

Maximizing Billing and Coding

Part 1 of 4

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- 30 years of practice management, physician credentialing/re-credentialing, contract management, and coding and clinical documentation experience.
- Certified Professional Coder (CPC) credentialed by the American Academy of Professional Coders since 1998 and a Registered Health Information Administrator (RHIA) since 2011 credentialed by the American Health Information Management Association (AHIMA). She is also credentialed by AHIMA as an ICD-10-CM/ICD-10-PCS Approved Trainer.
- As the Chief of Health Information Management (HIM) working for the Veterans Administration, she is currently responsible for ensuring that all of the HIMS coding staff are properly trained and ready for the ICD-10 coding implementation. She also ensures that documentation and coding information is disseminated timely to clinicians and other administrative staff at the Veterans Administration.

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- ensure that best practices in patient care are met.
- remain abreast of each health plans regulatory requirements since regulations, policies and/or coding guidelines cited in this presentation are subject to change without further notice.
- ensure that every reasonable effort is made to adhere to applicable regulatory guidelines within their respective jurisdiction.

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Learning Outcomes

- Explain the importance of proper documentation in patient health records
- Identify and explain CPT codes
- Identify and explain office visit Evaluation and Management (E&M) codes
- Differentiate between new patient and established patient
- Differentiate between preventive medicine visit codes and preventive medicine counseling visit codes
- Identify and explain commonly used modifiers

Coding Acronyms Used

- **AMA** - American Medical Association
- **ART** – Antiretroviral Therapy
- **cc** - Chief Complaint
- **CMS** - Centers for Medicare and Medicaid Services
- **CPT** - Current Procedural Terminology
- **E&M** - Evaluation and Management
- **EPF** - Expanded Problem Focused
- **GYN** - Gynecology/Gynecologist
- **HIV** - Human Immunodeficiency Virus

Coding Acronyms Used (cont.)

- **HPI** - History of Present Illness
- **MDM** - Medical Decision Making
- **OS** - Organ System
- **PMFSH** - Past Medical, Family and Social History
- **PE** - Physical Examination
- **PF** - Problem Focused
- **PrEP** – Pre-exposure Prophylactics
- **PEP** – Post-exposure Prophylactics
- **ROS** - Review of Systems

Approved Health Care Providers

Providers must:

- Be board certified physicians or certified nurses (MD's, NP's, PA's, CNM's)
- Possess a valid NPI number and/or Medicaid participating provider ID number

Ancillary health care professionals perform services based on the requesting physician's orders documented in the health record

- Examples of ancillary health care professionals:
 - Phlebotomists
 - Medical office assistants
 - LPN's

Approved Health Care Providers (cont.)

Approved Primary Care Specialties:

- Family Practice/Family Medicine
- Internal Medicine/Adult Medicine
- OB/GYN
- Pediatrics

Sub-specialties (list is not extensive):

- Allergy/Immunology
- Cardiology
- Clinical Neurophysiology
- Critical Care
- Emergency Medicine
- Geriatrics
- Hematology
- Infectious Disease
- Pathology & Laboratory

Medical Record Documentation

- The medical record should be complete and legible
- Documentation should include:
 - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results (as applicable)
 - Assessment, clinical impression and all diagnoses treated
 - Medical plan of care
 - Date and legible identity of the health care professional

Medical Record Documentation (cont.)

- Documentation should include:
 - Past and present diagnoses should be accessible to the treating and/or consulting physician
 - Appropriate health risk factors should be identified
 - The patient's progress, response to and changes in treatment, and revision of diagnosis should be clearly documented
- The diagnosis and treatment codes reported on the health insurance claim form should be supported by the documentation in medical records

CPT Codes

CPT - Current Procedural Terminology

- Developed by AMA in 1966
- Updated annually (available January)
- CPT codes describe the procedures and services that are performed to treat medical conditions
- Reported on professional (physician) claims for services rendered on an outpatient basis
- CPT codes comprise of 6 sections

CPT Codes (2)

6 SECTIONS OF CPT CODES

- Evaluation and Management (Series 1)
- Anesthesia
- Surgery
- Radiology
- Pathology and Laboratory (Series 2)
- Medicine

CPT Codes (3)

E & M Codes (99201–99499)

- E&M stands for Evaluation and Management
- Used to report medical (non-surgical) services provided by physicians
- Used by all specialties as appropriate
- Each E&M code is incremental in nature and reflects the resources necessary to provide health care to patients
- E&M codes reflect medical care, preventive care and preventive counseling care

CPT Codes (4)

New vs. Established Patient Definition

- The E&M documentation guidelines provide a clear and concise definition of new vs. established patient:
 - New patient – has not received any face -to-face professional services from a physician within the same specialty within the last three years
 - Also within same health care entity

CPT Codes (5)

- Established patient – has received face-to-face professional services from a physician within the same health care entity within the last three years
 - Commonly referred to as “follow up care”
 - Satisfactory statements include:
 - Patient here for HIV test results follow up
 - Patient here for antiretroviral therapy follow up

CPT Codes (6)

E & M Documentation

Key Components

- History
- Physical Examination
- Medical Decision Making

CPT Codes (7)

New Patient Clinic Visit Codes

HISTORY	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
EXAM	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
MEDICAL DECISION MAKING	Straight Forward	Straight Forward	Low	Moderate	High
Code/Level	99201	99202	99203	99204	99205
Typical Time Spent	10 minutes	20 minutes	30 minutes	45 minutes	60 minutes

Established Patient Clinic Visit Codes

HISTORY	*	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
EXAM	*	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
MEDICAL DECISION MAKING	*	Straight Forward	Low	Moderate	High
Code/Level	99211	99212	99213	99214	99215
Typical Time Spent	5 minutes	10 minutes	15 minutes	25 minutes	40 minutes

* Minimal problem that may NOT require the presence of a Physician

Key Component #1

History – a description of the patient's present illness related to the chief complaint

- History typically includes:
 - CC, HPI, ROS, PMFSH

Component #1

cc - a clear concise statement that describes the reason for the medical encounter typically in the patient's own words

- Usually the first sentence in the health record
- The medical record should clearly reflect the chief complaint
- The statement patient “here for follow up care” is insufficient as this does not clearly state the reason for the patient seeking medical care
- Satisfactory statements include:
 - Patient here for HIV test results follow up
 - Patient here for antiretroviral therapy follow up

Component #1 (page 2)

Each type of history includes documentation of some or all of the following HPI elements:

- Location – symptomatic areas
- Quality – the quality of the symptom
- Severity – intensity of the symptom
- Duration – how long the symptoms occurred
- Timing – onset of the symptoms
- Context – what the patient was doing when symptoms began
- Modifying factors – factors that improve or worsen the patient's symptoms
- Associated signs and symptoms – additional complaints that add to the symptoms

Component #1 (page 3)

Review of Systems (ROS):

- The status of each body system
- Defines the problem
- Clarifies differential diagnoses
- Identifies the need for diagnostic tests
- Serves as baseline data for other affected body systems that may impact management and treatment options

Component #1 (page 4)

ROS – Body Systems

- Constitutional systems
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Component #1 (page 5)

PMFSH Elements

PMFSH consists of a review of 3 pertinent areas:

- Past medical history – personal illnesses, injuries, major operations and medication
- Past family history – review of family medical illnesses
- Past social history – age appropriate review of past and current activities

Documentation of all 3 areas is required for new patient encounters

Key Component #2

Physical Examination (PE)

- An objective assessment of organ systems or body areas pertinent to the medical complaint, illness or injury
- The extent of the exam performed depends on the physician's clinical judgment and the patient's reason for seeking medical attention

Component #2

PE Body Areas

- Head, including face
- Neck
- Chest, including breast and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

Component #2 (page 2)

PE Organ Systems

- Constitutional systems
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Component #2 (page 3)

Physical Exam Documentation Tips

- Examine the body systems/body areas related to the presenting problem
- Abnormal and relevant negative exam findings of the affected or symptomatic body areas or organ systems must be documented in detail
 - A statement of “normal” is sufficient
 - A statement of “abnormal” or “asymptomatic” without any explanation is not acceptable
 - Examples include:
 - Abnormal skin/positive for skin rashes or lesions should be documented as “discolored skin lesions on the left arm and face”

Component #2 (page 4)

The AMA and CMS developed a set of physical examination documentation guidelines in 1995 and again in 1997

- The 1995 guidelines are somewhat subjective
- The 1997 guidelines reflect clearly defined examination elements for physicians to understand
- Physicians may chose to use either set of guidelines; but not both
- Most physicians defer to the 1995 guidelines

Component #2 (page 5)

1995 E&M Physical Exam Guidelines

Problem Focused	1 body area or organ system
Expanded Problem Focused	2 - 4 body areas or organ systems
Detailed	5 - 7 body areas or organ systems
Comprehensive	8 or more organ systems OR a complete exam of a single system

1997 E&M Physical Exam Guidelines

Problem Focused	1 - 5 elements in any system or body area
Expanded Problem Focused	At least 6 elements in any system or body area
Detailed	At least 2 elements from each of 6 areas/systems <u>OR</u> at least 12 elements in 2 or more areas/systems
Comprehensive	At least 2 elements from each of 9 areas/systems

Key Component #3

Medical Decision Making (MDM)

Complexity of establishing final diagnoses, selection of management options, and/or preparation of the patient's treatment plan

Component #3

MDM is determined by:

- Number of possible diagnoses and/or management options considered
- Documentation of data reviewed, amount of data and/or complexity data for review
- Risks of significant complications, morbidity and/or mortality relevant to the reason for seeking healthcare
 - Refer to “Table of Risk”

Component #3 (page 2)

Number of possible diagnoses and/or management options considered:

- Clinical impression
- Management plans and/or further evaluation
- If treatment is for an established condition, documentation should clearly reflect whether the problem is improving, well controlled, resolving, resolved, controlled, inadequately controlled, worsening or failing to change as expected
- The initiation of, or change in treatment or medication must be clearly documented
- Referrals to specialists must clearly reflect the type of specialist and reason for the referral

Component #3 (page 3)

Documentation of data reviewed and/or complexity of data for review:

- Diagnostic tests such as labs, radiology or procedures which are ordered
- Review of diagnostic test results such as labs, radiology or other procedure results
- Discussions with health care professionals who performed labs, radiology or procedures
- Direct visualization and independent interpretation of image tracings or lab specimens that were previously interpreted by other physicians
- Relevant findings from old medical records, history obtained from family members, caretakers or other sources

Component #3 (page 4)

Risks of significant complications, morbidity and/or mortality relevant to the reason for seeking healthcare based on:

- The risks associated with the presenting problems, diagnostic tests, procedures and specialty referrals
- The risks related to the disease process anticipated between the present encounter and the next encounter
- Diagnostic tests, procedures and specialty referrals based on the risks during and immediately after diagnostic tests, procedures and specialty referrals

Component #3 (page 5)

TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
<i>Minimal</i>	<ul style="list-style-type: none"> One self-limited or minor problem, eg, cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> Laboratory tests requiring venipuncture Chest x-rays EEG/EEG Urinalysis Ultrasound, eg, echocardiography KOH prep 	<ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings
<i>Low</i>	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> Physiologic tests not under stress, eg, pulmonary function tests Non-cardiovascular imaging studies with contrast, eg, barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
<i>Moderate</i>	<ul style="list-style-type: none"> One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, eg, lump in breast Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness 	<ul style="list-style-type: none"> Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
<i>High</i>	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss 	<ul style="list-style-type: none"> Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic Endoscopies with identified risk factors Discography 	<ul style="list-style-type: none"> Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

E&M Service Codes

New Patient Visit

CPT	99201	99202	99203	99204	99205
HISTORY - HPI	1 -3	1-3	>4 acute problems or status of 3 active chronic problems	>4 acute problems or status of 3 active chronic problems	>4 acute problems or status of 3 active chronic problems
HISTORY - ROS	N/A	1	2-9	>10	>10
HISTORY - PMFSH	1	1	1	3	3
1995 EXAM (Body areas/organ systems)	1	2-4	5-7	>8 OS or comprehensive exam of 1 single system	>8 OS or comprehensive exam of 1 single system
MDM	SF	SF	LOW	MOD	HIGH
AVERAGE TIME SPENT	10 minutes	20 minutes	30 minutes	45 minutes	60 minutes

E&M Service Codes (2)

Established Patient Visit

CPT	99211	99212	99213	99214	99215
HISTORY - HPI	*	1-3	1-3	>4 acute problems or status of 3 active chronic problems	>4 acute problems or status of 3 active chronic problems
HISTORY - ROS	*	N/A	1	2-9	10
HISTORY - PMFSH	*	N/A	N/A	1	2-3
1995 EXAM (Body areas/organ systems)	*	1	2-4	5-7	>8 OS or comprehensive exam of 1 single system
MDM	*	SF	LOW	MOD	HIGH
AVERAGE TIME SPENT	5 minutes	10 minutes	15 minutes	25 minutes	40 minutes

* May not require the presence of an MD. Typically, 5 min are spent performing these services.

E&M Service Codes (3)

Preventive Medicine/Well Visits

NEW	ESTABLISHED	CODE DESCRIPTION
99381	99391	AGE YOUNGER THAN 1 YEAR
99382	99392	EARLY CHILDHOOD (AGE 1 TO 4 YEARS)
99383	99393	LATE CHILDHOOD (AGE 5 TO 11 YEARS)
99384	99394	ADOLESCENT (AGE 12 TO 17 YEARS)
99385	99395	EARLY ADULT (AGE 18 TO 39 YEARS)
99386	99396	ADULT (AGE 40 TO 64 YEARS)
99387	99397	ADULT (AGE 65+ YEARS)

*Note: These codes include preventive medicine counseling with risk factor reduction.
Do not report CPT codes 99401-99404*

E&M Service Codes (4)

Preventive Medicine Counseling Visits

Preventive Medicine Counseling and/or Risk Factor Intervention Visits (without history and physical exam)

CODE	CODE DESCRIPTION
99401	15 minutes
99402	30 minutes
99403	45 minutes
99403	60 minutes

Note: These codes are included in the preventive medicine visit codes. Do not report CPT codes 99381-99397 together with CPT codes 99401-99403

Routine Bloodwork Code

Venipuncture: collection of venous blood

- CPT 36415 – routine venipuncture
- Report 36415 for HIV blood screening for bloodwork collected in physician's office and sent to lab for processing (lab codes covered in series 2)
- Report applicable E&M counseling or service code as primary service
 - 99201-99205: sick visit codes
 - 99381-99397: preventive visit codes
 - 99401-99403: counseling visit codes

What are Modifiers?

Modifiers are two digit (numeric or alphanumeric) codes that indicate that a procedure or service has been altered by a specific circumstance, but has not changed the code's definition

- There are CPT modifiers and HCPCS modifiers
- Some modifiers impact reimbursement
- Modifiers are never reported alone
- Modifiers are never reported on ICD-10 codes
- ICD-10 codes covered in Series 3
- Each state Medicaid agency determines the approved modifiers
- Contact your local Medicaid agency for specific guidance

Modifiers

Modifier 25 - Significant, Separately, Identifiable E&M Service by Same MD on the Same Day of a Procedure, Service or Other E&M Service

- Only report with E&M service codes (99201-99499)
- Do NOT report with any other CPT code type
- Do NOT report with HCPCS codes
- Contact your local Medicaid agency for specific guidance

Note: Modifier 25 will be covered in detail with specific examples in Series 4.

HIV Pre-Testing with Preventive Care

Case Study #1: A 27 year old patient presents to his primary care physician's office concerned about recently having unprotected sex and requests an HIV test. The physician notices that the patient is also due for a well visit this year and performs it. The physician decides to perform a preventive medicine visit exam, spends 35 minutes counseling the patient and performs a rapid HIV test. This is an established patient.

Report a preventive medicine code based on the patient's age and established patient status with the applicable modifier

**Office Service
99395**

HIV Pre-Testing with Preventive Care (cont.)

Case Study #1 Rationale:

- This is an established preventive medicine visit with counseling and HIV testing
- Report the established preventive medicine visit E&M code – CPT 99395
- Since the preventive medicine visit E&M codes include counseling as a component, do NOT report the counseling codes separately

HIV Post Test Counseling Negative Results

Case Study #2: The patient returns for their HIV test results. The physician advises the patient that the results are negative and counsels the patient for 30 minutes on the importance of safe sex and contraceptive methods. The physician also distributes contraception and advises the patient to return in 3 months for a retest.

Report a counseling code based on the total time spent counseling the patient

**CPT Code
99402**

HIV Post Test Counseling Negative Results (cont.)

Case Study #2 Rationale:

- The patient returned for their HIV test results. Since the results are negative and counseling on safe sex was documented, report the preventive medicine counseling E&M code
- Select the code based on the amount of time spent counseling the patient – CPT code 99402
- Do not report the regular preventive medicine E&M visit code since the documentation states that this was a counseling service

HIV Post Test Counseling Positive Results

Case Study #3: The patient returns for HIV test results. The physician advises the patient that they are HIV+. The physician explains what it means to be HIV+. The physician performs an expanded problem focused history and exam, counsels the patient. Prescriptions are dispensed, along with discussing the proper use of medications. A treatment plan is prepared and discussed with the patient. This is an established patient visit.

**Report an established patient office visit
E&M based on level of history, exam and
medical decision making**

**Office E&M
99213**

*Note: Assign the applicable diagnosis code which designates HIV+ vs. AIDS.
Diagnoses codes are covered in Series 3.*

HIV Post Test Counseling Positive Results (2)

Case Study #3 Rationale:

- The patient returned for their HIV test results. Since the results are positive, this is considered a sick visit encounter
- A brief history and exam is performed and documented in the health record
- Prescriptions are dispensed and documented in the health record
- Instructions for proper medication use and treatment plan are both documented in the health record
- The E&M components are: expanded problem focused history, expanded problem focused exam and medical decision making is low
- Assign an established patient E&M code based on the level of care provided
- The E&M code for this scenario is 99213

HIV Post Test Counseling Positive Results (3)

Case Study #4: A 27 year old patient presents to his primary care physician's office concerned about recently having unprotected sex and requests an HIV test. Since this is a new patient, the physician decides to perform a preventive medicine visit exam, spends 35 minutes counseling the patient and performs a rapid HIV test.

Report a preventive medicine code based on the patient's age and new patient status

**Office Service
99385**

HIV Post Test Counseling Positive Results (4)

Case Study #4 Rationale:

- This is an initial preventive medicine visit with counseling and HIV testing on a 27 year old patient
- Report the initial preventive medicine visit E&M code – CPT 99385
- Since the preventive medicine visit E&M codes include counseling as a component, do NOT report the counseling codes separately

HIV Counseling without Testing

Case Study #5: A 17 year old patient presents to her GYN to discuss contraception options and safe sex. The physician counsels the patient on the various methods and suggests an HIV test. The patient agrees, but then minutes later declined to the HIV screening test. The physician spends 45 minutes counseling the patient and asked her to reconsider the HIV test at a later date.

Report a preventive medicine counseling code based on the total

**Office Service
99403**

HIV Counseling without Testing (cont.)

Case Study #5 Rationale:

- The patient presents for counseling on the various contraception options and safe sex
- There is no distinction between new patient vs. established patient. Select the code based on the amount of time spent counseling the patient – CPT code 99403
- Do NOT report the preventive medicine visit E&M codes because in this instance, the patient presented for counseling only

PrEP ART Visit Newborn

Case Study #6: An HIV+ mom presents to the pediatrician's office for antiretroviral therapy follow up for her 2 month old baby. The physician documents an expanded problem focused history and performs a brief exam. Upon review of the lab results, the physician makes the decision to modify the antiretroviral medication. A revised treatment plan is discussed and the physician advises the patient to return in 1 month.

Report an established patient office visit E&M based on level of history, exam and medical decision making

**Office E&M
99213**

Note: Assign the applicable diagnosis code which designates HIV+ vs. AIDS. Diagnoses codes are covered in Series 3.

PrEP ART Visit Newborn (cont.)

Case Study #6 Rationale:

- An HIV+ mom visits the pediatrician's office with her 2 month old baby for antiretroviral therapy follow up. This is considered a sick visit encounter
- An expanded problem focused history and brief exam is performed and documented in the health record
- Lab results are reviewed which results in modification of the medication. Prescriptions are dispensed and documented in the health record
- The E&M components are: expanded problem focused history and exam with low medical decision making low
- Assign an established patient E&M code based on the level of care provided
- The E&M code for this scenario is 99213

PEP Visit Office Staff

Case Study #7: A medical assistant accidentally punctures finger with needle after drawing bloods on an HIV patient. The office manager completes the workplace injury forms while the medical assistant is treated by a physician in your office. The physician performs a detailed history and problem focused exam. Medical decision making includes blood work, a supply 48 hour PEP medication and counsels the medical assistant regarding transmission prevention. Bloodwork sent to lab for processing.

Report a new patient office visit E&M based on level of history, exam and medical decision making Modifier 25 to indicate that an additional service was rendered during E&M visit	Office E&M 99203-25
Routine bloodwork performed in physician's office	36415

Note: Assign the applicable diagnosis code which designates HIV+ vs. AIDS. Diagnoses codes are covered in Series 3.

PEP Visit Office Staff (cont.)

Case Study #7 Rationale:

- Encounter for accidental needle stick with needle after drawing bloodwork from a patient with AIDS.
 - This is considered a sick visit encounter
- A detailed history and problem focused exam is performed and documented in the health record
 - Assign new patient E&M code based on the level of care provided
 - The E&M code for this scenario is 99203
- Bloodwork is drawn (CPT 36415), PEP medications administered bloodwork to the lab for processing
- HIV Antigen code reported by Pathologist (covered in series 2)

Coding Tips

- HIV Pre-Test with Testing and Preventive Care including Counseling

Report:

- CPT 99381-99397 for patients that meet the new patient criteria
 - CPT 99391-99397 for patients that meet the established patient criteria
- HIV Counseling without Testing (excluding Preventive Care)
- ## Report:
- CPT 99401-99404 based on total time spent counseling the patient

Coding Tips (cont.)

- HIV Post Test Counseling (Results Negative)

Report:

– CPT 99401 to 99404 - OR - CPT 99211 to 99215

- HIV Post Test Counseling with Coordination of Care (Results Positive)

Report:

– CPT 99401 to 99404 - OR - CPT 99211 to 99215

NOTES

- E&M counseling codes or established patient codes
- Contact your local Medicaid agency for specific coding guidance

Web Resources

Centers for Medicare and Medicaid Services (CMS)

<http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html>

<http://www.cms.gov/center/coverage.asp>

Food and Drug Administration (FDA) [[Link](#)]

American Medical Association (AMA) [[Link](#)]

National Center for Health Statistics (NCHS) [[Link](#)]

Centers for Disease Control (CDC)

<http://www.cdc.gov/hiv/>

Web Resources (cont.)

- American Academy of Professional Coders (AAPC)
<http://www.aapc.com/resources/index.aspx>
- American Health Information Management Association (AHIMA)
<http://www.ahima.org/resources/default.aspx>
- The American Academy of Family Physicians (AAFP)
<http://www.aafp.org/online/en/home/practicemgt/codingresources.html>
- American Hospital Association (AHA)
<http://www.aha.org/advocacy-issues/medicare/ipps/coding.shtml>

Other Resources

- CPT® 2015 Professional Edition. Publisher: American Medical Association.
- Pocket Guide to E&M Coding and Documentation. Publisher: Healthcare Quality Consultants.

Note: Coding resources are updated annually. Please be sure to update coding resources each year.

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