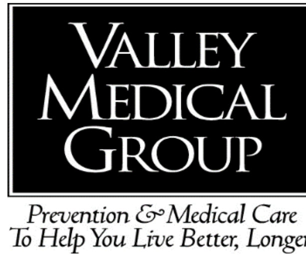

Billing Training for New Providers

October 18, 2023

Agenda/ Table of Contents

1. Intranet Resources
2. Snapshot/ Tableau Files
3. Coding Best Practices
4. Medical Decision-Making Guidelines
5. Billing on time
6. E&M with a wellness- see article
7. TCMS Billing
    a. High vs. moderate
8. Understanding RVUs
9. RAF & HCC Coding
10. Medicare Wellness
11. Counseling Codes
12. U1/ U2 Modifiers
13. IUD coding
14. Billing incident to
15. Additional Coding Cheat Sheets
16. Questions?

Intranet Resources

IMPORTANT INFORMATION LINKS

HOME | TELEPHONE INFORMATION AND DIRECTORIES | PHOTO DIRECTORIES | SUGGESTION BOX

EGGPLANT NEWSLETTERS | INFORMATION FOR VMG PRACTITIONERS
NEW PRACTITIONER ONBOARDING INFORMATION | EMPLOYMENT OPPORTUNITIES

DM EDUCATION AND NUTRITION PROGRAM OFFERINGS | LABORATORY | PEDIATRIC PEARL | REFERRALS |
DEI COMMITTEE | BILLING WORKGROUP NEWSLETTERS

QUALITY AND REPORTING | EXECUTIVE DASHBOARD | CLINICAL GUIDELINES | CLINICAL CHAMPIONS UPDATI

AthenaTelehealth Training Information

Information for VMG Practitioners

VMG Business Information

VMG Meeting Schedule 2023

Quick Links

- ADP
- Annual Training
- Athena
- Athena BACKUP Site
- Athena Training Videos

Scroll down to find > “Coding and Billing Changes” and “Provider Quick Links”

Clinical Resources

Coding Education Session Recording

Coding and Billing 2023 Changes

Billing and Compliance for Practitioners

Unexpected Closure Policy

- Interpreter - Video For Office Visits
- Interpreter - Video Visits on Zoom
- IT Corner
- MassPAT Log in
- New Hire Training
- Nursing Inservice Handouts
- Patient and Family Advisory Council
- Patient Incident/Complaint Form
- Patient Portal QUICK Tips
- Primary Care Standing Orders
- Provider Quick Links

Quality and Reporting > Tableau Dashboards

IMPORTANT INFORMATION LINKS

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DEI COMMITTEE | BILLING WORKGROUP NEWSLETTERS

QUALITY AND REPORTING | EXECUTIVE DASHBOARD | CLINICAL GUIDELINES | CLINICAL CHAMPIONS UPDATES

AthenaTelehealth Training Information

Quality and Reporting

Tableau Dashboard Files

Executive Dashboard

Morphine Equivalents Summary

Quick Links

- ADP
- Annual Training
- Athena
- Athena BACKUP Site
- Athena Training Videos
- Clinical Operations Updates
- Coaguchek Link
- Diversity, Equity, & Inclusion Re

Coding Best Practices

Code E/M in 2 steps:

1. Use total time if that credits you appropriately for the work you did,
2. Use medical decision making to code the visit based on the level of problems you addressed and medication management.
3.

Document Medical Decision-Making level in 1 sentence:

Problem:	*Status:*	*Rx (prescription management):*
Hypertension (HTN)	BP elevated	Increase amlodipine
Diabetes mellitus (DM)	A1C not to goal	Increase insulin glargine
(ADHD)	Not improving	Increase Adderall
Hyperlipidemia	Worsening	Start atorvastatin
Chronic kidney disease	Stable	Continue current medication
Coronary artery disease	Controlled	Continue isosorbide mononitrate
Depression	Doing well	Taper off sertraline

Level 3 examples (one stable chronic Illness + Rx):

- ADHD, doing well, continue amphetamine/dextroamphetamine 20 mg. OR
- Gout, controlled, uric acid 4, continue allopurinol 300 mg. OR
- Type 2 DM on insulin, A1C 6.5%, continue current medications.

Level 4 examples (one unstable or two stable chronic conditions + Rx):

- Mixed hyperlipidemia, not to goal, increase atorvastatin to 40 mg.
- Hypothyroidism, controlled, continue current dose of levothyroxine **and** Peptic ulcer disease, stable, continue omeprazole.

Key things to remember:

- When documenting unstable chronic illnesses, it is imperative to use descriptive terms such as “unstable,” “not to goal,” “not improving,” “elevated,” “worsening,” or “uncontrolled.” Failing to do so may result in level 4 work being coded as level 3.

- Be careful how you word an “improving” chronic condition. If it’s improving but *still not to goal*, make sure to say so. Otherwise, it could be interpreted as now stable rather than unstable, and level 4 work could be downgraded to level 3. This is easier to document for conditions that have a quantitative goal, such as an A1C below 7% for patients with diabetes under age 75. For conditions that don’t have a quantitative goal, such as depression, you can write something like “improved, but still significant.”

- Include “continue current medications” in your documentation to signal that you evaluated a patient’s response to medication and, therefore, should be credited with prescription drug management even if you decided not to change anything. You might think that statements such as “HTN stable” or “diabetes controlled” imply Rx management, but it’s best to spell it out explicitly for coders, insurers, and auditors.

— edited from Keith W. Millette, MD, FAAFP, RPh by S. Killip
Posted on Dec. 12, 2022

Medical Decision-Making Guideline

See MDM 2023 Chart (B. Nicoletti Presentation)

Codes Overview

OVERVIEW OF CODES

CODE New/Established	TOTAL TIME New/Established	MDM: medically appropriate H&P plus:
~~99201~~/99211	n/a	-
99202/99212	15-29 mins/ 10-19 mins	Straightforward Level of MDM
99203/99213	30-44 mins/ 20-29 mins	Low Level of MDM
99204/99214	45-59 mins/ 30-39 mins	Mod Level of MDM
99205/99215	60-74 mins/ 40-54 mins	High Level of MDM

Prolonged service code (99XXX) is over 74/54 mins if new/established patient.

UNDERSTANDING THE ELEMENTS OF MDM

1. Number and complexity of problems addressed
    a) Minimal, low, moderate, or high
2. Amount and/or complexity of data to be reviewed and analyzed
    a) Understanding categories of data
        (1) Tests, documents, or independent historian(s)
        (2) Independent interpretation of tests
        (3) Discussion of management or test interpretation
    b) Minimal/none, limited, moderate, or extensive
3. Risk of complications and/or morbidity or mortality of patient management (Risk of tests/treatments to the patient)
    a) Minimal, low, moderate, or high risk of morbidity from additional diagnostic testing or treatment

MDM TABLE ELEMENTS

- #1 Number & Complexity of **Problems Addressed** at the Encounter
  - Must show that you review and analyzed a piece of data, not just copy & paste.
  - Cohesive encounter that can be documented in as few words as possible
- #2 Amount and/or complexity of **Data** to be reviewed & analyzed
  - Straightforward
    - Minimal/None
  - Low (1 Category)
    - TWO documents/ or Independent Historian
  - Moderate (1 Category)
    - Count (3 items: documents or historian)
    - Interpret
    - Confer
  - High (2 Category)
    - Count (3 items: documents or historian)
    - Interpret
    - Confer

#3 Risk of Complications and/or Morbidity or Mortality of Patient Testing & Treatment

Straightforward: Minimal Risk from Treatment/ no treatment or testing. (No risk essentially)

Low: low risk of any poor outcomes, minimal discussion/consent.

Moderate: More risk we would review with patient, obtain consent, monitor labs, social factors may affect management

High: discuss risk for poor outcomes, required monitoring discussed, more serious discuss with or without treatment, decision to hospitalize.

Medical Decision Making Vs. Time Based Billing Chart

From Millette, K. W. (2020) Countdown to the E/M Coding Changes. *FPM*. www.aafp.org/fpm.

Visit level	Total time	Medical decision making	Example
Level 2	<20 minutes (<30 minutes for new patients)	No medication prescribed	viral upper respiratory infection, or simple recheck for stable problem
Level 3	20-29 minutes (30-44 minutes for new patients)	One acute problem PLUS medication prescribed OR one test ordered and reviewed	strep screen, UTI w/ Urinalysis
Level 4	30-39 minutes (45-59 minutes for new patients)	At least one of the following: • One unstable chronic illness • Two stable chronic illnesses addressed • Acute complicated injury (e.g., concussion, fracture), • Acute illness with systemic symptoms (e.g., pyelonephritis or pneumonia), • New problem with uncertain prognosis (e.g., breast lump). PLUS at least one of the following: A. Prescription drug management, B. X-ray or ECG that is ordered and interpreted C. Total of three unique tests ordered or reviewed, external notes reviewed, or independent historians used (requires three "points" where each instance equals one point — e.g., three unique tests ordered or reviewed equals three points), D. Patient's management or test discussed with external provider, E. Patient's diagnosis and treatment limited by lack of money, food, or housing. OR: Prescription drug management plus at least one of the following: B, C, or D above.	Unstable=includes BP or A1C not to goal Chronic illness: HTN, DM, CKD
Level 5	40-54 minutes (60-74 minutes for new patients)	Severe acute illness or worsening chronic illness posing a threat to life or bodily function (e.g., myocardial infarction, pulmonary embolism, acute renal failure, severe respiratory distress, acute neurological change) PLUS at least one of the following: • Two of three from B, C, or D above, • Patient admitted by someone other than yourself, • Patient placed on warfarin, • Patient made DNR, care de-escalated.	

Updates for Billing 99214

The recent training with Betsy highlighted some nuances with billing for 99214's that I want to highlight here.

- If you bill a 99214 by medical complexity, the EKG does not count as data(because you bill separately for this).
- When you bill on medical complexity you need to meet that requirement with 2 of the 3 columns: 1) the number and complexity of problems 2) data 3) risk of treatment.
- It is sometimes difficult to meet the requirement through data. This needs to be 3 unique tests that are not billed for separately like an EKG.
- The "Risk" column is more about the risk of treatment. Prescribing a medication and the risk of that treatment is a factor. **Documenting a decision to hospitalize or not hospitalize is a good way to meet the risk column** if applicable (chest pain).
- Examples: For a patient with palpitations: If you do an EKG, this can't count as a data as we bill separately for it. However, if you order a CBC, TSH, and a Holter monitor this would meet the data requirement. If you document a discussion about needing/not needing to go to the hospital, this would meet the risk column for 99214.
- Example: For a patient with chest pain being worked up outpatient, if you order a stress test and you document your medical decision making on hospitalization versus not hospitalization, then this can meet the risk column for a 99214. *You will not meet the 99214 requirements by data, you need to meet it by (1) documenting the risk of the treatments plus (2) the complexity of the problem*.

E&M at Wellness visits

Betsy agreed that at MOST wellness visits it is appropriate and expected to add an E&M code. Take credit for the work you are doing. Currently we are at about 40%. *Please make sure you have the documentation to support the E&M code in the chart, A&P.*

TCMS

The Medical complexity decisions for billing a 99214 vs 99215 also translate in choosing HIGH vs. MODERTATE TCMS codes. Most TCMS visits are probably moderate, even if they meet the 7-day time frame. Do not choose the TCMS code solely based on the time frame.

RVU Comparison Charts

Description	Code	Work RVUs
Transitional care management, moderate, 14 day	99495	2.78
Transitional care management, high, 7 day	99496	3.79
Initial Medicare annual wellness visit	G0438	2.6
Subsequent Medicare annual wellness visit	G0439	1.92
Welcome to Medicare (Initial Preventive Physical Exam)	G0402	2.6
Well-woman exam	G0101	0.45

Description	Code	Work RVUs	Description	Code	Work RVUs
Level 1, new	99201	n/a	Level 1, established	99211	0.18
Level 2, new	99202	0.93	Level 2, established	99212	0.70
Level 3, new	99203	1.6	Level 3, established	99213	1.3
Level 4, new	99204	2.6	Level 4, established	99214	1.92
Level 5, new	99205	3.5	Level 5, established	99215	2.8

Description	Code	Work RVUs	Description	Code	Work RVUs
< 1 year, new	99381	1.5	< 1 year, established	99391	1.37
1-4 years, new	99382	1.6	1-4 years, established	99392	1.5
5-11 years, new	99383	1.7	5-11 years, established	99393	1.5
12-17 years, new	99384	2	12-17 years, established	99394	1.7
18-39 years, new	99385	1.92	18-39 years, established	99395	1.75
40-64 years, new	99386	2.33	40-64 years, established	99396	1.9
65+ years, new	99387	2.5	65+ years, established	99397	2

Description	Code	Work RVUs
Obtaining screening Pap smear	Q0091	0.37
Smoking cessation counseling, 3-10 minutes	99406	0.24
Smoking cessation counseling, more than 10 minutes	99407	0.50
Edinburgh depression scale	96161	0
Developmental pediatrics testing	96110	0
Fluoride varnish	99188	0.2

(Sources Kantner, 2023)

RAF

-Heat maps are reviewed in the quality dashboard to see how often a provider touches the RAF diagnosis. Goal is over 50%.

Assessment & Plan DIAGNOSES & ORDERS
Sign Orders Next
Supervising Provider Steven B. Esrick, MD
1 potential diagnosis has not been added to a claim this year.
Risk score 0.451 | Gap 0.150

Prescription drug monitoring report
Viewed by skillip on 05/16/2022

benign neoplasm of skin of face
D23.30 Other benign neoplasm of skin of unspecified part of face
reassured - seems to be healing well.
suggest bandaid, wide brim hat for sun protection.

-If the Athena RAF counter has disappeared. Here is how to fix it:

Go to the gear on Athena Health
Go to User preferences
Put a check next to "show patient risk score instead of potential diagnosis count in Problem List"

Find
Allergies
Problems
Meds
Vaccines
Vitals
Results
Visits
History
Quality
Care
Apps

Active Problems Historical (1)
Move Multiple Settings
1 Other Diagnosis
history of diverticulitis
Z87.19 Personal history of other diseases of the digestive system
Surgery 2/2020 Dr. Kelly colon-uterine fistula; ileostomy followed by reversal
cellulitis and abscess of toe (Left)
L02.611 Cutaneous abscess of right foot
morbid obesity
BMI = 42.7, 9/28/22 (also qualifies if BMI > or = 35 plus diagnosis of HTN).

Patient Risk
Learn more | Dismissed risk (0)
Potential Diagnoses (1) Gap 0.250
Existing clinical and claim data suggests the following as potential diagnoses for this patient.
Schedule an appointment to determine whether these diagnoses are valid.
HCC 22: Morbid Obesity RAF weight 0.250
ICD-10 E66.01: Morbid (severe) obesity due to excess calories
Source MANUAL : BMI = 42.7, 9/28/22 (also qualifies if BMI > or = 35 plus diagnosis of HTN)., mcardinal1 10/05/2022
Suspected Diagnoses (0)
These suspected diagnoses have not been clinically verified. They have been inferred from evidence such as labs, screenings, and prescriptions. Determine if these diagnoses are valid before documenting them.
Risk Adjustment Factors Risk score 0.392

Find
Allergies
Problems
Meds
Vaccines
Vitals
Results
Visits
History

Active Problems Historical (1)
Move Multiple Settings
Risk 0.392/Gap 0.250
history of diverticulitis
Z87.19 Personal history of other diseases of the digestive system
Surgery 2/2020 Dr. Kelly colon-uterine fistula; ileostomy followed by reversal
cellulitis and abscess of toe (Left)

ICD-10 — HCC CODING REFERENCE FOR FAMILY MEDICINE

If your patient has any of these problems, document the diagnosis, assessment, and plan, and report the corresponding code annually.

Examples	ICD-10	HCC[1]	HCC weight[2]	Notes
Type 2 diabetes (T2D)				
T2D without complications	**E11.9**	**19**	**0.104**	Always has HCC weight.
T2D with hyperglycemia	E11.65	18	0.318	Document as specifically as possible.
T2D with hypoglycemia, no coma	E11.649	18	0.318	
T2D with mild retinopathy	E11.329	18	0.318	
T2D with diabetic chronic kidney disease (CKD)	E11.22	18	0.318	
T2D with polyneuropathy	E11.42	18	0.3168	
Long term (current) insulin use	Z79.4	19	0.104	
Hypertension (HTN)				
HTN with congestive heart failure (CHF)	**I11.0**	**85**	**0.323**	Isolated essential HTN has no HCC weight.
HTN + CKD stage 5/end stage renal disease (ESRD)	I12.0	136	0.237	Relationship must be explicitly documented.
HTN + CHF + CKD stage 1-4	I13.0	85	0.323	
HTN + CHF + CKD stage 5/ESRD	I13.2	85	0.323	
HTN + heart disease (no CHF) + CKD 5/ESRD	I13.11	136	0.237	
Chronic kidney disease (CKD)				
CKD stage 4, glomerular filtration rate (GFR) 15-29	**N18.4**	**137**	**0.237**	No HCC weight unless stage 4 or worse, or associated with HIV.
CKD stage 5, GFR <15	N18.5	136	0.237	
ESRD	N18.6	136	0.237	
Major infections				
HIV/AIDS	**B20**	**1**	**0.312**	Active infections — serious, systemic, opportunistic, or bone/joint/muscle.
Sepsis	A41.8	2	0.455	
Cancer				
Breast cancer	**C50.9**	**12**	**0.146**	Active cancers — new, under treatment, or treatment declines — with documentation of any metastases.
Prostate cancer	C61	12	0.146	
Lung, gastrointestinal, or pancreatic cancers	Varies	9	0.970	
Metastasis to lymph nodes	C77.X	8	2.625	
Hematologic problems				
Myelodysplastic syndrome	**D46.9**	**46**	**1.388**	
Aplastic anemia	D61.9	46	1.388	
Acquired coagulopathy	D68.4	48	0.221	
Senile purpura	D69.2	48	0.221	
Immune thrombocytopenic purpura	D69.3	48	0.221	
Thrombocytopenia	D69.6	48	0.221	
Morbid obesity				
Morbid obesity	**E66.01**	**22**	**0.273**	No HCC weight unless BMI is 40 or greater or there are comorbidities.
Code BMI if known	Z68.41-45	22	0.273	

Malnutrition				
Protein-calorie malnutrition	**E46**	**21**	**0.545**	Malnutrition requires documentation of objective data (e.g., albumin less than 3.4) or subjective data (wasted appearance).
Cachexia	R64	21	0.545	
Chronic lung disease				
Smoker's cough	**J41.0**	**111**	**0.328**	Document specifically if possible (smoking history, chest computed tomography results, pulmonary function tests, etc.). *Also code Z99.81, dependent on supplemental oxygen.
Emphysema	J43.X	111	0.328	
Chronic obstructive pulmonary disease (COPD), other	J44.X	111	0.328	
COPD, unspecified	J44.9	111	0.328	
Pulmonary fibrosis	J84.10	112	0.209	
Chronic respiratory failure	J96.10*	84	0.302	
Inflammatory bowel disease				
Crohn's disease	**K50.90**	**35**	**0.294**	
Ulcerative colitis	K51.90	35	0.294	
Chronic hepatitis				
Chronic hepatitis C	**B18.2**	**29**	**0.165**	
Chronic hepatitis, unspecified	K73.9	29	0.165	
Cirrhosis				
Alcoholic cirrhosis	**K70.30**	**28**	**0.390**	
Non-alcoholic cirrhosis	K74.60	28	0.390	
Esophageal varices, no bleed	I85.00	27	0.962	
Portal hypertension	K76.6	27	0.962	
Chronic pancreatitis				
Chronic pancreatitis	**K86.1**	**34**	**0.276**	
Rheumatologic problems				
Lupus	**M32.9**	**40**	**0.423**	
Sicca syndrome (Sjoren)	M35.00	40	0.423	
Rheumatoid arthritis	M06.9	40	0.423	
Inflammatory polyarthropathy	M06.4	40	0.423	
Polymalgia rheumatica	M35.3	40	0.423	
Psychiatric problems				
Schizophrenia	**F20.9**	**57**	**0.608**	"Run-of-the-mill" depression/anxiety has no HCC weight. Must document *Diagnostic and Statistical Manual of Mental Disorders* criteria.
Schizoaffective disorder	F25.9	57	0.608	
Major depression, recurrent	F33.9	58	0.395	
Bipolar disorder	F31.9	58	0.395	
Alcoholism	F10.20	55	0.383	
Alcoholism, in remission	F10.21	55	0.383	
Drug dependence	F1X.20	55	0.383	
Drug dependence, in remission	F1X.21	55	0.383	
Neurologic problems				
Parkinson's disease	**G20**	**78**	**0.585**	Remember to list these chronic diseases annually, even if primary management is by a consultant.
Multiple sclerosis	G35	77	0.441	
Paralysis	G83.9	104	0.395	
Seizure disorder	G40.909	79	0.227	
Ischemic stroke	**Varies**	**100**	**0.265**	

Cardiac disease				
Angina	**I20.9**	**88**	**0.140**	
Coronary artery disease with angina	I25.119	88	0.140	
Unstable angina	I20.0	87	0.218	
Acute myocardial infarction	I21.3	86	0.233	
Pulmonary hypertension	I27.2	85	0.323	
Cor pulmonale	I27.81	85	0.323	
Cardiomyopathy	I42.9	85	0.323	
CHF	I50.9	85	0.323	
Atrial fibrillation	I48.91	96	0.268	
Aortic atherosclerosis	I70.0	108	0.298	
Abdominal aortic aneurysm	I71.4	108	0.298	
Deep venous thrombosis (DVT)				
DVT, acute	**I82.40**	**108**	**0.298**	
DVT, chronic	I82.50	108	0.298	
Vascular disease				
Peripheral vascular disease	**I73.9**	**108**	**0.298**	
Diabetic peripheral vascular disease	E11.51	18	0.318	
Venous stasis ulcers with varicose veins	I83.0	107	0.400	
Chronic venous stasis ulcer	I87.31	107	0.400	
Ophthalmology				
Wet macular degeneration	**H35.32**	**124**	**0.499**	
Proliferative diabetic retinopathy	E11.359	18	0.318	
Trauma				
Concussion w/o loss of consciousness, sequelae	**S06.0X0S**	**167**	**0.191**	Any code reflecting major or severe head trauma has HCC weight.
Head injury with subdural hemorrhage	S06.6X6A	166	0.584	
Hip fracture	S72.009A	170	0.418	
Artificial openings				
Tracheostomy status	**Z93.0**	**82**	**1.055**	
Gastrostomy status	Z93.1	188	0.571	
Colostomy status	Z93.3	188	0.571	
Cystostomy status	Z93.5	188	0.571	
Amputation status				
Specify site	Z89.4-6	189	0.588	Lower limb only.
Major organ transplant				
Heart transplant status	Z94.1	186	1.000	Can be any duration from surgery.
Lung transplant status	Z94.2	186	1.000	
Liver transplant status	Z94.4	186	1.000	
Excluded chronic conditions				
Essential hypertension, hyperthyroidism or hypothyroidism, iron deficiency anemia, gastroesophageal reflux, osteoarthritis, and tobacco use.				

1. 2017 midyear final ICD-10 mappings. Centers for Medicare & Medicaid Services (CMS) website. http://go.cms.gov/2ELI0qM. Accessed February 15, 2018.

2. Announcement of calendar year 2017 Medicare capitation rates and Medicare Advantage and Part D payment policies and final call letter. CMS website. http://go.cms.gov/1V577FB. April 2016. Accessed February 15, 2018.

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

Developed by Daniel Belatti, MD, and Megan Lykke, MD, FAAFP. Copyright © 2018 American Academy of Family Physicians. Physicians may duplicate or adapt for use in their own practices; all other rights reserved. Related article: https://www.aafp.org/fpm/2018/0300/p26.html.

Counseling codes

Reminders for using counseling codes Caution to how many time-based codes you add on to a wellness. You may be better off with an E&M code added to the wellness

Explanation of Counseling (G Codes)

Sometimes a provider will do more screening/counseling on a certain topic. Here are some examples:

Cardiovascular Counseling 99446:
This involves screening a patient for cardiovascular risks with cholesterol and blood pressure measurements. Discussing a patient's 10-year cardiovascular risk. Exploring the pros and cons of medications including aspirin for risk modification. Discussing lifestyle changes that will help reduce cardiovascular risk.

> GCODE: CVDcounsel-G0446 (>7.5m)
> Today we discussed your 10-Year cardiovascular disease risk and ways to reduce your chances of having a heart attack or stoke. Things that that you can do to help prevent cardiovascular events include eating a diet high in fiber (fruits and vegetables) and low in simple carbohydrates (bread, rice, pasta, alcohol, potatoes), decreasing processed foods, limiting juice and alcohol, limiting saturated fats (butter, ice cream, and cheeses), and adding regular daily activity. Having blood pressure that is <130/80. Having well controlled cholesterol (LDL and triglycerides) by eating a healthy diet and taking medications when necessary. Managing daily stress with meditation or yoga. Taking a daily aspirin to reduce cardiovascular disease risks may be recommended in people with high risk for heart attack or stroke-as discussed.
> *>7.5min add to procedure*

Depression Screening/Counseling G0444
This involves completing a screening tool for depression. Your provider will then review and discuss the results with you.

> Depression counsel EP:G0444 (annual subsequent medicare only-g0439)
> Today we screened for, reviewed, and discussed ways to help manage depression and anxiety. Many patients live with symptoms of depression and anxiety. Tools that can help manage these symptoms include good sleep hygiene, regular daily activity, meditation, and mindfulness practices. Having good supports from friends, family, and therapists are beneficial. Occasionally medications can be used.
> *>7.5min add to procedure*
>
> Anxiety/depression ScreeningEP:96127 Z13.89
> We completed a mental health screening tool. We discussed the results.

Alcohol Use Screening and Counseling G0442/3
This involves screening for alcohol use. The provider will review the results, discuss, and counsel based on the screening tool results.

> Alcohol ScreenEP:G0442 (1x a year 15m) or just screen 96127
> We screened for alcohol use today using the AUDIT tool. We discussed your risks of alcohol consumption. We explored alternatives to drinking for stress relief.

Alcohol counsel EP: G0443 (4x/year 15m)
We have used the 5 As (assess, advise, agree, assist, arrange) to evaluate your daily alcohol use and create strategies to improve your health. We discussed your alcohol use and the health risks associated with drinking. We explored ways to reduce or stop alcohol consumption to improve your overall health. We discussed resources available to support your goal to cut back or stop including primary care behavioral health, AA, medications.
Your personal goal:
Time >7.5minutes-Add to procedure

Tobacco Cessation Counseling 99406
This involves a provider engaging in a discussion about stopping or cutting back on smoking in order to reduce risk of stroke, heart problems and lung problems.

Tobacco EP 99406/ Z13.89
We discussed your smoking today for more than 3 minutes. Cigarette use is the leading cause of preventable disease, disability, and death in the United States. We talked about tools and medications available to help you in smoking cessation. We discussed utilizing our smoking cessation coach and online resources.
Your personal goal:

Greater than 3minutes added to procedure

Obesity Counseling 99447:
This involves screening for and counseling patients with a BMI>30. It involves discussing a patient's diet, and exploring behavioral modifications that might help a patient reach a healthy weight.

BMI>30counsel: G0447
We reviewed your current weight. We discussed your goal to work towards a body weight that allows you to feel comfortable participating in daily activities. We discussed that working towards your best weight will decrease strain on your joints and reduce your risks of developing issues with your heart and sugar. We explored strategies to reach your healthy weight goal such as daily activity, portion control, reducing simple carbohydrates in your diet. We also discussed online and in person tools that might help you reach your goal.
Your personal goal:
>7.5min add to procedure

Developmental and Behavioral Health Screenings at Well Child Checks

Test	Administers/Location	Concerning Score	Billed By	Billing Code	Add Modifier
Edinburgh PostNatal Depression Scale (EPDS) Newborn visit, 1 month, 2 months, 4 months, 6 months	Scored by Athena Screening Section	Concerning Score: 10 or higher	Medical Assistant	CPT 96110 Dx Code Z00.129/121	U1 (no need identified) *AND* UD (test administered) OR U2 (need identified) *AND* UD (test administered)
SWYC Ages 2 months to 5 years old	Scored by Staff – Developmental Milestones Section Scored by Provider – PPSC, BPSC, POSI, etc	Concerning Score: By age group – see cheat sheet	Provider	CPT 96110 ages 3 years old and younger CPT 96127 ages 4-5 years old Dx Z00.129/121	U1 (no need identified) OR U2 (need identified)
PSC Ages 6-10 years old	Scored by Athena Screening Section	Concerning Score 28 or higher Review Subscales	Provider	CPT 96127 Dx Z00.129/121	U1 (no need identified) OR U2 (need identified)
PSC-Y Ages 11-18 years old	Scored by Athena Screening Section	Concerning Score 30 or higher Review Subscales	Provider	CPT 96127 Dx Z00.129/121	U1 (no need identified) OR U2 (need identified)
PHQ-9 Ages 18-21 years old	Scored by Athena Screening Section	Concerning score 5 or higher	Medical Assistant	CPT 96127 Dx Code Z13.31	U1 (no need identified) OR U2 (need identified)
M-CHAT-R Ages 18 and 24 months	Scored by Athena Screening Section	Concerning score: 3-7 is moderate risk, 8-20 is high risk	Provider	CPT 96110 Dx Z00.129/121	U3 (no need identified) OR U4 (need identified)

BILLING CODES					
Type	**Code**	**Requirements**	**Time**	**Frequency**	**Notes**
Digital Rectal Exam	G0102	For prostate cancer screening, over 50 years old	N/A	Annually	Procedure template. DX Z12.5
Diabetes Outpatient Self Management Teaching	G0108	How to use glucometer, insulin teaching, how to adjust insulin, etc	> 15 mins		
Alcohol Misuse Screening	G0442	Screening or discussion of limiting alcohol. Must use screening tool such as Audit-C in chart. Review family and social HX.	> 7.5 min	Annually	Procedure template. DX Z13.89
Positive Alcohol Screen Discussion	G0443	Counseling a patient on positive alcohol screen	> 7.5 min	Up to 4X year	Procedure template. DX Z71.41
Annual Depression Screening	G0444	Completion of PHQ-9, scoring of screening, provider reviewing score, brief discussion with patient of result	>7.5 min	Annually	Procedure template. DX Z13.89
High Risk Sexual Practices Counseling	G0445	High intensity counseling to lower risk of STIs and change sexual practices	>15 mins	Semi-annually	
Cardiovascular Risk Reduction Counseling	G0446	Behavior change counseling to lower cardiovascular risk (weight reduction, medication adherence, etc). 40 years and older. Must discuss BP, weight, exercise, family HX and ASA.	>7.5 min	Annually	Procedure template. Do not have to have CVD but can still bill for patients w/CVD as trying to reduce risk. DX Z71.9, HTN, HLD, CVD etc.
Behavioral Counseling for Obesity	G0447	Counseling, developing weight loss plan, BMI over 30	>7.5 mins	First month: Weekly x 4 weeks. 2-6 months: every other week. 7-12 months can bill if lose 3 kg	Procedure template. Can add on to a HTN or Diabetes visit, etc if discussed weight loss plan. DX = obesity.

				up to 22 visits per year.	
Prolonged Prevention Service	G0513	Prevention service	> 30 mins		Need to document reason. Must be beyond typical service time of primary procedure. Cannot be billed incident to. Must be billed by performing provider.
Developmental Screening	96110	Pediatric			Modifiers: U1 Physician, no behavioral health needs ID'ed. U2 Physician, behavioral health needs ID'ed. U5 NP no behavioral health needs ID'ed U6 NP, behavioral health needs ID'ed. U7 PA no behavioral health needs ID'ed. U8 PA behavioral health needs ID'ed.
Behavioral Health Scored Screening Tests/Brief Emotional Assessment	96127	Opioid Risk Tool, PHQ-9, BH screening tests such as GAD and MCHAT	N/A	Up to 4 tests per visit	Procedure template. Can be used for PHQ-9 if using to monitor patients with depression (bill G0444 if with physical). Results need to be scored and documented in chart. If the test is positive, needs a brief action plan.
Chart/Historical Medical Record Review	99358	Reviewing medical records, talking to other providers regarding case, if family came to visit without patient present	30 min or more of non-face to face time. One continuous block of time (not in place of CCM billing)		
Chart/Historical Medical Record Review, Addtl. 30 mins.	99359	Reviewing medical records, talking to other providers regarding case, if family came to visit without patient present	30 additional minutes of non-face to face time		
Smoking and tobacco use counseling	99406		3-10 minutes	Up to 8 X year	

Smoking and tobacco use counseling	99407		> 10 mins	Up to 8 X year	
Advanced Care Planning	99497	Counseling and discussion, can include MOLST and health care proxy form	> 15 mins		Procedure Template.
Advanced Care Planning, addtl 30 mins.	99498	Counseling and discussion, can include MOLST and health care proxy form	Each addtl 30 min (can bill after spending 45 min).		

Medicare Wellness Required Elements

	IPPE - G0402	Initial AWV - G0438	Subsequent AWV - G0439
Information gathering	☐ Review the medical and social history with attention to modifiable risk factors: • Past medical/surgical history, • Current medications and supplements, • Family history, • History of alcohol, tobacco, and illicit drug use, • Diet, • Physical activity. ☐ Review potential risk factors for depression or other mood disorders ☐ Review functional ability and level of safety: • Hearing impairment, • Activities of daily living, • Fall risk, • Home safety.	☐ Establish the medical/family history: • Past medical/surgical history, • Current medications and supplements, • Family history. ☐ Review the patient's health risk assessment, which includes: • Demographic data, • Self-assessment of health status, • Psychosocial risks, • Behavioral risks, • Activities of daily living (dressing, bathing, walking, etc.), • Instrumental activities of daily living (shopping, housekeeping, etc.). ☐ Review potential risk factors for depression. ☐ Review functional ability and level of safety: • Hearing impairment, • Activities of daily living, • Fall risk, • Home safety. ☐ Establish a list of current providers and suppliers regularly involved in the individual's medical care.	☐ Update the medical/family history: • Past medical/surgical history, • Current medications and supplements, • Family history. ☐ Review the updated health risk assessment, which includes: • Demographic data, • Self-assessment of health status, • Psychosocial risks, • Behavioral risks, • Activities of daily living (dressing, bathing, walking, etc.), • Instrumental activities of daily living (shopping, housekeeping, etc.). ☐ Update the list of current providers and suppliers regularly involved in the individual's medical care.
Exam/ assessment	☐ Obtain the following: • Height, • Weight, • Body mass index, • Blood pressure (BP), • Visual acuity, • Other items as appropriate. ☐ Conduct end-of-life planning if the individual agrees.	☐ Obtain the following: • Height, • Weight, • BMI (or waist circumference), • BP, • Other items as appropriate. ☐ Detect any cognitive impairment.	☐ Obtain the following: • Weight (or waist circumference), • BP, • Other items as appropriate. ☐ Detect any cognitive impairment.
Counseling	☐ Educate, counsel, and refer based on the previous five elements. ☐ Educate, counsel, and refer for other preventive services. Create a brief written plan (e.g., a checklist) that includes: • A once-in-a-lifetime screening electrocardiogram (G0403-G0405), as appropriate, • Other appropriate screenings and preventive services that Medicare covers.	☐ Establish a written screening schedule, such as a checklist for the next 5 to 10 years, as appropriate. ☐ Establish a list of risk factors and conditions for which interventions are recommended or underway. ☐ Furnish personalized health advice and a referral as appropriate to health education or preventive counseling services or programs. ☐ Provide any other element determined appropriate through the National Coverage Determination process.	☐ Update the written screening schedule developed at the initial AWV. ☐ Update the list of risk factors and conditions for which interventions are recommended or underway. ☐ Furnish personalized health advice and a referral as appropriate to health education or preventive counseling services or programs. ☐ Provide any other element determined appropriate through the National Coverage Determination process.

SOURCE

FPM Toolbox To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

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How to avoid Medicare annual wellness visit denials

If you're seeing a high number of denials for Medicare annual wellness visits (AWVs), you're not alone. Identifying whether to code for an Initial Preventive Physical Exam (IPPE, or the "Welcome to Medicare" visit), an initial Medicare AWV, or a subsequent Medicare AWV can be tricky.

Common reasons for denial include the following:

1. Billing a G0438 (initial Medicare AWV) or G0439 (subsequent Medicare AWV) when the patient has been enrolled in Medicare Part B for 12 months or less. This situation instead calls for billing G0402 (IPPE).

2. Billing for a Medicare AWV when the patient only has Medicare Part A. They must have Part B coverage as well.

3. Using the wrong primary diagnosis code. If the primary diagnosis code is problem-oriented (e.g., diabetes or hypertension), Medicare will most likely deny a claim for an AWV, because AWVs are "well visits." Instead, list a well code (e.g., Z00.0X, "encounter for general adult exam") as the primary diagnosis.

The IPPE also has a slightly different set of required components (e.g., advance care planning and visual acuity screening with documentation of results in the note) than the two types of AWVs (e.g., instrumental activity of daily living and assessment of cognitive function).

Here are some frequently asked questions to help you further navigate the world of AWV billing, as well as a side-by-side comparison of the three types of Medicare wellness visits.

FAQs

Q - What is the difference between a Medicare AWV and a preventive visit?

A - Medicare AWVs consist of three specific visit types statutorily covered by Medicare with no co-pay or deductible. They are the IPPE (the "Welcome to Medicare" visit, G0402), the initial AWV (G0438), and the subsequent AWV (G0439). These visits do not require a comprehensive physical exam. Preventive visits (9938X and 9939X) are covered by commercial/managed care and Medicaid plans and require a comprehensive physical exam. They are also include no co-pay or deductible.

Q - Can a Medicare patient receive a preventive visit?

A - Yes, but traditional Medicare does not cover these visits (9938X and 9939X are statutorily prohibited), so patients with that coverage will have to pay 100% out-of-pocket. However, some Medicare Advantage plans cover both Medicare AWVs (G codes) and non-Medicare (commercial) preventive visits (9938X and 9939X). Medicare Advantage patients would need to check their plan benefits to find out if they have coverage for both.

Q - Is the IPPE the same as the initial AWV?

A - No, the IPPE is the Initial Preventive Physical Examination, also known as the "Welcome to Medicare" visit (G0402), while the initial AWV (G0438) is the patient's first Medicare AWV following the IPPE. These are two different types of visits, and billing a G0438 when the patient was actually only eligible for a G0402 is a common cause of denials.

Q - What diagnosis code should I use to bill a Medicare wellness exam?

A - Use the Z00 family of codes.

Q - Do Medicare wellness visits need to be performed 365 days apart?

A - No. A Medicare wellness visit may be performed in the same calendar month (but different year) as the previous Medicare wellness visit. For example, if a patient had a Medicare AWV on June 30, 2020, then that patient is eligible again on June 1, 2021. If a patient had a Medicare AWV on June 1, 2020, then that patient is also eligible again on June 1, 2021. But if you bill a Medicare AWV for either patient on May 31, 2021, it will be denied, because it is in a different calendar month and too soon.

Q - Can I bill for a Medicare AWV and a commercial insurance preventive visit for the same patient in the same year?

A - Yes, you can do this if the patient has both as part of their covered benefits. Some patients have a commercial payer as their primary insurance and Medicare as their secondary.

Q - Can I perform Medicare wellness visits in skilled nursing facilities or as home visits?

A - Yes. Just make sure the place of service (POS) on the claim corresponds to the correct location.

Q - Can I perform a pap smear or pelvic exam during a Medicare AWV?

A - Yes, and they are both separately billable. Use code Q0091 for the screening pap smear in a Medicare patient. The pelvic exam must be combined with a breast exam and then billed together using G0101. Specific documentation components are required for the G0101.

Q - If a patient has a managed Medicare plan (non-traditional Medicare), can I still bill a G code (G0402, G0438, or G0439) for a wellness visit?

A - Yes. Traditional Medicare and all managed Medicare plans will accept the G codes for AWVs.

Q - Can I bill a routine office visit with a Medicare AWV?

A - When appropriate, a routine office visit (9920X and 9921X) may be billed with a Medicare AWV. Modifier -25 should be appended to the evaluation and management (E/M) code. Cost sharing will apply to the E/M service, though, just as it would without the Medicare AWV. Make sure patients are aware of this, as some may expect that all services provided on the same day as the Medicare AWV are covered at 100%.

Which type of Medicare AWV is this?

	IPPE (Welcome to Medicare, G0402)	Initial AWV (G0438)	Subsequent AWV (G0439)
How often?	Once in a lifetime	Once in a lifetime	Annually
Eligibility	Within first 12 months of Medicare Part B enrollment	12 months after the IPPE (or if patient did not receive an IPPE during 12-month eligibility window)	Every year after the initial AWV
Minimum time since previous AWV	Not applicable (first visit)	At least 11 full months after G0402. (Can be billed when you reach same calendar month as previous year's visit.)	At least 11 full months after G0438 or G0439. (Can be billed when you reach same calendar month as previous year's visit.)
Required physical exam components	Height, weight, body mass index (BMI), blood pressure (BP), visual acuity screening (w/ documentation)	Height, weight, BMI, and BP (visual acuity screen not required)	Weight and BP (height, BMI, and visual acuity screen not required)
Electrocardiogram (ECG) screening covered?	Yes, but co-pay and deductible apply (ECG codes G0403, G0404, and G0405)	No	No
Can advance care planning (ACP) be billed separately?	No. ACP is included as a mandatory component of this visit.	Yes, CPT 99497 and 99498 can be billed separately as long as minimum time requirements are met. Use modifier -33 to avoid co-pay and deductible.	Yes, CPT 99497 and 99498 can be billed separately as long as minimum time requirements are met. Use modifier -33 to avoid co-pay and deductible.

— Vinita Magoon, DO, JD, MBA, MPH, CMQ, Baylor Scott & White Health, Temple, Texas

Posted on Feb 04, 2021 by FPM Editors

IUD Coding

Pharmacy provided vs. Buy and Bill

- Check appointment note and patient case for info if IUD was pharmacy provided or buy and bill. (Pharmacy provided units will have a pharmacy label on the box.)
- If the unit is NOT pharmacy provided: the unit is a "buy and bill." The provider will need to bill for the unit **in addition** to billing for the procedure insertion code.
  - Code for IUD unit
  - Code for insertion or insertion/ removal
- If the unit is pharmacy provided (there is a pharmacy label on the unit), then bill for the insertion procedure only.
  - Code for insertion or insertion/ removal
- It is helpful to write in comments to the biller these details as a secondary safeguard.

Insertion AND Removal in the same visit

- Always bill for the *insertion (58300) first* and *then the removal (58301)*
- modifier 51 should be added to the removal procedure (58301), the lesser paying code

Failed insertions and procedures

- Any failed IUD must be kept in the original packaging and given to the health center manager, even if it was opened.
  - If package was opened, place IUD back in package and biohazard bag with patient info. Give to Nurse manager or IUD contact person.
- Failed insertion codes with modifiers must be added to the encounter plan
  - Please document reason for failed insertion. This may include any code associated with reason, such as cervical stenosis.

Common IUD Codes for Discontinued Services

- **Failed insertion Code- 58300**, with modifier -52 (failed proc.) -53(discontinued)
  - Diagnosis code: Z30.42, encounter for IUD + Diagnosis of complication which caused failed procedure/discontinuation
  - Modifier 52 failed d/t stenosis or anatomical abnormality
  - Modifier 53, discontinued d/t patient well-being, pain, vasovagal
- **Perforation - 58300-** 53, if procedure d/c due to perforation
  - Diagnosis codes Z30.430 + T83.39XA (other mechanical complication of IUD initial, sub, seq)
- **Failed removal code – 58301, w/ modifier 52/53**
  - modifier 52(failed for anatomical/ structural reason) or 53(stopped d/t patient well-being concerns)
  - Diagnosis Encounter for IUD and T83.32XA, displacement of IUD
    - Document reason for failed/ stopped procedure
- Modifier 59- removal/insertion same day, document reason (expired)
- Modifier 76/77, repeat procedure, ex. IUD expelled.

IUD Removals

- Please bill a removal procedure code 58301.

Incident-to Billing and Medicare: A reminder and key points

Key points to remember is that since we no longer auto default to incident-to billing, you must instead document in the note/ billing slip if "incident-to" criteria is met. This will result in a 15% increase in Medicare reimbursement.

-Medicare pays Advanced practice clinician (APC) visits at 85% of a physician’s fee schedule. Billing “incident-to” will result in 100% reimbursement.

-When billing incident-to, there needs to be a physician visit that the incident-to service directly relates to.

-If the APC(NP/PA) is following a plan of care that a physician established in the previous visit, the visit qualifies as incident-to billing.

-If a new course of care is needed and differs from the prior physician’s plan, the service is not billed as incident-to.

-However, if the treatment plan needs to be adjusted and the APC discusses this with a collaborating physician who does a quick “face-to-face”, the visit can then be billed incident-to.

-For compliance, a physician must be physically on site and available.

-Best practice for documenting is to write in the chart note; “Dr. XYZ is on site and available.” Also document on the billing slip "billing incident-to DR. XYX."

-Also, the physician could add an addendum on the chart stating that they “reviewed the note and agree with the plan of care.” Although this addendum is not a CMS requirement.

Reference

Ulmer, E. G. & Harris, A.V. (2023). Billing for Non-Physician Provider Services to Support the Delivery of Physician Care. *Family Practice Management, 30(1):* 13-17.
https://www.aafp.org/pubs/fpm/issues/2023/0100/billing-for-npp-services.html

Additional Cheat Sheets and Resources

Coding based on time

CODE New/Established	TOTAL TIME New/Established	MDM: medically appropriate H&P plus:
~~99201~~/99211	n/a	-
99202/99212	15-29 mins/ 10-19 mins	Straightforward
99203/99213	30-44 mins/ 20-29 mins	Low Level
99204/99214	45-59 mins/ 30-39 mins	Mod Level
99205/99215	60-74 mins/ 40-54 mins	High Level

Please watch training from Betsy Nicoletti posted on the intranet from September 13, 2023. The slide below is from her presentation.

Medical decision making

Code	Level of MDM 2 of 3 elements	Number and Complexity of Problems Addressed	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	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 99212	Straight forward	**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:** o __Review of prior external note(s) from each unique source*; o __Review of the result(s) of each unique test*; o __Ordering of each unique test* OR □ **Category 2**: Assessment requiring an independent historian(s)	**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:** o __Review of prior external note(s) from each unique source* o __Review of the result(s) of each unique test*; o __Ordering of each unique test* o __Assessment requiring 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**) (in the field right above,)	**High risk** of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major procedure 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

Recorded 9/13/23 ©2023 Betsy Nicoletti

from the AMA(2020)		***Elements of MDM: Coding based on 2 out of 3 of these elements***			
Established/New	***MDM***	***# of Problems Addressed***	***Amount/ Complexity of Data Reviewed***	***Risk Level***	***Examples***
Level 2: 99212/99202	***Straightforward***	***1 self-limited, minor problem***	***Minimal/None***	***Minimal***	
Level 3: 99213/99203	***Low***	***2 or more self-limited problems -or- 1 stable chronic illness -or- 1 acute, uncomplicated illness or injury***	***Limited (1 of 2 categories required)*** **Category 1: Test/Documents/Historians (need 2)** -reviewing prior external notes -reviewing results, each unique test -ordering of a unique test **Category 2**: -assessment requiring a historian that is independent	***Low Risk from testing/ treatment***	***URI***
Level 4: 99214/99204	***Moderate***	***1 or more chronic illness (w/ exacerbation/progression/ side effects of treatment) -or- 2 or more stable chronic illnesses -or- 1 undiagnosed new problems/ uncertain prognosis -or- 1 acute illness w/ systemic symptoms -or- 1 acute complicated injury***	***Moderate (1 out of 3 categories required)*** **Category 1: Test/Documents/Historians (need 3)** -reviewing prior external notes -reviewing results, each unique test -ordering of a unique test -assessment requiring a historian that is independent **Category 2: Independent Interpretation** -independent review of a test performed by another healthcare professional, not reported separately **Category 3: External Discussions** -Consultation/ discussion with external health care provider on management or test interpretation	***Moderate Risk from additional testing/ treatment***	***Medication management, minor or elective surgery discussions, social determinants of health limit diagnosis & treatment***
Level 5: 99215/99205	***High***	***1 acute or chronic illness or injury that threatens life or bodily function***	***Extensive (2 out of 3 categories required)*** **Category 1: Test/Documents/Historians (need 3)** -reviewing prior external notes -reviewing results, each unique test -ordering of a unique test -assessment requiring a historian that is independent **Category 2: Independent Interpretation** -independent review of a test performed by another healthcare professional, not reported separately **Category 3: External Discussions** -Consultation/ discussion with external health care provider on management or test interpretation	***High Risk from additional testing/ treatment***	***Decision to hospitalize, start Warfarin therapy, decision for elective major or emergent surgery, DNR discussion***

Updated Coding cheat sheets

Updated 2023

Code based **on either** total time **or** medical decision making. (Millette, K. W. (2020) Countdown to the E/M Coding Changes. *FPM*. www.aafp.org/fpm.

Updated Visit level	**Total time**	**Medical decision making**	**Example**
Level 2	<20 minutes (<30 minutes for new patients)	No medication prescribed	viral URI, or simple recheck for stable problem
Level 3	20-29 minutes (30-44 minutes for new patients)	One acute problem PLUS medication prescribed OR one test ordered and reviewed	strep screen, UTI w/ Urinalysis
Level 4	30-39 minutes (45-59 minutes for new patients)	**At least one of the following:** • One unstable chronic illness • Two stable chronic illnesses addressed • Acute complicated injury (e.g., concussion, fracture), • Acute illness with systemic symptoms (e.g., pyelonephritis or pneumonia), • New problem with uncertain prognosis (e.g., breast lump). **PLUS at least one of the following:** A. Prescription drug management, B. X-ray or ECG that is ordered and interpreted (But not reported separately) C. Total of three unique tests ordered or reviewed, external notes reviewed, or independent historians used (requires three “points” where each instance equals one point — e.g., three unique tests ordered or reviewed equals three points), D. Patient’s management or test discussed with external provider, E. Patient’s diagnosis and treatment limited by lack of money, food, or housing. **OR:** Prescription drug management plus at least one of the following: B, C, or D above.	Unstable=includes BP or A1C not to goal Chronic illness: HTN, DM, CKD
Level 5	40-54 minutes (60-74 minutes for new patients)	Severe acute illness or worsening chronic illness posing a threat to life or bodily function (e.g., myocardial infarction, pulmonary embolism, acute renal failure, severe respiratory distress, acute neurological change) **PLUS at least one of the following:** • Two of three from B, C, or D above, • Patient admitted by someone other than yourself, • Patient placed on warfarin, • Patient made DNR, care de-escalated.	