WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Maximizing Billing and Coding [Part 1]

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STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh, and I'd like to welcome you to the Maximizing Billing and Coding Part 1 webinar. This webinar is brought you by the Partnerships for Care, HIV Training, Technical Assistance, and Collaboration Center, or HIV TAC. The Partnerships for Care project is a three-year, multi-agency project funded by the Secretary's Minority Aids Initiative Fund and the Affordable Care Act.

The goals of the project are to, one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV; two, to build sustainable partnerships between health centers and their state health department; and three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance, and Collaboration Center, or HIV TAC.

Our speaker today is Stacey Murphy. Stacey is a seasoned health care professional with more than 30 years of experience. She has held positions with the Veterans Administration, Lebanon Hospital Center in the Bronx, and other private sector entities. She's an active member of the American Academy of Professional Coders, and is very active with the NY MAC chapter in Queens, New York. She completed her undergraduate work in Health Administration at Saint Joseph's College in Brooklyn, New York, and obtained an executive master's degree from Baruch College in Public Administration.

She received her CPC coding designation in 1998, and is a designated ICD-10 trainer. Stacey currently teaches health information management and medical coding courses at City University, New York, School of Professional Studies. And she teaches medical terminology and other health administration courses at Saint Joseph's College. Stacey's latest achievement is as a contributor to the upcoming American Health Information Management Association, AHIMA, white paper, "State of Coding in Health Care Today." Please join me in welcoming Stacey Murphy.

STACEY L. MURPHY: Good afternoon. Thank you for joining the Maximizing Third Party Reimbursement through Enhanced Medical Documentation and Coding webinar series. As Stephen mentioned, I've been working in the health care field for over 30 years. In addition to everything that Stephen just mentioned, I am also a consultant for JMS Billing Solutions. We're a health care consulting firm that has been in existence since 2004.

So some of the key highlights of the services that we provide are EMR documentation and training, HCC risk adjustment training and documentation, [INAUDIBLE] documentation and training, DRG analysis chart audits. And the most recent services that we've been providing are the ICD-10 transition and ICD-10 documentation and training. So I keep myself quite busy with all of the projects and the initiatives that I am involved in.

So without further ado, when don't we get into the presentation, because we have a lot of information to cover and we only have a short period of time to get through it. So here our your learning outcomes for today's webinar series. We're going to explain the importance of proper documentation in patient health records, identify and explain CPT codes, identify and explain office visit Evaluation and Management E&M codes, differentiate between new versus established patient, differentiate between the Preventive medicine visit code versus the preventive medicine counselling visit codes, and identify and explain commonly used modifiers for the services that you're performing in your practices.

So the next two slides are just some acronyms that are used in the presentation, so please feel free to circle back to those.

So let's begin today with a polling question. What role do you play at your health care facility? Please select one of the choices that are on the slides. A is clinical staff, which comprises of your MDs, your NPs, your PAs, your RNs, and all the other clinical staff in your office. Are you the office manager or supervisor working at the front desk or patient intake? Are you the biller, coder, or insurance followup specialist, or other?

Great. So look at the results. So we have just a small percentage of clinicians on the call. And it looks like everyone else is in the other three categories, either an office manager, supervisor, or front desk or patient registration. And then looks like we have quite a few billers and coders and insurance followup specialists on the line, so that's great. The information on the slides will be very beneficial to you.

So let's move on. So in terms of approved health care providers, we only have a small percentage of providers on the call, but I'd like to go through some information anyway so that we are all on the same page in terms of the codes that we'll be using. And so the providers that are in your facilities must be board-certified physicians or certified nurses. So your examples would be your MDs, your NPs, your PAs, and your certified nurses. They must possess a valid NPI number, as well as a Medicaid participating provider ID number.

And the ancillary staff that work in your offices are authorized to document information in patient medical records, such as carrying out physician orders. And some of the examples of the ancillary health care professionals that may be working in your offices are your phlebotomists, your medical office assistants, and your LPNs.

Some of the various specialties that are also able to utilize the codes that we're going to discuss in today's presentation are your family practice practitioners, your family medicine specialists,

internal medicine, adult medicine. Some of the subspecialties are allergy or immunology, cardiology, emergency medicine, infectious diseases. So this is just a list of the approved health care providers that commonly report Evaluation and Management codes, and some of the various codes that will be discussed in today's session, as well as in the upcoming session.

So let's talk a little bit about medical record documentation. The medical record should be complete and legible. Now, if you're using an electronic medical record, your templates that you put into your electronic medical record system should contain the data points that your health insurance plans that you participate in require when they're coming in to do their chart audits. Some of the very important key elements of a medical record that should always be present is the reason for the patient's seeking medical attention. Any relevant history should be documented. If a physical exam is part of the encounter, that should be documented. Any diagnostic tests that are performed in conjunction with the medical encounter should also be documented.

There should also be a plan of care, the assessment. Your clinical impression includes all of your final diagnoses and your treatment options. And so once again, if you're using an electronic medical record system, your electronic medical record system will capture the date and the identity of the health care professional. If you're still using paper charts, these components must be documented legibility in a record in order for the record to be considered compliant.

Some additional documentation points for our providers that are on the calls, documentation should include past and present diagnoses. Now, regarding the past diagnoses, if the past diagnoses are pertinent to that particular encounter for that day, then you should document them. If there is no correlation or there's no relevance to the reason for the patient coming in for a visit, then you don't need to put any of the past diagnoses.

Appropriate health risk factors should be identified. The patient's progress, whether their progress is improving or if it's declining, this should be documented in the record. The diagnoses and treatment codes reported on your health insurance claims must be supported by your documentation. So for example, if you're reporting that a patient is coming in to your practice for a well visit, the expectation when an auditor comes in to review the records is that you have documented the components of a well visit to coincide with the well visit diagnosis code and the well visit E&M code that you're going to--

So one of the codes that you're using in your practice are your CPT codes. So just a brief overview of what the CPT codes are. It's a code system that's developed by the American Medical Association in 1966. It's updated annually. And the codes in the CPT coding book describe the procedures and services that are performed to treat the various medical conditions that you see in your practices. For the most part, these codes in this book are reported by the physicians that are in the outpatient hospital settings or in the clinic settings.

In terms of the CPT coding book, it's comprised of six different sections. The first section is the Evaluation and Management section, which we'll be covering today. You have your anesthesia

section, your surgery section, your radiology section. The pathology and laboratory codes will be covered in Series 2, next week Tuesday. And you have some codes from the medicine section. The medicine section are your vaccines.

So in terms of the Evaluation and Management codes, just to give a little bit more details, the acronym E&M stands for Evaluation and Management. The codes in this section are nonsurgical, so the codes are medical and nonsurgical in nature. They can be used by any specialty as appropriate. And most of the Evaluation and Management codes that you will come across comprise of components that we'll get to in a moment.

And they're incremental in nature, so with the exception of your preventive medicine visits, which are based on patient's age, the most common E&M codes that you will use in your practice are incremental in nature. So for example, a Level I new patient visit would be an 99201. A Level II new patient visit would be a 99202. So in terms of incremental in nature, that's the definition of incremental.

The other types of codes in your Evaluation and Management section are your preventive medicine visit codes and your counseling, your preventive counseling codes. So again, just to reiterate, the preventive medicine visit codes are based on age. And so when we get to those slides, I'll show you those.

So in terms of the definition of new versus established, a new patient, according to the American Medical Association's definition, is one who has not received any face-to-face professional services from a physician within that same specialty within the last three years. So for example, when a patient presents to your practice to see an internal medicine physician for the very first time, you would report a new patient visit code. If the patient returns within a two-year time span and they see another internal medicine physician in your practice, that patient is still considered-- I'm sorry, that patient is considered now an established patient, because they have seen an internal medicine physician in your practice within the past three years.

An established patient is one who has received face-to-face care by a physician within the same specialty. And in health care, the commonly referred to terminology that describes an established patient is a follow-up patient. So most records that I have reviewed, the doctors will document "patient here for follow-up" or "follow-up care," it's the same as an established patient.

So in terms of satisfactory statements that physicians should document in the record, when you just write "patient here for follow-up," when an auditor comes in to review the records, that would be considered a non-compliant record, because all patient records have to clearly designate what type of service the patient is receiving and what's the reason for that service. So when you write "patient here for follow-up," you should further elaborate that statement by providing some additional details that describe why the patient presents for follow-up.

The Evaluation and Management documentation guidelines rely on the three key components. Those three key components of an Evaluation and Management service code are history, exam, and medical decision-making. So now when we get to the next slide, there is a table that just gives you the snapshot of the five different codes. I'm sorry, the five different codes to describe your new patient clinic visit versus your established patient clinic visit.

Now, when you look at the bottom table, if you'll notice, the established patient visit code, 99211, should never be reported by a physician in your practice. This is a low-level code that describes a visit that's provided by an RN who's carrying out an order that's written in a chart by a physician. So for example, if a patient returns for a blood pressure recheck or maybe their PPD reading, the 99211 would be reported for that service.

So just some information regarding the history component. The history component further breaks down into elements are your Chief Complaint, that's what the CC stands for, the history of the present illness, your review of systems, and your past medical, family, and social history. And because we have such a small percentage of providers on the call and more billers, coders, and registration personnel on the phone, because we have quite a few slides to get through, I will try to spend more time on the coding side. And if we have any questions from any of the clinical-- the clinicians on the phone, we can come back to these.

Regarding the Chief Complaint, here is some tidbits of information. It's a clear, concise statement that describes the reason for the patient requiring medical attention. It's usually the first statement. It's not necessarily the first statement, but it must be in the record. Again, just to reiterate, "patient here for follow-up" is not sufficient, so you really have to explain and elaborate the reason why a patient presents to your practice for follow-up.

Another element of the history is your HPI, your History of the Present Illness. When an auditor comes in to review a medical record, the record kind of tells a story. Without having access to all of the details, the record tells a story. So when the patient comes in and they have a medical complaint, you want to build your story by explaining some of the details.

So patient here complaining of pain, that's your location. The patient complaints that the pain, that they've been having the pain symptoms for the past five days, that's your duration. So these are elements that kind of help you to build a story as a clinician as you're trying to diagnose the patient to determine the reason for them seeking medical attention. Now, it is not necessary to document all of these elements. You would just document the elements that apply to the patient's complaint.

The next slide speaks about your review of systems. It's just a status of the body systems that are involved with the patient's complaint. It helps the physician to clarify any differential diagnoses or the need for any type of diagnostic tests.

The next two slides describe the body systems and the-- body systems and organ areas. So here are a list of the body systems. And so again, based on the patient's complaint would determine what body systems the doctor will document in the record.

So your Past Medical, Family, and Social History. Your Past Medical, Family, Social History contains a review of three pertinent areas. That's the patient's past medical history. That's the patient's past family history, and the patient's social history. In terms of the documentation requirements, all new patients require all three elements.

When an established patient presents for follow-up in your practice, it is not necessary to document Past Medical, Family, Social History unless there are some complaints that the patient presents with that correlates to the justification for doing the documentation of your Past Medical, Family, Social History element.

A physical exam is key component number two. So remember we said that there are three components, it's your history, your exam, and your medical decision-making. So your exam is an objective assessment of the organ systems or the body areas that are pertinent to the reason why the patient came in for a complaint. When a physician makes the decision to do an exam on a patient, you really want to focus on the organ systems or the body areas that pertain to the complaint.

There have been some inconsistencies with information that is communicated to providers in terms of whether or not they should perform a full physical exam versus whether or not they should just focus on those body areas or those organ systems that apply to the patient's complaint. As an auditor, what I would say to you is if you make the decision as a provider to examine all of the body systems and body areas for the purposes of increasing your E&M level, if an insurance company comes out to do an audit and they don't see the justification, they may decide to lower your E&M level and recoup over-payments. So I would use caution when you make that decision to do a full exam on a patient that doesn't necessarily need a full exam.

So this slide gives you the overview of the body areas that are pertinent to a physical exam. And then the next slide gives you the overview of the organ systems. So if you'll notice the similarities, the body systems and the body areas and organ systems are similar to what you saw in the history component.

So just some tips, some documentation tips. When you're doing an exam, again you want to examine the body systems or the body areas that are related to the complaint. If there are any abnormalities or any relative negative findings, these should be documented in the medical record. A statement of normal is sufficient. However, a statement of abnormal or asymptomatic without any explanation is not acceptable. So here's an example of an abnormal statement that clearly details what those abnormalities are.

So the AMA, the American Medical Association, and the CMS, Centers for Medicare and Medicaid Services, have two sets of physical exam guidelines. You have your 1995 guidelines

and you have your 1997 guidelines. Most physicians utilize the '95 guidelines, because they are not as stringent to get to in terms of an E&M level.

The '97 guidelines, on the other hand, those are typically used by specialties. So internal medicine, most of the practices that I've worked with have used as their baseline the '95 guideline. We can see the difference between the '95 and the '97 physical exam guidelines.

So at the top slide, you'll notice the '95 guidelines. When you compare a problem-focused physical exam to the '97 problem-focused physical exam, the documentation only requires one body area or one organ system, versus in '97, you need one to five elements in any system or body area. So as you can see when you do the comparison between the two exam guidelines, the reason why most physicians prefer the 1995 guideline.

Medical decision-making is the final component of an Evaluation and Management service. The medical decision-making describes the complexity of your diagnoses, your management, options and your treatment, your patient's treatment. Your medical decision-making is determined by the possible number of diagnoses, the documentation of the data that you reviewed, or the amount of that data that you had to review, such as lab work or x-rays, and the risk of complications, morbidity, and/or mortality relative to the patient's reason for seeking medical attention.

And so in the 1997 guidelines, CMS prepared-- or rather, the AMA as well as CMS provide a table of risk that can be used to gauge the final component of an E&M service. So the first component of the medical decision-making is your number of possible diagnoses. And so that entails your clinical impression, your management plans, and further evaluation. If the treatment is for an established condition, the documentation should clearly reflect whether the problem is improving, whether it's well controlled, whether it's worsening or failing. The initiation of or change of the treatment plan or medications should be clearly documented and referrals to any specialists. So these are all elements under that first bullet for your medical decision-making.

Documentation of data reviewed and/or complexity, such as the diagnostic tests, your labs, radiology, procedures, the review of any diagnostic tests or labs, discussions with other health care professionals, whether or not you've had to look at any film, X-ray film, and relevant findings from old records. So when I meet with a lot of our clients, what I tell my providers is that it's very important that you document the medical decision-making, because in terms of the three key components, medical decision-making is really the source that drives your final code selection. And so if you're lacking in documentation, then you're not going to get the benefit of making sure that you're assigning the most appropriate code for the services that you're providing.

The final element of your medical decision-making is risk of significant complications, morbidity, and/or mortality. So any risk associated with the presenting problem, problems, your diagnostic tests, your procedures, and specialty referrals, any risk related to the disease process that's

anticipated between that encounter and the next encounter with that patient, your diagnostic tests, procedures, and specialty referrals, based on the risk during and immediately after diagnostic tests, procedures, and specialty referrals. So anything that's pertinent to that particular patient's encounter should be documented in the record pertaining to the risk.

This is the table of risk. And I apologize if it's not really that clear or legible. We have prepared a resource document that will be provided to all webinar participants. And the table of risk is on one of those pages and you'll be able to see all of the elements.

But just to give you an idea of how you use the table of risk as it pertains to your medical decision-making, if you look at the four columns you'll see the level of risk in the first column, minimal, low, moderate, or high. The next column describes the presenting problems. The next column are your diagnostic procedures ordered. And then the final column is your management options.

So any time a patient has a medical problem that's stable, such as like a well controlled hypertension or a well controlled diabetes, that falls under your Presenting Problems column but it maps to Level of Risk low. But let's say the doctor makes a decision to do some type of deep needle or incisional biopsy. And I'm just moving around on the table so that you can kind of get an idea of the information that's on there. Or let's say the physician makes a decision to do some minor surgery that has some identified risk.

Well, even though the diagnosis that you initially assigned was a low level of risk, because your diagnostic procedures and management options is at the moderate level, your final level of risk would be moderate, because it takes into account the highest level from any one of the three tables-- from any one of the three columns.

So just to recap, the new patient visit codes, there are five of them for your outpatient office encounters, your 99201 to 99205. And we [INAUDIBLE] the webinar by discussing the three components, which we said were history, exam, and medical decision-making. Time is here just to give you a baseline of the average amount of time spent for every code. So in the event you're seeing a patient and you're spending a lot of time counseling the patient, the coding guidelines state that if you're spending more than 50% of the time that is allotted for that code counseling the patient, then you can use counseling as a component in making the decision to go to the next code level.

So let's say for example you were going to assign a 99202 for your new patient, and according to the coding guidelines it says that the average time spent for a 99202 is roughly 20 minutes. So if you're spending 10 to 15 minutes just counseling that patient, then you as the provider can make the decision to increase your code selection to a 99203. But in order to do that, you must document how much time you spent counseling the patient, and you must indicate clearly what you counseled the patient on.

So let's say for example the patient is not complying with taking meds. And you've informed the patient that they need to maybe go see a nutritionist. So if you document spent five minutes counseling the patient on nutrition or 10, 15 minutes counseling the patient on proper nutrition, that they need to go see a nutritionist, that they need to increase their workout regimen, if you document that and it's pertinent to some of the reasons why the patient presented, instead of assigning a 99202, now you have justification for the reason why you're assigning a 99203/

So the established patient visit codes we said are used for your patients whom have seen a doctor in your practice within the past three years. The 99211 is never to be reported by a physician. This code is typically reported by an RN that's working in your practice under your purview. So for example, if an RN is-- if a patient returns for TB to get the TB read, they come in for their blood pressure recheck, those would be typical services that an RN would perform under the scope of a physician once that's documented in the record for the patient when they come in for their revisit.

Your preventive medicine visit service codes. So if you notice when we looked at the Evaluation and Management sick visit codes-- and we call them sick visit codes because most of the time when the patients come in they have a medical condition or an injury or some illness that the physician's going to manage, versus when you look at the preventive medicine visit codes, these codes are used for your well visit encounters.

And there are two types of codes. You have your new patient well visit encounters and your established patient visit encounters. And it follows the same definition of the new versus the established patient. Patients that are seen within a three-year period would be considered an established patient. The patients who have not been seen within a three-year period by a physician in your practice, those would be considered your new patients.

But now if you'll notice, these codes are selected on the basis of the patient's age. So your 99385 codes are for your adult patients between the ages of 18 through 39 years, versus your 99387 codes are your adult codes for your patients that are 65 years of age or older. Now, the preventive medicine visit counseling codes would never be reported together in conjunction with the preventive medicine visit well visit codes, because those services are considered inclusive of the preventive visit codes that you see here on your screen.

And so the next slide are the preventive medicine counseling codes. So these are time-based codes. And these codes are used for patients that are coming in [INAUDIBLE] medicine counseling or risk factor intervention where the physician will not perform a history or any type of a physical exam. So if you'll notice these codes are time-based. And your 99401 is a 15-minute code all the way through your 99403, which is a 60-minute code.

Now, we spoke about counseling in the regular E&M section. These codes are a little different in terms of if a patient is just coming in for counseling, and if you'll notice, it says without a history and without an exam. The regular E&M codes when the patient has a history and their

physical exam as part of their visit that also includes counseling, you would use those E&M codes that we looked at in the earlier slide.

Another type of code that you would be utilizing in your office is the venipuncture code for routine blood work. The CPT code is 36415. When your patients come in for any type of blood, HIV blood screening or any other type of blood work, in addition to the E&M service code that you would be reporting, you would also report the 36415. And so typically, when the venipuncture code is reported, it's typically reported with the 99201-- and that should say 92215, because it encompasses your new and your established patient visit codes, or it's reported with the preventive visit code. And if the patient is coming in for an HIV test where they are also going to provide counseling, then it would be reported with your 99401 through 99403-- I think the slide said 4, so it might be an error here.

So that was a lot of information to cover. So let's see how much you remember. What type of E&M code would you assign when a patient returns following a positive HIV test result? So remember, the patient is returning for their test results. We'll give you a couple of minutes.

Very nice. OK. So now let's discuss the results, because we have some of the webinar participants have selected established patient, which is correct. And then some of the webinar participants selected the counseling visit code, so let's discuss why that one is not correct.

The patient is coming in and now because their results are positive, while there will be a component of the visit where the doctor or another health care professional will counsel the patient, now there is another component that will be included, which is preparation of a treatment plan. So because the health care physician will now spend time talking with the patient, giving them information about their condition, and pertinent details about taking their meds, this is considered an established patient visit. And each visit thereafter, unless it's with a social worker, which we're not really discussing on this call, when the patient comes in to see the physician, there's always going to be one of the established patient visit codes, 99212 through 99215.

And typically, even though the codes on the slide show you the range of codes, typically when the patient comes in for the follow-up visit with the physician, it's going to be a Level II or a Level III. You very rarely would assign a 99214 or -215.

The exception would be if your patient has multiple chronic conditions that you're also managing. So if you're managing a patient that has multiple chronic conditions, depending on the level of services that you're providing, you may be reporting a 99214. If you send the patient from your office to the emergency room, you would report a 99215.

So now let's talk about modifiers. Modifiers are two-digit numeric or alphanumeric-- we call them codes, but they're not really codes, but that's what they're called-- that indicate that a procedure or a service has been altered by a specific circumstance but has not changed the actual code's definition. There are CPT modifiers and their HCPCS modifiers. Now, we haven't

really looked at any HCPCS codes in this series, but in Series 2, we'll spend a lot of time looking at some HCPCS codes and you'll see some of the HCPSCS modifiers that tie into those HCPCS codes.

Some modifiers impact reimbursement. Modifiers are never reported alone, modifiers are never reported on ICD-10 codes, which is covered in Series 3. And for the correct way to report your modifiers, you should follow up with your local Medicaid state agencies or the insurance companies that you participate in for clarification on how you should assign modifiers.

So the two modifiers that we'll look at-- or rather I should say I think there's one here, Modifier 25 is an E&M modifier. The description of this modifier is significant, separately identifiable E&M service by the same physician on the same day of a procedure, service, or other E&M service. So in terms of your Modifier 25, you would only append this to one E&M service.

So let's say for example your patient comes in and they come in for some blood work, or maybe they're presenting for vaccines and some blood work. You should check with your local Medicaid agency and the insurance plans that you participate in, because guidance is very different across the spectrum. Some payers require that a Modifier 25 be appended to the E&M service and some payers do not want the modifier appended. So you really need to check with your agencies or your insurance carriers for clarification on how to report they Modifier 25. But your take-away should be that the Modifier 25 is only appended to your E&M service code.

So let's look at a few case studies so that we can get to some Q&A. So this first case study is an HIV pre-test with preventive medicine. So a 27-year-old patient presents for a visit with their primary care. And they have discussed with their doctor that they recently had unprotected sex. Now PowerPoint Series discusses the CPT codes, specifically the E&Ms. When we get to Series 3, we'll look at the diagnoses that tie in to these services.

So because this was a preventive medicine visit, the final E&M code for this visit is a 99395. And if you go back and you look at your preventive medicine visit codes, you'll recall that these codes are selected on the basis of the patient's age, so 99395 correlates to a patient that's within this age group. And so even though it says that this is a counsel, that the physician spent 35 minutes counseling the patient, this particular service was designated as a preventive medicine visit, so we're using the 99395 to report this service. And as you can see, the final statement says this is an established patient, so that really clarifies the reason for the 99395.

So basically the next slide just gives you the rationale for the reason why we're assigning a 99395. So again, this was an established patient that came in for a preventive visit and they also have HIV testing. And actually there's an error on this slide. We forgot to include the CPT 36415 for the blood work if there was any mention of blood work. But it did say that there was HIV testing, so it could have been a rapid. It could've been blood work. So if it was a rapid, we would still report the Modifier 25 for those payers that require the use of the Modifier 25.

So HIV post-test counseling for a patient with negative results. So if you'll notice, the patient in Scenario 1 returns for their results. And the physician informs the patient that the results are negative. So your code for the counseling for a patient whose results are negative is 99402.

But again, check with your insurance payers, because I'm here on the East Coast, and in New York City, a lot of the payers are not paying or rather I should say not reimbursing for the counseling codes. The exception would be the Medicaid plans. The Medicaid plans are reimbursing for those. But a lot of the payers are not reimbursing for the preventive counseling services.

So your next slide just gives you the rationale for the reason why we're selecting the 99402. So this is for just the return for results. And because the results are negative, this is a counseling service. But it could have very well been reported as a 99212, depending on the insurance carrier that you're reporting the service to. But you wouldn't report the 99385, the 99381 through 99397 codes, because those are your preventive medicine visit codes that describe patients that are coming in for well visits.

So I'm going to-- after we do this scenario, I'm going to stop and turn it back over to Steve so that we have some time for Q&A. So this scenario is an HIV post-test counseling for a patient whose results are positive. So as you can see, the physician spent some time counseling the patient and the prescriptions are dispensed and discussion about the proper use of the medications and explaining to the patient their treatment plan and all of the various options that they had. So this particular visit was coded as a 99213, and the reason why is because the patient has a positive result.

And if you look at the visit, there are some components that are involved. There's medical decision-making, which is the doctor discussing the results. There was a problem-focused history and a problem-focused exam, which is a very brief type of an exam that's performed. And the medical decision-making was the key driver in selecting this 99213, because really and truly, this probably could have been a 99212, one of the lower-level codes.

So I'm going to stop here. And I'll let Steve take over so if anyone has any questions, we can begin to address the questions.

STEVE LUCKABAUGH: OK. Thank you. We'd like to take questions at this time. If you have any questions, please enter them into the Questions pane on the GoToWebinar toolbar, and we will address those.

We have one that reads, would it be appropriate to use a 99211 code when a nurse is giving a patient a repeat vaccine in a series, or a repeat birth control injection? These meds have already been ordered by the provider at the previous visit. We currently only bill for the injection CPT and the medication. Should I also be billing a nurse code 99211?

STACEY L. MURPHY: From a coding perspective, the answer would be yes. But what my recommendation to you would be to check with your payers, because again, there are two layers of rules that we're dealing with. We're dealing with the coding rules and the coding guidelines, and then we're dealing with the payer rules and the payer regulations. Some payers state that they're following the coding guidelines. And since the coding guidelines would tell you to utilize the 99211 in those situations, then you would use that. But the payer may come back and say, well, we only want to see the code that describes the actual service that was performed. So there's always that grey area.

STEVE LUCKABAUGH: OK. That's the only question we've had so far. I'm going to a new-- we have Michael Shankle on the line. I'm going to unmute you in case you wanted to chime in with anything here.

MICHAEL SHANKLE: Stacey, can you talk a few minutes around rejected claims and a little bit-- I know we have some upcoming documentation around that, but when claims are rejected, going back and reviewing those claims?

STACEY L. MURPHY: OK. Sure. So the first thing you want to do when you get your EOBs is you want to review those to determine the reason why those were rejected. Most of the payers provide a very specific explanation of the reason why they may have denied a claim, and some don't. So if you get an EOB that says claim denied and there's no justification, you can always pick up the phone and call the payer and ask them to explain. And they will do their very best to explain the reason why a claim was denied.

So let's say, for example, let's say you did an E&M preventive medicine visit service and you also did some vaccines during that encounter. Well, the coding guidelines say that when you do preventive service and other services, that you should append the Modifier 25. So let's say hypothetically you neglected to append the Modifier 25 to your preventive counseling, your preventive medicine visit and either that service was denied but the other services were paid. Well, the reason why it was denied is because you forgot your modifier.

So now you can go back and do an appeal, or you don't want to resubmit the claim again, because it would just be denied again as A duplicate. So instead of resubmitting the claim, you would go back and do a claims correction, or you would appeal the claim. The quickest way would be to do a claims correction with a cover letter that says you forgot to append the Modifier 25, please process this claim. So that would be my recommendation.

Or let's say you submitted a claim and the diagnosis was incorrect and it was denied for medical necessity. So let's say, for example, you did a well visit on a patient but your diagnoses was for sick-related diagnoses. The diagnosis doesn't support the reason for the visit. So again, you would just go back and do an adjusted claim or an appeal of that claim stating the reason why you feel the claim should be [INAUDIBLE]. Any other questions?

STEVE LUCKABAUGH: Yes. We do have a couple of more questions. If you were coding for the immunodeficiency outpatient clinic and the patient is HIV-positive, would you ever charge for a preventive visit in that clinic or would all visits be an E&M because the patients are coming into this clinic based on their HIV diagnosis?

STACEY L. MURPHY: In the case of the immuno-- you said which clinic? Well, in a nutshell, the well visit codes are typically reported by primary care, internal medicine, family medicine. I can honestly say I've never had any interaction with any other types of providers that are using the well visit codes with the exception of GYNs. So your GYN, your primary care, internal medicine, family medicine, pediatricians, those would be the only physician types that typically report the preventive medicine visit codes. So in that setting, if you're using these codes, and these are not the types of providers that I just mentioned, then you should be using the other E&M service calls, your 99201 through 992015 for those services.

STEVE LUCKABAUGH: OK. And another one is, CDC HIV testing guidelines specify that in clinical settings, HIV screening can be performed without counseling, if the provision of counseling is a barrier to implementing routine testing. Could you reiterate what to do if a lab-based HIV test is performed sans any counseling?

STACEY L. MURPHY: I don't-- off the top of my head, I don't think that there are any restrictions or any guidelines that say you have to report the counseling code. And I think we will be exploring that more in depth when we get to the Series 3, which are your diagnoses codes. The counseling codes that are in this slide are your E&Ms and those are more so for patients that are your high-risk patients that you just want to counsel them or some other risk-based type of a scenario where you are evaluating or treating a patient.

In terms of the diagnoses itself with regards to testing, you don't have to necessarily report the counseling code. But I do believe when we get to Series 3 most of the slides show a pattern of the testing and the counseling code going hand in hand. I hope that kind of answered your question.

STEVE LUCKABAUGH: OK. Thanks. That's all the questions I have right now. Any final thoughts before we wrap it up?

STACEY L. MURPHY: I just want to go back and add, we were talking about E&Ms, and I think I may have overlooked mentioning that with respect to the three key components, all three components must be documented for all new patients. Your established patients, you only need to document two out of the three components. So we said that those components were history, exam, and medical decision-making.

So for all new patients, you want to make sure you have all three components. And for your established patients, most of the times what I've noticed in records, the doctor's given a history. They don't necessarily do an exam, or they do a very, very brief type of an exam, and then the medical decision-making, which entails diagnoses, any of your treatment options,

prescriptions, referrals. So again, your take-away from that should be your medical decision-making is critical. It must be documented on all patient records.

STEVE LUCKABAUGH: All right. Thank you for participating in today's webinar. We hope that you were able to find the information provided useful as you continue your P4C project, and ask that you take a few moments to complete the feedback survey you will receive when you close out of this webinar. You will also receive it via email.

Today's webinar contained a lot of very detailed information, and I know you're going to want to review it again. You're in luck. Today's webinar was recorded, and audio and video versions of the entire webinar, as well as the slides from today's webinar, will be available on the P4C website within the next few weeks.

Copies of all our prior P4C webinars are currently available on the website, on the P4C Resource Materials page, at p4chivtac.com. You will need to log in to access the materials. If you need login credentials, send an email to p4chivtac@mayatech.com.

Also, a reminder that Part 2 of this series will be next Tuesday, December 1, at the same time, 3:00 PM Eastern time. Part 3 will be on December 14, and Part 4 will be on December 18. So be sure to register for each session. Registration information will be sent out via the listserv, so be on the lookout for that.

Thank you again for participating in today's webinar. And thank you, Stacey, for that excellent presentation. If you have any additional questions for the P4C project, or for Stacey, please email us at p4chivtac@mayatech.com. Thanks, and take care, everybody.