Coding and Reimbursement: What You Don’t Know Can Hurt You!!

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Objectives

Upon completion of this lecture, the nurse practitioner will be able to:

- Identify some of the most common CPT codes utilized in a primary care setting
- Discuss ways to effectively code in order to optimize billing and collectibles
- Identify common mistakes made with coding

Patient # 1

CC: Cold symptoms x 2 days
8 year old child presents today complaining of a runny nose-yellow discharge x 1 day. Began 2 days ago. Seems to be worsening. Has treated with OTC decongestants without relief. Now accompanied by fever or 99.2, 1 episode of vomiting last evening and a nonproductive cough. Feels miserable

ROS:
- Ears: denies pain or discharge
- Nose: denies sinus pain
- Mouth: denies sore throat
- Neck: denies stiffness
- Skin: denies rash
- Abdo: denies pain, nausea, diarrhea; No vomiting since last evening
- Lungs: denies SOB, pain with inspiration
- GU: Last urination 2 hours ago
- PMH: Asthma
- PFSH: No strep exposure; no one else ill; No cigarette exposure
Patient # 1

- Physical examination
  - 8 year old female in NAD; wd/wn; smiling and playing with sibling
  - VS: T 99.1; R: 18 even, nonlabored; pulse: 102; BP: 98/60; Weight: 87 pounds
  - Eyes: Conjunctiva with injection; no discharge; PERRL; EOMI
  - Skin: pink/warm/dry; no pallor or rashes
  - Ears: Canals/TMs normal
  - Nose: Turb/mucosa pink; clear discharge; sinuses nontender without erythema

- Mouth: Mucosa moist; Post pharynx/tonsils pink; no exudate
- Nodes: nonpalp, nontender
- Lungs: clear to A & P
- Heart: S1S2; RRR; no S3, S4, murmurs
- Abdomen: Soft; + BS; no masses, tenderness, hsm, bruits, rebound, guarding
- Neck: no rigidity

Diagnoses

- Viral URI-No need for antibiotics at this time
- Vomiting-1 episode; Most likely secondary to postnasal drip; well-hydrated at present; will continue to monitor
- Cough-most likely related to viral syndrome
- Asthma-appears to be stable but at risk for exacerbation given URI
Is There an Art to Positioning These?

- Put your highest acuity diagnosis first, even if it is not what they came in for:
  - Asthma
  - Vomiting
  - Cough
  - Viral URI

How Would You Code This Visit?

- A. 99211
- B. 99212
- C. 99213
- D. 99214
- E. 99215

It Is Essential That The Nurse Practitioner Understand Coding Because...

- Proper coding can improve billables
- Proper coding can reduce the number of rejected claims
- Whereas, improper coding can cause the practice to be audited and potentially fined
- Improper coding can affect the practice's billables:
  - Either decreasing your billing inappropriately or...
  - Increasing your billing inappropriately which may result in substantial fines
Undercoding Can Really Cost the Practice

- Difference between: 99213 and 99214: $20.00
- 15 patients per day x $20.00 = 300.00:
- 4 days per week x $300.00 = 1200.00 / week
- $1200.00 per week x 50 weeks/year = 60,000.00 per year of lost revenue

Reality:
Reimbursement from Medicare:
Fee for Service

- 99211: $20.89
- 99212: $37.21
- 99213: $51.68
- 99214: $81.06
- 99215: $118.84

Here’s the Latest

- Nurse practitioner’s see: 15-20 patients daily
- NP’s make approximately 80 K yearly
Projected Yearly Income from NP

- 15 patients daily
  - 50.00 per visit; $187,500 yearly
- 15 patients daily
  - $75.00 per visit; $281,250.00 yearly

What Are We Looking At For Profit?

- Collectables: 187,500.00
- Salary: 80,000
- Benefits: 20,000  
  - (25% of pay)
- Overhead: 80,000  
  - (same as salary for assistants, rent)
- Profit: $7,500.00

How Can We Generate More?

- More patients?
  - NO!!!!!!
- Better coding and reimbursement?
- Higher level visits?
- Keeping more procedures in house?
Terminology

Codes Are Divided Into Three Levels

- Three levels of codes
  - Level I: CPT-4 Codes
    - E&M Codes (Medical evaluation and surgical procedures)
  - Level II: National Codes
    - Expanded codes that allow you to charge for supplies
  - Level III: Local Codes
    - 5 digit alpha-numeric code, starts with the letter W, X, Y or Z
    - Allow the Medicare carrier to identify items that are endemic to a particular geographic region or locality
    - W9005: Follow-up on an emergency room visit

CPT-4 CODES

- Current Procedural Terminology (CPT) is a national system utilized to identify and bill for particular services or procedures
- Developed by the American Medical Association and the Health Care Financing Administration (HCFA) **No longer called HCFA
  - Center for Medicare and Medicaid Services
- Has been adopted by Medicare and third party payers i.e. insurance companies
- Each insurance company, including Medicare, has a corresponding fee attached to each CPT code
Diagnoses

- When claims are electronically remitted (as well as paper claims), generally – only the first four diagnoses are transmitted
  - Prioritize – place new problems, highest acuity in first position
  - Leave depression, anxiety for last position
  - Fatigue, insomnia would be better diagnoses for payment with many insurers

CPT – 4 CODES

- Always a five digit code
- Code ranges from 99201 – 99499
- These codes are often referred to as E&M codes
  - Evaluation and Management Coding
  - These particular codes represent a health care provider’s cognitive services (office/clinic visits), consultations, preventive medication examinations and critical care services
  - This is the code used when you take a history, perform an examination, make a diagnosis and then...recommend treatment

Additional E & M Codes

- In addition to the E&M codes utilized for office visits, you will also use other CPT – 4 codes to bill for various procedures
- Each specialty has a corresponding set of numbers:
  - Anesthesiology: 00100-01999 and 99100 – 99140; Surgery: 10040-69979; Radiology: 70010 to 79999; Pathology and Laboratory: 80002-89399; Medicine: 90701-99199
- Examples would include:
  - Suturing: 12001 (Simple repair), irrigation of ear wax (69210), audiometry (92552) and nebulizer treatments (94664)
ICD-9 Code

- Code used to indicate a particular medical diagnosis
- All medical diagnoses have a 3-6 digit code
  - i.e. Diabetes: 250; Chronic Renal Failure: 585
- The more digits present, the more specific the code
- In general, the more specific the code, the more accurate the coding

ICD-10

- Need to begin preparation to move to ICD-9
- Much more specific
- Easier to find what you are looking for for diagnosis
- More symptom based ICD codes

Coding a Visit

- When you code a visit using an E&M code, it is important to make sure that the ICD-9 codes is/are consistent with the E&M code
  - For instance, you should not bill a high level visit (99214) and then use an ICD-9 for a viral pharyngitis
  - Well...you can do this but you better have documentation to support this in the event of an audit
Words of Warning

- Only include the diagnosis or diagnoses (ICD-9) being addressed at that visit:
  - Many people believe that by adding diagnoses you can justify the increase in billing/receivables
  - This is NOT true
    - You must have documentation from that visit to support each of those diagnoses
    - Only include secondary diagnoses if they influence the patient’s current problem or if you addressed them and documented it.

Other Words of Warning

- Some insurances may not reimburse for diagnoses such as:
  - Obesity
  - Pes planus
    - Ortho/podiatry code
  - Presbyopia
    - “Ophthalmology” code

Another Word of Warning

- Only you should be coding your visit
- No one should be reviewing the super bill or encounter sheet and making changes without your knowledge
- You are responsible for the billing done on your behalf so you better have a clear understanding of what is being done by the medical biller or billing company
Specific Evaluation and Management Codes (E and M Codes)

Evaluation and Management Services

- The descriptors for the levels of E&M services recognize 7 components which are used in defining the levels of E&M services:
  - History
  - Physical Examination
  - Medical Decision Making
  - Counseling
  - Coordination of Care
  - Nature of the Presenting Problem
  - Time (Least important component)

Evaluation and Management Services

- History
- Physical Examination
- Medical Decision Making

**These 3 components are the key components in selecting the level of E/M services**
Of Secondary Importance...

- Counseling
- Coordination of Care
- Nature of the Presenting Problem
- These are of secondary importance

**Time, as previously mentioned, is the least important component**

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These Are The Things We Do Every Day.

Now...We Just Have To Document Them Appropriately In Order To Get Reimbursed Correctly

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History

- The E&M Codes as they pertain to history are based upon four components of the history.
- History is comprised of:
  - Chief complaint
    - Document what the person is in for!
  - HPI
    - Location
    - Quality
    - Severity
    - Duration
    - Timing
    - Context
    - Modifying factors
    - Associated signs and symptoms
History

- History is comprised of:
  - ROS
  - Past History, Family History and/or Social History
  - Only as these pertain to their HPI

**It is the thoroughness and number of the above that you perform that determines your type of history for which you code.**

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<table>
<thead>
<tr>
<th>Components</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Cc/1 – 3</td>
<td>Cc/1 – 3</td>
<td>Cc/4 or &gt; 2</td>
<td>Cc/4 or &gt; 10</td>
<td></td>
</tr>
<tr>
<td>CC/HPI (8)</td>
<td>N/A</td>
<td>N/A</td>
<td>9</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>ROS (14)</td>
<td>N/A</td>
<td>N/A</td>
<td>9</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>PMFH</td>
<td>N/A</td>
<td>N/A</td>
<td>9</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Established Patient: Must meet or exceed 2 of 3 sections
New Patient: Must meet or exceed 3 of 3 sections

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Physical Examination

- The physical examination coding is divided into two categories: **General Multi-System Exam (GMSE)** or a Specialty Exam
- The body is divided into organ systems
  - Constitutional, ENMT, Eyes, Cardiovascular, Gastrointestinal, Musculoskeletal, Neurologic, Psychiatric, Hematologic/Lymphatic/Immunologic, Respiratory, Skin, GU – Male and Female
Physical Examination

- The physical examination coding is divided into two categories: **General Multi-System Exam (GMSE)** or a Specialty Exam
- It is the number of "bullets" in each of these sections performed by you that determine the level of the physical examination

Constitutional

- Bullets: must measure any 3 of the following 7 vital signs
  - Sitting or standing blood pressure
  - Supine blood pressure
  - Pulse rate and regularity
  - Respiration
  - Temperature
  - Height
  - Weight
  - May be obtained by the ancillary staff

- General appearance of the patient
  - Development
  - Nutrition
  - Habitus
  - Deformities
  - Attention to Grooming

Eyes

- Bullets
  - Conjunctivae and lids
  - Pupils and irises (reaction to light etc)
  - Ophthalmoscopic examination
ENT

- Bullets
  - Inspection of ears and nose
  - Otoscopic examination of canals and tympanic membrane
  - Hearing
  - Inspection of nasal mucosa, septum, and turbs

- Bullets continued
  - Inspection of lips, teeth and gums
  - Examination of the oropharynx

Physical Examination

- The levels of the E&M codes are based on 4 levels of physical examination:
  - Problem – Focused (99212):
    - Specialty exam: Limited examination of the affected body area or organ system
    - GMSE: 1-5 bullets in 1 or > organ systems or body areas
  - Expanded Problem-Focused (99213)
    - Specialty exam: As above, plus any other symptomatic or related body area or organ system
    - GMSE: 6 bullets in 1 or > organ systems or body areas

- Detailed (99214)
  - Specialty exam: An extended examination of the affected body area or organ system or any other symptomatic or related body area or organ system
  - GMSE: 6 or > organ systems or body areas with at least two bullets addressed per system (12 items)

- Comprehensive (99215):
  - Specialty exam: A general multisystem evaluation or a complete examination or a single organ system
  - GMSE: 9 or > organ systems with at least 2 bullets per system (18 items)
Physical Examination Components

<table>
<thead>
<tr>
<th>Components</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Examination GMSE</td>
<td>Provider presence not required</td>
<td>1 – 5 bullets in 1 or &gt; organ systems</td>
<td>6 – 11 bullets in 1 or &gt; organ systems</td>
<td>2 bullets in 6 organ systems or 12 bullets</td>
<td>2 bullets in 9 organ systems or 18 bullets</td>
</tr>
</tbody>
</table>

Complexity or Level of Medical Decision Making

- This is probably the most difficult or nebulous section of the coding
- Complexity of decision making is broken down into 4 levels:
  - Straightforward
  - Low Complexity
  - Moderate Complexity
  - High Complexity

Complexity of Medical Decision Making

<table>
<thead>
<tr>
<th>Number of Dx or Management options</th>
<th>Amt +/- or Complexity of Data</th>
<th>Risk of complications +/- or morbidity</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal 99212</td>
<td>Minimal or none</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited 99213</td>
<td>Limited</td>
<td>Low</td>
<td>Low complexity</td>
</tr>
<tr>
<td>Multiple 99214</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High complexity</td>
</tr>
</tbody>
</table>
### Components

<table>
<thead>
<tr>
<th>History</th>
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<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC/HPI</td>
<td>1 - 3</td>
<td>N/A</td>
<td>4 or &gt;</td>
<td>4 or &gt;</td>
<td>4 or &gt;</td>
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<tr>
<td>ROS</td>
<td>N/A</td>
<td>1 - 3</td>
<td>2 - 9</td>
<td>10 or &gt;</td>
<td>3 of 3</td>
</tr>
<tr>
<td>PMFSH</td>
<td>N/A</td>
<td>Problem Pert</td>
<td>N/A</td>
<td>1 of 3</td>
<td>3 of 3</td>
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### Physical Examination

<table>
<thead>
<tr>
<th>GMSE</th>
<th>Provider presence not required</th>
<th>1 - 5+</th>
<th>6 - 11</th>
<th>2 bullets in 6 areas or 12 bullets</th>
<th>2 bullets in 9 areas or 18</th>
</tr>
</thead>
</table>

### Decision Making

<table>
<thead>
<tr>
<th># of Dx</th>
<th>Risk of complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None</td>
</tr>
<tr>
<td>2</td>
<td>Minimal</td>
</tr>
<tr>
<td>3</td>
<td>Limited</td>
</tr>
<tr>
<td>4</td>
<td>Moderate</td>
</tr>
<tr>
<td>5+</td>
<td>Extensive</td>
</tr>
</tbody>
</table>

### Coding

- When I code on my EHR system, it asks me the following:
  - Simple/minor complaint
  - Established problem – stable
  - Established problem – worsening
  - New problem – no additional workup
  - New problem – additional workup

### Other Prompts

- Also asks:
  - Reviewing labs
  - Ordering labs or radiology tests
  - Prescription/IM medication
  - Review old charts
  - Obtain additional records
  - Respiratory treatments
  - Discuss with other healthcare providers
### Comparison of Requirements

<table>
<thead>
<tr>
<th>Level of Visit</th>
<th>History</th>
<th>Exam</th>
<th><strong>De</strong></th>
<th><strong>Data Reviewed</strong></th>
<th><strong>Risk</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<tr>
<td>99212</td>
<td>1 descriptor</td>
<td>1 bullet in 1 or more systems</td>
<td>1 minor or established</td>
<td>Order or study 1 lab</td>
<td>1 minor prob Noninv labs</td>
</tr>
<tr>
<td>99213</td>
<td>1 descriptor 1 ROS</td>
<td>6 bullets in 1 or more systems 6</td>
<td>2 minor or estab; or 1 new</td>
<td>Order or study 2 labs; or review old records</td>
<td>2 minor; 1 chronic stable or 1 acute</td>
</tr>
<tr>
<td>99214</td>
<td>4 descriptors 2 ROS 1 PFSH</td>
<td>2 bullets in 6 systems or more 12</td>
<td>1 new or 1 worse and 1 minor</td>
<td>Order or study 3 labs, or order 1 lab and summarize</td>
<td>1 chronic problem – worse; 1 chronic stable &amp; 1 acute</td>
</tr>
<tr>
<td>99215</td>
<td>4 desc, 2 PFSH, 10 ROS</td>
<td>2 bullets in 9 systems 18</td>
<td>1 new</td>
<td>4 labs</td>
<td>1 severe chronic, 1 life threatening</td>
</tr>
</tbody>
</table>

### Setting Fees for Services

- **Fees**
  - Determine highest payer
  - Set fees approximately 10 – 20% above highest payer
  - Will make collections appear to be lower
  - However, never want to bill below what your payers are willing to pay

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### Fees

- Be very careful re: discussing fees and reimbursement with other providers
- Collusion
Let’s Take A Look At Some Coding...

Office Visits (E&M Codes)
- E&M Codes are separated into new patients and established patients
  - Reimbursement is higher for new patients
  - Please remember, a patient can be considered new if...he or she has not been seen in the facility within the past 3 years

For Instance...
- 99201: New patient code (equivalent to 99211 code)
  - In order to code for this level in a new patient, 3 out of the 3 criteria must be met or exceeded
Established Patient Codes

- **99211**
  - May not require the presence of a clinician
  - Presenting problems are minimal
  - 5 minutes spent performing these services
  - We use this for nurse visits
    - Example: Vitamin B12 injection by nursing staff; Dressing change; Allergy injection, Nurse confirms a rash has disappeared and gives note to return to school; Read PPD, Blood pressure check; Peak flow meter check

Can You Opt Not To Bill?

- Undercoding vs. overcoding
- Equally problematic?
### Comparison of Requirements

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<td>None</td>
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<tr>
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### Additional Codes, Rarely Utilized, That May Significantly Increase Your Billables

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### Modifiers

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Modifiers

- These are used by health care providers to indicate that a particular service or procedure has been modified by some special circumstance but not changed in its definition
  - Service or procedure was performed by more than one provider
  - Only part of a service was performed
  - Unusual events occurred

Modifiers can also be used to...

- Indicate that a service or procedure has both a professional and technical component
- Service or procedure has been increased or decreased
- Bilateral procedure was performed
- Service or procedure was provided more than once

Modifier 25

- Modifier 25 is utilized for the following conditions:
  - Condition 1: If the nurse practitioner is performing some type of preventive service, i.e. a physical examination, and encounters a problem or abnormality that is significant enough to require additional work to perform the key components of a problem oriented E/M service, then the appropriate code can also be used
Examples From My Practice

- 52 year old man presents for a complete physical examination. Needs to renew his antihypertensive medications. On ROS: Increasing urination, polyphagia and a 45 pound weight loss within the last 3 months
- Last physical examination: approximately 10 years ago despite encouragement from previous physicians

Mr. H’s Physical Examination Findings

- BP 124/80; Weight 208 pounds
- Pulse: 108 and regular
- Heart: S1S2; RRR; +S4; No murmurs or S3
- Lungs: clear
- Eyes: PERRLA; Fund: Optic disc: round, regular; No cupping. Retina: pink; no exudates or hemorrhages
- PV: DPPT: 2+ bilaterally
- Neuro: Sensation intact to light touch and vibration
- Urine dip: 4+ glucose; no ketones
- Finger stick: 448

Mr. H

- Codes utilized: Complete physical examination
- And...
  - Modifier 25 plus 99214 code because of his new onset Type 2 diabetes
Physical Examinations

- 90% of all of our physicals are modified
- Very rarely does a patient come in for preventive care with no other complaint
- So...
  - Complete PE
  - Mod 25
  - 99213 - AOM, Malaise, Asthma exacerbation, Nevus

Another Example

- The nurse practitioner sees the patient for a follow-up of his hypertension and diabetes. During the visit, the patient mentions an abnormal nevus that seems to be enlarging
  - During the visit you examine it and feel very strongly that it is a melanoma
  - You decide to biopsy that day

You can...

- Code the visit as a 99213 using the diagnostic code: Diabetes and Hypertension
- Add a modifier 25 and also bill for the surgical procedure during the same visit
It is Essential to Remember...

- An insignificant or trivial problem or abnormality that is encountered in the process of performing the preventive evaluation and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.

Additional Modifiers

- Modifier 50: bilateral procedure
  - Bilateral digital block for lacerations of index fingers on both hands
- Modifier 21: Prolonged Evaluation and Management Services
  - When the face-to-face services provided is prolonged or greater than that usually required for the highest level of evaluation and management service within a given category
- Modifier 51: Multiple Procedures
  - Cryosurgery for verruca vulgaris
  - Biopsy of an abnormal nevus
  - Shave excision for infected nevus

Don’t Forget....

- Specimen handling fee for any specimen that gets handled/prepared: 99000
  - Pap
  - Throat culture
- Immunization administration fee: 90471
- Injection administration fee: 90772
- Collect capillary blood: 36416
- Collect venous blood: 36415
- Occult blood: 82270
- Wet mount: 87210
Remember....

- Make sure you are familiar with components of a Medicare Annual Wellness examination
- It is wrong to use an E&M code (i.e. 99213) code to get it covered if you performed a physical examination

Medicare

- Pre-ops: no longer consultation code – use E&M.
  - Many insurances are following this – MVP
  - G codes for PSA – etc have been removed

Another Important Code

- Transition of care codes
  - Used following a discharge from a hospital, SNF, or CMHC stay, outpatient observation, or partial hospitalization
    - Will only pay x 1 in 30 day period
  - 99495: contact by end of 2nd business day after discharge, visit within 14 days
  - 99496: contact by end of 2nd business day after discharge, visit within 7 days
  - Medical complexity: moderate or higher
Payment

- Remember...
  - Just because an insurance doesn't pay for a service doesn't mean you should not bill it

"Incident to" Services

- "Incident to" means incident to a physician's professional service
- Only utilized for the Medicare system
- This can be utilized with or without the nurse practitioner having obtained a Medicare number
- The nurse practitioner must be an employee of the physician or the physician group
“Incident to” Services

- In order to qualify for this service, the nurse practitioner must provide these services under a physician’s direct personal supervision
- Three O’s
  - Old patient
  - Old Problem
  - On Site

Let’s Talk About Incident To...

- Examples:
  - Nurse practitioner wants to bill all services under a physician’s number using the incident to code:
    - Think about this realistically
    - This gives the practice an additional 15% beyond what the nurse practitioner would receive with his/her own number but...
    - What happens if the physician is late?
    - What happens if the physician is called out of the office?
    - What happens if the patient mentions a sore throat in the course of a visit?

Continued...

- Also...
  - Because the visit is incident to a physician, the nurse practitioner should really only use a 99212 code or 99213 (very few follow-ups deserve a 99214 or higher code).
  - Billing incident to with high level codes frequently signals for an audit
  - Most nurse practitioners on their own use 99213 and above for codes
  - In fact, using this code regularly may significantly decrease your revenue...not increase it.
Here's What We Recommend...

- The billing company is instructed to never use incident to unless the NP instructs them to do so
- We all have our own Medicare billing number and will occasionally see a patient in follow-up for the physician
- It is then that we will instruct the company to bill using the incident to modifier

Remember

- Incident to...can never be used to bill for an inpatient service
  - It is a code that only applies to billing in an outpatient “clinic” setting

Home Visits

- It is permissible to bill “Incident to” for home visits but both the nurse practitioner and the physician must be in the patient’s home
Long Term Care Facilities

- It is possible to bill “Incident to” in Long-term care facilities but:
  - 1. The visit must be done in an "office" within the facility
  - 2. Both the physician and the nurse practitioner must be present with the patient

Documentation

- Now that we have spent this time discussing the various ways to bill and code, I would be remiss if I did not emphasize how important it is to make sure that your documentation matches your level of coding
- If you are ever audited and the documentation fails to match your coding consistently, you may be accused of Medicare/Medicaid fraud

“The single most important component of reimbursement is the requirement for accurate documentation of what the clinician sees and does.”

Mazzocco, W. Key Elements of Reimbursement Coding: A Guide for Nurse Practitioners; Advance for Nurse Practitioners; Sept 2001
How Can You Simplify the Coding Process?

- Use reference sheets to scan for physical examination and medical decision making/complexity rather
- Using handwritten notes, it is very hard to accurately document the criteria necessary to meet the various levels
  - Consider dictation
  - Consider forms

Remember...
with the IRS, ignorance is not a good defense

How Did You Code the Child?

- A. 99211
- B. 99212
- C. 99213
- D. 99214
- E. 99215
What Would You Code This Visit As?

- Most NP's would code a 99213:
  - I would code it as a 99214
- CC/HPI: 4 or more components
- ROS: 2-9 body systems
- PMFSH: 1 out of the 3
- Physical exam: 2 components in 6 areas (12)
- Decision making: multiple (3);
- **Must meet or exceed 2 out of 3 of these

Happy Coding!

Thank You

I Would Be Happy To Entertain Any Questions