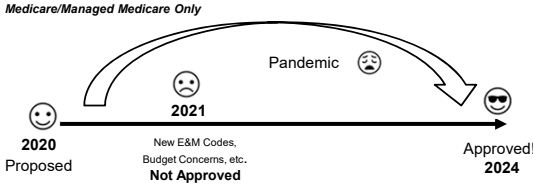
For Medicare
New patients: 89 minutes
Established patients: 69 minutes

- 99417
  - Non-Medicare
  - Add to MINIMUM time

For Non-Medicare
New patients: 75 minutes
Established patients: 55 minutes

Inherent Complexity Code: G2211

Medicare/Managed Medicare Only



Why does this matter?

- Additional $16 per visit when added
- Additional 0.33 wRVU per visit
- No cost sharing to patient
- It accounts for time!
- Acknowledges work done by staff
- It applies to most visits you do!

Which visits is it ok to use G2211 with?

- Yes
  - Any E/M code
  - Video visit
  - Chronic Care Management Services
- No
  - Annual Wellness Visits
  - Transitional care management
  - Electronic Portal Visits

Scenarios

- **Would bill G2211**
  - Seeing a patient for any chronic issue
  - Seeing a patient for any chronic issue AND a new, acute issue comes up
  - Seeing a patient for a *NEW, SERIOUS, ACUTE* issue and DO NOT address chronic issues
  - Seeing a patient for chronic conditions AND do a procedure

Documentation Requirements:

- Minimal!
- Add on code ***NOT A MODIFIER***
- Documentation should demonstrate:
  - Clear direction and a care plan
  - Indicate patient return
- For acute visits:
  - Visit is outside the needs of their typical care plan.

Preventive Health/Wellness visits

AMA
AMERICAN MEDICAL ASSOCIATION

Coding and Billing for Preventive and Problem-Focused E/M Services in the Same Encounter

THE MYTH

Physicians should not bill for both preventive/wellness and evaluation and management (E/M) services when they are performed during the same visit.

When is this appropriate?

A new, significant, issue arises and must be addressed

A chronic issue is addressed that requires management

When is this appropriate?

A new, significant, issue arises and must be addressed

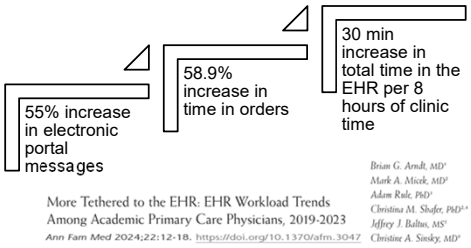
A chronic issue is addressed that requires management

Preventive Health Code

25 Modifier

Add E/M code

Electronic portal visit: I know you feel it



More Tethered to the EHR: EHR Workload Trends Among Academic Primary Care Physicians, 2019-2023
Ann Fam Med 2024;22:12-18. https://doi.org/10.1370/afm.3047

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Patient Portal Visits (99421-99423)

- Inquiry must be patient generated
- Based on cumulative time over a 7 day period
  - 99421: 5-10 minutes
  - 99422: 11-20 minutes
  - 99423: >21 minutes
- Must clearly document time or it will be changed to lowest level visit
- Work that results in an in person visit for the same complaint would not be billed
- What counts toward code (all of the below):
  - Review of patient record and related data for problem assessment
  - Development of a management plan
  - Need to order a test or Rx
  - Any ongoing communication that does not include a separate E/M service

Accessed 4/23/21: https://www.ama-assn.org/practice-management/cpt/new-2020-cpt-codes-recognize-em-work-happens-online

Telephone visits/Touch Base

- Touch Base
  - Require consent
  - Time based
  - Medicare
  -
- Telephone Visits
  - Require consent
  - Time based
  - Private and Medicaid

Can't be related to an E/M visit in previous 7 days

Telephone/Touch Base

- Touch Base
  - G2012: 5-10 min
  - G2252: 11-20 min
- Telephone
  - 99441: 5-10 minutes
  - 99442: 11-20 minutes
  - 99443: >21 minutes

Depression Screenings

- G0444
  - Medicare only
  - Annual code with AWV
  - Bill if screen positive
  - Document factors contributing
  - Document plan and tool to assess
- 96127
  - Medicare and private insurance
  - Used for positive screenings *OR* for management
  - Can bill two on same DOS with diagnostic codes

Preventative Health (New)	wRVU	Preventative Health (Established)	wRVU	E/M Code New and Established	wRVU	Electronic portal visits and Telephone/Touch Base Codes	wRVU	Inherent Complexity Code	wRVU
99391	**1.75**	*99381*	**1.61**	*99202*	**0.93**	*99421*	**0.25**	*G2211*	**0.33**
99392	**1.92**	*99382*	**1.71**	*99203*	**1.60**	*99422*	**0.50**	*G0444*	**0.18**
99393	**1.92**	*99383*	**1.82**	*99204*	**2.60**	*99423*	**0.80**	*96127*	***
99394	**1.92**	*99384*	**2.14**	*99205*	**3.50**	*99441*	**0.25**		
99395	**2.18**	*99385*	**2.05**	*99212*	**0.70**	*99442*	**0.50**		
99396	**2.24**	*99386*	**2.49**	*99213*	**1.30**	*99443*	**0.80**		
99397	**2.43**	*33987*	**2.68**	*99214*	**1.92**	*G2012*	**0.25**		
G0439	**1.92**	*G0402*	**2.60**	*99215*	**2.80**	*G2252*	**0.50**		
		G0438	**2.60**	*99417/G2212*	**0.61**				

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