CME MOC

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Optimize your documentation to improve Medicare reimbursement

ABSTRACT

There's nothing more frustrating than not getting credit for work performed. Physicians often leave large amounts of compensation on the table, because even though services were provided, insurance payers do not recognize the work due to suboptimal documentation. This problem is especially apparent in preventive medicine and wellness visits with adult and geriatric patients, and results in physician services being undervalued. This article outlines specific documentation requirements for receiving full credit for the work already provided by most primary care physicians.

KEY POINTS

Billing for outpatient evaluation and management has 5 levels, determined by 3 elements: the history, physical examination, and medical decision-making. In a new patient, all 3 elements must meet the criteria for a given level to be compensated at that level, but in an already established patient, only 2 of the 3 need to.

It is important to classify geriatric visits into 2 separate categories: the new wellness visit and the standard office visit.

Many clinics have adopted screening questions to assess patients' overall health, which patients can answer by filling out a form while waiting for their visit.

To receive compensation for a preventive service, 3 components must be documented: the amount of time spent counseling, the Current Procedural Terminology code, and the linked diagnosis.

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Geriatric patients are complex. The typical older adult is more likely to suffer from severe end-stage diseases, adverse effects of polypharmacy, and lack of social support, resulting in poorer overall outcomes. The goal for the primary care physician is to address as many of these complaints as possible in an efficient matter, while documenting and billing appropriately for procedures to ensure that taking care of the geriatric population remains a cost-effective endeavor.

This article provides clear templates and instructions to ensure all geriatric services rendered are properly billed and coded for and briefly reviews general medical billing in the outpatient setting.

OVERVIEW OF GENERAL MEDICAL BILLING IN OUTPATIENTS

The Current Procedural Terminology (CPT) codes used in outpatient billing for evaluation and management are typically divided into 5 levels for new patients (99201–99205) and established patients (99211–99215), determined by the number of topics documented in the history, physical examination, and medical decision-making.

For a new patient, all 3 sections must meet the criteria for the level in order to bill for the corresponding level (**Table 1**).[1,2] For instance, if the history and the physical examination are documented to a level 3 standard, and the medical decision-making is documented to a level 4 standard, then the overall visit will count as a level 3, despite the medical decision-making, because the history and physical were not documented at the level 4 standard.[1] (A new patient is defined as one who has nev-

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Glossary

AWV–Annual Wellness Visit

CPT—Current Procedural Terminology

E/M—evaluation and management

HPI—history of present illness

IPPE—Initial Preventive Physical Examination

PFSH—past medical, family, and social history

ROS—review of systems

RVU—Relative Value Unit

er been seen by a physician in your group, or as a patient who has not been seen in 3 years.)

In an already-established patient, only 2 of the 3 areas need to meet the documentation criteria in order to bill at a specific level (**Table 2**). For example, if the history and examination meet the criteria for level 4, and the medical decision-making meets the criteria for level 3, the note can still be billed as a level 4.

As a side note, billing based on time is an acceptable alternative. However, significantly more time (30 minutes) is required to bill at a level 3, which is typically completed in the 15-minute patient time slot allotted in most clinics. When billing based on time, the history, examination, and medical decision-making do not need to hit the required level of documentation.[1,2]

Optimization can dramatically increase RVUs for services that most physicians already provide

GERIATRIC BILLING: DETERMINING THE VISIT TYPE

It is important to classify geriatric visits into 2 separate categories: the new wellness visit and the standard office visit. This is essential because while a large portion of preventive services (depression screening, advance care planning, smoking cessation, sexually transmitted diseases screening, alcohol counseling, weight counseling, and heart disease counseling) can be administered at either category of visit, a cognitive assessment is only billable during a wellness visit or a specific visit for cognitive assessment.[2] See **Table 3** for the complete inclusion criteria.

However, if the patient presents for a wellness visit with a separate chief complaint, it is also allowable to "split-bill" the visit as both a wellness and standard visit as long as 2 separate notes exist for the encounter. The caveat is that a patient can only be billed for a wellness preventive visit once per year, but split billing can often dramatically increase the Relative Value Units (RVUs) generated by a single wellness visit.

THE ANNUAL WELLNESS VISIT

The annual wellness visit (AWV) is an incentive visit provided by Medicare. Many people refer to the AWV as "the yearly physical," which is a misconception. The AWV is simple, and its main focus is to perform a health risk assessment and create a personalized prevention plan.

There are 2 billable codes for an AWV: G0438—initial annual wellness visit, which can only be assigned once in a patient's life, and G0439—subsequent annual wellness visit.[3] Of importance, certain documentation is required to bill for these codes (**Table 4**).

As a side note there is a "Welcome to Medicare" visit code (G0402) that is considered an Initial Preventive Physical Examination (IPPE) and not a billable code for AWV. The IPPE is covered only once within the first 12 months of Medicare Part B enrollment. The goal of the IPPE is essentially to review medical and social history along with health promotion, education, disease prevention, and detection. The initial AWV (G0438) can be offered 12 months after the patient received the IPPE or 12 months after the patient was enrolled under Medicare Part B. A subsequent wellness visit (G0439) can be offered annually.[2,4]

For more detailed information see: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf.

This may seem like a lot of documentation, but with appropriate staff coordination, previsit data collection, and appropriate templates it will not take more than 20 minutes with documentation included.[3,4] **Table 5** is a sample note with the required documentation to bill for an annual wellness visit.

COGNITIVE ASSESSMENT

Cognitive assessment is an examination to evaluate a person's cognitive level, remain-

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TABLE 1

New patient office visit evaluation and management codes

	Requirement (all 3 must be at the billed level)						
	History			Examination	Medical decision-making		
Level	HPI	ROS	PFSH	Organ systems	Diagnoses/complexity/risk	Time (minutes)	RVUs
Level 1 (N1) 99201	1–3	None	None	1	Straightforward	10	0.48
Level 2 (N2) 99202	1–3	1	None	2–7 (no detail)	Straightforward	20	0.93
Level 3 (N3) 99203	≥ 4	2–9	1–2	2–7 (with detail)	Low complexity	30	1.42
Level 4 (N4) 99204	≥ 4	≥ 10	3	≥ 8	Moderate complexity	45	2.43
Level 5 (N5) 99205	≥ 4	≥ 10	3	≥ 8	High complexity	60	3.17

HPI = history of present illness; PFSH = past medical, family, and social history; ROS = review of systems; RVU = Relative Value Unit

TABLE 2

Established patient office visit evaluation and management codes

	Requirement (at least 2 of the 3 must be at the billed level)						
	History			Examination	Medical decision-making		
Level	HPI	ROS	PFSH	Organ systems	Diagnoses/complexity/risk	Time (minutes)	RVUs
Level 1 (E1) 99211	1–3	None	None	1	Problem-focused	5	0.18
Level 2 (E2) 99212	1–3	1	None	1	Straightforward	10	0.48
Level 3 (E3) 99213	≥ 4	1	None	2–7	Low complexity	15	0.97
Level 4 (E4) 99214	≥ 4	2–9	1	2–7 (with detail)	Moderate complexity	25	1.5
Level 5 (E5) 99215	≥ 4	≥ 10	2–3	≥ 8	High complexity	40	2.11

HPI = history of present illness; ROS = review of systems; PFSH = past medical, family, and social history; RVU = Relative Value Unit

ing abilities, and capacity to function. It can be provided to any patient who exhibits any signs or symptoms of cognitive impairment,[3] in either a wellness visit or a specific cognitive assessment visit (see below).

Several standardized tests are available to be used by any eligible medical provider (physicians, nurse practitioners, clinical nurse specialists, and physician assistants). Some acceptable tools to assess cognition are the Mini-Cog, Montreal Cognitive Assessment, Mini-Mental State Examination, Saint Louis University Mental Status Examination, Memory Impairment Screen, and AD8 Dementia Screening Interview.[5,6]

Specific cognitive assessment visit

For geriatric patients with suspected cognitive dysfunction, a specific cognitive assessment visit (CPT 99483) can be performed. The cognitive assessment visit is a stand-alone visit code and it can be cobilled with wellness visits or preventive services, but not with a standard office visit.[5,7,8] It is recommended that if a cognitive assessment is performed, the entire visit should be billed as a cognitive assessment (3.44), as the total number of RVUs generated exceeds a new patient level 5 visit (3.17). The cognitive assessment visit requirements are not the same described in the AWV (**Table 5**). See **Table 6** for the required elements that need to be documented in order to code CPT 99483.[5]

For more detailed information see: www.alz.org/careplanning/downloads/cms-consensus.pdf.

MAXIMIZING PREVENTIVE SERVICES

Regardless of the chief complaints, many clinics have adopted automatic screening questions or quality metrics to assess patients'

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TABLE 3

Billable preventive services

Service	Wellness visit	Standard office visit	Cognitive assessment visit
Cognitive assessment	Yes	No	Yes
Advance care planning	Yes	Yes	No
Depression screen	Only if patient is established (G0439; not with G0402 or G0438)	Yes	Yes
Smoking cessation	Yes	Yes	Yes
Alcohol screening	Yes	Yes	Yes
Alcohol counseling	Yes	Yes	Yes
STD counseling	Yes	Yes	Yes
Cardiovascular counseling	Yes	Yes	Yes
Weight counseling	Yes	Yes	Yes

G0439 = subsequent annual wellness visit code; G0402 = welcome to Medicare visit code; G0438 = initial annual wellness visit code; STD = sexually transmitted disease

TABLE 4

Required documentation for an initial annual wellness visit

Demographic data

Self-assessment of health status

Psychosocial risks

Behavioral risks

Activities of daily living

Instrumental activities of daily living

Updated personal and family history

Substance use disorder assessment

List of current health care providers and suppliers

Documentation of weight, height, body mass index, and blood pressure

Detection of cognitive impairment during visit (direct observation or third-party information helps)

Depression screening

Functional ability and level of safety (ability to successfully perform activities of daily living, fall risk assessment, hearing impairment screening, home safety assessment)

Update all screenings recommended by US Preventive Services Task Force and vaccines recommended by US Centers for Disease Control and Prevention

Action plan for any identified risks

For more detailed information see: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf

overall health, such as body mass index monitoring, screening for smoking and alcohol use, or even "health vital signs" such as asking patients to estimate how much exercise they perform in a week. Often, these screening questions are given to the patient on a paper form to fill out while waiting for the doctor's visit.[6,7] The reason these monitoring metrics are included is to maximize the billing for any particular encounter.

To optimize potential for billable preventive services, annual wellness screening paperwork should include questions regarding depression, alcohol use, tobacco use, sexually transmitted disease risk factors, and cardiovascular risk factors. A positive answer on any of these screens should prompt a brief discussion during the encounter with the appropriate billing code and time documented. The reason for including these questions on the AWV is that many counseling services can only be billed for once a year.[7,8]

To maximize preventive services, wellness visits should be set for at least a 30-minute time slot, not only to manage whatever chief concern the patient brings, but also to address as many positive screening questions as possible. Furthermore, having more time in the wellness visit allows for overlapping counseling such as smoking cessation, cardiac risk factor counseling, and alcohol cessation to ensure the time criterion is met for each topic. See **Table 7** for the requirement time for each billable code, RVU value, and the required interval of time before each service can be billed for again.

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TABLE 5

Annual wellness visit template

Reason for visit

Chief complaint

Subjective narrative

Review of systems
"Please refer to patient-completed questionnaire (previsit template with checkboxes)."

Past medical history (diagnoses and dates)

Past surgical history

Family history

List of medications

Socioeconomic history

Substance use disorder assessment

Occupational history

Tobacco use

Recent hospitalizations

Objective
Vital signs, weight, height, body mass index
Physical examination
Vision and hearing evaluation
"Pertinent lab results and tests in the record were reviewed with the patient and a copy was provided to the patient as needed."

Assessment of any cognitive impairment

General appearance

Mood and affect

Input from others

Notes and plan

Depression screening (PRIME MD-PHQ2)
Refresh note if PHQ-9 was completed
Follow-up plan for depression

Functional ability
Does the patient exhibit a steady gait?
How long did it take the patient to get up and walk from a sitting position?
Is the patient self-reliant (can the patient do their own laundry, prepare meals, do household chores)?
Does the patient handle his or her own medications?
Does the patient handle his or her own money?
Is the patient's home safe (eg, good lighting, handrails on stairs and bath)?
Did you notice or did patient express any hearing difficulties?
Did you notice or did patient express any vision difficulties?
Were distance and reading eye charts used?
Notes and plan

Advance care planning
Was patient offered the opportunity to discuss advance care planning?
If no, did you provide information on advance directives?
Notes and plan

Smoking cessation counseling

Electrocardiogram results
Required only in initial AWV

Vaccines

Screening recommendations

Assessments and plan

DOCUMENTING FOR PREVENTIVE VISITS

To receive compensation from Medicare for a preventive service, 3 components must be documented,[8] ie, the amount of time spent counseling, the CPT code, and the linked diagnosis. This will improve Medicare reimbursement for the preventive services that a primary care physician regularly provides. However, these services are not exclusive to primary care physicians: they can be billed for by any medical specialist as long as they are properly documented and not billed by another physician (usually the primary care physician) in the specific required interval for that service. For example, if a primary care physician documents and bills for a particular service after a subspecialist does, the primary care physician won't get reimbursed.

For more detailed information see: https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.

The time documented in the services requiring time attestation cannot overlap be-

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TABLE 6

Cognitive assessment visit: Required elements

Cognition-focused evaluation including a pertinent history and examination
Medical decision-making of moderate or high complexity
Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity
Use of standardized instruments for staging of dementia (eg, Functional Assessment Staging Test [FAST], Clinical Dementia Rating [CDR])
Medication reconciliation and review for high-risk medications
Evaluation for neuropsychiatric and behavioral symptoms, including depression, with use of standardized screening instrument(s)
Evaluation of safety (eg, home), including motor vehicle operation
Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks
Development, updating or revision, or review of an advance care plan
Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support
Typically, 50 minutes are spent face to face with the patient, family, or caregiver
For detailed information see: https://www.alz.org/careplanning/downloads/cms-consensus.pdf

tween the time for the standard office visit and the time for other preventive services. See **Table 8** for examples of time attestation.

REIMBURSEMENT FOR CARE PROVIDED

The role of the primary physician is to provide comprehensive care to the individual. But often, the care provided is not reflected in the Medicare reimbursement as a result of incomplete or inadequate documentation. While initially daunting, proper optimization of the clinic visits to include previsit screening questions, increased time slots for wellness visits, and note templates with prebuilt preventive coding can dramatically increase the RVUs generated for services that most physicians already provide.

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TABLE 7

Billing and documentation criteria for preventive services

Service	CPT code	RVUs	Time (minutes)	Recommended diagnosis	Required interval	Other requirements
Cognitive assessment	99483	3.44	None	None	180 days	Cognitive Assessment Template Not the same cognitive assessment described in the AWV
Advance care planning	99497 99498	1.5 1.40	15–45 > 45	None	None	Document discussion, outcomes, and signed forms
Depression screening	G0444	0.18	≤ 15	713.31: Encounter for screening for depression	365 days	
Smoking cessation	99406 99407	0.24 0.50	3–10 > 10	Several[a]		
Alcohol screening	G0442	0.18	> 15	Any alcohol use code	365 days	Patient must be having adverse effects from use
Alcohol counseling	G0443	0.45	> 15	Any alcohol use code	4 sessions per year	Patient must have positive alcohol screen
STD counseling	G0445	0.45	> 30	Several[b]	180 days	Document education and skills provided
Cardio-vascular counseling	G0446	0.45	> 15	713.6: Screening for cardiovascular disease	365 days	Must include intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardio-vascular and diet-related chronic diseases If a patient has a current diagnosis of hyperlipidemia and/or hypertension, the diagnosis codes for these diseases should be used instead of Z13.6; screening codes cannot be used if the patient already has a confirmed diagnosis
Weight counseling	G0447	0.45	> 15	BMI > 30.0 kg/m^2 and weight-related diagnosis must be documented	Month 1: weekly Months 2–6: biweekly Monthly thereafter	Goal-oriented behavior

[a]For example, F17.210: Nicotine dependence, cigarettes, uncomplicated; F17.220: Nicotine dependence, chewing tobacco, uncomplicated; Z87.891: Personal history of nicotine dependence.

[b]For example, Z11.3: Encounter for screening for sexually transmitted infection; Z11.59: Encounter for screening for other viral disease; Z72.89: Other problems related to lifestyle; Z72.51: High-risk heterosexual behavior; Z72.52: High-risk homosexual behavior; Z72.53: High-risk bisexual behavior.

For detailed information see: https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.

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TABLE 8

Time attestation for 2 services

Advance care planning

This is a time code. You must enter in the number of minutes spent on advance care planning.

Example: "I spent ___ minutes with the patient on advance care planning."

You may also state "I have spent > 16 minutes on advance care planning."

Template suggestion: "I spent ___ minutes with the patient in counseling and discussion of goals of care, code status, and advance directives as detailed in the assessment and plan (excluding visit time and annual wellness visit time)."

Depression screening

This is a time code. You must enter in the number of minutes spent on depression screening

Example: " ___ minutes were spent on depression screening."

You must enter in the minutes on each patient.

Template suggestion: "I spent ___ minutes with the patient on screening and counseling about depression (excluding advance care planning and annual wellness visit time)."

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