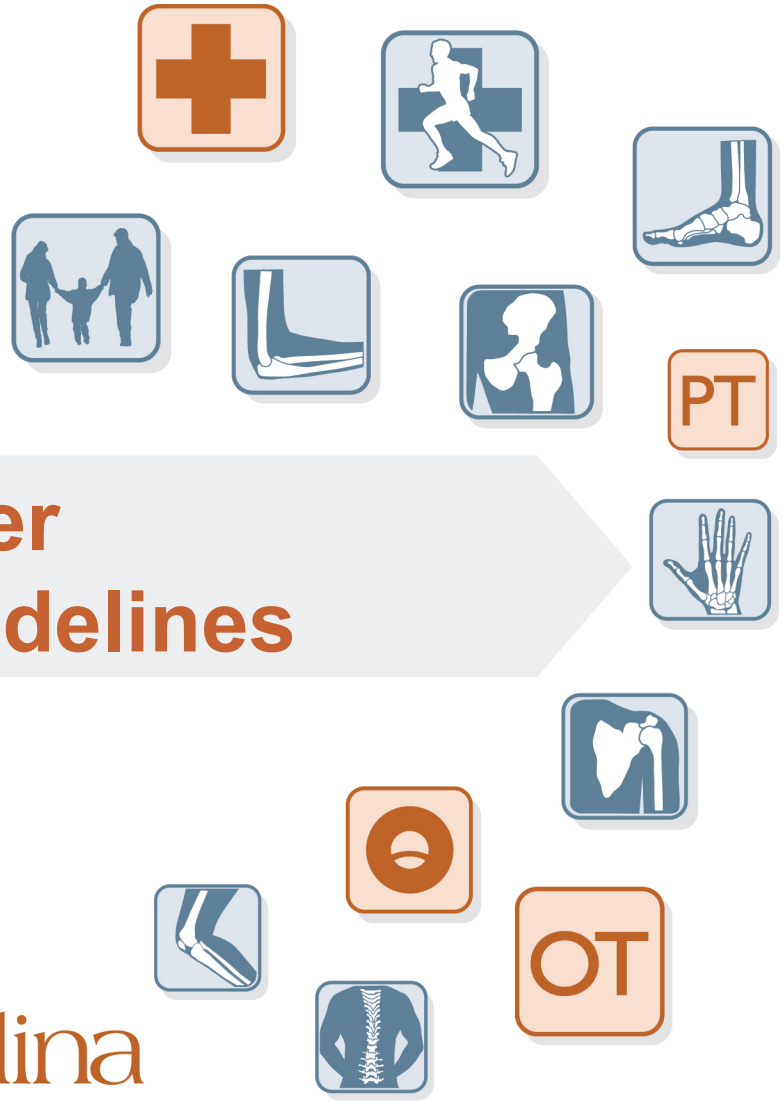
2021 EM Office or Other Outpatient Coding Guidelines



OrthoCarolina

EXCELLENCE
IN ORTHOPEDICS

Topics

- EM Coding
  - New Guidelines for 2021
  - Pre 2021 Guidelines: Hospital EM & Consults
    - History
    - Examination
    - Medical Decision Making & Medical Necessity
  - New vs Established Definitions
  - Consultation coding
- Other Coding Tips
  - Office EM Modifiers 24 & 25
  - Xrays
  - Smoking Cessation
  - Diagnosis Coding: ICD10
- Medicare
  - Incident To
  - Shared Visits

Evaluation & Management

- EM codes include services such as office visits, hospital visits and consultations.

- Federal Documentation Guidelines
  - Applies to Medicare & Medicaid encounters
  - Most commercial payers also use the federal guidelines

Evaluation & Management

- 2021 brings the first revision to the Guidelines since 1997; purpose is to reduce the administrative burden & update the coding rules to reflect current medical practice.
- Currently, the changes apply only to Office EM codes 99202 – 99215. Coding for Hospital EMs and Consult remains the same – confusing matters somewhat. (Changes coming to Consults and Hospital EM in 2023.)
- **Office EM codes are now selected based on TIME OR Medical Decision Making**

2021 Time Guidelines

- 2021 Time will be based on Total Visit Time
  - Contributing factors include: preparing for the visit (such as reviewing tests); getting or reviewing the history; performing the exam; counseling and providing education to the patient, family or caregiver; ordering medicines, tests, or other procedures; communicating with other healthcare providers; documenting in the medical record; interpreting results and sharing that information with the patient; and care coordination.

  - One item you cannot include: if you are getting reimbursed separately for a test, you cannot count it in time calculation. For example, xray where you bill for the technical component and the interpretation. You may count time for reviewing and interpreting xray, MRI or CT results if the interpretation of the results are billed by another entity.

2021 Time Chart

EM Code	Minutes
99202	15-29
99203	30-44
99204	45-59
99205	60-74
99212	10-19
99213	20-29
99214	30-39
99215	40-54

Time Statement

- If you select your office EM code based on the Time criteria, you must document a Time statement to support, for example:

Total time spent on the day of the encounter was _____, excluding time spent for services reported separately.

2021 Guidelines for MDM

- As previously, the Level of MDM will be based on 2 out of 3 categories (or elements) of MDM. They are:

- Elements of Medical Decision Making
  - Number and Complexity of Problems Addressed
  - Amount and/or Complexity of Data to be Reviewed and Analyzed
  - Risk of Complications and/or Morbidity or Mortality of Patient Management (Patient or Procedure Risk)

2 of 3

CPT E/M Office
Level of Medical Decision Making (MDM)

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Category 1 Number and Complexity of Problems Addressed	Category 2 Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Category 3 Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 99212	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213	Low	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or** • **1** acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 99214	Moderate	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	**High** • **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Meeting 2 of 3 categories will determine the MDM. For example, to support Level 4 at least 2 categories must meet Moderate

2021 Guidelines for MDM

Category 1 Definitions

- To qualify as a ***problem addressed***, the provider must evaluate or treat the problem. Consideration of further testing that is decided against because of risks involved or patient choice counts as addressed. Notation that another professional is managing a problem does not count as addressed. There must be additional assessment or care coordination. Another area that does not qualify as addressing the problem is referral without evaluation (using history, exam, or diagnostic studies) or considering treatment.

2021 Guidelines for MDM

- A ***self-limited or minor problem*** is a problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status. Relevant to straightforward MDM – Level 2

- An ***acute, uncomplicated illness or injury*** is recent & short term; low risk of morbidity; little to no risk of mortality with treatment; full recovery is expected. Relevant to Low MDM – Level 3

- A ***stable, chronic illness*** is a problem expected to last one year or until the patient's death; change in stage or severity does not change whether a condition is chronic; treatment goals determine if the condition is stable & a patient who has not achieved their treatment goal is not stable; risk of morbidity is significant without treatment. Relevant to Low and Moderate MDM – Levels 3 and 4

2021 Guidelines for MDM

- A ***chronic illness with exacerbation, progression or side effects of treatment*** is getting worse, is not well controlled or is progressing 'with an intent to control progression'; the condition requires additional care or treatment of side effects; hospital care is not required. Relevant to Moderate MDM – Level 4

- An ***undiagnosed new problem with uncertain prognosis*** is a problem in the differential diagnosis that represents a high risk of morbidity without treatment. Relevant to Moderate MDM – Level 4

- An ***acute illness with systemic symptoms*** has significant risk of morbidity without treatment; systemic symptoms may be single system or general. Does not apply to minor illnesses with symptoms such as fever or fatigue – consider acute, uncomplicated problem instead. Relevant to Moderate MDM – Level 4

2021 Guidelines for MDM

- An ***acute complicated injury*** is one that requires evaluation of body systems separate from the injured body part; the injury is extensive; there are multiple treatment options; there is risk of morbidity without treatment. Relevant to Moderate MDM – Level 4

- A ***chronic illness with severe exacerbation, progression or side effects of treatment*** is one where risk of morbidity is significant and the patient may require hospitalization (or surgery). Relevant to High MDM – Level 5

- An ***acute or chronic condition that may pose a threat to life or bodily function*** is not a new phrase – AMA clarified/added "in the near term without treatment". Relevant to High MDM – Level 5

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CPT E/M Office
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Meeting 2 of 3 categories will determine the MDM. For example, to support Level 4 at least 2 categories must meet Moderate

2021 Guidelines for MDM

Category 2 Definitions

- An ***independent historian*** is a family member, witness, or other individual who provides patient history when the patient can't provide a complete history or the provider thinks a confirmatory history is needed. This term is used in Low, Moderate and High MDM - Levels 3 to 5.

- An ***external physician or other qualified healthcare professional*** is someone who is not in the same group practice or is classified as a different specialty or subspecialty. Discussion with an external provider is included in Moderate & High MDM - Levels 4 and 5.

2021 Guidelines for MDM

- ***External records*** are from an external physician/provider, facility or healthcare organization. This term is used in Low, Moderate and High MDM – Levels 3 to 5.

- ***Independent interpretation*** (of a test interpreted by another provider) is interpretation of a test for which there is a CPT and interpretation is customary. For example, our MRIs are interpreted by Triad Radiology. This term is relevant to Moderate and High MDM – Levels 4 and 5.

- ***Appropriate Source*** is a professional who is not a healthcare professional but may be involved in the management of the patient, ie; case manager, parole officer, lawyer, teacher. It does not include family or informal caregivers. Relevant to Moderate and High MDM – Levels 4 and 5.

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Meeting 2 of 3 categories will determine the MDM. For example, to support Level 4 at least 2 categories must meet Moderate

2021 Guidelines for MDM

Category 3 Definitions

- ***Risk*** is related to probability of something happening, but risk and probability are not the same for EM coding purposes. High probability of a minor adverse effect may be low risk, depending on the case. The terms high, medium, low, and minimal risk are meant to reflect the common meanings used by clinicians. For MDM, base risk on the consequences of the addressed problems when they're appropriately treated. Risk also comes into play for MDM when deciding whether to begin further testing, treatment, or hospitalization.

2021 Guidelines for MDM

- ***Morbidity*** is a “state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.” Morbidity is an important term to understand for the acute and chronic illness definitions.

- ***Social determinants of health (SDOH)*** are economic and social conditions that influence health, for example; food or housing insecurity, transportation issues, lack of education, social isolation, and other constraints. Your documentation must support how the SDOH limits diagnosis and/or treatment. Relevant to Moderate MDM – Level 4

2021 Guidelines for MDM

- ***Major Surgery*** – procedure that has a 90 day Global. Relevant to Moderate and High MDM – Levels 4 and 5

- ***Drug therapy requiring intensive monitoring for toxicity*** is relevant to High MDM – Level 5 and is defined as:
  - The drug can cause serious morbidity or death.
  - Monitoring assesses adverse effects, not therapeutic efficacy.
  - The type of monitoring used should be the generally accepted kind for that agent, although patient-specific monitoring may be appropriate, too.
  - Includes both long-term or short-term monitoring.
  - Lab, imaging, and physiologic tests are possible monitoring methods. History and exam are not.
  - Monitoring affects MDM level when the provider considers the monitoring as part of patient management.

Coding Examples

Follow up of ***one*** chronic problem with an exacerbation AND Rx or injection is now 99214 instead of 99213. (Chronic = condition has lasted or will last a year or more) – Used to require 2 presenting problems to meet Moderate.

Follow up visit with interpretation of MRI is now 99214 instead of 99213. Independent interp (by itself) is now Moderate on data reviewed – used to be Low.

Acute uncomplicated problem (simple sprains, contusions, etc) AND Rx or injection is now 99213 instead of 99214. Result of eliminating New vs Est problem & getting 'more credit' for addressing a New problem.

Scenario #1

Follow up of ***one*** chronic problem with an exacerbation AND Rx or injection is now 99214 instead of 99213. (Chronic = condition has lasted or will last a year or more) – Used to require 2 presenting problems to meet Moderate.

HISTORY OF PRESENT ILLNESS:

59-year-old patient returns today for follow-up of left elbow pain. Status post cubital tunnel release approximately 8 months ago. Recently having increased discomfort. Rates his pain level is a 5. He has noticed some swelling in the left elbow area in the area around the incision.

PLAN:

Discussed options. Will place him on a Medrol Dosepak. Follow up here in 4 weeks for recheck. Discussed possibility further diagnostic measures such as MRI to rule out possibility of soft tissue mass.

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Meeting 2 of 3 categories will determine the MDM. For example, to support Level 4 at least 2 categories must meet Moderate

Scenario #2

Follow up visit with interpretation of MRI or CT is now 99214 instead of 99213. Independent interp (by itself) is now Moderate on data reviewed – used to be Low.

HISTORY OF PRESENT ILLNESS:

The patient is a pleasant 26-year-old who follows up today for re-evaluation of his left foot after having a CT scan. Plain x-rays had revealed a navicular fracture. He is still using crutches. He is using a boot. Mild pain. Mild swelling. Worse with activity. Better with rest. He has been out of work

DIAGNOSTIC STUDIES:

CT scan and report reviewed on atrium Stentor shows a comminuted navicular fracture with transverse and longitudinal components and extending into the articular surface of the talar navicular joint. There is very minimal displacement and some early healing.

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Scenario #3

Acute uncomplicated problem (simple sprains, contusions, etc) AND Rx or injection is now 99213 instead of 99214. Result of eliminating New vs Est problem & getting ‘more credit’ for addressing a New problem.

HISTORY OF PRESENT ILLNESS:

Pleasant 50-year-old female presents today to the Orthopedic Urgent Care for right foot pain which began earlier today when she accidentally kicked a door. She rates her pain 5/10. She locates her pain over the 3rd and 4th toes. She denies any pain to the midfoot or to the ankle. Denies numbness or tingling.

DIAGNOSIS/PLAN: Right 3rd and 4th toe contusions.

X-rays were reassuring today with no obvious evidence of fracture. We will start with buddy taping system which I would like her to continue over the next couple weeks. She may begin increasing her activity to tolerance however would advise giving herself about a week to let the swelling come down. We will start Mobic 7.5 daily with food. See us back on an as-needed basis.

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99202 99212	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213	Low	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or** • **1** acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 99214	Moderate	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	**High** • **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Meeting 2 of 3 categories will determine the MDM. For example, to support Level 4 at least 2 categories must meet Moderate

Hospital & Consult EM Codes

- Unfortunately, these EM categories continue to be scored using the ‘pre 2021’ Federal Guidelines until 2023.
  - History
  - Exam
  - MDM
  - or Time

History

- Defined by 3 elements:
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past, Family & Social Histories (PFSH)

History of Present Illness - HPI

- A description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present
- Must be recorded by the MD or PA/NP
- Must contain specific descriptors – there are 8 descriptors to choose from

HPI Descriptors

Indicator	Example
Location	*Back*
Quality	*Stabbing*
Severity	*Severe – 9 on scale of 10*
Duration	*One month*
Timing	*Occasional*
Context	*With activity*
Modifying Factors	*Not relieved with Motrin*
Associated Signs and Symptoms	*Leg numbness*

Review of Systems - ROS

- Inventory of body systems obtained through a series of questions seeking to identify signs/symptoms
- May be obtained by clinical staff using intake forms or electronic device
- Provider should review information
- 14 systems per federal guidelines

Review of Systems

- Constitutional
- Eyes
- ENT
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymph
- Allergic/Immunologic

PFSH - Examples

- **Past History**
  - Illnesses, Surgeries, Medications, Allergies
- **Family History**
  - Hereditary or other diseases of family that may place the patient at risk – it may be specific to orthopedics
  - “Non-contributory” is not acceptable
- **Social History**
  - Employment, martial status, school status, use of drugs, alcohol, tobacco

1995 Exam - 12 Systems

- Constitutional
  - *General appearance*
- Eyes
- ENT
- Cardiovascular
  - *Pulse, edema, capillary refill*
- Respiratory
  - *Nonlabored breathing*
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
  - *Scars, bruises*
- Neurological
  - *Sensation*
- Psychiatric
  - *Alert & oriented*
- Lymph/Hema/Immune
  - *Lymphadenopathy*

4 Types of Exam

- **Problem Focused**
  - 1 organ system
- **Expanded Problem Focused**
  - 2 organ systems
- **Detailed**
  - 2-7 organ systems with detail (2+ specifics) in at least 2 systems, ie Musculoskeletal – ROM, strength
- **Comprehensive**
  - 8 organ systems

Medical Decision Making - MDM

- Use 2021 MDM guidance to decide this category

- Billing based on TIME is different for Hospital and Consults codes – see Coding cards

New vs Established

- A patient is considered **NEW** when he/she has not had professional face-to-face services from the physician or from a physician of the *same specialty in the group* within **3 previous years**

- If you have seen the patient in the past 3 years – even while billing under a different tax ID #, the patient is ESTABLISHED to you

Consultation Criteria

- **The "3 Rs" of a consultation:**
  - Request – a written or verbal request and the reason for consultation must be documented in the patient's record by the consultant.
  - Render – the consultant renders an E&M service to the patient related to the specified problem, and
  - Respond –findings and recommendations are communicated back to the requesting physician via written report.

- ER, Urgent Care, Self, neighbors & friends are not valid requesters for consultations

- Inter-group consults are possible
  - Examples:
    - Physiatry seeks evaluation/opinion of spine surgeon
    - Generalist seeks evaluation/opinion of Hand specialist
  - Use caution that it makes sense as a consult

Consultation Criteria

- The HPI must be clear that it is a CONSULT and not a REFERRAL
  - *Payers look for the specific word – 'consultation'*
  - "Seeing Suzy in ***consultation*** for evaluation of left arm pain at the request of Dr Sam Adams"
- It can be a Consult even if you decide to treat the patient
- Consult means – you are under the impression there is a Provider who is expecting to receive results of your evaluation
  - *Payers looks for the communication back to specific requester*

OTHER CODING TIPS

Office Modifiers 24 & 25

- 24 Unrelated EM During the Post-operative (Global) Period
  - Complications are not 'Unrelated'
  - Medicare defines Global = all medical services related to surgery including care of complications (only procedures performed in the OR are billable in the Global)

- 25 **Significant**, Separately Identifiable EM on the Same Day of Procedure
  - Initial injections
  - Frequent flyers
  - Synvisc/Euflexxa
  - There is some EM inherent to all procedures (RVU/reimbursement reflects this: Work RVU has pre, intra and post components)
  - NOEVAL charge code for Allscripts

Xray Documentation

Documentation must clearly state the # and/or type of views ordered by you at the encounter
AND
Official interpretation of the X-Ray findings

- Failing to document an order for the X-Rays and an official interpretation can result in down coding to bill for Technical Component only

- If Rad Techs are involved in billing, make sure you are on the same page about what is billed vs what is documented in the Provider note

Xray Documentation

- **Non-Compliant Documentation Examples:**
  - "X-Rays show no changes since last visit"
  - "X-Rays of the ankle today show degenerative joint disease".
- **Compliant Documentation Examples**:
  - AP and Lateral lumbar spine X-Rays ordered, taken and reviewed in the office today show lumbar spondylosis with disk space narrowing at L4-5 and L5-S1 and a slight anterolisthesis at L5 and S1.
  - Three view X-Ray of the knee ordered, taken and reviewed in the office today reveal severe bone on bone arthritis.

Injections & Drug Billing

- Key to document:
  - Consent
  - Anatomic location of injection
  - Medication injected
  - Dosage of medication injected
  - Results/patient reaction
- Drug Billing
  - Billed in mg
  - Providers like to document in cc
  - mg and cc are not always equal
- Example:
  - Celestone J0702 is billed “per 3mg”
  - If you inject 1 cc of 6 mg strength, you bill 2 units

Tobacco Cessation

- ***CPT 99406: Smoking and tobacco use cessation counseling, 3+ minutes***
- All patients who use tobacco = 99406
- Adjunct code to EM code
- All commercial payers cover it – including Work Comp and Medicaid

Tobacco Cessation - Medicare

- Covers 8 sessions per 12 month period per beneficiary (from all providers seeing that patient)
- All patients with Part B coverage who use tobacco
- The patient does not have co-insurance due for this service (they will not be billed anything for 99406)
- Medicare pays *$14.15* in addition to EM code

Tobacco Cessation

- Medical record documentation must state that *>3 minutes of cessation counseling was provided*
  - *Not just simply telling the patient he/she needs to quit which is considered minimal counseling and is included in the EM code*
  - *Create a template to include in your A&P for easy & accurate documenting*
- Cessation counseling must be provided/billed by Physicians and PAs (not clinical staff)
- Assess/Assign correct billing Diagnosis code for billing:
  - Tobacco Use/dependence

UNSPECIFIED ICD10 Codes

- Do not use Unspecified codes for Knee – they are not covered and your claim will be denied. They end in “9” - Example:
  - M17.0 Bilateral primary osteoarthritis of knee
  - M17.11 Unilateral primary osteoarthritis, right knee
  - M17.12 Unilateral primary osteoarthritis, left knee
  - **M17.9** Primary osteoarthritis of **unspecified** knee
- Laterality is required
- Type of OA is required – primary, secondary, post-traumatic

Hospital E&M Coding

- Inpatient Consults 99251 – 99255
  - No Medicare
- Initial Inpatient EM 99221 – 99233
  - H&Ps and Medicare IP consults
- ED Evaluations 99281 - 99285

Inpatient Consultations – 3 of 3

CPT Code	History			Examination	Medical Decision Making		
	HPI	ROS	PFSH	1995 Exam Organ System	C1. Presenting Problem(s)	C2. Amt and/or Complexity of Data to be reviewed	C3. Table of Risk
99251	1-3 elements	N/A	N/A	1 Organ System	Minimal		
99252	1-3 elements	1 system	N/A	2-7 Organ Systems **(Limited)**	Minimal		
99253	4 elements	2-9 systems	1 history	2-7 Organ Systems **(Detailed)**	Low		
99254	4 elements	10+ systems	3 histories	8+ Organ Systems	Moderate		
99255	4 elements	10+ systems	3 histories	8+ Organ Systems	High		

Initial Inpatient EM (H&P) – 3 of 3

CPT Code	History			Examination	Medical Decision Making		
	HPI	ROS	PFSH	1995 Exam Organ System	C1. Presenting Problem(s)	C2. Amt and/or Complexity of Data to be reviewed	C3. Table of Risk
99221	4 elements	2-9 systems	1 history	2-7 Organ Systems **(Detailed)**	Low		
99222	4 elements	10+ systems	3 histories	8+ Organ Systems	Moderate		
99223	4 elements	10+ systems	3 histories	8+ Organ Systems	High		

ED Consults – 3 of 3

CPT Code	History			Examination	Medical Decision Making		
	HPI	ROS	PFSH	1995 Exam	C1. Presenting Problem(s)	C2. Amt and/or Complexity of Data to be reviewed	C3. Table of Risk
99281	1-3 Elements	N/A	N/A	1 Organ System	Minimal		
99282	1-3 Elements	1 System	N/A	2-7 Organ Systems **(Limited)**	Minimal		
99283	1-3 Elements	1 System	N/A	2-7 Organ Systems **(Limited)**	Low		
99284	4 Elements	2-9 Systems	1 History	2-7 Organ Systems **(Detailed)**	Moderate		
99285	4 Elements	10+ Systems	2 Histories	8+ Organ Systems	High		

MEDICARE & PA/NP

Incident-To Billing

- Definition: services provided by a PA are billed to **Medicare** in the supervising Physician's name
- Medicare reimbursement 100% vs 85% of the physician fee schedule
- Criteria:
  - Must be an Established patient
  - Must be an established problem initially evaluated by the Physician with care plan by the Physician
- Recommendation: Do not bill Incident*to because the majority of visits by the PA are new problems
- Providers responsibility to ensure Medicare is billed using the PA's own billing number

Medicare Shared Visits

- Hospital EM service that is ‘shared’ between the MD and the PA
- MD and PA services may take place at different times on *the date of service*
- May be billed under the MD’s name:
  - MD must provide face-to-face service and document involvement….not just review and countersign chart
- If the PA sees the pt for initial consult and MD does not see pt until the following day for surgery, the consult must be billed in the PA’s own name

OC Resources

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