

BILLING AND CODING FOR PHYSICIAN SERVICES

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Week 6

Educational Objectives:

1. Explain the meaning and use of CPT and ICD codes
2. Understand the coding components needed for appropriate billing
3. Select appropriate diagnosis codes for clinical and coding/billing purposes
4. Select appropriate CPT E/M codes for outpatient office visits based on type of visit and key components of a visit
5. Understand, for billing/coding purposes, when a preceptor must physically see a patient with a resident

Questions:

1. **I just want to learn how to take care of patients. Why do I have to learn about billing/coding?**

2. **What does CPT code stand for, and what are these codes used for? Find the location of the CPT codes on your encounter sheet, billing sheet, or EMR in your clinic.**

3. **What does ICD-9-CM stand for, and how are these codes used? Review the location of the ICD-9-CM codes in your office/clinic encounter sheet, billing sheet, or EMR. Review the ICD-9-CM codes for common conditions such as diabetes and hypertension.**

4. **You see a patient for nocturnal cough and think the patient might have asthma, but you are not sure. What should you do for a diagnosis (ICD-9-CM) code?**

5. You saw an established patient of yours who has hypertension, coronary artery disease, and hypothyroidism. However, today the person is in for an urgent visit related to acute lower back pain only. Which ICD-9-CM codes should be listed?

6. Decide whether each of the following constitutes a 'New Patient' or an 'Established Patient' for the purposes of coding/billing:
 - a. A patient who you are seeing today for the first time. He has been seen in your clinic every three months by a resident who graduated two months ago.

 - b. A patient who you are seeing today for an urgent problem. You have never seen him before. He was last seen in your clinic four years ago by your preceptor when she was a resident!

 - c. A patient who was seen last week in your clinic for the first time ever for a "one-time only" hospital follow-up by a fellow resident. You have never seen her before but are seeing her today for a comprehensive visit, and she has been assigned to your continuity panel.

 - d. A patient who was seen in your clinic for the first time ever last week by one of the general surgeons who uses the same office space. The patient's surgical problem has resolved, and he is coming to see you today for a medical exam.

 - e. A patient you last saw two years ago who was referred to you for preoperative medical evaluation by her gynecologist.

7. The “Key Components” that determine the levels of E/M services for most patient visits are the History (Hx), Physical Examination (PE), and Medical Decision Making (MDM). Answer the following questions about these three components (Hint: use the tables provided on coding/billing):
- What are the four types of history and the differences between them?
 - What are the four types of physical examinations, and what are the differences between them?
 - What are the four types of Medical Decision Making (MDM)?
 - What three categories of information are considered in determining the level of MDM? What’s the minimum number of such categories that must be “met or exceeded” to qualify for a given level of MDM? How is ‘risk’ determined?
8. Determine a CPT code for each of the following visits based on the key component types listed.

Type of Patient	Level of History Documented	Level of Exam Documented	Level of MDM Documented	Time you spent	CPT CODE
New	Comprehensive	Comprehensive	Moderate Complexity	40 minutes	
New	Detailed	Comprehensive	High Complexity	60 minutes	
New	Comp.	Comprehensive	Straightforward	45 minutes	
Est.	Expanded Problem-Focused	None	Low Complexity	25 minutes	
Est.	Detailed	Problem-Focused	High Complexity	20 minutes	

9. Decide whether or not your preceptor must physically see (e.g. to confirm your Hx +/-or PEx findings) each of the following patients, in order to comply with CMS (Centers for Medicare and Medicaid Services) billing regulations. Assume that you have no questions or concerns that would otherwise require your preceptor’s “expert” presence in the exam room.
(Hint: These situations apply to physicians at teaching hospitals and are not discussed in the readings. The “Primary Care Exception” in the CMS guidelines

allows your clinic to bill for patient visits that your preceptor discusses with you without seeing the patient if you are beyond your first six months of post-graduate training and if it is a “Level 3” or lower-complexity visit, amongst other stipulations.)

House officer level and time of year	CPT E/M Code based on chart	Visit Content	Must preceptor see patient? (Y or N)
PGY-2 in August	99213	Follow-up of DM and HTN	
PGY-1, November	99212	Discussion of lipid profile results	
PGY-3 in March	99215	Elderly patient with severe AS and CP	
PGY-1 in January	99202	New Patient with Pharyngitis	
PGY-1 in May	99214	Follow-up of COPD, HTN, LBP	

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Primary Reference:

1. Summary Tables “EM Coding Guidelines for Outpatient Visits.”

Additional References/Coding Aids:

2. Family Physician Notebook Evaluation and Management Coding. <http://www.fpnotebook.com/MANI.htm>
3. Society of General Internal Medicine 2007 National Meeting Workshop entitled “See One, Do One, Teach One.” <http://sgim.org/am07/handouts/WB10.pdf>
4. AMA Physician ICD-9-CM 2008 published by the American Medical Society, AMA Press. (Note: a copy of this text may be available in your clinic from clinic staff). <https://catalog.ama-assn.org/Catalog/home.jsp?checkXwho=done>
5. Practical E/M: documentation and coding solutions for quality patient care. <https://catalog.ama-assn.org/Catalog/home.jsp?checkXwho=done>
6. Evaluation and management: selecting and documenting appropriate levels of service. A 2-page pamphlet (also available as a plasticized card) that can be downloaded for personal and instructional use by ACP members from the acponline website. <http://acponline.org/pmc/emsdals.htm>