E&M CODING PRACTICE CASES

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IN PARTNERSHIP WITH ISU COLLEGE OF PHARMACY

NOTICE

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CASE #1

- CC: ‘I need blood pressure medication’
- PMH: MH is a 37 y/o M presenting to establish care for HTN management. He recently moved to ID from OR and has not yet established with a PCP. He was diagnosed with HTN ~5 years ago and has been managed with losartan 50mg QD after failing ACE inhibitors due to cough. He is not following any specific diet or exercising regularly and he has not been checking home BP readings. He has 5 doses left and needs a refill before he leaves on a work trip in 4 days. He feels well and has no specific complaints, denies CP, palpitation, SOB.
- MHx: (-) MI, CVA, DM, CKD, Thyroid Disease, Cancer
- FHx: (+) HTN, CVA, (-) DM - Father; (-) HTN, DM – Mother
- SHx: (-) EtOH, Tobacco, Illegal Drugs; Works as a long haul truck driver

CASE #1

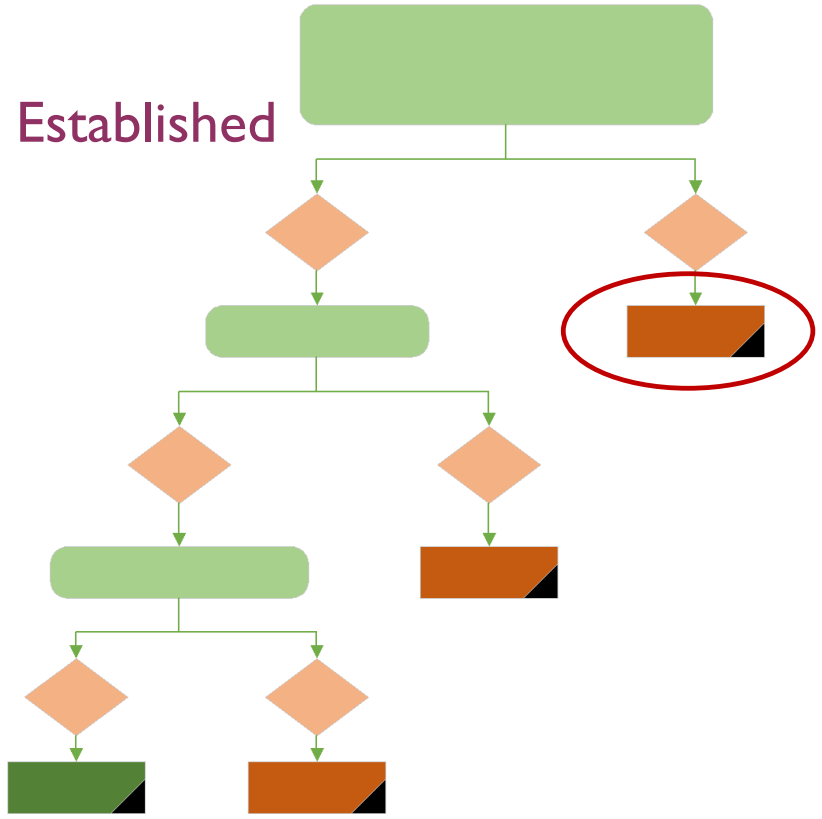
- Exam: BP – 163/98
- Assessment & Plan:
  - HTN – Uncontrolled on monotherapy with losartan, not following TLI
  - BMP ordered today
  - Ambulatory BP monitor provided, educated to test AM and PM daily
  - Discussed DASH diet and physical activity goals, wants to start walking around at rest stops 10 minutes per day, will investigate travel coolers for his truck to bring healthy food options with him
  - Add amlodipine 2.5mg QD and refill losartan 50mg QD
  - F/U in 2-4 weeks

- Total Visit Time: 37 minutes spent caring for the patient today, counseling on plan of care and documenting

CASE #1
ANSWER ON NEXT PAGE

SCORING: 99203

New or Established



Level 1-5

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

CASE #1 ADDITIONAL EXPLANATION

- Patient is new to this pharmacy
  - 9920 code set
- Documented encounter was 37 minutes (in the 30-44 minute range)
  - Code = 99203

- Document time if you are billing based off time
- If you are billing based of clinical decision making, including time may cause confusion for others helping to process the claim

CASE #2

- Exam: BP – 163/98
- Assessment & Plan:
  - HTN – Uncontrolled on monotherapy with losartan, not following TLI
  - BMP ordered today
  - Ambulatory BP monitor provided, educated to test AM and PM daily
  - Discussed DASH diet and physical activity goals, wants to start walking around at rest stops 10 minutes per day, will investigate travel coolers for his truck to bring healthy food options with him
  - Add amlodipine 2.5mg QD and refill losartan 50mg QD
  - F/U in 2-4 weeks

CASE #2
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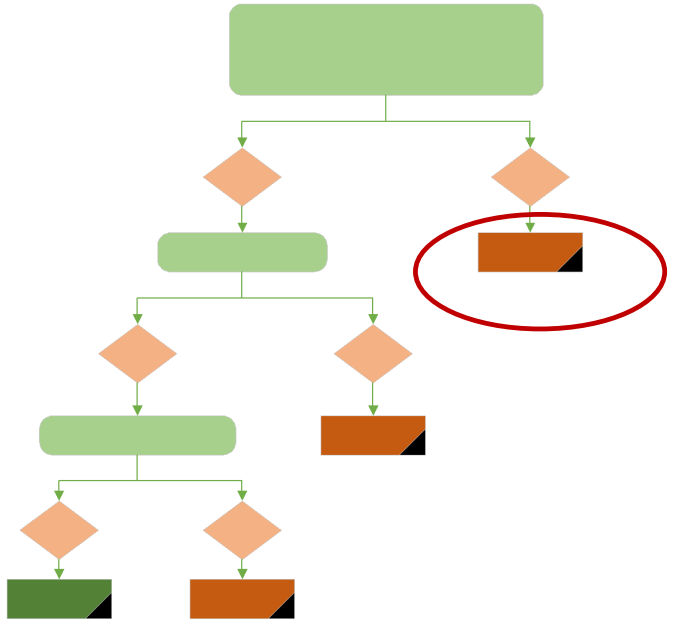
SCORING: 99204

New or Established



Level 1-5

CPT Code	Problems	Data	Risk	Final MDM Level
99202 99212	Minimal	Minimal or	Minimal	Straightforwa rd
99203 99213	Low	Limited	Low Risk	Low
99204 99214	Moderate	Moderate	Moderate	Moderate
99205 99215	High	Extensive	High Risk	High

CASE #2 ADDITIONAL EXPLANATION

- Patient is new to this pharmacy
- Score based on medical decision making
- Problem is moderate
  - Uncontrolled chronic illness
- Data is minimal/none
  - Only 1 data point (BMP that was ordered)
- Moderate risk
- Using the table, two points in moderate make this a moderate service
  - Code = 99204

CASE #3

- CC: ‘Blood Pressure F/U’
- JM is a 62 y/o F established with me for HTN management presenting for f/u after dose adjustment of amlodipine 4 weeks ago. JM reports full adherence to regimen of chlorthalidone 50mg QD and amlodipine 5mg QD. She has met her exercise goal of 120 minutes per week and is planning to increase to 150 minutes this month. She has been following the DASH diet. Reports all home readings have been under her goal BP. Denies any CP, SOB, LE Edema, Palpitations.
- PFMSH Unchanged

CASE #3

- Exam: BP – 123/78, Pulse 82
- Assessment & Plan:
  - HTN – Well controlled on current regimen
  - Praised current efforts and encouraged continued adherence to exercise plan, diet and medications without change
  - Continue ambulatory BP monitoring
  - Refill chlorthalidone and amlodipine at current doses
  - F/U in 3 months
- Total Visit Time: 12 minutes spent in patient history, counseling and documenting

CASE #3
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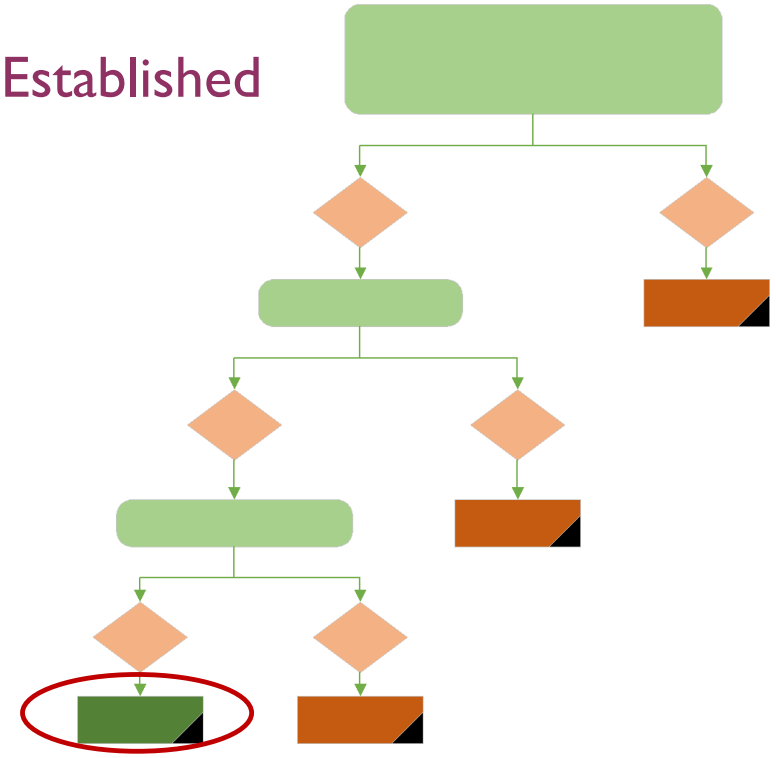
SCORING: 99212

New or Established



Level 1-5

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

CASE #3 ADDITIONAL EXPLANATION

- Time based billing
- Outpatient evaluation and management service
  - First three numbers of code = 992
- Established patient
  - Fourth number of code = 1
- Time based encounter with coded time of 12 minutes (in the 10-19 minute range)
  - Code = 99212

CASE #4

- Exam: BP – 123/78, Pulse 82
- Assessment & Plan:
  - HTN – Well controlled on current regimen
  - Praised current efforts and encouraged continued adherence to exercise plan, diet and medications without change
  - Continue ambulatory BP monitoring
  - Refill chlorthalidone and amlodipine at current doses
  - F/U in 3 months

CASE #4
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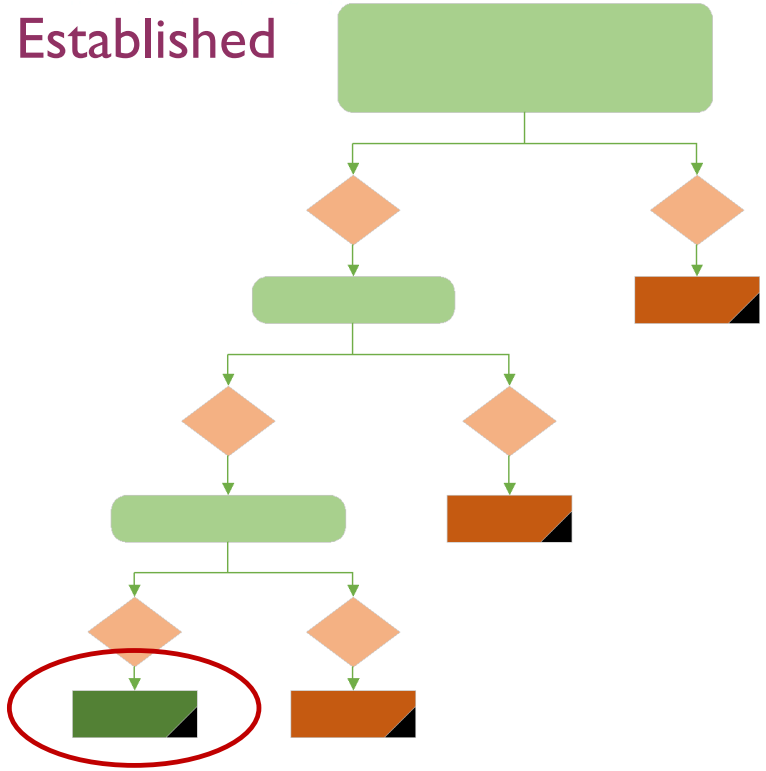
SCORING: 99213

New or Established



Level 1-5

CPT Code	Problems	Data	Risk	Final MDM Level
99202 99212	Minimal	Minimal or None	Minimal	Straightforward
99203 99213	Low	Limited	Low Risk	Low
99204 99214	Moderate	Moderate	Moderate	Moderate
99205 99215	High	Extensive	High Risk	High

CASE #4 ADDITIONAL EXPLANATION

- Medical decision making (MDM) based billing
- Established patient
  - Fourth number of code = 1
- Well controlled chronic illness
  - 1 stable chronic illness is a low level problem
- No data points reviewed
  - Minimal/none data level
- Treatment plan to refill prescriptions
  - Prescription medication management is moderate risk
- 1 box is moderate, no other boxes meet or exceed moderate so the final MDM level is low
- Code = 99213

CASE #5

- CC: “I need to get my sugars controlled”
- NR is a 28 y/o Hispanic M presenting to establish care with me for medication management of DM T2 per referral of PCP Dr. Nguyen in our practice. NR was just diagnosed with DM at his last visit with Dr. Nguyen after a confirmatory A1c of 8.6% and has not yet started any medications. He has been researching Diabetes and has many questions today and additionally reports he has switched from regular to diet sodas. He has noticed a slight decrease in urinary frequency, ROS otherwise unchanged from last visit with PCP. He is not testing blood sugars and does not have a meter. He is eager to make changes and prefers to target a lower A1c goal.
- Hx: No updates to PFMSHx in chart. PPs: MHx: Obesity, FHx DM T2 in Mo, Fa. PNs: HTN, CKD, Pancreatitis

CASE #5

- Exam: BP – 128/78, Pulse 86
- Labs(Reviewed): A1c 8.6%; BMP wnl other than fasting glucose of 178
- Assessment & Plan:
  - DM T2 – Newly diagnosed and untreated. Setting A1c goal of <6.5%
  - Counseled at length on DM pathophysiology, management approach, treatment goals, treatment options, therapeutic lifestyle interventions
  - Initiate therapeutic lifestyle interventions – ADA diet and gradual increase of physical activity to goal of 150+ minutes per week
  - Initiate Janumet 50/500mg BID
  - F/U in 4 weeks
- Total Visit Time: 49 minutes spent in providing patient care, counseling the patient, reviewing past test results and scheduling follow up

CASE #5
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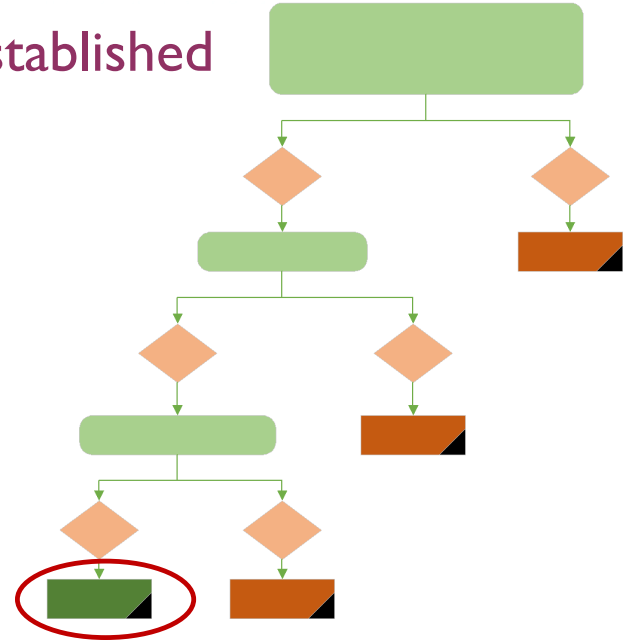
SCORING: 99215

New or Established



Level 1-5

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99205	60-74 Minutes	99215	40-54 Minutes

CASE #5 ADDITIONAL EXPLANATION

- Time based encounter
- New patient for pharmacist, but is already established by doctor in this clinical practice site
  - First four numbers of code = 9921
- Treatment took 49 minutes (in the 40-54 minute range)
  - Last number of code = 5
- Code = 99215

CASE #6

- Exam: BP – 128/78, Pulse 86
- Labs(Reviewed): A1c 8.6%; BMP wnl other than fasting glucose of 178
- Assessment & Plan:
  - DM T2 – Newly diagnosed and untreated. Setting A1c goal of <6.5%
  - Counseled at length on DM pathophysiology, management approach, treatment goals, treatment options, therapeutic lifestyle interventions
  - Initiate therapeutic lifestyle interventions – ADA diet and gradual increase of physical activity to goal of 150+ minutes per week
  - Initiate Janumet 50/500mg BID
  - F/U in 4 weeks

CASE #6
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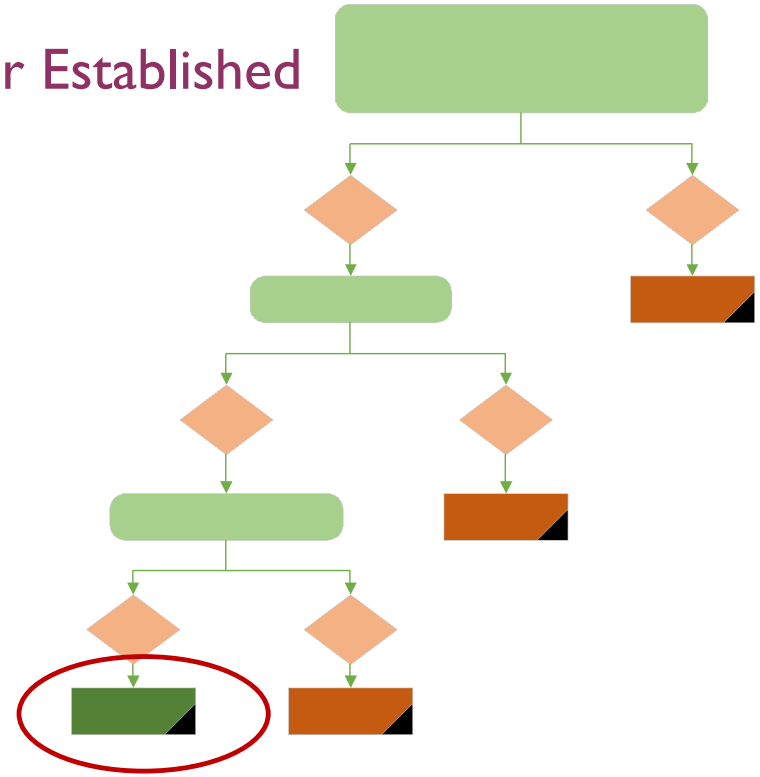
SCORING: 99214

New or Established



Level 1-5

CPT Code	Problems	Data	Risk	Final MDM Level
99202 99212	Minimal	~~Minimal~~	Minimal	Straightforward
99203 99213	Low	Limited	Low Risk	Low
99204 99214	~~Moderate~~	Moderate	~~Moderate~~	Moderate
99205 99215	High	Extensive	High Risk	High

CASE #6 ADDITIONAL EXPLANATION

- Medical decision making based encounter
- Established patient
  - First four numbers of code = 9921
- Type 2 diabetes, uncontrolled chronic condition
  - 1 uncontrolled chronic condition is a moderate problem
- Labs reviewed: A1c and BMP (already billed and considered by doctor at this practice so we cannot bill on this)
  - Minimal/none data level
- Prescription medication refills
  - Moderate risk
- Two boxes in moderate so overall level is moderate
  - Last number of code = 4
- Code = 99214

CASE #7

- CC: “I am here for my diabetes check.”
- NR is a 28 y/o Hispanic M who is established with me following up for 3 month A1c check. Following plan as documented in last note. Denies any new complaints.
- Exam: Weight decreased 6lb to 228lb from OV 3 months ago, Current BMI 31.8
- Labs: POC A1c – 6.2%

CASE #7

- Assessment & Plan:
  - 1. DM T2 – Controlled
    - No change to plan
    - Recheck A1c in 3 months
  - 2. Obesity – Improving with treatment plan for DM. BMI in Obese range
    - Agreed on an initial goal of 5% body weight reduction (~12lbs) over the next 3 months
    - Intensify TLI as per DM Plan
    - Referral to internal BH Provider to assist in long term behavior change
  - F/U with BH in 2 weeks, F/U with PharmD in 3 months or PRN

  - Total Time on DoS: 31 minutes spent in history, counseling, coordinating care and documenting

CASE #7
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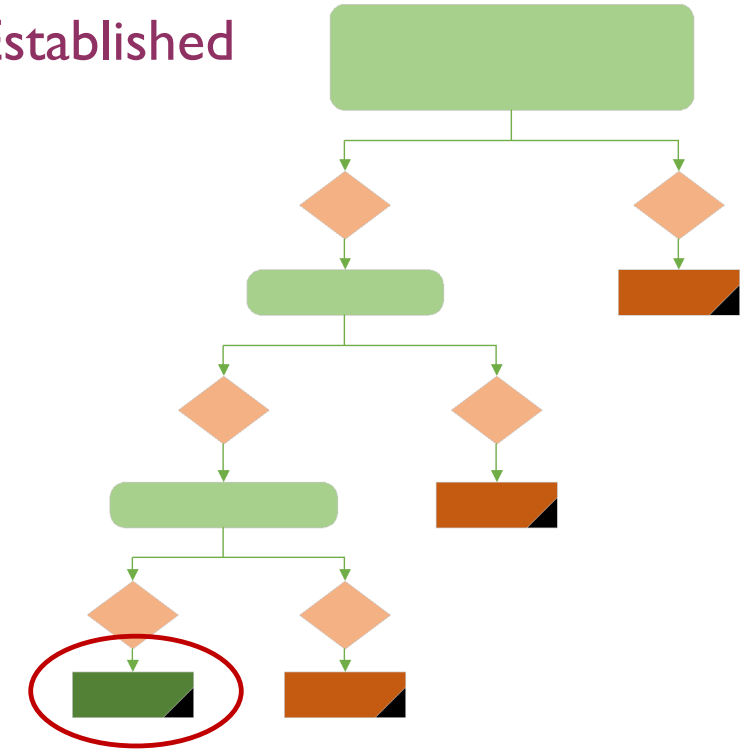
SCORING: 99214

New or Established



Level 1-5

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99205	60-74 Minutes	99215	40-54 Minutes

CASE #7 ADDITIONAL EXPLANATION

- Time based billing
- Established patient
  - First four numbers of code = 9921
- 31 minutes of time (in the 30-39 minute range)
  - Last number of code = 4
- Code = 99214

CASE #8

- CC: “I am here for my diabetes check”
- NR is a 28 y/o Hispanic M who is established with me following up for 3 month A1c after initiating and titrating Janumet and therapeutic lifestyle interventions. He endorses regular adherence and denies any new complaints. Current dose is Janumet 50/1000mg BID, current diet ADA diet, current exercise: 90 minutes weekly.
- Exam: Weight decreased 6lb to 228lb OV 3 months ago, Current BMI 31.8
- Labs: POC A1c – 6.2%

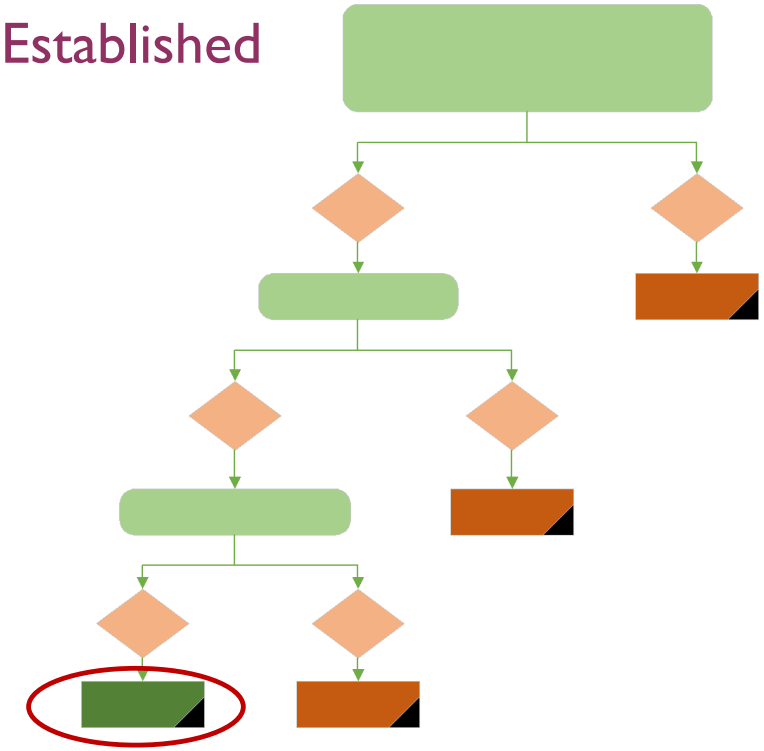
CASE #8

- Assessment & Plan:
  - 1. DM T2 – Controlled on current regimen of Janumet 50/1000mg BID and TLI
    - Continue current medication regimen. RF x 3 months
    - Continue TLI and continue increasing physical activity to goal of 150+ min/week
    - Recheck A1c in 3 months
  - 2. Obesity – Improving with treatment plan for DM. BMI in Obese range.
    - Agreed on an initial goal of 5% body weight reduction (~12lbs) over the next 3 months
    - Intensify TLI as detailed above
    - Referral to internal BH Provider to assist in long term behavior change
  - F/U with BH in 2 weeks, F/U with PharmD in 3 months or PRN

CASE #8
ANSWER ON NEXT PAGE

SCORING: 99214

New or Established



Level 1-5

CPT Code	Problems	Data	Risk	Final MDM Level
99202 99212	Minimal	Minimal or [illegible]	Minimal	Straightforward
99203 99213	Low	Limited	Low Risk	Low
99204 99214	Moderate	Moderate	Moderate	Moderate
99205 99215	High	Extensive	High Risk	High

CASE #8 ADDITIONAL EXPLANATION

- Medical decision making based billing
- Established patient
  - First four numbers of code = 9921
- 2 chronic conditions: 1 controlled, 1 uncontrolled
- Reviewed A1C, but this was already billed for so it is not considered for code selection
  - Data is minimal/none
- Managed prescription medication/refills
  - Moderate risk
- 2 items in the moderate category
- Code = 99214

CASE #9

- CC: “Osteoporosis”
- JM is a 71 y/o Caucasian F presenting to establish with me for medication management of osteoporosis. She just received the results of a DEXA scan ordered by her PCP at her AWV. She does not have a hx of fracture, but is concerned due to her parents’ history of osteoporosis w/ fracture and a friend’s recent experience with an osteoporotic fracture of the hip following a fall. Personal review of JM’s PCP notes indicates the conferment of a diagnosis of Osteoporosis with femoral T-score of -2.9 and a 10 year risk of major osteoporotic fracture of 31%. She is a current PPD smoker and does not want to discuss quitting today.

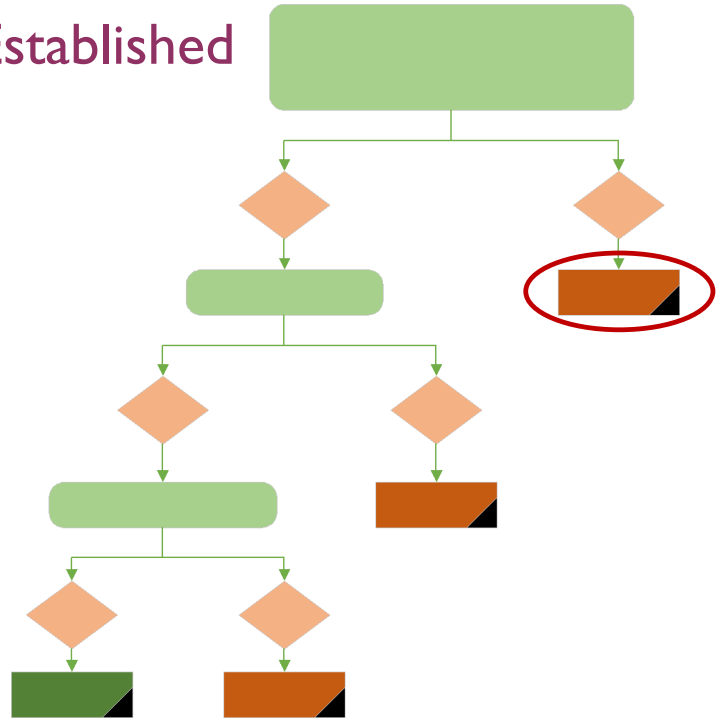
CASE #9

- Assessment & Plan:
  - 1. Osteoporosis without fracture – High risk
    - Initiate Calcium and Vitamin D OTC
    - Initiate Alendronate 70mg Weekly
    - Recommend smoking cessation. Pt declines
    - Recommended physical activity
  - 2. Tobacco Dependence – Active use, pre-contemplative, not willing to establish quit plan today
    - Ask, Advise and Assess
    - Recommended quitting, patient not interested today
    - Briefly discussed risk of continued smoking (CVD, Cancer) and contribution to fracture risk
    - Will continue to approach with motivational interviewing and assessment of readiness to change in future visits. (<3 minutes today)
  - F/U with 1 month or PRN

CASE #9
ANSWER ON NEXT PAGE

SCORING: 99204

New or Established



Level 1-5

CPT Code	Problems	Data	Risk	Final MDM Level
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99203 99213	Low	Limited	Low Risk	Low
99204 99214	Moderate	Moderate	Moderate	Moderate
99205 99215	High	Extensive	High Risk	High

CASE #9 ADDITIONAL EXPLANATION

- Medical decision making based billing
- New patient
  - First four numbers of code = 9920
- 2 uncontrolled chronic conditions: osteoporosis, tobacco use
  - Moderate problem level
- Reviewed external notes
  - Data is limited
- Treatment with OTC and prescription medications
  - Moderate risk
- 2 items in the moderate category
- Code = 99204