General Evaluation & Management Coding and Compliance
Valuing the work of an Evaluation and Management Service

- The Level of Service provided is based on:
  - Your resource expenditure
  - Patient’s presenting illness or condition

- Documentation should support:
  - Patient’s condition/diagnosis and the severity
  - Your effort in managing or treating the diagnosis
    - Components of history and exam
    - Other work, such as reviewing notes or images
    - Complexity of case
E/M Service Categories
Inpatient and outpatient services are E/M categories most used by UNC providers

- **Inpatient E/M Categories:**
  - Consultations:
    - 5 levels [99251 – 99255]
  - Initial and Subsequent Hospital care:
    - 3 levels [99221 – 99223; 99231 – 99233]
  - Initial and Subsequent Observation care: 3 levels
    - 3 levels [99218 – 99220; 99224 – 99226]

- **Outpatient E/M Categories:**
  - Consultations: 5 levels [99241 – 99245]
  - New Patients: 5 levels [99201 – 99205]
  - Established Patients: 5 levels [99211 – 99215]
New versus Established Patient

New Patient CPT codes: 99201-99205

- A new patient is defined as not having received any professional evaluation and management (E/M) services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years, including inpatient, outpatient or emergency room.

Established Patient CPT codes: 99201-99205

- A patient is considered established if they have received care (same specialty /same group practice) within the last three years.

Tip: A patient would still be considered “new” if an interpretation of a diagnostic test was billed, such reading an EKG or x-ray in the absence of an E&M service or other face-to-face visit.
Consultations are provided when the opinion of one physician is requested by another physician

A consultation is an E/M service

- provided when the opinion and/or advice of one physician is requested by another physician or appropriate source

- to either recommend care for a specific condition or problem

- or to determine whether to accept responsibility for ongoing management of the patient’s entire care for a specific condition or problem.
Consultations should be viewed as a three-part cycle:

1. a request is made
2. an evaluation is performed and
3. an opinion is rendered and sent to the requesting physician.
Consultation documentation has specific requirements

Documentation of a consultation request must be clearly stated in the note:

WRONG: “Mr. Patient was referred by Dr. Jones for management of diabetes.”

RIGHT: “Mr. Patient is seen in consultation at the request of Dr. Jones for evaluation of diabetes.”
EPIC handles consultation code translation for Medicare

- Medicare has not recognized consultation codes since 2010, but EPIC translates the consultation codes to the appropriate E/M category and level for Medicare.

- Please continue to bill consultation codes for all payors when provided and documented.

- Epic Tip: Including the referring provider in the referring provider field will assist in the communication process to the provider that requested a consult. A letter can be sent to the requesting provider through the communications tab in EPIC.
Documenting and Coding E/M Services
"The first equation explains the theory of relativity. This one we haven’t figured out yet."
Three key components are considered for E/M service level coding

- History
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past, Family, Social History (PFSH)
- Examination
- Medical decision making

Visits that consist predominately of counseling and/or coordination of care are an exception to this rule; for these visits, time is the key or controlling factor to qualify for a particular level of E/M service.
The documentation for each component must meet requirement for level of service billed

ALL three key components (History, Exam, and MDM) are required for:
- Consultations
- New outpatient visits
- Initial hospital admissions
- Initial observation services

Two of the three components are required for:
- Established outpatient visits
- Subsequent hospital care
- Subsequent observation care
The documentation of a Chief Complaint is required for ALL E/M services

A chief compliant (CC)

- a concise statement describing the symptom(s), problem(s), condition(s), diagnosis, or other factor that is the reason for the patient encounter
- is typically provided by the patient in their own words but can be the observation of the provider if the patient is unable to provide
- must be clearly documented

The use of only “Follow Up” without further expansion is not acceptable. Documentation should state the reason for the follow up encounter, such as “Follow up for hypertension”.

Example of a poor chief complaint: “Patient here due to multiple medical problems”
HPI: status of three chronic conditions or use of descriptors determines HPI level

- There are times when the documentation is reflective of the patient’s chronic conditions.

- It is the status of the three chronic conditions that allows for an extended HPI.
  - “Patient has DM controlled by diet, hyperlipidemia better with diet and exercise, and COPD controlled with medication.”

- The HPI can also be documented using the below descriptors:

<table>
<thead>
<tr>
<th>Location</th>
<th>Duration</th>
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</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Context</td>
</tr>
<tr>
<td>Severity</td>
<td>Modifying Factors</td>
</tr>
<tr>
<td>Timing</td>
<td>Associated Signs &amp; Symptoms</td>
</tr>
</tbody>
</table>
HPI must be documented by the provider, not ancillary staff or a medical student

- History of present illness may only be documented by the billing provider.

- The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

- If the history is unobtainable from the patient or other source, the record should describe the patient’s condition or other circumstance which precludes obtaining an history.
The ROS is the most often missed subcomponent of the history

- Document all pertinent positive and negative review of systems.
  - Recommended statement when a complete review of systems has been performed: “All other systems reviewed are negative.”
- Please use the term ‘system’ instead of ‘point’ when documenting the review of systems.
- If you are using a template/EHR and the ‘all others negative’ box is checked without any positives/negatives otherwise documented, a complete ROS is not counted.

Tip:

Review of Systems documentation must show the provider has asked the patient a question.

ROS may be documented in the HPI or in a separate ROS section. The provider may document “no abdominal pain, no shortness of breadth” and receive credit for gastrointestinal and respiratory ROS within the HPI.
Documentation of history has specific requirements

- The CC, ROS and PFSH may be listed as separate elements of history or they may be included in the description of the history of the present illness.

- A ROS and/or PFSH obtained during an earlier encounter does not need to be re-recorded; however, there must be evidence the physician reviewed and updated the previous information by:
  - Describing any new ROS and/or PFSH information or noting there has been no change in the information and
  - Noting the date and location of the earlier ROS and/or PFSH

- The ROS and/or PFSH may be recorded by ancillary staff or a form completed by the patient but there must be a notation indicating the physician reviewed information recorded by others.

- If the physician is unable to obtain a history from the patient or other source, the record should state why the history could not be obtained.
Either 1995 or 1997 Exam Guidelines, but not combination, may be used

- There are two versions of the documentation guidelines – the 1995 version and the 1997 version.

- The most substantial differences between the two versions occur in the examination documentation section.

- The physical examination is based on the medically necessary examination of organ systems and/or body areas as defined by either:
  - The 1995 guidelines recognize 10 body areas and 12 organ systems
  - The 1997 guidelines require more detail in the documentation but allow for comprehensive levels for specialty specific exams.

- As with the History component, a comprehensive exam is required when billing the two highest level E/M services.
The 1995 guidelines recognize 10 body areas and 12 organ systems

<table>
<thead>
<tr>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affected Body Area</td>
<td>Affected Area + Up to 6 others</td>
<td>2-7 Areas, more detail</td>
<td>8+ Areas</td>
</tr>
<tr>
<td>Affected Organ System</td>
<td>Affected Area + Up to 6 others</td>
<td>2-7 Areas, more detail</td>
<td>8+ Systems or Complete Single Organ System Exam</td>
</tr>
</tbody>
</table>

**Reminder:** The 1995 examination is based on either body areas or organ systems, not a combination of both.

**Per Palmetto GBA (NC Medicare):** A ‘general multi-system’ exam refers to 8 or more body areas or organ systems. The 1997 ‘comprehensive’ single organ system exam may be used as guidance when selecting and exam based on the 1995 ‘complete exam of a single organ system.’
Exam Component: 1995 Guidelines

The body areas recognized are:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity:
  - Right Arm
  - Left Arm
  - Right Leg
  - Left Leg

The organ systems recognized are:

- Constitutional
- Eyes
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic
Exam Documentation Tips:

When documenting the examination, the term ‘Abdomen’ refers to a body area, according to NC Medicare guidelines.

- Changing your exam template header to “Abdomen/Gastrointestinal” rather than “Abdomen” will help receive credit for an organ system when documentation reflects both the abdomen and GI system.

Per Palmetto GBA (NC Medicare Carrier) – “More Detail” for a detailed examination using the 1995 Exam Guidelines is defined as:

- At least 2 body areas or organ systems with at least 2 findings
Exam Component: 1997 Guidelines

There are two types of 1997 examinations:

- One General Multi-System
- Ten Different Single Organ System exams

- Each level is comprised of examination elements identified by bullet points within specific body areas and organ systems. Bullet points must be documented exactly as provided in the CMS exam templates.

- The 1997 exam guidelines are typically used more by specialists than primary care. However, most providers tend to document based on the 1995 exam (body areas/organ systems).
### General Multi-System Examination

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| Constitutional   | • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)  
• General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming) |
| Eyes             | • Inspection of conjunctivae and lids  
• Examination of pupils and irises (eg, reaction to light and accommodation, size and symmetry)  
• Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages) |
| Ears, Nose, Mouth and Throat | • External inspection of ears and nose (eg, overall appearance, scars, lesions, masses)  
• Otoscopic examination of external auditory canals and tympanic membranes  
• Assessment of hearing (eg, whispered voice, finger rub, tuning fork)  
• Inspection of nasal mucosa, septum and turbinates  
• Inspection of lips, teeth and gums  
• Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx |
| Neck             | • Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)  
• Examination of thyroid (eg, enlargement, tenderness, mass) |
MDM refers to the work performed by a provider to establish a diagnosis and/or select management or treatment options.

The work measures are represented by three tables:
1. The number of diagnosis and treatment options
2. Amount and/or Complexity of data reviewed
3. Patient risk for morbidity and mortality
Medical Decision Making Tips

- For each encounter, an assessment, clinical impression, or diagnosis should be documented.

- For a presenting problem with an established diagnosis the record should reflect whether the problem is:
  - Improved, well controlled, resolving or resolved, or
  - Inadequately controlled, worsening, or failing to change as expected

- Document the status of all problems/diagnoses that you are managing and/or treating and any conditions that impact your treatment or management of those problems.
## Medical Decision Making – Documentation Tips

- Document the discussion of test results with performing physician (i.e. radiologist)

- Document the decision to obtain old records and/or obtain history from someone other than the patient

- Document the review and summarization of old records and/or obtaining history from someone other than the patient and/or discussion of case with another health care provider
  - “*Patient’s wife states…*”; or “*I have reviewed previous records from…*”

- Document if you independently visualized an image, tracing, or specimen itself (not simply review of the report)
  - “*I have independently viewed the MRI of the brain from 03/10/16 and….*”

- Document the patient’s clinical risks if the patient has a high risk for morbidity/mortality

- Document the initiation of, or changes in, treatment

- If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested
Payors look to MDM for support of medical necessity

**Tip:** The guidelines do not state that MDM must be one of the key components documented as one of the two for established patients; however, payors look to MDM to support /steer medical necessity.

- For example a provider may document a comprehensive history and examination which would meet the requirements for CPT code 99215. However, you must determine if it was medically necessary to document a comprehensive history and exam based on the patient’s presenting problem(s).

- The patient’s diagnoses or problems and their management/treatment help substantiate the level of service.

*NC Medicare Carrier Palmetto GBA 7/15/15*
# Tips to Prevent Coding Errors

<table>
<thead>
<tr>
<th>History</th>
<th>Examination</th>
<th>Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not limit the CC to “follow up” without stating the identifying problem being addressed.</td>
<td>Always examine the system(s) related to the presenting problem.</td>
<td>Record relevant impressions, tentative diagnoses, confirmed diagnoses and all therapeutic options chosen related to every problem for Evaluation and Management is clearly demonstrated in the record of the other key components.</td>
</tr>
<tr>
<td>Describe HPI fully and in such a way that the nature of the presenting problem is clear. Higher level services require 4+ descriptors.</td>
<td>Abnormal findings should be noted and expanded upon. Documenting “normal” for other systems is sufficient.</td>
<td>Document all diagnostic tests ordered, reviewed, and independently visualized as part of the work of the encounter.</td>
</tr>
<tr>
<td>Record PFSH appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services.</td>
<td>Code the physical examination considering the clinical circumstances of the encounter. Do not code based on excessive and unnecessary information recorded solely to meet the requirements of a higher-level service when the nature of the visit dictates a lower-level service is medically appropriate. <strong>Be mindful of copy and paste functionality available within the EHR.</strong></td>
<td>Summarize old records or other outside information reviewed and incorporated into the decision making.</td>
</tr>
<tr>
<td>Record the Review of Systems (ROS) appropriate for the clinical circumstance of the encounter. Extensive ROS is unnecessary for lower-level services.</td>
<td></td>
<td>Understand the logic of templates and/or computer programs used for E/M service coding.</td>
</tr>
</tbody>
</table>
BEWARE OF COPY / PASTE!

- Use of Copy / Paste without editing for that visit does not establish the medical necessity of the unique service provided that visit.

- Patient care could be compromised if old treatment plans are copied and pasted.

- Copy / Paste can multiply the effect of an incorrect pieces of data.

- Copy / Paste contributes to “note bloat”.

- Copy / Paste is on the radar of our local Medicare carrier’s radar:

  “Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.” Palmetto GBA 10/31/14.
Putting it all together... Required elements for outpatient E/M coding

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>CPT Code</th>
<th>History &amp; Exam Type</th>
<th>History</th>
<th>Examination</th>
<th>Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>HPI</td>
<td>1995 Exam Organ System/Body Area</td>
<td>1997 Exam Elements</td>
</tr>
<tr>
<td>New</td>
<td>99201</td>
<td>Problem Focused</td>
<td>Brief (1-3)</td>
<td>Brief System/ Body Area</td>
<td>1-5 Elements</td>
</tr>
<tr>
<td></td>
<td>99202</td>
<td>Expanded Problem Focused</td>
<td>Brief (1-3)</td>
<td>Pertinent (1)</td>
<td>2-7 Limited Exam Org Syst/Bod Areas</td>
</tr>
<tr>
<td></td>
<td>99203</td>
<td>Detailed</td>
<td>Extended (4)</td>
<td>Extended (2-9)</td>
<td>2-7 Extended Exam Org Syst/Bod Areas</td>
</tr>
<tr>
<td></td>
<td>99204</td>
<td>Comprehensive</td>
<td>Extended (4)</td>
<td>Complete (10+)</td>
<td>8+ Organ Systems</td>
</tr>
<tr>
<td></td>
<td>99205</td>
<td>Comprehensive</td>
<td>Extended (4)</td>
<td>Complete (10+)</td>
<td>8+ Organ Systems</td>
</tr>
<tr>
<td>Established</td>
<td>99211</td>
<td></td>
<td>May not require the presence of a Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>99212</td>
<td>Problem Focused</td>
<td>Brief (1-3)</td>
<td>Brief System/ Body Area</td>
<td>1-5 Elements</td>
</tr>
<tr>
<td></td>
<td>99213</td>
<td>Expanded Problem Focused</td>
<td>Brief (1-3)</td>
<td>Pertinent (1)</td>
<td>2-7 Limited Exam Org Syst/Bod Areas</td>
</tr>
<tr>
<td></td>
<td>99214</td>
<td>Detailed</td>
<td>Extended (4)</td>
<td>Extended (2-9)</td>
<td>2-7 Extended Exam Org Syst/Bod Areas</td>
</tr>
<tr>
<td></td>
<td>99215</td>
<td>Comprehensive</td>
<td>Extended (4)</td>
<td>Complete (10+)</td>
<td>8+ Organ Systems</td>
</tr>
</tbody>
</table>
Putting it all together: History Billed as a 99204 supports 99205

Cc: Chest pain

HPI: The patient presents to express care with a complaint of palpitations and chest pressure. The patient states he has been having problems with intermittent palpitations for the past 2 years. He states he was seen for this problem once but he was not having any arrhythmia at that time. The patient states his current episode began a few hours ago. The palpitations are associated with some chest pressure, nausea and lightheadedness. He is not aware of any personal history of coronary artery disease. He states his mother did have a myocardial infarction in her 40s and his father had a microinfarction in his 60s. He denies a history of diabetes, hypertension or hyperlipidemia. He states he is not a smoker. He denies a history of deep venous thrombosis or pulmonary emboli. The patient states he is allergic to aspirin which causes swelling of his throat.

Past Surgical History: Appendectomy

Social History: Never Smoker

Review of Systems:

Constitutional: Negative for fever and chills.
HENT: Negative for ear pain, mouth sores and sore throat.
Eyes: Negative for pain and discharge.
Respiratory: Positive for chest tightness and shortness of breath. Negative for wheezing.
Cardiovascular: Positive for chest pain and palpitations. Negative for leg swelling.
Gastrointestinal: Negative for vomiting and abdominal pain.
Genitourinary: Negative for dysuria and frequency.
Musculoskeletal: Negative for arthralgia’s and joint swelling.
Skin: Negative for rash.
Putting it all together: Exam
Billed as a 99204 supports 99205

Exam: BP 158/101 | Pulse 105 | Temp(Src) 36.6 °C (97.9 °F) (Oral) | Resp 18 | Ht 177.8 cm (5' 10") |
Wt 113.399 kg (250 lb) | BMI 35.87 kg/m2 | SpO2 98%

Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished.

Complain of palpitations, chest pain, shortness of breath.

HENT:
Head: Normocephalic and atraumatic.
Right Ear: External ear normal.
Mouth/Throat: Oropharynx is clear and moist.
Eyes: Conjunctivae are normal. Pupils are equal, round, and reactive to light.
Cardiovascular: Intact distal pulses.

Rapid irregular rate and rhythm with rates up to 180 bpm.
Pulmonary/Chest: Effort short of breath, breath sounds normal. He has no wheezes. He has no rales.
Gastrointestinal: Soft. Bowel sounds are normal. There is no tenderness.
Musculoskeletal: Normal range of motion. He exhibits no edema and no tenderness.
Neurological: He is alert and oriented to person, place, and time. No cranial nerve deficit.
Skin: clammy

Documentation:
8 organ systems
2 body areas
Comprehensive Exam documented
**Diagnostic studies:** EKG shows episodes of rapid atrial rhythm either consistent with short bursts of PAT or atrial fibrillation. QRS complex narrow.

**ED course:** Following the history and physical exam and review the patient's EKG, further management was discussed with the patient. He'll be sent directly to the emergency department at UNC Healthcare for further evaluation management. EMS was contacted.

**Assessment:** Supraventricular arrhythmia. Chest Pain, Shortness of Breath. Consider MI, PE, CHF and unstable angina.

**Plan:** Patient to be taken directly to UNC Healthcare Emergency Department.

**Medical Decision Making:** High Supporting a 99205

New problem with work up (4 points) and a high risk patient
Billing Based on Time
Time Based Encounter billing based on threshold time of the service

- Evaluation and Management encounters can be billed based on time rather than the history, examination and medical decision making key components.

- Documentation should reflect the total time with the patient and that greater than 50% of that time was spent on counseling and/or coordination of care for the patient. The documentation should describe the counseling and/or activities to coordinate care.

  - Example: “I spent a total of 25 minutes with the patient, of which greater than 50% of which was spent counseling the patient regarding…”

- In the outpatient setting, the total time is based on the total face-to-face time the provider has with the patient.

- In the inpatient setting, the total time is based on the total face-to-face time the provider has with the patient as well as the unit/floor time that the provider spends in direct coordination or supervision of care for the patient.

- Each E/M CPT code has a designated level of time associated with that code. This designated time is used to bill the E/M service when billing based on time.
Time Based Encounters- psychotherapy, prolonged services and inpatient discharge

- **Psychotherapy**- Time associated with activities used to meet criteria for an E/M service is not included in the time used to report psychotherapy services. Time may not be used as a basis for reporting and E/M service with Psychotherapy. *Time spent in psychotherapy must be clearly documented.*

- **Prolonged E/M Services**- (CPT codes 99354-99355) represent time spent in an E/M or psychotherapy services that are beyond the typical time of the primary procedure. When prolonged services are billed, time must be documented.

- **Hospital Discharge Services**- (CPT 99238 and 99239) are also time based codes and require time to be documented.

  - Example: CPT code 99239 is used for a hospital discharge more than 30 minutes. Therefore, the discharge note would state, '45 minutes spent performing discharge services.'
### Threshold Times for E/M Services: Outpatient

<table>
<thead>
<tr>
<th></th>
<th>Outpatient New Patient Visits</th>
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</thead>
<tbody>
<tr>
<td><strong>Level of Service</strong></td>
<td>99201</td>
<td>99202</td>
<td>99203</td>
<td>99204</td>
<td>99205</td>
</tr>
<tr>
<td><strong>Threshold Time</strong></td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>45</td>
<td>60</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th></th>
<th>Outpatient Consultations</th>
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</thead>
<tbody>
<tr>
<td><strong>Level of Service</strong></td>
<td>99241</td>
<td>99242</td>
<td>99243</td>
<td>99244</td>
<td>99245</td>
</tr>
<tr>
<td><strong>Threshold Time</strong></td>
<td>15</td>
<td>30</td>
<td>40</td>
<td>60</td>
<td>80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Established Patient Visits</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Level of Service</strong></td>
<td>99211</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
</tr>
<tr>
<td><strong>Threshold Time</strong></td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>25</td>
<td>40</td>
</tr>
</tbody>
</table>
## Threshold Times for E/M Services: Inpatient

<table>
<thead>
<tr>
<th>Initial Hospital Admissions</th>
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<tbody>
<tr>
<td><strong>Level of Service</strong></td>
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<tr>
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<tr>
<th>Inpatient Consultations</th>
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<td><strong>Level of Service</strong></td>
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<td>Threshold Time</td>
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<tr>
<th>Subsequent Hospital Visits</th>
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<tbody>
<tr>
<td><strong>Level of Service</strong></td>
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<tr>
<td>Threshold Time</td>
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Modifiers that Impact Payment
Important Modifiers used in Ambulatory Billing

**Modifier -24:** The MD/APP may need to indicate that an E/M service was performed during the postoperative period of an unrelated procedure.

This circumstance is billed by adding the modifier “-24” to the appropriate level of evaluation and management service at the time of charge capture.

The E/M service submitted with the “-24” modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. A diagnosis code that indicating the reason the visit was unrelated to the surgery helps substantiate the service was “unrelated”.

**Clinical Example:**
A physician performs a major surgery and within the global period sees the patient for an unrelated E/M visit. The 24 modifier is appropriate because the E/M service is unrelated and during the postoperative period of the major surgery.

**Charge Capture:** Modifier 24 is added at charge capture to demonstrate to the payor that the visit was unrelated to the surgery and should be separately payable.
Important Modifiers used in Ambulatory Billing

**Modifier -25:** The MD/APP may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed.

**Clinical Example:**
*Patient presents with knee pain in the orthopedic clinic. After an extensive history and exam, the physician determines that the patient needs a joint injection. Since the decision for the need of the injection was made during the E/M visit based on the history and exam both the E/M and the procedure are billable. A -25 modifier would be added to the E&M level of service to indicate that the service was significant and separately identifiable. (i.e. 99214-25 and 20610)*

**Billing Tip:**
*If the patient is scheduled for a procedure and an Evaluation and Management service has been performed at a prior visit, an E/M service is not separately billable unless the patient has a different complaint or diagnosis. A brief history and exam performed to determine if the patient is clinical stable for a procedure does not support billing another E/M service.*
**Important Modifiers used in Ambulatory Billing**

**Modifier -57**: Evaluation and management services on the day before major surgery (90 day global period) or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.

**Clinical Example:**
A 65 year old female presents to the Emergency Department (ED) with complaint of severe ankle pain after a fall. The patient was found to have a displaced trimalleolar ankle fracture. The ED physician provided closed treatment of the ankle fracture with manipulation. The ED physician billed 99283 for the ED E/M visit and 27818 for the closed treatment of the fracture; with manipulation. The -57 modifier would be appended to the E/M CPT code. (i.e. 99283-57).

**Billing Tip:**
If the decision for a major surgery is made the day before, or the day of surgery, Modifier 57 informs the payor that you should be paid for your E/M service in addition to the surgery. This modifier breaks apart the global surgical package and informs the payor of your initial decision for surgery.
Important Modifiers used in Ambulatory Billing

**Modifier -52**: Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional.

**Clinical Example:**
*Patient presents with poor bowel preparation for a colonoscopy. A colonoscope was moved beyond the splenic flexure, but not to the cecum.*

**Billing Tip:**
Modifier 52 would be reported on the colonoscopy procedure code- CPT 45379- in order to indicate the service was reduced. (e.g., the full definition of the CPT code requirement was not met.)
Advanced Care Planning Codes

- **Advanced Care Planning (ACP):** Used to report face-to-face service between a provider and a patient, family member, or surrogate in counseling advance directive, with or without completion of legal forms
  - 99497 (1st thirty minutes) and 99498 (each additional thirty minutes)

- ACP may be reported in addition to another E/M code, if there is a separately identifiable evaluation and management service and the time requirements of the ACP code are met. **Modifier 25** is added to the E/M code.

- In order to have the deductible and coinsurance waived for ACP when performed with an Medicare Annual Wellness Visit (AWV), the ACP code(s) must be billed with modifier 33 (preventive services). The **modifier 33** is only added when ACP and the Annual Wellness Visit are performed on the same day and furnished by the same provider.

- See the UNC Professional Compliance Website for more information on ACP services.
Counseling E/M Codes

Counseling Risk Factor Reduction and Behavior Change Intervention Codes:

- Used to report services provided face-to-face by a provider for the purpose of promoting health and preventing illness or injury.
  - Preventative Medicine Individual Counseling: 99401, 99402, 99403
  - Behavior Change Intervention Individual: 99406, 99407 (Smoking and Tobacco Use), 99408 (Alcohol and/or substance)
  - Preventative Medicine, Group Counseling: 99411, 99412

- These codes may be billed in addition to an E/M service if a separately identifiable E/M service is rendered and was above and beyond the counseling E/M codes. Modifier -25 must be added to the E/M code.
Contact us—we are glad to help!

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