Coding and Billing 101

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Benefits of Coding

Correct Code assignment plays a significant role in

- Clinical Care
- Research
- Education
- Resource Utilization
- Reimbursement
- Health policy development and planning

Medical Coding

System to uniformly represent and report medical services

- **CPT** (Current Procedural Terminology) assigning a CPT code to a procedure or service is dependent on both the supporting documentation and the procedure recorded
- **HCPCS** (Healthcare Common Procedure Coding System) Level I or an alphanumeric **Level II HCPCS** code
- **ICD-10-CM** (International Classification of Diseases, Tenth Revision, Clinical Modification) diagnosis code, which must be well-documented in the medical record, is required to support medical necessity

What is CPT?

Current Procedural Terminology (CPT®) codes are developed, maintained, updated annually, and copyrighted by the American Medical Association (AMA).

They fall into three categories:

- Category I – These five-digit codes have descriptors which correspond to a procedure or service. Codes range from 00100 - 99499.
- Category II – These alphanumeric tracking codes are used for execution measurement. Using them is often optional.
- Category III – These are provisional codes for new and developing technology, procedures, and services. The codes were created for data collection and assessment of new services and procedures.

CPT Codes (cont)

Two-character modifiers are appended to CPT® codes to report special circumstances and to clarify or modify the description of the procedure. These modifiers are developed by the AMA and the Centers for Medicare & Medicaid Services (CMS).

The rules for assigning appropriate code(s) are complex, and although CPT® codes are standardized, the amount various practitioners are reimbursed for their services or procedures are not necessarily the same. In Medicare, CPT® is Level I of the Healthcare Common Procedure Coding System (HCPCS) code system and accompanied by the HCPCS Level II supply and service codes.

https://www.ama-assn.org/practice-management/cpt-code-process

Category I codes

Are used by physicians and by most outpatient providers when reporting a significant portion of their services and procedures. Category I codes are updated annually and are broken down into six sections.

1. Evaluation and Management
2. Anesthesiology
3. Surgery
4. Radiology
5. Pathology and Laboratory
6. Medicine

Category II codes

The are intended to facilitate the collection of information about the quality of care delivered by coding a number of services or test results that support performance measures. These performance measures have been agreed upon as contributing to good patient care.

The Category II Codes are alphanumeric and consist of four digits followed by the alpha character 'F.' The use of these codes is optional and are not a substitute for Category I codes.

CPT Category II codes will be arranged according to the following categories:

- Composite Measures 0001F
- Patient Management 0500F-0503F
- Patient History 1000F-1002F
- Physical Examination 2000F
- Diagnostic/Screening Processes or Results 3000F
- Therapeutic, Preventive or Other Interventions 4000F-4011F
- Follow-up or Other Outcomes 5000F
- Patient Safety 6000F

Composite Measures Category II Codes

Currently there are 11 Category II codes. They are:

1. 0001F Blood pressure measured
2. 0002F Tobacco use, smoking, assessed
3. 0003F Tobacco use, non-smoking, assessed
4. 0004F Tobacco use cessation intervention, counseling
5. 0005F Tobacco use cessation intervention, pharmacologic therapy
6. 0006F Statin therapy, prescribed
7. 0007F Beta-blocker therapy, prescribed
8. 0008F Ace inhibitor therapy, prescribed
9. 0009F Anginal symptoms and level of activity, assessed
10. 0010F Anginal symptoms and level of activity, assessed using a standardized instrument.
11. 0011F Oral anti-platelet therapy, prescribed (e.g., aspirin, clopidogrel/Plavix, or a combination of aspirin and dipyridamole/Aggrenox)

Category III Codes

Category III codes represent temporary codes for new and emerging technologies. They have been created to allow for data collection and utilization tracking for new procedures or services

The Category III codes are five characters long, with four digits followed by the letter 'T' in the last field (e.g. 0002T). The codes are intended to be temporary and will be retired if the procedure or service is not accepted as a Category I code within five years

The AMA releases new codes twice a year (January and July) on its Web site. The codes released in July are included in the next published edition of CPT. The most current listing of CPT III codes can be found on the AMA Web site at http://www.ama-assn.org/ama/pub/category/3885.html.

Early release of these codes is possible because payment for these services is based on the policies of payers and not on a yearly fee schedule

How are CPT codes created?

The AMA CPT® Editorial Panel is responsible for maintaining the CPT code set

CPT Editorial Panel meets 3 times each year

17 members

- 11 are physicians nominated by the **national medical specialty societies** and approved by the AMA Board of Trustees
  - One of the 11 is reserved for expertise in performance measurement

- One physician representative from each of the following;
  - Blue Cross and Blue Shield Association
  - America's Health Insurance Plans
  - American Hospital Association
  - CMS
- 2 seats on the CPT Editorial Panel are reserved for members of the CPT Health Care Professionals Advisory Committee.

https://www.ama-assn.org/practice-management/cpt-code-process

CPT Advisory Committee

Advisory committee is limited to national medical specialty societies seated in the AMA House of Delegates and to the AMA Health Care Professionals Advisory Committee (HCPAC), organizations representing limited-license practitioners and other allied health professionals.

The advisory committee's primary objectives are to:

- Serve as a resource to the CPT Editorial Panel by giving advice on procedure coding and appropriate nomenclature as relevant to the member's specialty.
- Provide documentation to staff and the CPT Editorial Panel regarding the medical appropriateness of various medical and surgical procedures under consideration for inclusion in the CPT code set.
- Suggest revisions to the CPT code set. The advisory committee meets annually at the CPT February meeting to discuss items of mutual concern and to keep abreast of current issues in coding and nomenclature.
- Assist in the review and further development of relevant coding issues and in the preparation of technical education material and articles pertaining to the CPT code set.
- Promote and educate its membership on the use and benefits of the CPT code set.

What is RBRVU?

Resource Based Relative Value Units

Developed at Harvard by Dr Hsai to make Medicare payments more equitable in 1992

payments are determined by the resource costs needed to provide them, with each service divided into three components:

- Physician work
- Practice expense
- Professional liability insurance (PLI)

The standard of payment for many public and private insurers

https://www.ama-assn.org/rbrvs-overview

What is RUC

AMA/Specialty Society RVS Update Committee (RUC), provides medicine a voice in shaping Medicare relative values.

provides relative value recommendations to CMS annually.

https://www.ama-assn.org/rvs-update-committee-ruc

What is an ICD?

International Statistical Classification of Diseases and Related Health Problems (ICD)

Diagnosis codes

ICD-10 is the 10th revision completed in 1992

Have “severity” scoring systems that look to see that physicians are paid appropriately for the work they deliver

What is HCPCS?

Healthcare Common Procedure Coding System (HCPCS) code set

HCPCS has its own **coding** guidelines and works hand in hand with **CPT**.

HCPCS includes separate levels of **codes**:

The American Hospital Association (AHA) and the Centers for Medicare & Medicaid Services (CMS) have joined together in establishing the AHA clearinghouse to handle coding questions on established HCPCS usage. https://www.codingclinicadvisor.com/

https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html

https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html

Levels of HCPCS codes

Level I **codes** consist of the AMA's **CPT codes** and is numeric. Level I HCPCS (CPT-4 codes) for hospital providers

Level II **codes** are the **HCPCS** alphanumeric **code** set and primarily include non-physician products, supplies, and procedures not included in **CPT**

Level II HCPCS codes for hospitals, physicians and other health professionals who bill Medicare

- A-codes for ambulance services and radiopharmaceuticals
- C-codes
- G-codes
- J-codes, and
- Q-codes (other than Q0163 through Q0181)

Evaluation & Management Codes (E/M)

Used for sick visits

Based on the severity of the illness and the work done

If more than 50% of visit is counseling, then time is an element

Required elements

- Expanded problem focused history
- Expanded problem focused exam
- Straightforward medical decision making

New Pt all 3 elements

Established Pt 2 of 3 elements

99211 Doesn’t require the presence of a physician

Well visits

“new” patients, not seen by clinician or practice in last 3 years

“established”

Age	CPT Code New Pt	CPT Code Established Pt
Under 1 yr	99381	99391
1-4 yr	99382	99392
5-11 yr	99383	99393
12-17 yr	99384	99394
18-39 yr	99385	99395

E/M Codes

	History	Exam	Medical Decision Making
99212	Expanded problem focused history	Expanded problem focused exam	Straightforward medical decision making
99213	Detailed history	Detailed examination	Medical decision making of low complexity
99214	Comprehensive history	Comprehensive examination	Medical decision making of moderate complexity
99215	Comprehensive history	Comprehensive examination	Medical decision making of high complexity

Why is E/M coding important

Clinicians may “under” code

Cost of under coding

- Increase from 5% 99214 to 20 % can increase net income by $20,000

Risk of over coding

- Medicare, Medicaid and private insurers may audit
- If the documentation doesn’t equal the code billed they may penalize

Bill for procedures

Know the codes for all the procedures done in the practice

Procedure codes pay better than E/M codes

HIPAA, however, requires the use of medical code sets that are valid at the time the service is provided.

All claims with discontinued CPT codes will be returned to the provider

E/M coding being revised in 2019 PFS Proposed Rule

Where can you learn more?

AAFP, AMA, ACP offer coding courses

Have access to current CPT and ICD 10 coding books in the practice

CMS Medicare Learning Network Catalog; April 2018

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf

Medical Coding: Accurate and Compliant

Coding Steps:

1. Assess documentation for completeness and clarity
    1. Is documentation complete?
    2. Are diagnoses clearly stated with supporting detail?
2. Determine provider, patient type, place and payer
3. Abstract the diagnoses and procedures
4. Assign accurate, complete codes
    1. Diagnoses and procedure codes should be linked to demonstrate medical necessity
    2. Codes must be based on documentation
    3. Codes must be current and consistent with HIPAA code sets
5. Verify codes are compliant
    1. Satisfy requirements, regulations, and policies for correct coding
6. Release codes for billing

Compliance

Fraud & Abuse

- Fraud = intentional act to obtain an illegal or unauthorized benefit (billing for services that weren't performed)
- Abuse = intentional or unintentional act that misuses government money (e.g. billing for services not medically necessary)

Enforcement by HHS office of the Inspector General (OIG)

Compliance Plans: written documentation of policies and procedures to identify, correct, and prevent fraud and abuse; includes physician and staff training

Place of Service

These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes. https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy **	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (Effective October 1, 2003)
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)
03	School	A facility whose primary purpose is education. (Effective January 1, 2003)
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). (Effective January 1, 2003)

What affects my billing

Type of practice
- Private
- FQHC
- Rural

Pt Coverage
- Medicare
- Medicare Advantage
- Medicaid
- Commercial

Contracts

Site of Service
- Off Campus Provider based
- Hospital
- Private Office

Care Management Services

Advance Care Planning

- Advance Care Planning Services Fact Sheet
- Advance Care Planning Services FAQs

Behavioral Health Integration

- Behavioral Health Integration Fact Sheet
- Behavioral Health Integration FAQs

Transitional Care Management

- Transitional Care Management Services Fact Sheet
- Transitional Care Management Services FAQs

Chronic Care Management

- Changes to Chronic Care Management Services for 2017 Fact Sheet
- Chronic Care Management Services Fact Sheet
- Chronic Care Management Services FAQs
- Chronic Care Management Outreach Campaign on Geographic and Minority/Ethnic Health Disparities
- Chronic Conditions in Medicare
- Chronic Conditions Data Warehouse

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html

CCM: Chronic Care Management

Chronic Care Management (CCM) services by a physician or nonphysician practitioner (Physician Assistant [PA], Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Certified Nurse-Midwife [CNM]) and their clinical staff,

Once per calendar month,

For patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Only 1 practitioner can bill CCM per service period (month).

General supervision in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), however only CPT 99490 is payable in these settings (complex CCM is not payable) and there is no add-on code/separate payment for initiating visits

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf

TABLE 1. SUMMARY OF 2017 CCM CODING CHANGES

BILLING CODE	PAYMENT (NON-FACILITY RATE)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
CCM (CPT 99490)	$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised, or monitored	Ongoing oversight, direction, and management Assumes 15 minutes of work
Complex CCM (CPT 99487)	$94	60 minutes	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 26 minutes of work
Complex CCM Add-On (CPT 99489, use with 99487)	$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 13 minutes of work
CCM Initiating Visit*	$44-$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

*(Annual Wellness Visit [AWV], Initial Preventive Physical Examination [IPPE], Transitional Care Management [TCM], or Other Qualifying Face-to-Face Evaluation and Management [E/M])

BHI CODING SUMMARY

BHI CODE	BEHAVIORAL HEALTH CARE MANAGER OR CLINICAL STAFF THRESHOLD TIME	ASSUMED BILLING PRACTITIONER TIME
CoCM First Month (99492)	70 minutes per calendar month	30 min
CoCM Subsequent Months** (99493)	60 minutes per calendar month	26 min
Add-On CoCM (Any month) (99494)	Each additional 30 minutes per calendar month	13 min
General BHI (99484)	At least 20 minutes per calendar month	15 min
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M)	N/A	Usual work for the visit code

*Medicare Physician Fee Schedule (MPFS) payment is available under the MPFS regardless of whether the beneficiary spends part or all of the month in a facility stay or institutional setting. Report the place-of-service (POS) where the billing practitioner would ordinarily provide face-to-face care to the beneficiary. Separate Part B payment can be made to hospitals (including critical access hospitals) when the billing practitioner reports a hospital outpatient POS.
**CoCM is furnished monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).
†Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management services

99492 Initial psychiatric collaborative care management

First 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- ● Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
- ● Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- ● Review by the psychiatric consultant with modifications of the plan if recommended;
- ● Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- ● Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies

99493 Subsequent psychiatric collaborative care management

- First 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:
  - Tracking patient follow-up and progress using the registry, with appropriate documentation;
  - Participation in weekly caseload consultation with the psychiatric consultant;
  - Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
  - Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
  - Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
  - Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

Collaborative Care Model Code 99494

Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)

99484 Care management services for behavioral health conditions

at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month, with the following required elements:

- ● Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- ● Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- ● Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- ● Continuity of care with a designated member of the care team.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

BHI Services

RESOURCES	WEB ADDRESS
BHI Frequently Asked Questions (FAQs)	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html
New England Journal of Medicine - Medicare Payment for BHI	http://www.nejm.org/doi/pdf/10.1056/NEJMp1614134
CoCM Implementation Resources	https://aims.uw.edu/collaborative-care/implementation-guide
Validated Rating Scales	
Care Planning Tools and Resources	http://www.ihi.org/resources/Pages/Tools/MySharedCarePlan.aspx http://catalyst.nejm.org/making-the-comprehensive-shared-care-plan-a-reality/ https://integrationacademy.ahrq.gov/playbook/develop-shared-care-plan

Medicaid: https://www.colorado.gov/hcpf/provider-services

Resources: CMS

HCPCS –General Information
https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html

National Correct Coding Initiative Medicare
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

The National Correct Coding Initiative in Medicaid
https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html

Resources: CMS

Federally Qualified Health Centers (FQHC) Centers: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions February 2018
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Resources CMS

Medicare Learning Network Catalog; April 2018

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf

Care Management Services; CCM, TCM, BHI, Advance Care Planning

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html

Future Billing/Coding Trainings

DISCUSSION

Audience:

- PTO
- Practice

How:

- Webinars
- CLS

When:

- Time of day
- Day of the week

Future PTO Trainings

7/25 – SIM PTO training-9-10 am – CANCELLED due to Stratus Training

7/26-- SPLIT Office Hours 9-10 am

Practice/PTO Trainings

7/20 -- The Collaborative Care Model, Clinician Training Grand Junction; 10 am – 2 pm

7/24 – Colorado QPP Coalition Office Hours webinar Improvement Activities Category; noon - 1 pm

7/25 -- SIM Stratus Training (in person in Denver)

7/26-- SPLIT Office Hours 9-10 am

7/27 -- SIM Cohort 3 Practice Webinar – noon-1pm

7/31 – SPLIT Cohort 3 Practice Training – noon – 1 pm

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