



# **Billing and Coding for LARCs – Part 1**

## **CDPHE – 2016 LARC Symposium**

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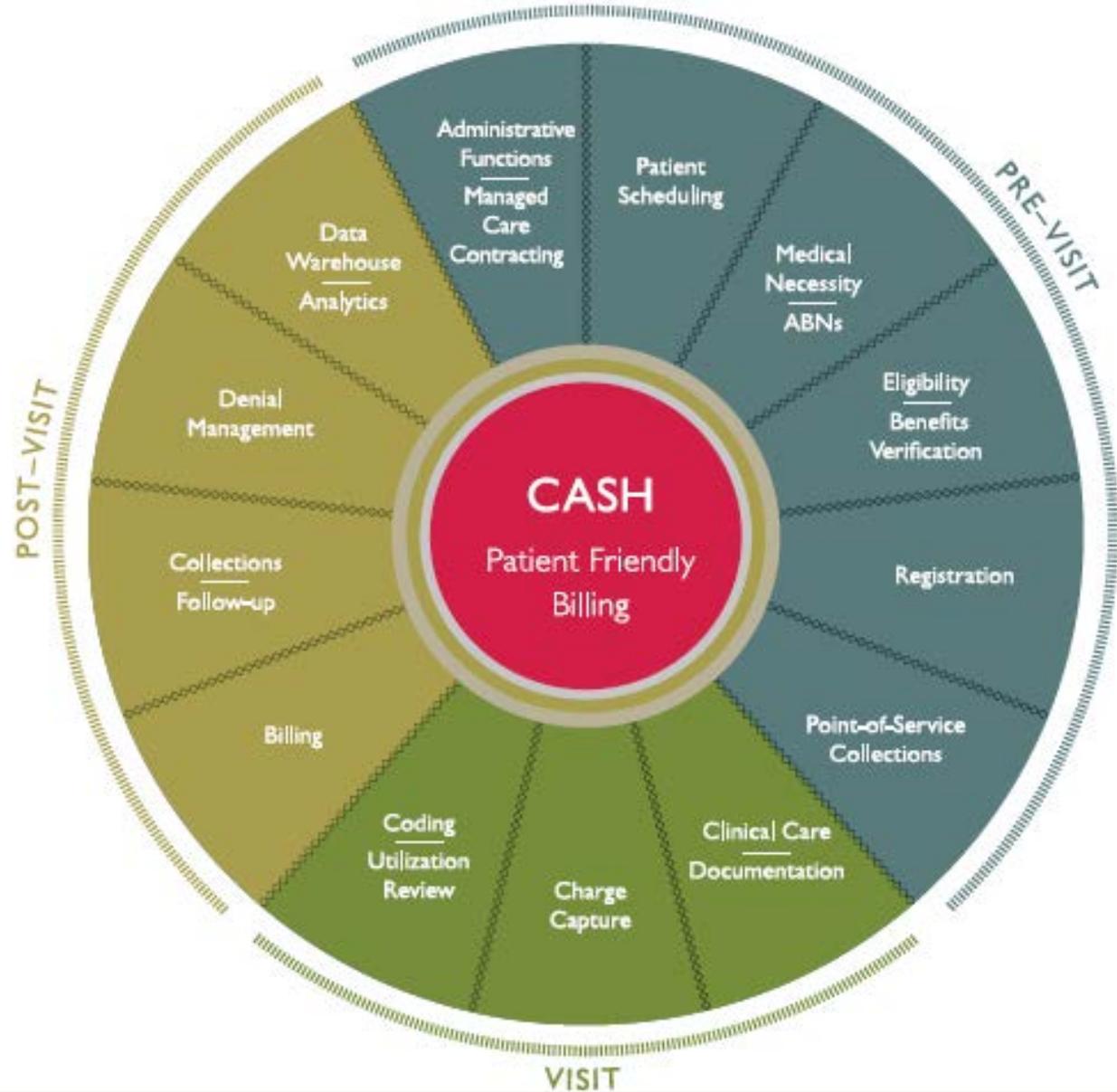


# Quick Audience Survey





# THE Revenue Cycle





# Why are codes used?

## The Language of Reimbursement!!!

You already know...**Coding provides a description of diseases, illnesses, injuries and procedures**

- Tracking of mortality and morbidity rates and statistical data
- Track DX treated by providers
- Communicate with payers for payment
  - Coding allows payers to evaluate resources
  - Develop quality measures
  - Assist in the treatment of conditions
- Provides the following information:
  - **What** service(s) was provided?
  - **Why** the service(s) was provided?
  - Increasingly – **What** works and what does not!



# Coding Responsibilities!

- Who is ultimately responsibility for coding encounters in your SBHC?
- Do your providers act as the “first-line” coders?
- How much involvement does your coding/billing staff actually have in the process?

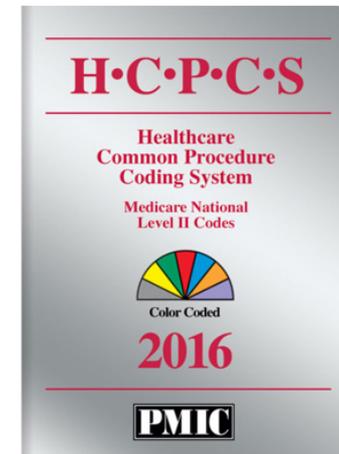
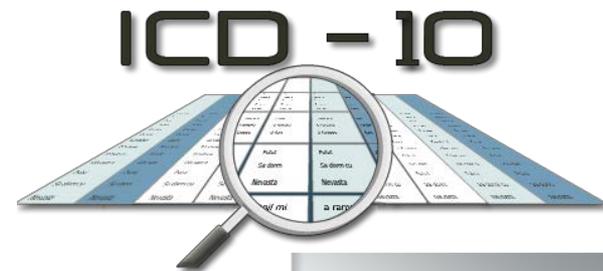
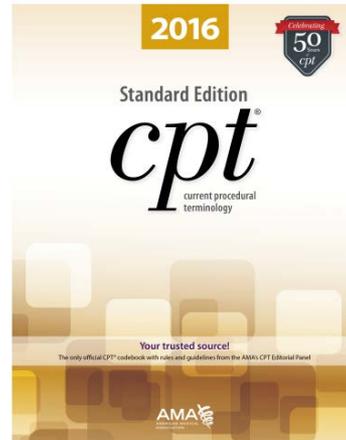




# Code Sets

3 different code sets used for reporting diagnosis coding, procedure coding, and supplies/other services:

- ICD-10-CM
- CPT
- HCPCS





# ICD-10-CM

## ICD-10-CM

- 3-7 characters in length
- Defines WHY the patient came in for services
- **First character is always alpha**
  - [Z30.011](#) Encounter for initial prescription of contraceptive pills
- All letters used except U
- **Character 2 always numeric**
  - [Z30.012](#) Encounter for prescription of emergency contraception
- **Characters 3 through 7 can be alpha or numeric**
- Approximately 68,000 codes versus approximately 13,000 ICD-9 diagnosis codes
- Use of decimal after 3 characters
- Alpha characters are not case-sensitive



# CPT - Current Procedural Terminology

- Defines **WHAT services were furnished** to the patient
- 5 digit code that can describe anything from an office visit to knee surgery
- **Code selection should be based on the documentation requirements for each procedural service**
- Example: Patient presents for a nexplanon removal.
  - **11982-Removal, non-biodegradable drug delivery implant**



# HCPCS

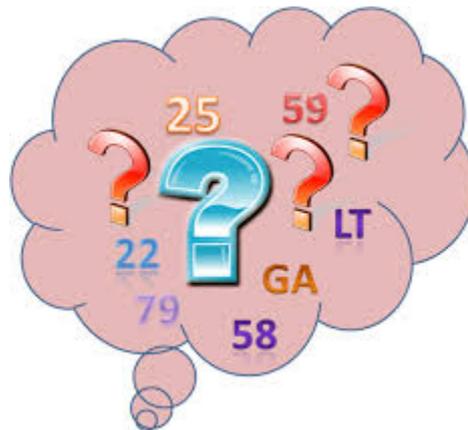
## Healthcare Common Procedure Coding System

- Used mostly for supplies
- Example: Patient receives Nexplanon implant
- Bill: J7307-Etonogestrel (contraceptive) implant system, including implant and supplies
  - ✓ J7300 ParaGard
  - ✓ J 7302 Mirena



# Modifiers

- Modifiers help to **“tell the story”** of the claim
- Either numeric or alpha-numeric
- Utilize new modifiers when applicable





# Modifiers

- **Modifier 25 – Significant and Separately Identifiable Service provided on same day as other E/M service or PX**
  - Append to CPT Codes 99201 – 99499
  - Used to reflect separate services provided at the same encounter
- **Modifier 59 – Distinct Procedural Service**
  - Append to procedures ONLY
  - Used to reflect separate procedural services provided at the same encounter



# Modifier 25 - Coding Scenario

Established patient who had an IUD inserted 2 years ago, but is now experiencing bleeding and cramping. They discuss removal of the IUD and other possible contraceptive methods. After discussion, the patient requests OCPs. The NP removes the IUD and dispenses birth control pills.

- Provider should code for (CPT and Dx Code):
  - 99213- 25 – N92.6 – bleeding and cramping
  - 58301 – Z30.432 – IUD removal
  - S4993 - Z30.011 – Initial prescription of OCPs



# Modifier 59 - Coding Scenario

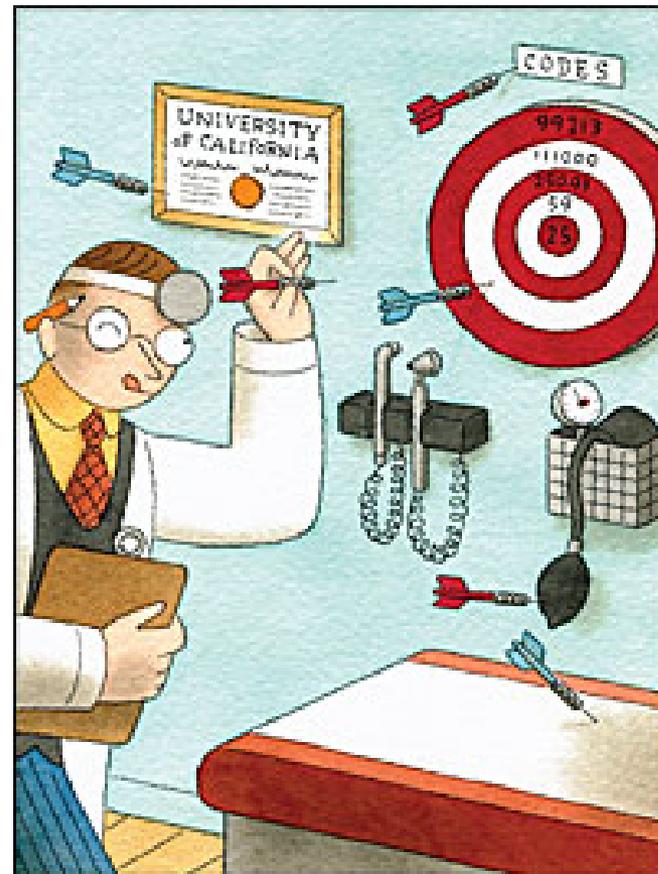
NP removes an IUD and places a nexplanon at the same encounter.

Provider should code for (CPT and Dx Code):

- 11981 – Z30.49 – Encounter for surveillance of other contraceptives
- 58301 – 59 — Z30.432 – IUD removal



- In most non-surgical settings, Evaluation and Management codes are the chief means of **revenue generation**.
- **E/M = Evaluation and Management (visits)**



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# Outpatient E/M Codes

- New Patient Codes: **99201-99205**
- Established Patient Codes: **99211-99215**
- Preventive Medicine Codes: **99381-99397**



# Patient Status: New or Established?

- A patient never before seen in the practice/specialty OR not seen by you or one of your partners of the same specialty in more than 3 YEARS
  - E/M codes for NEW patients
    - 99201, 99202, 99203, 99204, 99205
    - Preventative codes – 99384, 99385, 99386, 99387
- A patient who has been seen in the office by you or one of your partners of the same specialty within the last 3 YEARS.
  - E/M codes for ESTABLISHED patients
    - 99211, 99212, 99213, 99214, 99215
    - Preventative codes – 99394, 99395, 99396, 99397



# Outpatient E/M Codes

- **New Patient Codes: 99201-99205**
  - 99201
  - 99202
  - 99203
  - 99204
  - 99205

**These are the GO-TO office visit codes**

**80% of claims are for E/M services**



# Outpatient E/M Codes

- **Established Patient Codes: 99211-99215**
  - 99211 – RN service
  - 99212
  - 99213
  - 99214
  - 99215

**These are the GO-TO office visit codes**



# Evaluation and Management Services

## Requirements of E&M Documentation

- **3 Key Components:**

- **History**

- Chief complaint; past medical, social, and family histories; ROS

- **Exam**

- **Medical Decision Making**

- Number of dx or tx options; amount of data; risk



# History

## Subjective (patient-provided)

- Chief Complaint
- History of the present illness (HPI)
- Review of systems (ROS)
- Past, family, social history (PFSH)





# Chief Complaint

**Poor example:**

“Patient here for follow up”



**Good example:**

“Patient presents to discuss birth control methods.”

“Patient presents in follow-up to discuss issues with OCPs.”



# History of Present Illness (HPI)

- **Chronological description** of the development of the patient's presenting problem from the first sign and symptom, or from the previous visit to the current visit
  - In regards to elements as per coding tool, all must relate to one 'chief complaint'
- Must be personally performed by the provider
- Extent of HPI performed is based on provider's professional judgment depending on the needs of the patient



# History of Present Illness (HPI)

- ▶ **LOCATION:** Where, site of the symptoms
- ▶ **QUALITY:** Sharp, stabbing, radiating, dull, etc.
- ▶ **DURATION:** How long have the symptoms existed
- ▶ **SEVERITY:** Pain Scale
- ▶ **TIMING:** Relationship to something else (upon waking up or after eating)
- ▶ **MODIFYING FACTORS:** Influence symptoms
- ▶ **CONTEXT:** When does the symptom occur
- ▶ **ASSOCIATED SIGNS AND SYMPTOMS:** Symptoms that accompany complaint



# History of Present Illness (HPI)

Patient had an IUD placed a few weeks ago and now presents with vaginal pain at the insertion site x1 week. Patient describes the pain as sharp. Patient reports associated cramping.

- Location:** vaginal pain
- Duration:** 1 week
- Quality:** pain is sharp
- Associated signs and symptoms:** cramping



# Review of Systems

- **Subjective:** Verbal inventory of body systems obtained through a series of questions with the patient related to the presenting problem. Should include pertinent positives and negatives.
- May be obtained by the nurse, doctor, history form, or other ancillary staff
- Provider must review and corroborate the information if obtained by another source and document this review and agreement for credit.



# Review of Systems (ROS)

- Constitutional
- Eyes
- ENT
- Cardiovascular
- Respiratory
- Hematologic/lymph
- GI
- GU
- Musculoskeletal
- Integumentary/breast
- Allergic/Immunologic
- Neurologic
- Psychiatric
- Endocrine

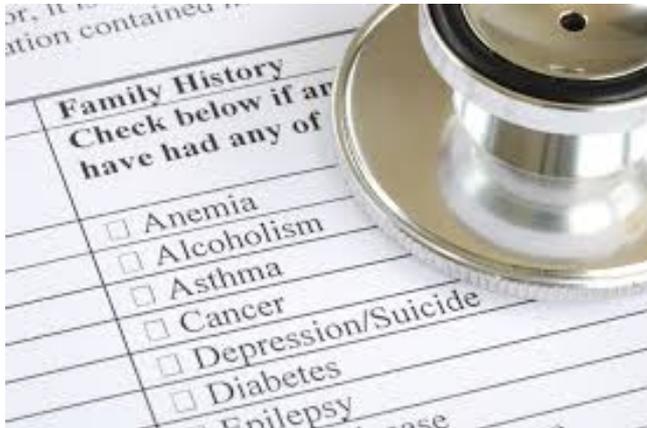


# Review of Systems

- A complete review of systems includes checking at least **10** separate systems.
- The statement, “all remaining 10 point review of systems are negative, except as noted in the HPI” is acceptable documentation.
- ROS do not have to be broken out individually by system to receive credit.
- If ROS is unobtainable – document such cases, as comprehensive (10 systems) credit will be given.



## Past Medical, Family, & Social **Histories**



- 3rd element of the ‘History’ section
- The needs of the patient determine the complexity of documenting PFSH
- Should be age and gender appropriate and relevant to patient presentation



# Past History

- Prior major illnesses or injuries
- Operations
- Prior hospitalizations
- Current medications
- Allergies
- Age appropriate immunization status
- Age appropriate feeding/dietary status



# Family History

- **A review of medical events in the patient's family that could be significant to the patient**
- Health status or cause of death of parents, siblings, or children (blood relatives)
- Specific diseases related to problems identified in the chief complaint, HPI or ROS
- Hereditary disease putting the patient at risk



# Social History

**Age appropriate review of past and current activities including:**

- Marital status
- Employment
- Occupational history
- Use of drugs, alcohol & tobacco
- Level of education
- Sexual history
- Exercise habits
- Other social factors



# Past Medical, Family, & Social Histories

Bad example:

“Reviewed unchanged.”

***Good example:***

Patient has a past medical history positive for HPV. Patient denies tobacco or alcohol use. Family history positive for breast cancer in mother.



# History

## 4 Levels of History

### – Problem Focused

- Requires 1-3 elements

### – Expanded Problem-Focused

- Requires 1-3 elements or status of 1-2 chronic conditions
- Requires at least one review of system

### – Detailed

- Requires 4 elements or status of 3 chronic conditions
- Requires 2-9 review of systems
- Requires at least one area of history (past/family/social)

### – Comprehensive

- Requires 4 elements or status of 3 chronic conditions
- Requires 10 review of systems
- Requires all 3 areas of history (past/family/social)



# History

- Expanded Problem-Focused for 99202, 99213
  - Requires 1-3 elements or status of 1-2 chronic conditions
  - Requires at least one review of system
- Detailed for 99203 and 99214
  - Requires 4 elements or 3 Chronic Conditions
  - Requires 2-9 review of systems
  - Requires at least one area of history (past/family/social)
- Comprehensive for 99204, 99205 and 99215
  - Requires 4 elements or 3 Chronic Conditions
  - Requires 10 review of systems
  - Requires all areas of history (past/family/social)



# Examination

- **Objective:** information the provider gathers
- Observations of the provider during the encounter
- Exam includes findings by body area or organ system
- Assessment of the patient's general appearance, vital signs, or level of distress
- There should ALWAYS be an exam of the affected body area(s) and/or system(s)



# Exam: 2 Sets of Acceptable Guidelines

1995-

- Used for counting body area(s) vs. organ system(s)



1997-

- Used for counting bulleted elements for each body area(s) or organ system(s)



# Body Areas vs. Organ Systems

- **Body Areas:** Head, back, chest, genitalia, abdomen, neck, each extremity
- **Organ Systems:**
  - Constitutional (vitals)
  - Eyes
  - ENT
  - Respiratory
  - GI
  - GU
  - Musculoskeletal
  - Skin
  - Neurologic
  - Psychiatric
  - Lymphatic

**\*Cannot COMBINE body areas and organ systems for calculation of level of physical exam\***



# Examination

Options include:

**1 x 1 = PF**

**2 x 1 = EPF**

**4 x 4 = DET**

**8 x 1 = COMP**



# Medical Decision Making

## Complexity of MDM based upon 3 elements:

1. Number of diagnoses
2. Amount and complexity of data to review/order
3. Overall level of risk of the patient



# # of Diagnoses

Number of Diagnoses or Treatment Options			
A	B	X	C = D
Problem(s) Status	Number	Points	Result
Self-limited or minor (stable, improved or worsening)	<i>Max = 2</i>	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	<i>Max = 1</i>	3	
New prob. (to examiner); add. workup planned		4	
<b>TOTAL</b>			

Multiply the number in column B, X C and put the product in column D



# # of Diagnoses Example

Established patient-F/U

- Chlamydia – resolved with course of antibiotics
- Bleeding/Cramping post IUD-worsening, wants to explore other methods



# Data To Be Reviewed/Ordered

## Amount and/or Complexity of Data to be Reviewed

- **1 point is assigned for:**
  - Review and/or order clinical lab tests (80000 code series)
  - Review and/or tests in CPT radiology section (70000 code series)
  - Review and/or tests in CPT medicine section (90000 code series)
  - Decision to obtain old records
  
- **2 points is assigned for:**
  - Independent interpretation of image, tracing or specimen itself (not simply review of report)
  - Discussion of case with other providers
  - Review and summarization of old records



# Level of Risk

**This part of medical decision making deals with the guidelines for determining risk of significant complications, morbidity or mortality**

- Level of risk is determined by where the patient falls highest in the following categories: presenting problems, diagnostic procedures ordered, and management options selected

**The table of risk may be used as a guide**



# Level of Risk

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below).

**MEDICAL DECISION**

**Risk of Complications and/or Morbidity or Mortality**

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
<b>Minimal</b>	<ul style="list-style-type: none"> <li>One self-limited or minor problem, e.g., cold, insect bite, tinea corporis</li> </ul>	<ul style="list-style-type: none"> <li>Laboratory tests requiring venipuncture</li> <li>Chest x-rays</li> <li>EKG/EEG</li> <li>Urinalysis</li> <li>Ultrasound, e.g., echo</li> <li>KOH prep</li> </ul>	<ul style="list-style-type: none"> <li>Rest</li> <li>Gargles</li> <li>Elastic bandages</li> <li>Superficial dressings</li> </ul>
<b>Low</b>	<ul style="list-style-type: none"> <li>Two or more self-limited or minor problems</li> <li>One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH</li> <li>Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</li> </ul>	<ul style="list-style-type: none"> <li>Physiologic tests not under stress, e.g., pulmonary function tests</li> <li>Non-cardiovascular imaging studies with contrast, e.g., barium enema</li> <li>Superficial needle biopsies</li> <li>Clinical laboratory tests requiring arterial puncture</li> <li>Skin biopsies</li> </ul>	<ul style="list-style-type: none"> <li>Over-the-counter drugs</li> <li>Minor surgery with no identified risk factors</li> <li>Physical therapy</li> <li>Occupational therapy</li> <li>IV fluids without additives</li> </ul>
<b>Moderate</b>	<ul style="list-style-type: none"> <li>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</li> <li>Two or more stable chronic illnesses</li> <li>Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</li> <li>Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis</li> <li>Acute complicated injury, e.g., head injury with brief loss of consciousness</li> </ul>	<ul style="list-style-type: none"> <li>Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test</li> <li>Diagnostic endoscopies with no identified risk factors</li> <li>Deep needle or incisional biopsy</li> <li>Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath</li> <li>Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</li> </ul>	<ul style="list-style-type: none"> <li>Minor surgery with identified risk factors</li> <li>Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</li> <li>Prescription drug management</li> <li>Therapeutic nuclear medicine</li> <li>IV fluids with additives</li> <li>Closed treatment of fracture or dislocation without manipulation</li> </ul>
<b>High</b>	<ul style="list-style-type: none"> <li>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</li> <li>Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., 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</li> <li>An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss</li> </ul>	<ul style="list-style-type: none"> <li>Cardiovascular imaging studies with contrast with identified risk factors</li> <li>Cardiac electrophysiological tests</li> <li>Diagnostic endoscopies with identified risk factors</li> <li>Discography</li> </ul>	<ul style="list-style-type: none"> <li>Elective major surgery (open, percutaneous or endoscopic with identified risk factors)</li> <li>Emergency major surgery (open, percutaneous or endoscopic)</li> <li>Parenteral controlled substances</li> <li>Drug therapy requiring intensive monitoring for toxicity</li> <li>Decision not to resuscitate or to de-escalate care because of poor prognosis</li> </ul>



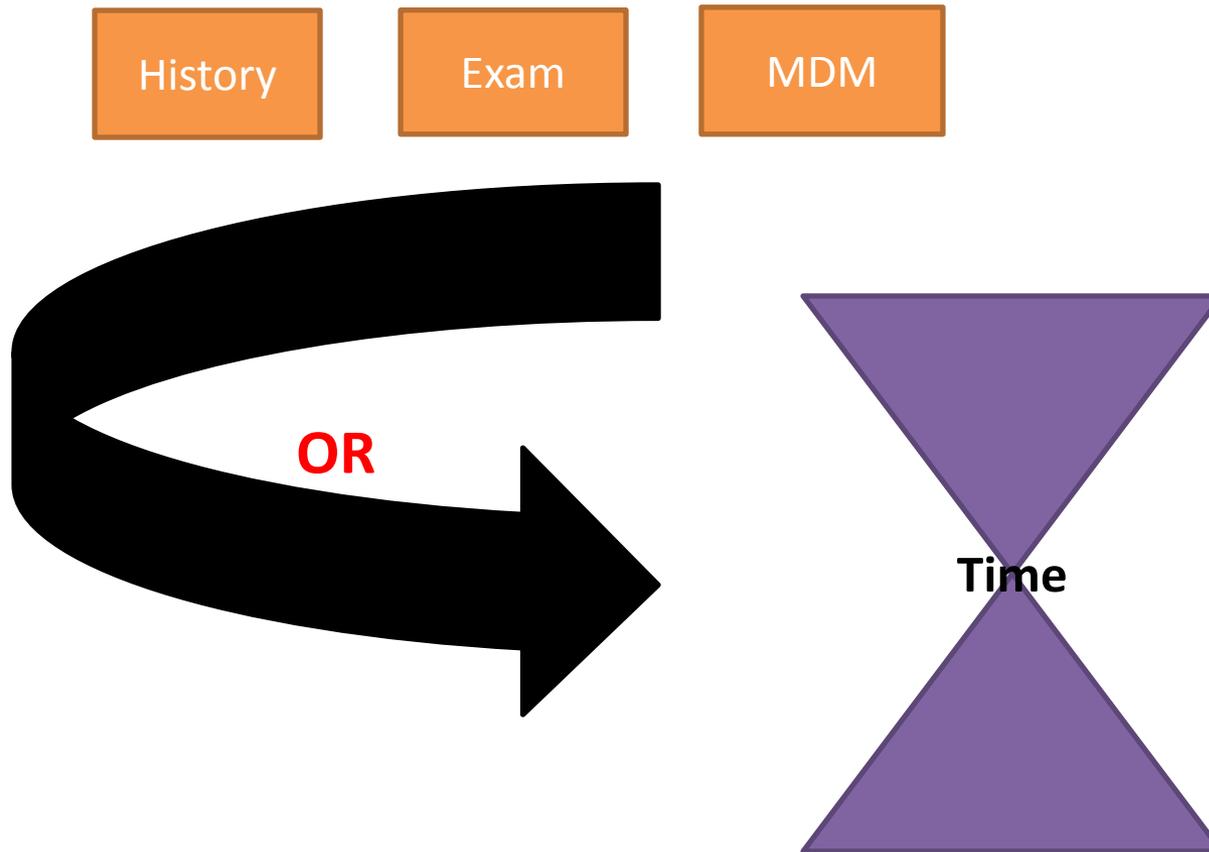
# The highest in 2/3 categories determines final complexity

making them the appropriate grid in section 6.

<b>Final Result for Complexity</b>					
<b>A</b>	Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
<b>B</b>	Highest Risk	Minimal	Low	Moderate	High
<b>C</b>	Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making		<b>STRAIGHT-FORWARD</b>	<b>LOW COMPLEX.</b>	<b>MODERATE COMPLEX.</b>	<b>HIGH COMPLEX.</b>



# Time-Based Coding





# Time-Based Coding

Documentation requirements include:

- total duration of the face-to-face visit,
- time spent in counseling and/or coordination of patient care, The time spent in counseling or care coordination must constitute greater than 50% of the total visit.
- the content of the counseling or care coordination.





# Time-Based Coding

**99201 = 10 minutes**

**99202 = 20 minutes**

**99203 = 30 minutes**

**99204 = 45 minutes**

**99205 = 60 minutes**



# Time-Based Coding

**99211 = 5 minutes**

**99212 = 10 minutes**

**99213 = 15 minutes**

**99214 = 25 minutes**

**99215 = 40 minutes**



# QUESTIONS?





# On Behalf of RTWelter & Associates...

**THANKS**  
for  
**ATTENDING**

