E/M Coding:

Learn It Now
or
Learn It The Hard Way

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Special Thanks to Dr. Charles Mabry
Portions adapted from UCSF Website

medicine.ucsf.edu/resources/docs/DOM_FY06COMPLIANCETRAININGMODULE.ppt -
Efficient Coding-
Where to find and claim lost revenue?

- Initial evaluation and management (E&M) services are not being documented on every surgical case
- Level of E&M service provided doesn’t always match the documentation or level charged (many charges are too low)
- Use of E&M coding in global period and modifiers is sub-optimal
E&M coding guidelines

- 1995- original documentation guidelines (DG) developed
- 1997- revised DG published- “bullets”
- Can use either 1995 or 1997 DG’s
- Rule: What is documented = what was done
- Time can be used by itself (no “bullets”)
E&M coding guidelines

Three main components:

- History, Physical Exam, Decision Making
- Initial new patient visit or consult - need three
- Established patient - need two out of three

MD can incorporate all available and attached documents into E&M service by reference -

- Personal, family, social history completed by patient or nurses
- Other MD consults, history & physical exams

Portions of the history can also count as items in family / social history or the review of systems
Seven Components of an E&M Code

1. History
2. Physical Examination
3. Medical Decision Making

**Contributory Components:**

- Time
- Counseling
- Coordination of Care
- Nature of Presenting Problem
History
Chief Complaint (CC)

Examples:

- 31 y/o female presents today w/severe shortness of breath
- 55 y/o male presents today w/severe chest pain
- 70 y/o man w/ asthma, GERD and pneumonia presents with cough, fever shortness of breath
- Not sufficient with just a statement patient is here for follow up
History of Present Illness (HPI): Always Get 4!

The following 8 elements are recognized:

- Location: low back pain
- Quality: describes discomfort as: pressure
- Severity: severity of condition is worsening
- Duration: condition has existed for one month
- Timing: pain is worse in the morning
- Context: pain occurred after lifting baby
- Modifying Factor: Tylenol does not help
- Associated signs and symptoms: pain radiating to the arm and shortness of breath

Requires 4+ or more HPI elements for the comprehensive level

Stating No Modifying factors, No Associated Signs/symptoms, patient not sure of duration counts!
Example HPI

CC: abdominal pain

- Location: RUQ
- Quality: Intermittent, sharp
- Severity: moderate
- Duration: started 2 days ago
- Timing:
- Context: worse with fatty foods
- Modifying Factors: not relieved by antacids
- Associated signs and symptoms: nausea

- 4 + HPI elements documented
Example HPI

CC: Painless Jaundice

- Location:
- Quality:
- Severity: moderate
- Duration: one month duration
- Timing:
- Context:
- Modifying Factors: none
- Associated signs and symptoms: itching

- 4 + HPI elements documented
Example HPI

CC: MVA with closed head injury

- History unobtainable because patient is intubated and GCS 3T.

- 4 + HPI elements documented
Review of Systems (ROS)

- **A problem pertinent** ROS identified, through a series of questions, inquires about the system directly related to the problem.

- **Extended ROS** must identify the positive responses and pertinent negatives for at least (2) and not more than (9) systems.

- **Complete ROS ten organ systems** must be reviewed. The attending physician may use "All other systems negative" when (2) pertinent positives and/or negatives are documented. In absence of such a notation, all systems must be documented.

- If unable to obtain, document why. If the patient is unable to communicate due to mental state or language barrier "ROS unavailable due to ....." unconscious, intubated, poor historian.
ROS

1. General/Constitutional
2. Eyes
3. Head/Neck
4. Hematology/Lymphatic
5. Heart
6. Lung
7. Musculoskeletal
8. GI
9. GU
10. Neuro
11. Psych
12. Reproductive
13. Skin
ROS Notations

- **Acceptable notations:**
  - Pulmonary: cough x4 weeks, otherwise negative.
  - Cardiac: negative except for c/o fatigue
  - Notation of pertinent positives and negative for several systems then statement “all other systems negative”
  - Note at least 2 systems and then “all other systems negative”

- **Unacceptable notations:**
  - ROS negative
  - Pulmonary: positive
  - ROS noncontributory
For a complete ROS ten organ systems must be reviewed.

The attending physician may use “remainder of the review of systems are negative” when (2) pertinent positives and/or negatives are documented.

In absence of such a notation, all systems must be documented.

Applies to CPT codes: 99222, 99223, 99254, 99255 which require 10 + ROS.
Review of Systems (ROS)

Patient has the following complaints:
- **Constitutional**: fevers, chills and night sweats
- **Eyes**: she also complains of itchy eyes
- **ENT**: nasal congestion, drainage from ear
- **Respiratory**: she reports shortness of breath
- **Cardiovascular**: left sided chest pain
- **Gastrointestinal**: diarrhea, constipation, abdominal pain
- **Genitourinary**: blood in urine
- **Allergies**: allergic to cypress, pine nuts, peanuts

*Did not state*: Remainder of the review of systems are negative

8 documented, requires 10 +
Example: ROS

- Patient has nausea and right upper quadrant pain, no pulmonary or cardiac complaints, and:
  - “The remainder of the review of systems are negative.”
  - 2 systems + all other systems negative = ROS 10+
Past, Family and Social History (PFSH)

- **Past** - Describe the patient’s past experiences examples:
  - Current medications
  - Past illnesses/injuries/trauma
  - Dietary status/Allergies
  - Operations/hospitalizations

- **Family** – Medical events in the patient’s family examples:
  - Health status or cause of death of siblings/parents
  - Hereditary/high risk diseases
  - Diseases related to the chief complaint, HPI, ROS

- **Social** – Describes age appropriate past and current activities examples:
  - Living arrangements
  - Marital status
  - Drug or tobacco use
  - Occupational/educational history
SUMMARY: HPI

Each type history includes some or all of the following Elements:

CC: Chief Complaint
HPI: History of present illness (4 elements)
ROS: Review of Systems (10 systems or 2 + all others neg)
PFSH: Past, family and/or social history (all 3)

1) Problem focused: HPI 1-3, ROS 1
2) Expanded problem focused: HPI 1-3, ROS 1, PFSH 1
3) Detailed: HPI 4+, ROS 10+, PFSH 3
4) Comprehensive: HPI: 4+, ROS 10+, PFSH 3

... Every HPI can easily be COMPREHENSIVE!
Physical Exam
Documenting Physical Exam

- Noting “negative” or “normal” is sufficient to document normal findings in unaffected areas.
- Note specific abnormal & relevant negative findings of the examination of the affected or symptomatic body area (s) or organ system (s) should be documented. A notation of “abnormal” without elaboration is insufficient.
- Describe abnormal or unexpected findings of body areas or organ systems.
# Physical Exam

<table>
<thead>
<tr>
<th>Level</th>
<th>Bullet Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>1-5</td>
</tr>
<tr>
<td>Expanded Problem</td>
<td>³ 6</td>
</tr>
<tr>
<td>Detailed</td>
<td>³ 12 bullet points from ³ 2 systems</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>All bullet points from ³ 9 systems and Document 2 bullet points from 9 areas</td>
</tr>
</tbody>
</table>
PHYSICAL EXAM (Check at least 2 elements from at least 9 systems for comprehensive; at least 12 total bullet points for detailed)

1. Constitutional
   - Vital Signs (at least 3) T: _______ P: _______ R: _______ BP: _______ Height: _______ Weight: _______
   - Normal □ Abnormal □ General Appearance

2. Eyes:
   - Normal □ Abnormal □ Inspection of conjunctiva and lids
   - Normal □ Abnormal □ Examination of pupils and irises (e.g. reaction to light and accommodation)
   - Normal □ Abnormal □ Ophthalmoscopic examination

3. Ears, Nose, Mouth & Throat
   - Normal □ Abnormal □ External inspection of ears and nose
   - Normal □ Abnormal □ Inspection of lips, teeth and gums
   - Normal □ Abnormal □ Assessment of hearing
   - Normal □ Abnormal □ Inspection of nasal mucosa, septum, turbinates
   - Normal □ Abnormal □ Examination of oropharynx: oral mucosa, salivary glands, palates, tongue, tonsils,
   - Normal □ Abnormal □ Otoscopic exam

4. Neck
   - Normal □ Abnormal □ Examination of neck (e.g. masses, symmetry, tracheal position)
   - Normal □ Abnormal □ Examination of thyroid

5. Respiratory
   - Normal □ Abnormal □ Respiratory effort
   - Normal □ Abnormal □ Palpation of chest (e.g. tactile fremitus)
   - Normal □ Abnormal □ Percussion of chest (e.g., dullness, hyperresonance)
   - Normal □ Abnormal □ Auscultation of lungs

6. Cardiovascular
   - Normal □ Abnormal □ Palpation of heart (e.g. location, size, thrills)
   - Normal □ Abnormal □ Extremities for edema and/or varicosities
   - Normal □ Abnormal □ Auscultation of Heart (abnormal sounds or murmurs)
   - Normal □ Abnormal □ Abdominal aorta (e.g. size, palpable mass, bruits)
   - Normal □ Abnormal □ Carotid arteries (e.g. pulse amplitude, bruits)
   - Normal □ Abnormal □ Femoral arteries (e.g. pulse amplitude, bruits)
   - Normal □ Abnormal □ Pedal pulses
7. Gastrointestinal
- Normal  Abnormal  Examination of abdomen for masses, tenderness
- Normal  Abnormal  Examination of liver and spleen
- Normal  Abnormal  Examination for hernias
- Normal  Abnormal  Examination of anus, rectum
- Normal  Abnormal  Stool sample for hemoccult

8. Skin
- Normal  Abnormal  Inspection of skin and SQ tissue
- Normal  Abnormal  Palpation of skin and SQ tissue

9. Lymphatic (palpation of lymph nodes in 2 or more areas)
- Normal  Abnormal  Neck
- Normal  Abnormal  Axillae
- Normal  Abnormal  Groin
- Normal  Abnormal  Epitrochlear
- Normal  Abnormal  Popliteal

10. Chest (Breasts)
- Normal  Abnormal  Inspection of breasts (e.g. symmetry, nipple discharge)
- Normal  Abnormal  Palpation of breasts and axillae (e.g. masses, tenderness)

11. Psychiatric
- Normal  Abnormal  Mood and affect (e.g. depression, anxiety, agitation)
- Normal  Abnormal  Orientation to time, place and person
- Normal  Abnormal  Recent and remote memory
- Normal  Abnormal  Description of judgement and insight

12. Neurologic
- Normal  Abnormal  Examination of sensation (e.g. by touch, pin, vibration)
- Normal  Abnormal  Examination of deep tendon reflexes
- Normal  Abnormal  Cranial nerve testing
13. Musculoskeletal
- Normal  Abnormal  Examination of gait and station
- Normal  Abnormal  Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis)
Examination of joints, bones and muscles of one or more of the following 6 areas (check all that apply)
- Head/neck  Spine, ribs and pelvis  Right upper extremity  Left upper extremity
- Right lower extremity
- Left lower extremity
- Normal  Abnormal  Inspection and/or palpation for alignment, symmetry, crepitation, defects, tenderness
- Normal  Abnormal  Assessment of range of motion with notation of any pain, crepitation or contracture
- Normal  Abnormal  Assessment of stability with notation of any dislocation, subluxation or laxity
- Normal  Abnormal  Assessment of muscle strength and tone

14. GU (Male)
- Normal  Abnormal  Exam of scrotal contents (e.g. testicular mass, hydrocele)
- Normal  Abnormal  Examination of the penis
- Normal  Abnormal  Digital rectal exam of prostate

15. GU (Female)
- Normal  Abnormal  Pelvic examination including:
- Normal  Abnormal  Exam of external genitalia and vagina
- Normal  Abnormal  Exam of urethra
- Normal  Abnormal  Exam of the bladder
- Normal  Abnormal  Cervix
- Normal  Abnormal  Uterus
- Normal  Abnormal  Adnexa/Parametria
Physical Exam: 16 Bullet Points without ever touching the patient!

1. General
2. Vital Signs
3. Inspection of conjunctivae and lids
4. Examination of pupils and irises
5. External inspection of ears and nose
6. Assessment of Hearing
7. Inspection of lips, teeth and gums
8. Assessment of respiratory effort
9. Extremities for edema and varicosities
10. Inspection of breasts
11. Gait and Station
12. Inspection of digits and nails
13. Inspection of Skin
14. Judgment and Insight
15. Orientation
16. Mood and affect
Physical Exam: 7 Bullet Points by barely touching the patient (no stethoscope)!

1. Percussion of chest (dullness, hyperresonance)
2. Palpation of chest (tactile fremitus)
3. Palpation of heart (location, size, thrills)
4. Examination of neck (massses, symmetry, tracheal position, crepitus)
5. Examination of thyroid
6. Cervical lymph nodes
7. Carotid pulse
Typical Exam

- **General:** WDWN WM NAD
- **HENT:** NC/AT
- **Eyes:** PERRLA
- **Neck:** No masses
- **Cardiovascular:** RRR no M/R/G
- **Respiratory:** Clear to auscultation.
- **GI:** Abdomen is soft, non-tender, no masses
- **Ext:** No C/C/E
- **Neurologic:** There are no focal deficits

Expanded Problem Focused, no better than 6 bullet points.
Medical Decision Making

Crack:
What someone was on when they developed these requirements.
Medical Decision Making

Three Categories:

- Number and severity/risk of diagnoses/treatment options
- Risk of Complications, Morbidity, Mortality
- Amount and/or Complexity of Data and Diagnostic procedures
Medical Decision Making (MDM)

Four levels:
- Straightforward
- Low complexity
- Moderate complexity
- High complexity

Two of the three areas:
- Dx. Options
- Amount of Data
- Risk

Establish the MDM Level

<table>
<thead>
<tr>
<th>Dx./mgt. options</th>
<th>0-1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of data</td>
<td>0-1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Overall risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Level of MDM</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>99251 99252</td>
<td>99221 99231 99253</td>
<td>99222 99232 99254</td>
<td>99223 99233 99255</td>
</tr>
</tbody>
</table>
## Medical Decision-Making (MDM)

<table>
<thead>
<tr>
<th>Number of Diagnosis &amp; Treatment Options</th>
<th>Points</th>
<th>No. of problems</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor stable, improved or worsening, (maximum of 2 )</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Established problem to examiner; stable or improved</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Established problem (to examiner); worsening</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New Problem (to examiner) no additional workup planned, maximum of 1</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New Problem to examiner additional workup planned</td>
<td>4</td>
<td>New</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total Points</strong></td>
<td></td>
<td></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>
## Risk of Complications, M&M

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedures ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Σ One self-limited or minor problem (e.g. cold, insect bite, tinea corporis)</td>
<td>Blood tests, CXR, EKG, UA, U/S, KOH Prep</td>
<td>Rest, gargles, superficial dressings, elastic bandages</td>
</tr>
</tbody>
</table>
| Low           | Σ Two or more self-limited or minor problems  
Σ One stable chronic illness  
Σ Acute uncomplicated illness (e.g. cystitis, simple sprain) | Contrast imaging studies (CT, barium enema, UGI)  
Superficial needle biopsy (eg, FNA)  
Skin biopsy  
PFTs, ABG | Σ Minor surgery with no identified risk factors  
Σ OTC drugs,  
Σ PT, OT,  
Σ IV fluids |
| Moderate      | Σ Undiagnosed new problem with uncertain prognosis (e.g. lump in breast, abdominal pain)  
Σ Acute complicated injury (e.g. head injury with brief loss of consciousness)  
Σ One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment  
Σ Two or more stable chronic illnesses  
Σ Acute illness with systemic symptoms (e.g. pyleonephritis, pneumonia, colitis) | Diagnostic endoscopy with no identified risk factors  
Deep needle or incisional biopsy  
Arteriogram or cardiac cath  
Obtain fluid from body cavity (eg, thoracentesis) | Σ Minor surgery with identified risk factors  
Σ Elective major surgery with no identified risk factors  
Σ Prescription drugs  
Σ IV fluids with additives  
Σ IV Antibiotics |
| High          | Σ Acute or chronic illnesses or injuries that may pose a threat to life or bodily function (e.g. cancer, multiple trauma, PE, organ failure, jaundice, MI)  
Σ One or more chronic illnesses with severe exacerbation, progression or side effects of treatment  
Σ An abrupt change in neurologic status (e.g. severe CHI) | Diagnostic endoscopies with identified risk factors  
Therapeutic endoscopy  
Cardiac cath | Σ Elective major surgery with identified risk factors  
Σ Emergency major surgery  
Σ IV or IM Narcotics/controlled substances  
Σ Drug therapy requiring toxicity monitoring  
Σ DNR order |
## Medical Decision Making

### Data Elements

<table>
<thead>
<tr>
<th>Amount and/or Complexity of data reviewed</th>
<th>Points</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Points are assigned to each section below based on the number of data items reviewed max = 4 pts</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of clinical labs</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Review and/or order of Xray tests</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Discussion of diagnostic study w/interpreting MD</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtaining history From someone other than the patient</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Review and summarization of old records or gathering data from source other than patient</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total Points</strong></td>
<td><strong>3</strong></td>
<td></td>
</tr>
</tbody>
</table>

10/4/10
Data Reviewed

- **Laboratory Studies**: white count 11.9, hematocrit 30.8, glucose 380 (1 pt.)
- **CHEST X-RAY** – which I reviewed: diffuse interstitial pattern in both lungs (2pts)
- **EKG**: ordered (1pt)
## Medical Decision Making Data Elements

**Dx./mgt. options:**
- Chest Pain, Shortness of Breath

**Amount of data:**
- Chest X-Ray personally reviewed
- EKG
- Lab studies

**Overall Risk:**
- PATIENT IS FULL CODE
- Decision making total: 2 of the 3 must be meet

<table>
<thead>
<tr>
<th>Dx./mgt. options</th>
<th>0-1</th>
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<td>4</td>
</tr>
<tr>
<td>Overall risk</td>
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<td>Low</td>
<td>Moderate</td>
<td>4</td>
</tr>
<tr>
<td>Level of MDM</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High 99223, 99233, 99255</td>
</tr>
</tbody>
</table>

10/4/10
### Final Result for Medical Decision Making

Circle the point scores from the three categories above, A, B, C. The row with 2 equivalent point scores indicates the final complexity of medical decision making. If no row contains 2 equivalent point scores, the middle score indicates the final medical decision making complexity, the middle score circled (or second one from the top) indicates the final complexity of decision making.

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Points from: A. Number of Diagnoses or Treatment Options</th>
<th>Points from: B. Risk of Complications, Morbidity, Mortality</th>
<th>Points from: C. Amount and Complexity of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>High Complexity</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
Inpatient CPT Codes

- Admission (admit, H&P) 99221 – 99223
- Subsequent care (per day) 99231 – 99233
- Inpatient consultation 99251 - 99255
- Discharge (last day) 99238 - 99239
Consultations 99241-99245

An E/M service must meet the “three R’s” in order to be billed as a consultation:

- A request from a provider must be documented in the patient’s record;
- The receiving provider must render the service and
- The consulting provider must prepare and send a written report of his/her findings back to the requesting provider.
Consultation Phrases

- Mr. Patient is seen in consultation at the request of Dr. Welby for evaluation of abdominal pain.

- Thank you for allowing me to consult and assist in care of your patient.

- **WRONG:** Mr. Patient referred by Dr. Jones for management of pulmonary hypertension
Coding by Time

- Time can also be your ally for non-critical care E&M codes
  - Use the “Counseling and coordination of care” section of the E/M Services Guidelines to properly code for work provided to trauma patients
  - “When counseling and /or coordination of care dominates (more than 50%) the physician / patient /family encounter (face-to-face time), then time may be considered the key or controlling factor to qualify for a particular level of E/M services.”

- Counseling / coordination < 50% of time spent-
  Documentation Guidelines apply
- Counseling / coordination > 50% of time spent-
  Time applies
Coding by Time

Documenting Time:

- If the physician elects to report In cases where counseling and/or coordination of care dominates more than 50% of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital), time is considered the key or controlling factor to qualify for a particular level of E&M service.

- The level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and recorded, the documentation should describe the nature of the counseling and/or activities to coordinate care.
Counseling & Coordination of Care

Counseling is a discussion with the patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies;
- Prognosis, risks and benefits of management (treatment) options; instructions for management and/or follow-up; importance of compliance with chosen management options;
- Risk factor reduction; and patient family education
## E&M coding guidelines - Time

<table>
<thead>
<tr>
<th>CPT code</th>
<th>2003 MFS Descriptor</th>
<th>Standard Time (minutes)</th>
<th>Coordination/counseling &gt;50% time</th>
<th>Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td>Office/outpatient visit, est</td>
<td>25</td>
<td>13</td>
<td>$ 56.65</td>
</tr>
<tr>
<td>99215</td>
<td>Office/outpatient visit, est</td>
<td>40</td>
<td>20</td>
<td>$ 91.23</td>
</tr>
<tr>
<td>99222</td>
<td>Initial hospital care</td>
<td>50</td>
<td>25</td>
<td>$ 109.25</td>
</tr>
<tr>
<td>99223</td>
<td>Initial hospital care</td>
<td>70</td>
<td>35</td>
<td>$ 151.92</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent hospital care</td>
<td>25</td>
<td>13</td>
<td>$ 54.07</td>
</tr>
<tr>
<td>99233</td>
<td>Subsequent hospital care</td>
<td>35</td>
<td>18</td>
<td>$ 76.88</td>
</tr>
<tr>
<td>99253</td>
<td>Initial inpatient consult</td>
<td>55</td>
<td>28</td>
<td>$ 96.01</td>
</tr>
<tr>
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<td>Initial inpatient consult</td>
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<td>40</td>
<td>$ 137.95</td>
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<td>Initial inpatient consult</td>
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<td>55</td>
<td>$ 189.81</td>
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<tr>
<td>99356</td>
<td>Prolonged service, inpatient</td>
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<td>$ 87.18</td>
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<tr>
<td>99357</td>
<td>Prolonged service, inpatient addnl. 30 min</td>
<td>30</td>
<td></td>
<td>$ 87.55</td>
</tr>
</tbody>
</table>

Time calculated is for a 24 hour period.
## E&M coding guidelines - Time

<table>
<thead>
<tr>
<th>CPT code</th>
<th>2003 MFS Descriptor</th>
<th>Standard Time (minutes)</th>
<th>Coordination / counselin &gt;50% time</th>
<th>Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td>Office/outpatient visit, est</td>
<td>25</td>
<td>13</td>
<td>$ 56.65</td>
</tr>
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<td>Office/outpatient visit, est</td>
<td>40</td>
<td>20</td>
<td>$ 91.23</td>
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<tr>
<td>99222</td>
<td>Initial hospital care</td>
<td>50</td>
<td>25</td>
<td>$ 109.25</td>
</tr>
<tr>
<td>99223</td>
<td>Initial hospital care</td>
<td>70</td>
<td>35</td>
<td>$ 151.92</td>
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<td>25</td>
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<td>$ 54.07</td>
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<td>99356</td>
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<td>30</td>
<td></td>
<td>$ 87.55</td>
</tr>
</tbody>
</table>
When Time Trumps HPI, PE & MDM

Time-based service in an inpatient setting:

— Time spent with an inpatient by other members of the care team, cannot be used toward the total service time or counseling and coordination of care.

— Physician must be in the patient’s hospital unit for the total service, office time does not count.

— The total length of the service, and the total length of time spent specifically on counseling and/or coordination of care and what was discussed must be documented.
Time Based service

Allowable floor time would be time spent:

- Discussing an inpatient’s progress with other health care professionals involved with the care of the patient or pulling up and reviewing the patient’s medical records on the hospital computer.

- Time spent on coordination of care with the patient’s family in the inpatient setting is also countable only when it is necessary to get information from the family to formulate a plan of care.
Subsequent Hospital Visits

- **99231**: Stable and recovering without new problems, with discharge planning imminent.
- **99232**: Patients are not responding as quickly or adequately to treatment as expected, or developed minor to moderate complications.
- **99233**: Severe or unstable patients, developed significant complication or a significant new problem.
## What Difference Does It Make?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Typical Charge</th>
<th>Medicare Allowable</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>INITIAL HOSPITAL VISIT 30 MINS</td>
<td>$225</td>
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</tr>
<tr>
<td>99222</td>
<td>INITIAL HOSPITAL VISIT 50 MINS</td>
<td>$375</td>
<td>103.44</td>
</tr>
<tr>
<td>99223</td>
<td>INITIAL HOSPITAL VISIT 70 MINS</td>
<td>$550</td>
<td>144.10</td>
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</tbody>
</table>
Teaching Physician Documentation Requirements
Proper Teaching Physician Attestation

- The teaching physician must document their presence and participation for any service which s/he will be billing.

- The TP note alone or a combination of resident and TP note may be used to support the level of service billed.

- A resident or fellow cannot document the TP’s presence.

- The attestation may be dictated, typed, or handwritten.
Teaching Physician Attestation

— “I have seen and examined the patient. I have discussed the case with the resident/fellow and agree with the findings and treatment plan as documented”.

— “I have seen and examined the patient. I have discussed the case with the resident/fellow and agree with the findings and treatment plan as documented, except…”
Teaching Physician Rules for Evaluation & Management Services

The following are examples of **unacceptable** TP linking statements (with signature):

- Agree with above
- Rounded, reviewed and agree
- Discussed with resident and agree
- Seen and agree
- Patient seen and evaluated
- Countersignature alone

- The Teaching Physician must personally provide the statement, not the Resident
Conclusions

Why is the E/M Coding system so complex?

- They don’t want you to get the money
- They know you won’t spend the time to figure it out
- They know you will throw away money every day

Don’t let them win.
Play their game to win.
E&M Coding & Reimbursement
What Residents Need to Know

Charles Mabry MD, FACS
Efficient Coding-
Where to find and claim lost revenue?

- Initial evaluation and management (E&M) services are not being documented on every surgical case
- Level of E&M service provided doesn’t always match the documentation or level charged (many charges are too low)
- Use of E&M coding in global period and modifiers is sub-optimal
Efficient Coding-
Where to find and claim lost revenue?

- Education about CPT, ICD-9, and global period
- Review correct way to document and code evaluation and management (E&M) codes
- Improved use of E&M codes:
  - Non-operative management
  - Within the global surgical period
- How and when to use modifiers
- Resident teaching guidelines and billing
- Putting it all together: Impact of efficient coding upon your practice
ICD-9 coding

- ICD-9 used to code diagnosis (vol. 1)
- ICD-9 also used to code procedures (vol. 3)
- Used on CMS 1500 (for physician claims) to describe diagnosis or why a particular service was performed
- Use of different ICD-9 code than “operative” ICD-9 for E&M services in the global period
Current Procedural Terminology - CPT codes

- 4th Edition - currently in use
- American Medical Association - has copyright and ownership of codes

General structure of code:
- Five digit code
- Descriptor
- Modifiers
- Code numbers arranged in families of similar procedures
- Ex- 44140 Colectomy, partial; with anastomosis
E&M coding guidelines

- 1995 - original documentation guidelines (DG) developed
- 1997 - revised DG published - “bullets”
- Can use either 1995 or 1997 DG’s
- Rule: What is documented = what was done
- Time can be used by itself (no “bullets”)
E&M coding guidelines

• Three main components:
  ✷ History, Physical Exam, Decision Making
  ✷ Initial new patient visit or consult- need three
  ✷ Established patient- need two out of three

• MD can incorporate all available and attached documents into E&M service by reference-
  ✷ Personal, family, social history completed by patient or nurses
  ✷ Other MD consults, history & physical exams

• Portions of the history can also count as items in family / social history or the review of systems
Lesson #1 -

- ATLS initial & secondary assessment for multiple trauma count as an upper level E&M code
- Need to document history, physical exam, and medical decision making in medical record
- Can incorporate nursing / EMT information into history by notation

<table>
<thead>
<tr>
<th>CPT code</th>
<th>2004 MFS Descriptor</th>
<th>Medicare Payment</th>
</tr>
</thead>
<tbody>
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<td>99221</td>
<td>Initial hospital care</td>
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<td>$ 111.27</td>
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<tr>
<td>99223</td>
<td>Initial hospital care</td>
<td>$ 154.95</td>
</tr>
</tbody>
</table>
Lesson #2-

- Complexity of decision-making determines whether you code either the higher or highest-level code
- Most multiple trauma or emergency surgery qualifies for the highest level of decision-making
- Decision-making has three components:
  - the number of diagnosis or treatment options,
  - the amount and/or complexity of data to be reviewed,
  - the risk of complications, morbidity or mortality
Lesson #2- Complexity of Decision Making

Table of Risk- 1995 E&M Guidelines

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem (s)</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>• Acute complicated injury,</td>
<td>• Minor surgery with identified risk factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Elective major surgery with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>• Acute illnesses or injuries that pose a threat to life or bodily function An abrupt change in neurologic status</td>
<td>• Elective major surgery with identified risk factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Emergency major surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• IV narcotics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
Lesson #2- Complexity of Decision Making

Assume you have documented a standard ATLS initial and secondary evaluation with MD orders. What initial encounter code do you pick?

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Diagnosis / management options</th>
<th>Complexity of data to be reviewed</th>
<th>Complications, morbidity or mortality</th>
<th>Hospital, initial encounter</th>
<th>Hospital consult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>99221</td>
<td>99253</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>99222</td>
<td>99254</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>99223</td>
<td>99255</td>
</tr>
</tbody>
</table>

10/4/10
Lesson #4 -

- Proper knowledge and use of the Critical Care Codes (CPT 99291-2) can be rewarding
- Time 30 – 74 minutes = 99291
- Time over 74 minutes = 99292 per 30 minute increments
- Time spent at bedside of patient or immediately available, can be non-continuous time
- Includes time spent for coordination of care with other MDs, obtaining history from others, family counseling and discussion of care plan
- Can be combined with other E&M codes on same day (i.e.- deterioration of patient)
Lesson #5-

- Time can also be your ally for non-critical care E&M codes
- Use the “Counseling and coordination of care” section of the E/M Services Guidelines to properly code for work provided to trauma patients
- “When counseling and/or coordination of care dominates (more than 50%) the physician/patient/family encounter (face-to-face time), then time may be considered the key or controlling factor to qualify for a particular level of E/M services.”

- Counseling / coordination < 50% of time spent - Documentation Guidelines apply
- Counseling / coordination > 50% of time spent - Time applies
## E&M coding guidelines- Time

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<thead>
<tr>
<th>CPT code</th>
<th>2003 MFS Descriptor</th>
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<tbody>
<tr>
<td>99214</td>
<td>Office/outpatient visit, est</td>
<td>25</td>
<td>13</td>
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</tr>
<tr>
<td>99215</td>
<td>Office/outpatient visit, est</td>
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<td>99222</td>
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<td>Prolonged service, inpatient</td>
<td>30</td>
<td></td>
<td>$87.55</td>
</tr>
</tbody>
</table>
Global Period Concept

- Global concept- includes surgery plus pre- & post-operative care normally associated with procedure
- 0 day global procedures- day of surgery
- 10 day global procedures- day of surgery plus 9 days post op
- 90 day global procedures-
  - Pre-operative visits day of surgery
  - Typical E&M services during hospital stay
  - Typical post-operative care for 90 days
Global Period

Remember: It varies

- Medicare, BC/BS, United Health- 90 days-
- all related services within 90 days of surgery
- Some commercial insurance- 10 days
- Medicaid (some states)- 10 days
- Global modifiers useful for global period-
  - 24 & 25,
  - 57 & 58,
  - 78 & 79
CPT Coding Tips-
Proper use of Modifiers

° Modifier 24- E&M service provided post-op in global period for unrelated diagnosis / reasons.
  ✤ Needs different ICD-9 code than operation

° Modifier 25- Significant, separately identifiable E&M service on same day as 0 or 10 day global surgery
Lesson #6- Proper use of –24 & -25 Modifiers

Impact of correct coding: Assume that a general surgeon performs about 800 cases per year

Assume that 10% of those cases will have some type of medical / unrelated problem in the same day or post-operative global period

Assume that half are covered with Medicare and half with commercial insurance
## Impact of -24 & -25 Modifier

<table>
<thead>
<tr>
<th>CPT</th>
<th>Cases</th>
<th>% other problems</th>
<th>E&amp;M</th>
<th>Medicare BC/BS</th>
<th>Medicare</th>
<th>BC/BS</th>
</tr>
</thead>
<tbody>
<tr>
<td>800</td>
<td>10%</td>
<td>80</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>Office/outpatient visit, est</td>
<td>40</td>
<td>20</td>
<td>20</td>
<td>$626.82</td>
<td>$827.20</td>
</tr>
<tr>
<td>99214</td>
<td>Office/outpatient visit, est</td>
<td>40</td>
<td>20</td>
<td>20</td>
<td>$1,030.51</td>
<td>$1,355.20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,657.33</td>
<td>$2,182.40</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Total per surgeon</strong></td>
<td><strong>$3,839.73</strong></td>
<td></td>
</tr>
</tbody>
</table>

10/4/10
Lesson #7-
Proper use of Modifier -57

• Modifier 57- E&M service that results in a decision to operate (90 global) on the same day as the initial encounter (office, ER, or consult)

• Remember - If operation is 0 or 10 day global, use –25 modifier for E&M code

• Impact of correct coding: Assume that 10% of operations are urgent or emergent and –57 can be used

• Assume that half are covered with Medicare and half with commercial insurance
## Impact of –57 Modifier

<table>
<thead>
<tr>
<th>CPT</th>
<th>Cases</th>
<th>% other problems</th>
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<tr>
<td>800</td>
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<td>10%</td>
<td>80</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99253</td>
<td>Initial inpatient consult</td>
<td>40</td>
<td>20</td>
<td>20</td>
<td>$2,501.66</td>
<td>$3,300.00</td>
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<td>99254</td>
<td>Initial inpatient consult</td>
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<td>$6,344.98</td>
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<td>$8,368.80</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total per surgeon</td>
<td></td>
<td></td>
<td></td>
<td>$14,713.78</td>
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</table>
Combined Impact of -24, -25, & -57 Modifiers per surgeon

<table>
<thead>
<tr>
<th>CPT</th>
<th>Cases</th>
<th>% other problems</th>
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<table>
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<td>80</td>
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<td>$14,713.78</td>
<td></td>
</tr>
</tbody>
</table>

$18,554
Potential increased income per surgeon
CPT Coding Tips- Proper use of Modifiers

- Modifier 58- Staged (Related) Procedure by same MD during post-op global period
- Modifier 78- Return to OR for Related procedure during post-op global period
- Modifier 79- Return to OR for Unrelated procedure during post-op global period
CPT Coding Tips-
Proper use of Modifiers

Modifier 58 - Staged (Related) Procedure by same MD during post-op global period
- Not used for complication requiring return to OR
- Procedure planned prospectively at initial procedure (ex- diverting colostomy – closure)
- More extensive than initial procedure (ex- Excision of SCC – wider re-excision + margins)
- Therapeutic procedure following initial diagnostic procedure (ex- lumpectomy + SNLD following positive breast biopsy)
CPT Coding Tips-
Proper use of Modifiers

 Modifier 78- Return to OR for Related procedure during post-op global period
  - Used for complication requiring return to OR
  - Payment made only for intra-op portion (60-80%)
  - Complication not requiring return to OR- use EM code if you are not operating surgeon

 Modifier 79- Return to OR for Unrelated procedure during post-op global period (ex- Splenectomy post MVA, with Omentopexy for perforated duodenal ulcer a week later)
What’s New In CPT codes?

- Skin excision codes- method of description
- Previous method- paid based upon size and character of lesion excised
- New method- paid based upon size of excision and character of lesion
- Payment has been adjusted to new method of description- March 2003
Excision codes -

- 10000 series - used for skin only
- 19000 series - used for breast only
- 20000 series - used for SQ, muscle, fascia, bone
- Thorax / Abdomen - use 30000 – 40000 series codes

- Excision - includes simple repair

- Repair -
  - Simple, intermediate, complex
  - Advancement Flap
  - Pedicle, skin graft, myocutaneous
Excision benign lesions-
 rules of coding

- Excision is defined as full-thickness (through the dermis) removal of a lesion, including margins, and includes simple (non-layered) closure when performed.

- The margins refer to the most narrow margin required to adequately excise the lesion, based on the physician's judgment. The measurement of lesion plus margin is made prior to excision.

- The excised diameter is the same whether the surgical defect is repaired in a linear fashion, or reconstructed (e.g., with a skin graft, flap, etc.).
Excision malignant lesions—rules of coding

- When frozen section pathology shows the margins of excision were not adequate, an additional excision may be necessary for complete tumor removal.

- Use only one code to report the additional excision and re-excision(s) based on the final widest excised diameter required for complete tumor removal at the same operative session.

- To report a re-excision procedure for a malignant lesion, (performed to widen margins) at a subsequent operative session, see codes 11600-11646 (malignant skin lesion excision codes), as appropriate.

- Append the modifier '-58' (staged / related operative procedure) if the re-excision procedure is performed during the postoperative period of the primary excision procedure.
Excision benign lesions- rules of coding

- Repair by intermediate or complex closure use the appropriate intermediate (12031-12057) or complex closure (13100-13153) codes, in addition to excision codes
- For reconstructive closure, see 11400-14300, 15000-15261 (skin graft section), 15570-15770 (complex flap / myocutaneous flap)
Instructions for listing services at time of wound repair:

- Simple repair is used when the wound is superficial; eg, involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure. This includes local anesthesia and chemical or electrocauterization of wounds not closed.
Instructions for listing services at time of wound repair:

- **Intermediate repair** includes the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure.

- **Single-layer closure** of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.
Instructions for listing services at time of wound repair:

- Complex repair includes the repair of wounds requiring more than layered closure, viz., scar revision, debridement, (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures.
- Necessary preparation includes creation of a defect for repairs (e.g., excision of a scar requiring a complex repair) or the debridement of complicated lacerations or avulsions.
- Complex repair does not include excision of benign or malignant lesions.
Instructions for listing services at time of wound repair:

1. The repaired wound(s) should be measured and recorded in centimeters,

2. When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and from all anatomic sites that are grouped together into the same code descriptor.

Do not add lengths of repairs from different groupings of anatomic sites or different classifications.
Instructions for listing services at time of wound repair:

- 3. Decontamination and/or debridement:

  - Debridement is considered a separate procedure only when:

  ✤ gross contamination requires prolonged cleansing,
  ✤ when appreciable amounts of devitalized or contaminated tissue are removed, or
  ✤ when debridement is carried out separately without immediate primary closure.

- For extensive debridement of soft tissue and/or bone, see 11040-11044.
Lesson #8 - Correct Coding Pays

- Wound is debrided, including skin, SQ, and muscle, and bone
- How much do they pay you to dictate "muscle" and "bone" in op note?

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Instructions for listing services at time of wound repair:

- For extensive debridement of soft tissue and/or bone, not associated with open fracture(s) and/or dislocation(s) resulting from penetrating and/or blunt trauma, see 11040-11044
- For extensive debridement of subcutaneous tissue, muscle fascia, muscle, and/or bone associated with open fracture(s) and/or dislocation(s), see 11010-11012
- How much do they pay you to dictate “open fracture”?
- $140 difference between two codes
Instructions for listing services at time of wound repair:

- 4. Involvement of nerves, blood vessels and tendons:
  - Report under appropriate system for repair of these structures.
  - The repair of these associated wounds is included in the primary procedure unless it qualifies as a complex wound, in which case modifier '-51' applies.
- Simple ligation of vessels in an open wound is considered as part of any wound closure.
Instructions for listing services at time of wound repair:

- Simple "exploration" of nerves, blood vessels or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required.

- If the wound requires
  - enlargement, (to determine penetration),
  - debridement, removal of foreign body(s),
  - ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s) of the SQ tissue, muscle fascia, and/or muscle,
  - Use codes 20100-20103, as appropriate.
Lesson #9-
Correct Coding Pays

- 24 y/o male with 5.0 cm superficial stab wound to neck, explored in ER with repair
- Do you code a skin repair or other code, and how much difference is there?

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<td>13132</td>
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<td></td>
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<td>Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm</td>
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<td>20100</td>
<td>15.44</td>
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Operative Reports- Dictating Tips

Operative note- Skin excision should include:

- Size of lesion, malignant or benign
- Size of excision (ex- 3 X 4 cm.)- using largest dimension of lesion plus adequate excision size, if irregular
- Adequate excision size = smallest margin
- Method of closure- simple, complex, flap advancement, etc.
- Any planned (staged) procedures in future, or if procedure is follow-up procedure of prior excision
ACS Practice Management Help

- ACS Coding Hotline
  - 1-800-ACS-7911
- ACS Bulletin
- ACS Coding Courses
- ACS Practice Management Courses

ACS Bulletin—E&M coding

10/4/10
Conclusions

- E&M codes are valuable, but underutilized asset to most practices
- Important to understand global period and proper use of modifiers
- Documentation guidelines are important to know and follow
- Important to capture all possible billing opportunities