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## 10 billing & coding tips to boost your reimbursement

Keep more of what you earn by avoiding these costly coding missteps

**T**imes are tough for primary care physicians—so tough that American Academy of Family Physicians' President Jim King, MD, recently called for health care reform to ensure that coverage is affordable and that "physicians can continue to care for [patients] without fear of bankruptcy."<sup>1</sup> Yet in virtually every family practice, opportunities to maximize reimbursements are missed. Undercoding, omitting modifiers, and submitting claims without the documentation needed to support them are everyday events.

The lost revenue is no small change. At the current Medicare reimbursement rate of \$96.01 for a 99214 visit and \$63.73 for a 99213 visit, a physician who undercodes just one level 4 visit per day could lose as much as \$8,393 over the course of a year.<sup>2</sup>

Some family physicians undercode simply because they underestimate the value of the services they provide. Others deliberately take a conservative approach in hopes of avoiding a government audit—a misguided tactic that some coders believe is as likely as habitual overcoding to arouse suspicion.<sup>3</sup> For still other physicians, the time it takes to document a level 4 visit is not worth the trouble. Brushing up on the requirements for higher-level visits (**TABLES 1 AND 2**)<sup>4</sup> and using encounter templates to guide you through a review of systems, symptoms, and severity can help lighten the documentation load.

To provide additional help, we've developed 10 coding and billing tips based on our experiences in family practice. Each of these can help you to maximize reimbursement.

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## 1 Document and bill more 99214s

Centers for Medicare & Medicaid Services (CMS) data show that in 2006, family physicians billed 55.2% of their established outpatient visits as level 3s (99213) and 31.6% as level 4s (99214).<sup>2</sup> Evidence suggests that the percentage of 99214s could legitimately be higher. A study comparing family physicians' choice of codes with those selected by expert coders re-

vealed that the physicians undercoded one third of their established patient visits. In most cases, visits that warranted 99214 codes were instead coded as 99213s.<sup>5</sup>

To bill for a level 4 established patient visit, CPT (Current Procedural Terminology) guidelines require you to fulfill 2 out of 3 of the following components:

- a detailed history

- a detailed physical examination
- medical decision making of moderate complexity.<sup>4</sup>

When the history and medical decision making indicate a higher level of complexity, you can bill for a 99214 visit without having to count or document individual body systems or detailed exam elements. A new diagnosis with a prescription, an order for laboratory tests or X-rays, or a request for a specialty consult are all examples of moderately complex decision making. When it is necessary to show that you performed a comprehensive system review to justify a 99214 claim, history forms, filled out in the waiting room and subsequently reviewed with the patient, can be a valuable time-saver.



## 2 Avoid the 99203/99204 “complexity” pitfall

In 2006, CMS data showed that family physicians billed 43.9% of new patient visits as level 3s (99203) and just 28.5% as level 4s (99204).<sup>2</sup> In many cases, opportunities to bill for 99204s are missed.

Unlike a level 4 visit for an established patient, a 99204 code requires all 3 components—a detailed history, detailed physical examination, and moderately complex decision making (TABLE 2).<sup>4</sup> Thorough data collection is crucial to justify the higher level code, which is appropriate whenever a new patient presents with a complex medical history warranting a new diagnosis, new medication, and tests or a specialty evaluation.

Beware of the tendency to code the

visit based on the complexity of the diagnosis, rather than the extent of decision making involved. A new patient visit from a woman, age 57, who presents with congestion and a persistent cough occasionally accompanied by chest pain might warrant a 99204 if her medical history (eg, obesity, hypertension, and gastroesophageal reflux disease) and review of systems made it necessary to rule out acute myocardial infarction and congestive heart failure, among other serious conditions, before arriving at a diagnosis of bronchitis. If you’re unsure of whether you can use the higher code, review the coding and documentation requirements in TABLE 2.

### FAST TRACK

**Beware the tendency to code according to the complexity of the diagnosis, rather than the extent of decision making involved**

## 3 Remember to use modifier -25 with the proper documentation

The Office of Inspector General notes that you can bill for an office procedure performed on the same day as you evaluate the patient, if the procedure “is significant, separately identifiable, and above

and beyond the usual preoperative and postoperative care associated with the procedure....” To do so, though, it is necessary to attach modifier -25 to the evaluation and management (E/M) code, and

**TABLE 1**

**Established patient visits: CPT codes and documentation requirements**

	E/M CODE				
	99211	99212	99213	99214	99215
<b>History</b>					
Chief complaint	Required	Required	Required	Required	Required
History of present illness	NR	1-3 elements	1-3 elements	≥4 elements or ≥3 chronic diseases	≥4 elements or ≥3 chronic diseases
Review of systems	NR	NR	1 system	2-9 systems	≥10 systems
Past history/family history/social history	NR	NR	NR	1 element	≥2 elements
<b>Examination</b>	NR	1 system (1-5 elements)	2 brief systems (6-11 elements)	1 detailed system + 1 brief system (≥12 elements)	8 systems or 1 complete single system (comprehensive)
<b>Medical decision making</b>					
Risk	NR	Minimal	Low	Moderate	High
Diagnosis or treatment options	Minimal	Minimal	Low	Moderate	High
Data	NR	Minimal	Low/Moderate	Moderate	High
<b>Time*</b>	5 minutes	10 minutes	15 minutes	25 minutes	40 minutes

CPT, current procedural terminology; E/M, evaluation and management; HPI, history of present illness; NR, not required.  
 \*At least one half of total face-to-face time must involve counseling or coordination of care.  
 Adapted from: American Medical Association.<sup>4</sup>

**FAST TRACK**

**When you bill for an E/M service and a procedure, the work performed for each must be clearly defined**

to provide evidence that you performed 2 separate services.

Proper documentation is critical here. In 2002, Medicare approved some 29 million claims using modifier -25, then disallowed nearly 35% of them for failing to meet the documentation requirements.<sup>6</sup> How can you avoid a similar fate?

While most third-party payers do not require physicians who bill for an E/M

service and a procedural service for the same patient on the same day to submit 2 separate progress notes, the work performed for each must be clearly defined. If you saw a patient with diabetes for a medication check and she asked you to remove a wart, you would need to document the dimensions, depth, and location of the wart, along with details of your targeted evaluation and management.

**4 Know when to bill for preventive and E/M services**

We're all familiar with the patient who comes in for a yearly health maintenance examination, then wants to discuss her depression or chronic back pain. In such a case, you may be justified in billing for both preventive services and an office visit—again, using modifier -25 to indicate that you provided significant, separate services.

The distinction can be harder to establish than when separating an E/M service and a procedure, however. If the acute or chronic problem that you evaluate is stable and closely related to the preventive examination—well-controlled asthma not requiring a change in medication, for example—submitting an E/M code is not warranted. But a new problem

TABLE 2

## New patient visits: CPT codes and documentation requirements

	E/M CODE				
	99201	99202	99203	99204	99205
<b>History</b>					
Chief complaint	Required	Required	Required	Required	Required
History of present illness	1-3 elements	1-3 elements	≥4 elements or ≥3 chronic diseases	≥4 elements or ≥3 chronic diseases	≥4 elements or ≥3 chronic diseases
Review of systems	NR	1 system	2 systems	≥10 systems	≥10 systems
Past history/family history/social history	NR	NR	1 element	≥3 elements	≥3 elements
<b>Examination</b>	1 system (1-5 elements)	2 brief systems (6-11 elements)	1 detailed system + 1 brief system (≥12 elements)	8 systems or 1 complete single system (comprehensive)	8 systems or 1 complete single system (comprehensive)
<b>Medical decision making</b>					
Risk	Minimal	Minimal	Low	Moderate	High
Diagnosis or treatment options	Minimal	Minimal	Low	Moderate	High
Data	Minimal	Minimal	Low	Moderate	High
<b>Time*</b>	10 minutes	20 minutes	30 minutes	45 minutes	60 minutes
CPT, current procedural terminology; E/M, evaluation and management; HPI, history of present illness; NR, not required. *At least one half of total face-to-face time must involve counseling or coordination of care. <b>Adapted from:</b> American Medical Association. <sup>4</sup>					

or an exacerbation of an existing problem requiring a significant history, physical examination, and treatment beyond what would typically be performed during a routine preventive visit would be a valid reason to bill for E/M services.

Management of 2 or more medically significant chronic problems requiring prescription refills and either laboratory or radiographic tests also justifies concomitant billing of an E/M code.

## 5 Charge for patient counseling

When more than half the time you spend with a patient is devoted to counseling or coordination of care, “time may be considered the key or controlling factor to qualify for a particular level of E/M service,” according to CPT guidelines.<sup>4</sup> That is, you may be able to justify the use of a higher level E/M code based

**The best laid plans....** Even when billing for preventive and problem-oriented care is appropriate and the proper codes and documentation are submitted, you may not be reimbursed for both. Some third-party payers will pay a portion of each; others will deny the additional claim entirely. There are also some health plans that will require any patient who generates 2 charges on the same day to pay 2 separate copays.

solely on time, regardless of the complexity and detail of the medical history, physical examination, or medical decision making (**TABLES 1 AND 2**).

Medicare’s *Documentation Guidelines for E/M Services* direct physicians to document the total time of the patient encounter and to describe in detail

### FAST TRACK

**You may be able to use a higher level E/M code based solely on time, regardless of the complexity of the medical history, physical exam, or decision making**

the nature of the counseling or activities to coordinate care.<sup>7</sup> That said, time spent before and after the face-to-face encounter—retrieving and reviewing records or test results in preparation

for the visit and arranging referrals or communicating with other health care providers afterwards, for example—*cannot* be counted toward the total time of the patient encounter.

## 6 Watch your words when billing for derm procedures

To maximize your reimbursement of dermatologic procedures, you need to be especially mindful of the terminology you use and the descriptive details you record.

**Start with terminology.** A biopsy generally indicates that only a portion of a lesion was removed to obtain a histologic diagnosis, as in the case of a punch biopsy. When you remove an entire lesion, you use either a shave (horizontal partial-thickness cut that does not include the entire dermal layer) or an excision (a full-thickness removal of the lesion through the dermis to the adipose tissue). Using the correct terminology will ensure that you are properly reimbursed for the procedure you performed.

**Focus on measurements.** Size matters, too: The larger the lesion, the greater the reimbursement.

To bill for an excision, the size of the lesion must be documented and the excised area calculated by adding the lesion's maximum diameter plus the sum of the narrowest margin.<sup>4</sup> While mar-

gins are counted for excisions, that's not the case with shaved lesions. The margins of a shaved lesion are not factored into the reimbursement formula, so document only the measurement of the lesion itself.

Location also dictates the scale of reimbursement, which is typically lower for procedures involving the trunk, arms, or legs than for those on the face or in the anogenital area. Malignant lesions also generate higher charges.

**File multiple claims for multiple lesions.** When multiple lesions are biopsied or removed during a single visit, file multiple claims, using modifier -59 for distinct (separate) procedural services.<sup>8</sup> Be aware, however, that third-party payers may not provide full reimbursement for each lesion. For Medicare enrollees, routine excision of skin lesions is considered cosmetic and is not covered unless the lesions have malignant or potentially malignant, symptomatic, or functionally impairing features.

## 7 Use a template for the "Welcome to Medicare" exam

All new Medicare Part B beneficiaries are entitled to a "Welcome to Medicare" exam within their first 6 months of enrollment. It has 7 elements, all of which are required for full reimbursement. To appropriately conduct and bill for this exam, create a template listing all the requisite elements:

1. A comprehensive review of the patient's medical, social, and family history
2. A review of risk factors for depression
3. A review of functional ability and

level of safety

4. A focused physical exam (weight, height, blood pressure, and visual acuity are the only requirements)
5. An electrocardiogram, with interpretation
6. Brief education, counseling, and referral to address any issues discovered in the first 5 elements
7. Brief education, counseling, and referral, with a written plan for the patient regarding preventive services covered by Part B.<sup>9</sup>

### FAST TRACK

**In billing for an excision, include the margins in the measurement; the larger the lesion, the greater the reimbursement**

**TABLE 3****Preventive services covered by Medicare**

<ul style="list-style-type: none"> <li>• <b>Vaccinations</b> Influenza (yearly) Pneumococcal (once) Hepatitis B (1 series)</li> <li>• <b>Bone mass measurement</b> For those at risk for osteoporosis (every 2 years)</li> <li>• <b>Cardiovascular disease screening</b> Fasting lipid panel (every 5 years) Ultrasound screening for abdominal aortic aneurysm for men who have a family history or are between the ages of 65 and 75 and have smoked at least 100 cigarettes</li> <li>• <b>Colorectal cancer screening</b> (according to risk category) Colonoscopy Flexible sigmoidoscopy Barium enema Fecal occult blood testing</li> <li>• <b>Glaucoma screening</b> (yearly)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Diabetes screening</b> Fasting blood glucose or oral glucose tolerance test yearly for those who are at risk for diabetes or have at least 2 of the following:               <ul style="list-style-type: none"> <li>– Obesity</li> <li>– Family history of diabetes</li> <li>– Age &gt;65</li> <li>– History of gestational diabetes</li> </ul>               Twice yearly screens for those diagnosed with prediabetes Diabetes outpatient self-management training and medical nutritional therapy for patients with diabetes and/or renal disease             </li> <li>• <b>Mammography</b> (yearly, with baseline at age 40)</li> <li>• <b>Pap test and pelvic screening exam</b> (every 2 years unless high risk)</li> <li>• <b>Prostate cancer screening</b> (yearly) Digital rectal examination Prostate-specific antigen (PSA) assay</li> </ul>
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**Adapted from:** Centers for Medicare and Medicaid Services.<sup>9</sup>

To be reimbursed for the Welcome to Medicare exam, it is necessary to use 2 separate billing codes: G0344 for the physical examination (paid at a rate equal to a 99203 visit) and G0366 for the electrocardiogram.<sup>9</sup> Although CMS does

not provide coverage for a general preventive examination other than this initial “Welcome to Medicare” visit, many recommended preventive health services are covered by Medicare at specified intervals (**TABLE 3**).<sup>9</sup>

## 8 Code injections with care

Whether you are administering vaccines or analgesics, coding for injections presents multiple opportunities for error. Physicians often include the code for a vaccine, but forget the procedure code for its administration.

Omitting the dose indication is another common occurrence. (If you inject a 30-mg dose of ketorolac and submit a J1885 code, which covers a 15-mg dose, for example, it is necessary to indicate that you administered a double dose.) It’s also not unusual for physicians to fail to include all the required codes for patients who receive multiple vaccinations at a single visit.

If a 68-year-old man, an established patient, comes in for an annual flu shot and is given the pneumococcal vaccine during the same visit, the correct codes would be:

- 90658 (flu vaccine)
- G0008 (flu vaccine administration)
- 90732 (pneumococcal vaccine)
- G0009 (pneumococcal vaccine administration)

Omitting both procedure codes could cost you nearly \$20—and could run into thousands of dollars a year if the error is a daily occurrence.

CONTINUED

### FAST TRACK

**When billing for vaccinations, include both the vaccine code and the procedure code for its administration**

## 9 Prioritize diagnoses

Many patients present with multiple diagnoses to be addressed during a single routine office visit, each of which may be applicable for billing for services rendered. ICD-9 coding guidelines state that physicians should “list first the ICD-9-CM code for the diagnosis, condition, problem or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided, then list additional codes that describe any coexisting conditions.”<sup>10</sup>

Selecting the primary diagnosis for billing and coding, then listing the others in order of importance lets third-party payers know how you prioritized patient care—and helps ensure that you are reimbursed accordingly. (Be sure to list active and acute medical conditions discussed during the visit on the encounter form [eg, type 2 diabetes, hypertension] rather than those that are stable and not addressed that day—eg, seasonal allergies or migraine headaches.)

## 10 Bill extra for emergency services

From time to time, an unexpected office emergency arises that takes you away from the patient you are currently evaluating. In such cases, you can use CPT code 99058 to bill for services “provided on an emergency basis in the office, which disrupts other scheduled office services”—and bill for basic services provided to the patient, as well.<sup>4</sup> Documentation, of course, must include the chief complaint, evaluation, diagnosis, and therapeutic plan and fully describe the emergent nature of the service

to justify billing for the “emergency encounter.”

**Be aware**, however, that even when you code and document appropriately, you may not receive full reimbursement. Medicare and Medicaid often bundle emergency services with other services provided on the same day. Other third-party payers respond in different ways: Some pay the full fee; others pay only a small percentage. Depending on the payer’s policy, billing for a level 4 or 5 E/M visit may be preferable. ■

### FAST TRACK

**Selecting the primary diagnosis, then listing the others in order of importance, helps ensure that you’ll be reimbursed accordingly**

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