Basics of Billing and Coding and Understanding Pre-Authorization

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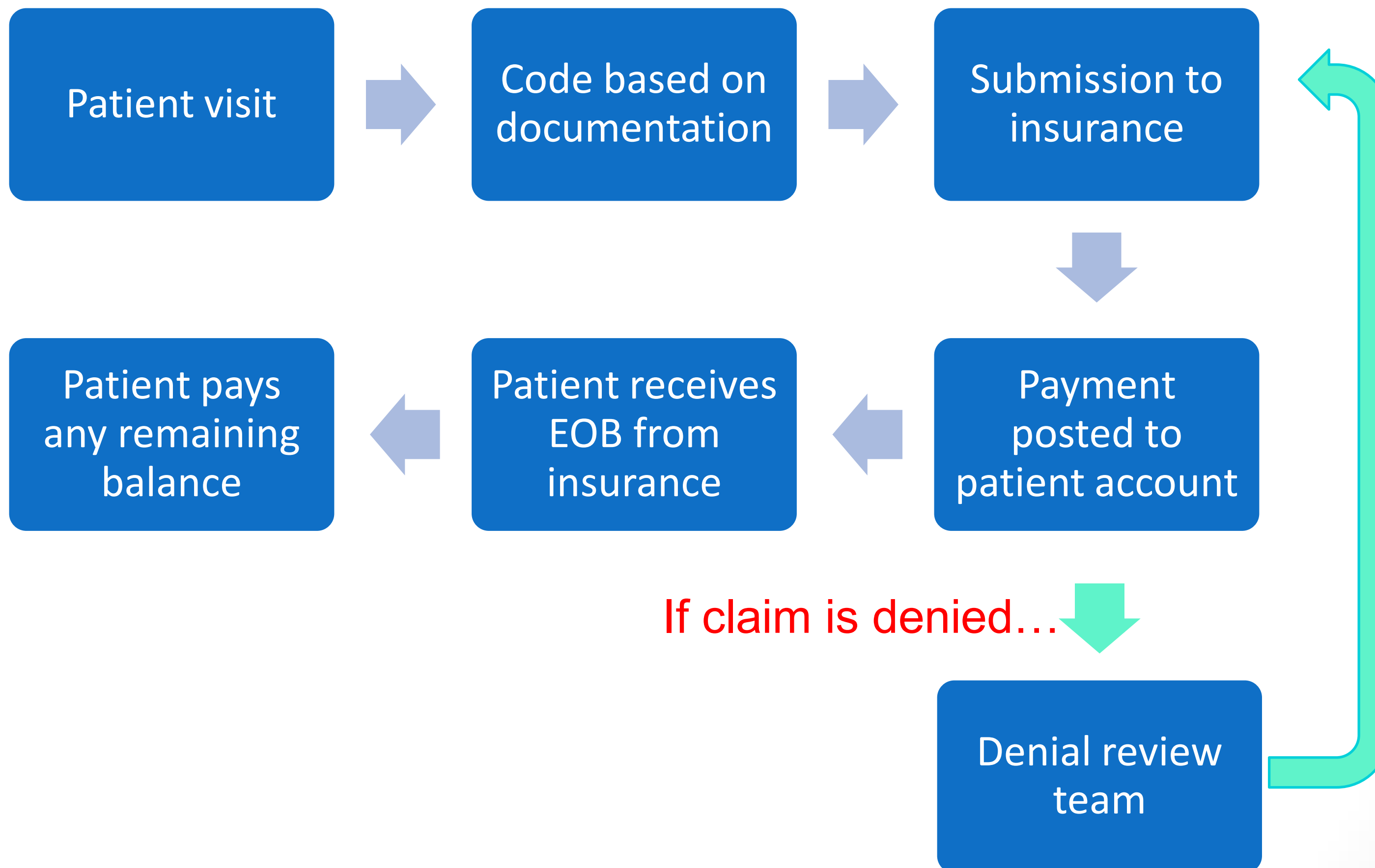
Disclosures

- None!

Objectives

- Understand Evaluation and Management (E&M) coding
- Differentiate between time-based and component billing
- Know when E&M service can be billed with minor procedure
- Be familiar with “Incident To” criteria
- Know how to document to improve prior authorization

Billing Process



Clinic Coding

CPT codes: procedures and services

ICD 10: diagnoses

- Any diagnosis addressed in visit should be coded
- Reimbursement not currently impacted by number of diagnoses

May be entered by coding team or provider

Outpatient/Clinic Codes

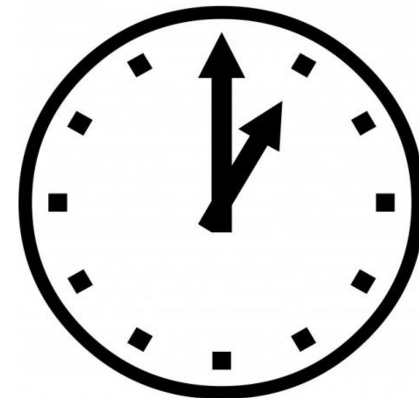
Visit type	CPT codes	Use	Elements of billing on documentation
New patient	99201-99205	Self referred or has not been seen by provider in the same specialty within the past 3 years	All 3 (History, Exam, Medical Decision Making)
Established patient	99211-99215	Patient seen by a provider in the same specialty within the past 3 years	2 of 3
Consultation	99241-99245 (not applicable to Medicare)	Another provider has asked for advice or opinion	All 3

Time-Based Billing

Face-to-face time only

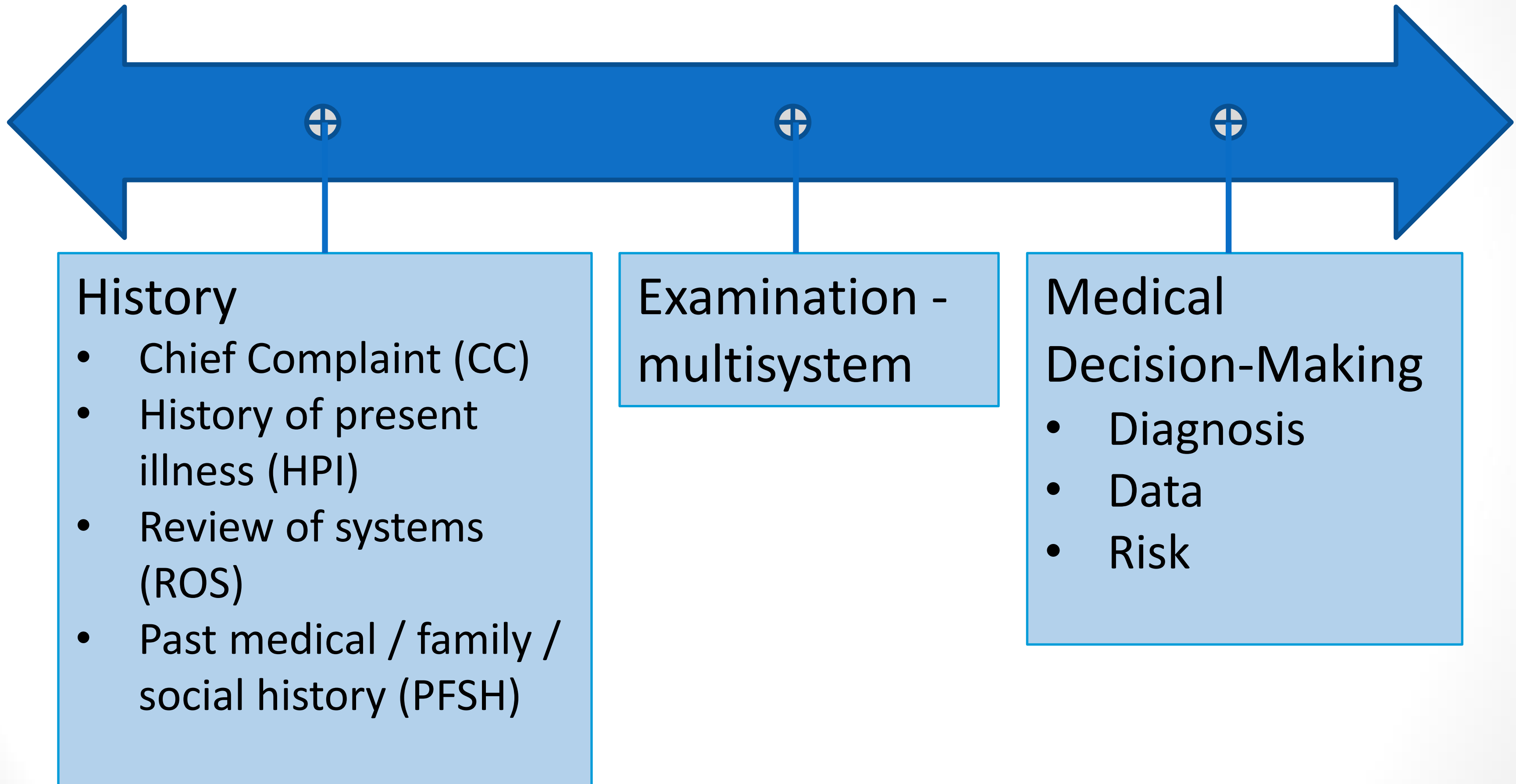
>50% counseling and/or coordination of care

Billable provider's time only



Times included in visit note
e.g. TT: 30 mins CT: 20 mins

Component Billing



History

Chief Complaint (CC)

- Concise statement describing reason for visit

History of Present Illness (HPI)

- A chronological description of development of patient’s illness from first sign/symptom to present

Past Medical/Social/Family History (PFSH)

- Document history that is pertinent to condition

“Non-contributory” and “unremarkable” are **not acceptable** documentation without further details

Review of Systems (ROS)

Document pertinent positives and negatives and make statement "All other systems were reviewed and found negative except as noted in HPI"

or

Document reason for inability to obtain info (such as patient comatose, confused, intubated)

or

10+ reviews of system = comprehensive

Multisystem Exam

- Constitutional (Ht, Wt, appearance, BMI)
- Eyes
- ENT (ears, nose , throat, mouth, thyroid)
- CV (heart sounds, pulses, carotids, edema)
- Respiratory
- GI (abdomen, rectum)
- GU (prostate, external/internal)
- Skin/breast
- Musculoskeletal (muscles, joints, gait)
- Neuro (reflexes, cranial nerves)
- Lymph (any area)
- Psychiatric/mental status (mood, affect)

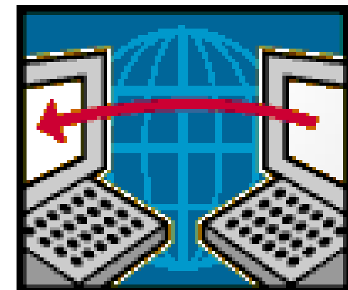
Medical Decision Making

- **Diagnosis**
- **Data**
- **Risk**

Must meet 2 out of 3

Medical Decision Making

- **Diagnosis**
  - Document all diagnoses and/or symptoms that you took into account at this visit
- **Data**
  - Work effort: what you **ordered/reviewed**
  - Review and summarization of outside records
  - Decision to obtain old records
  - Obtain history from someone other than patient
  - Discussion of test results with the performing physician



Medical Decision Making - Risk

Present at today's visit that warrant risk	
Prescription meds	OTC
Chemotherapy	Surveillance
Emergent	Elective
Mild or severe exacerbations	Stable dx
Starting/stopping/changing treatment	No change
New dx with uncertain prognosis	Multiple chronic dx

vs.

Prolonged Service

With direct patient contact:

- Add-on code
- Insurance reimburses (Medicare around $132 for 99354)
- CPT 99354: first hour (must be at least 30min)
- CPT 99355: each additional 30 mins

Example: Established level 5 time billed is 40 min. If provider sees patient for 40 min + 31 min = 71 min then would bill 99215 and 99354

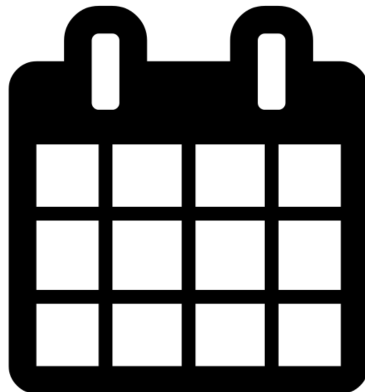
Prolonged Service

Without direct patient contact:

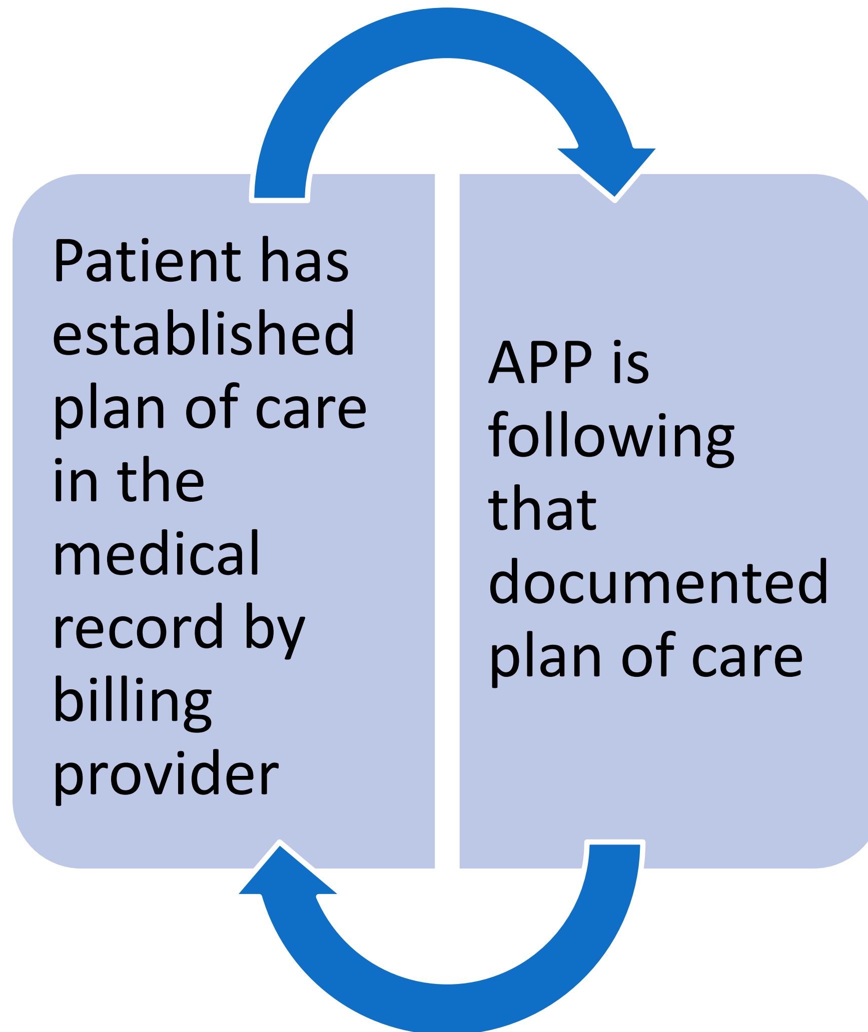
- Not an add-on code
- Must be seeing the patient face to face the same day or next day
- Time is not cumulative over multiple days
- Can use for reviewing outside records, phone calls, meeting with family members
- Must be documented in medical record
- Insurance reimburses (Medicare around $113 for 99358)
- CPT 99358: first hour (must be at least 30 min)
- CPT 99359: each additional 30 min

E&M Visit with Same-Day Procedure

- Specific circumstances may allow billing for both an E&M visit and a procedure/ treatment
- Documentation must support the procedure/service and the significant and separately identifiable E&M service
- E&M visit requires Modifier 25



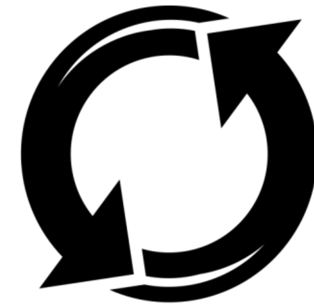
Incident-To Billing



Pre-Authorization

Document diagnosis clearly as to why a service or drug is being ordered
-- e.g. Patient has cancer but is given a drug for neutropenia, not for cancer

Document dose (in mg), frequency (every __ weeks), duration (__ cycles)



Most insurances will not retro-authorize services. Ensure authorization is in place prior to service!

Summary

- Bill appropriately based on documentation
  - E&M codes
  - Time-based or component billing
  - Service with same-day procedure
  - Incident-to billing
- If service is billed, documentation/ support for diagnosis must be in the medical record
- Document to improve prior authorization

Thank you!