Adventures in Billing & Coding: Evaluation & Management for Interventional Radiology

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The IR Clinical Practice of Today & Tomorrow

Why Does E&M Coding Matter?

E&M Case Scenarios

IR believes that clinical practice is important...

American College of Radiology Practice Guideline for Interventional Clinical Practice: A Commitment to Patient Care

Timothy P. Murphy, MD

J Vasc Interv Radiol 2005; 16:157–159

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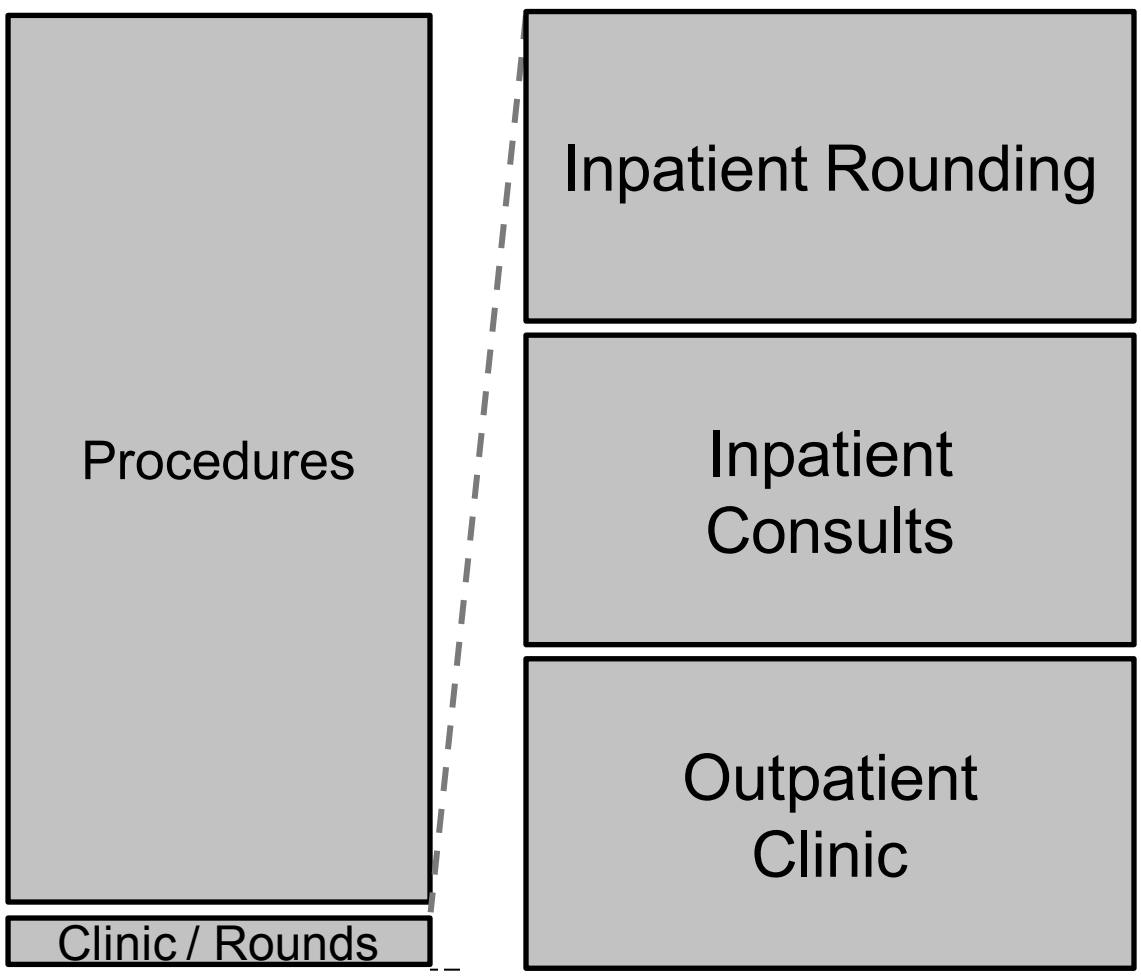
...however, referring physicians still have trouble understanding IR as a clinical specialty

"It's impossible to get in touch with the IR physicians"

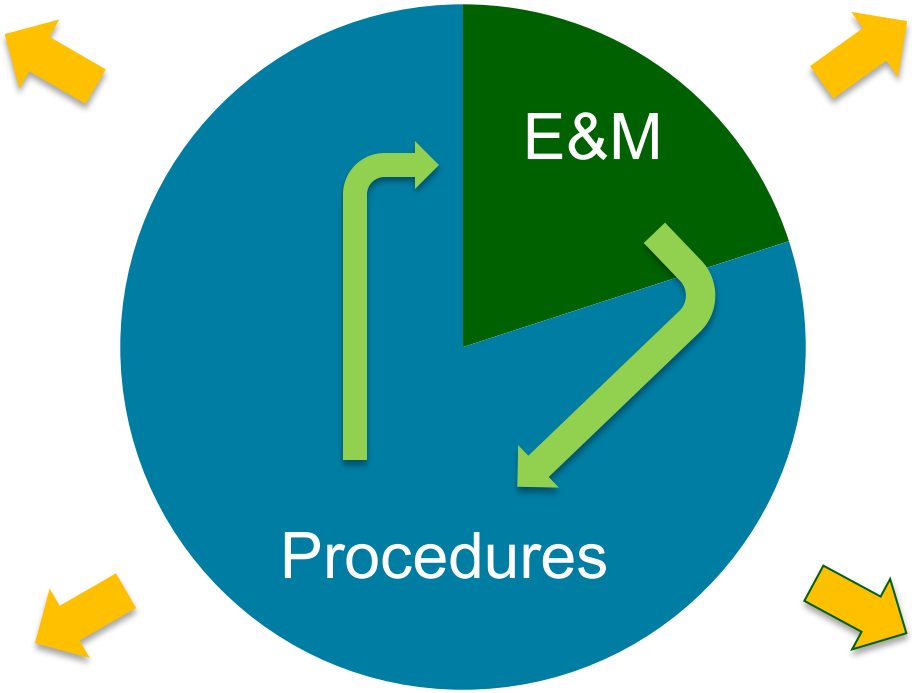
"Those guys just do the procedure, and don't take care of the patient."

"I'll just send my patient directly to IR for a procedure, and see him in my own clinic afterwards."

Traditional IR mindshare is focused primarily on procedures



However, there is an opportunity for improvement



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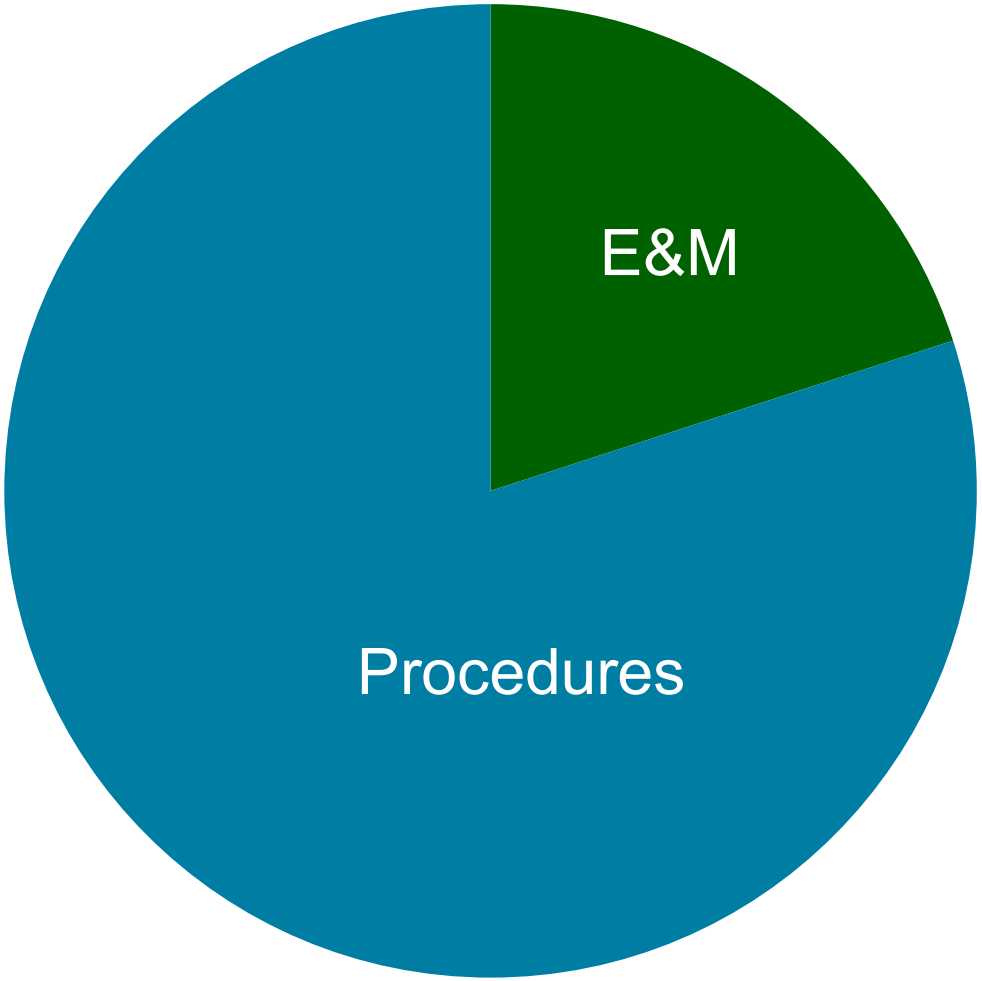

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“Best practice” clinical IR can be complex

	Inpatient Team	Outpatient Team
Team	 Attending + APC(s) + Trainee	 Attending + APC(s) +/- Trainee
Patient population	• New consults for IR expertise • Pre- and post-procedural care on IR or med/surg inpatient service	• New referrals, self-referrals to IR clinic • Pre-procedural, follow-up, and longitudinal care for IR patients
Setting	• Inpatient floors (med/surg/ICU) • Emergency room • Observation units	• Stand-alone IR clinic, often near angio suites • Co-located clinics (e.g. multidisciplinary HCC/onc)
Examples	• Consult for acute GI bleed, +/- angio, +/- follow up visits on ICU service • s/p UAE for pain management on IR service	• HCC patient seen with team of hepatology, med-onc, transplant surg, IR • Chronic venous insufficiency patient seen in IR clinic

Inpatient rounding teams require significant commitment...

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...and outpatient clinics may not show direct RVU generation

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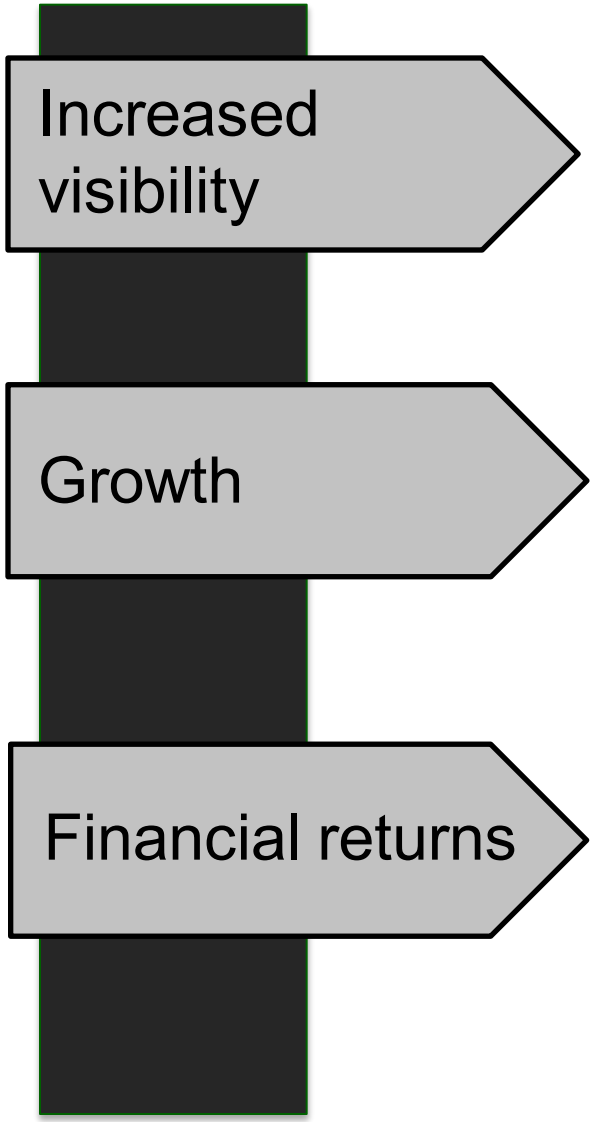
E&M Case Scenarios

Benefits are clear across the spectrum



- Stronger voice amongst hospital leadership
- Expanded clinical impact of the IR practice
- Documentation of work already being done

- Virtuous cycle of increasing referral base
- Increased complexity of case mix

- Return on investment can be modeled and proven
- Provide for resources to continue to develop clinical mission

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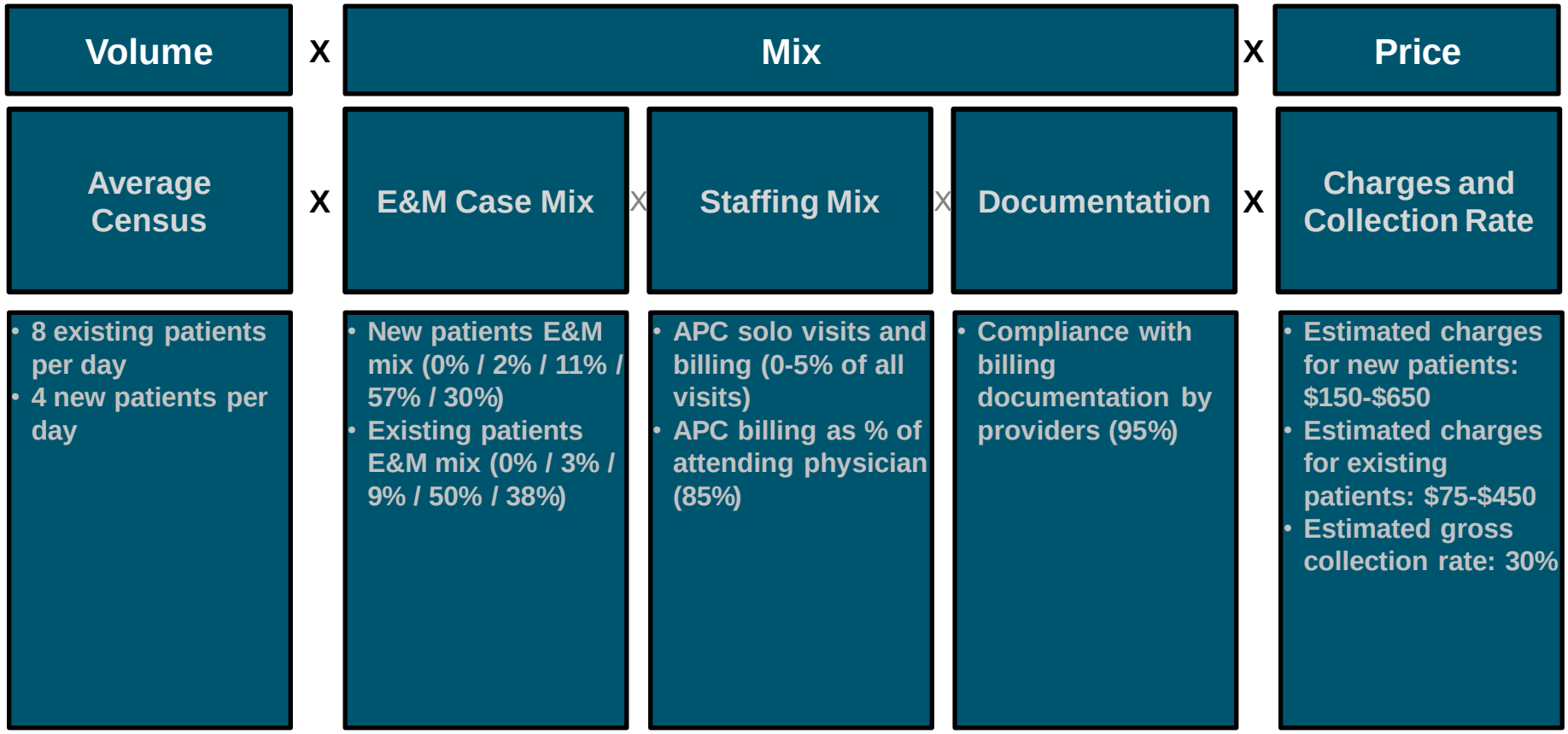
Financial modeling can help assess the benefits



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We are leaving money on the table if we don't capture our inpatient rounding revenues

Practice Type:	Small	Moderate	Large	Mega
Clinic Days/Week	0.5	2.0	4.0	5.0
Number MDs (I				
Number APCs				
New Consults/I				
Existing Consults/Day				
Estimated annu charges				83
Estimated annu collected rever				5

Practice Type:	Moderate	Large
Estimated annual charges	$284,298	$991,961
Estimated annual collected revenues	$85,289	$297,588

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Our clinics need to be sustainable sources of revenue as well

Practice Type:	Small	Moderate	Large	Mega
Full Billing Days/Week	5	5	5	5
Number MDs (FTE)	Variable			
Number APCs (FTE)	0.5	1.0	2.0	4.0
New C				
Existin Consul				
Estima charge				
Estima collecte				

Practice Type:	Moderate	Large
Estimated annual charges	$643,761	$2,264,672
Estimated annual collected revenues	$110,574	$389,612

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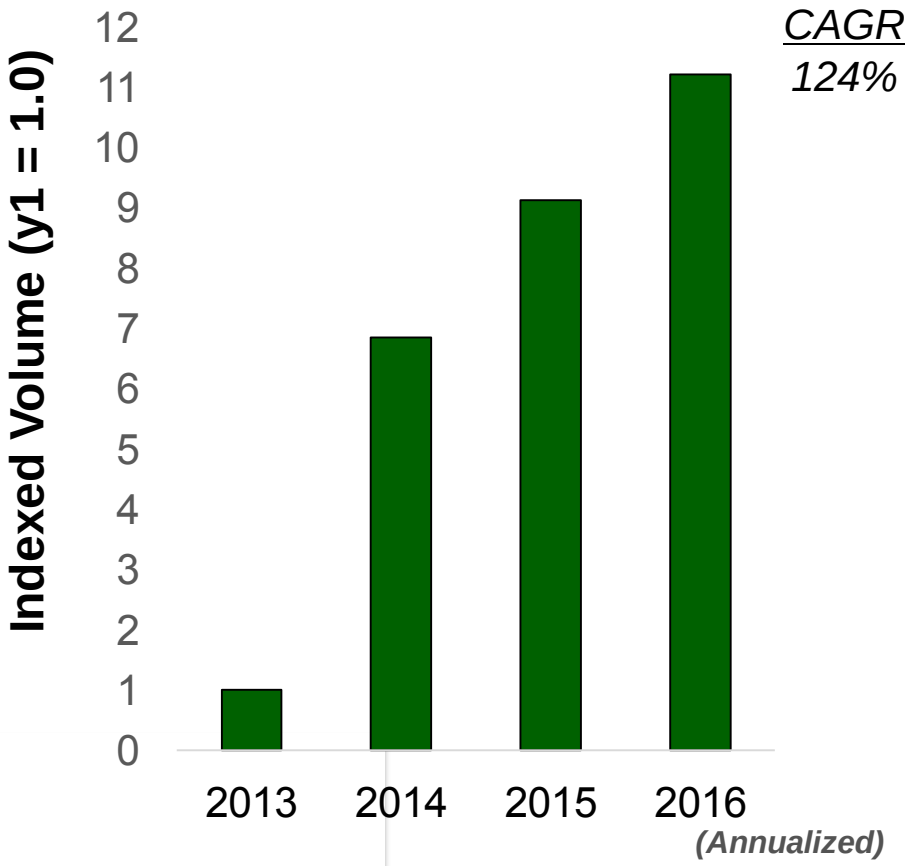
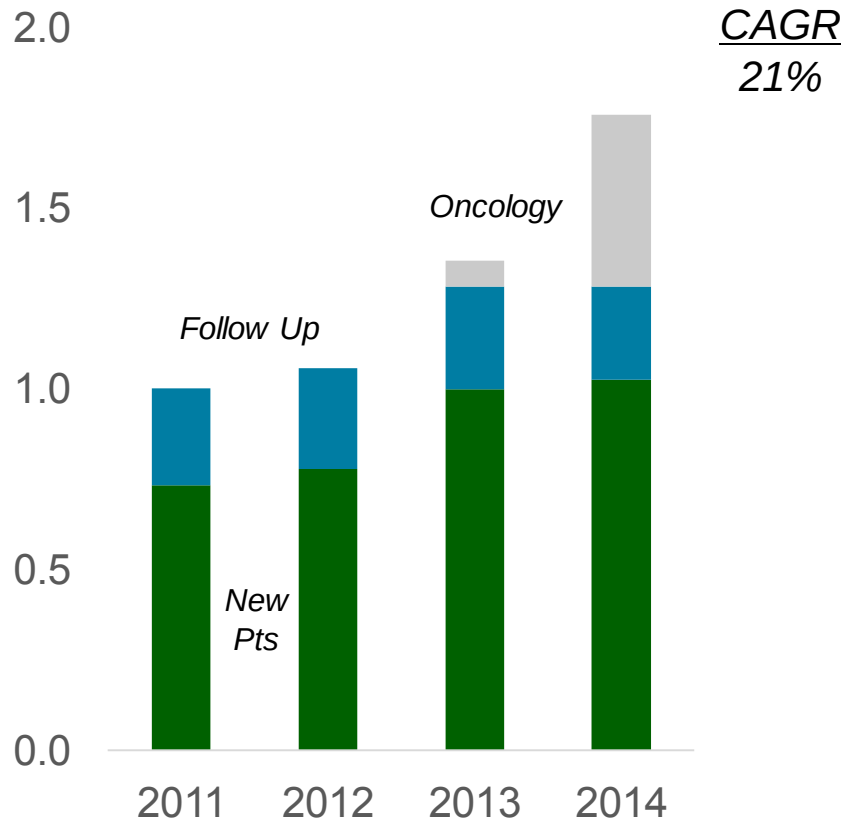
Growth of both inpatient & outpatient volumes…

Year-over-year growth 124% (inpatient), 21% (outpatient)

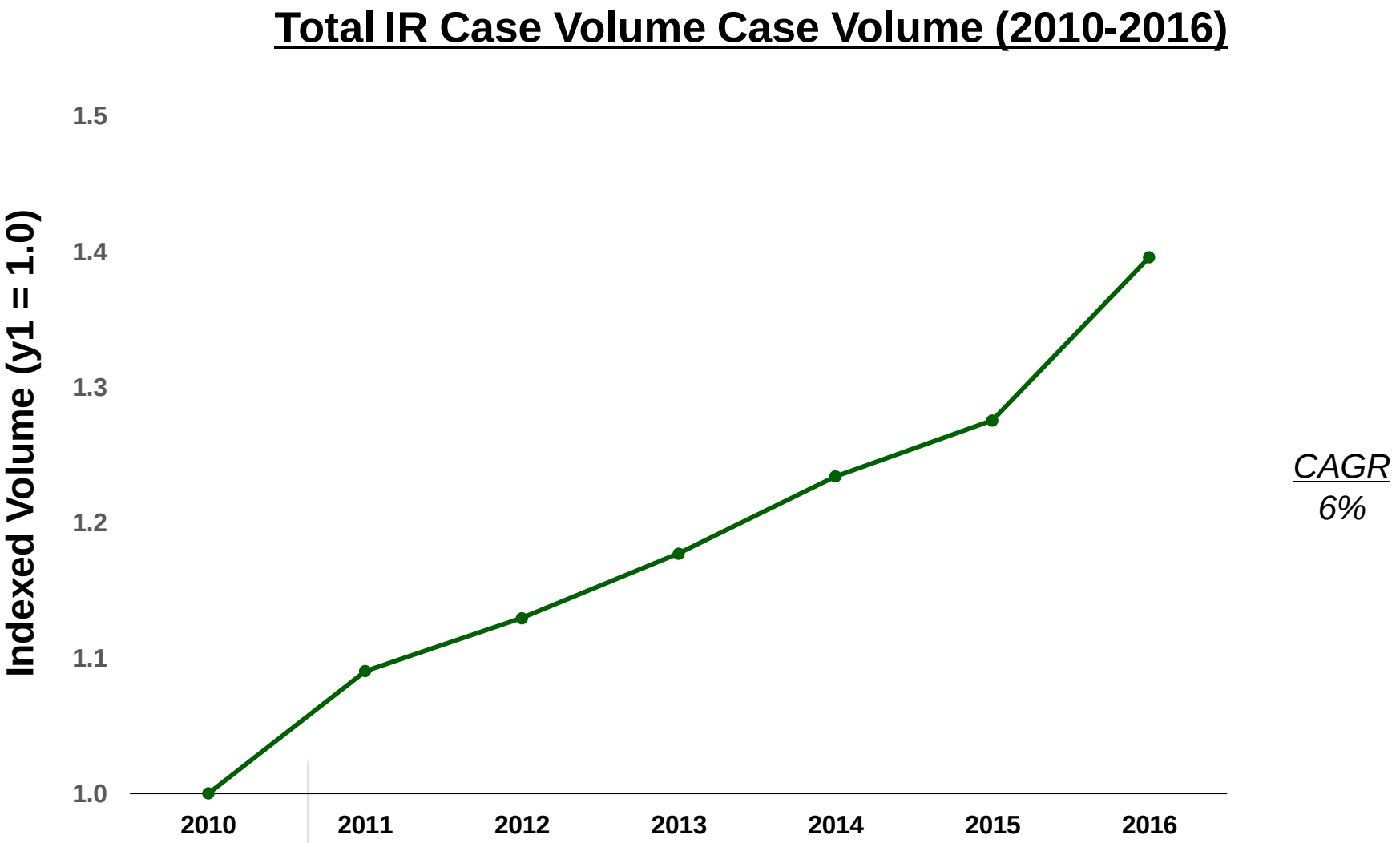
Inpatient E&M Volume (2013-2016)



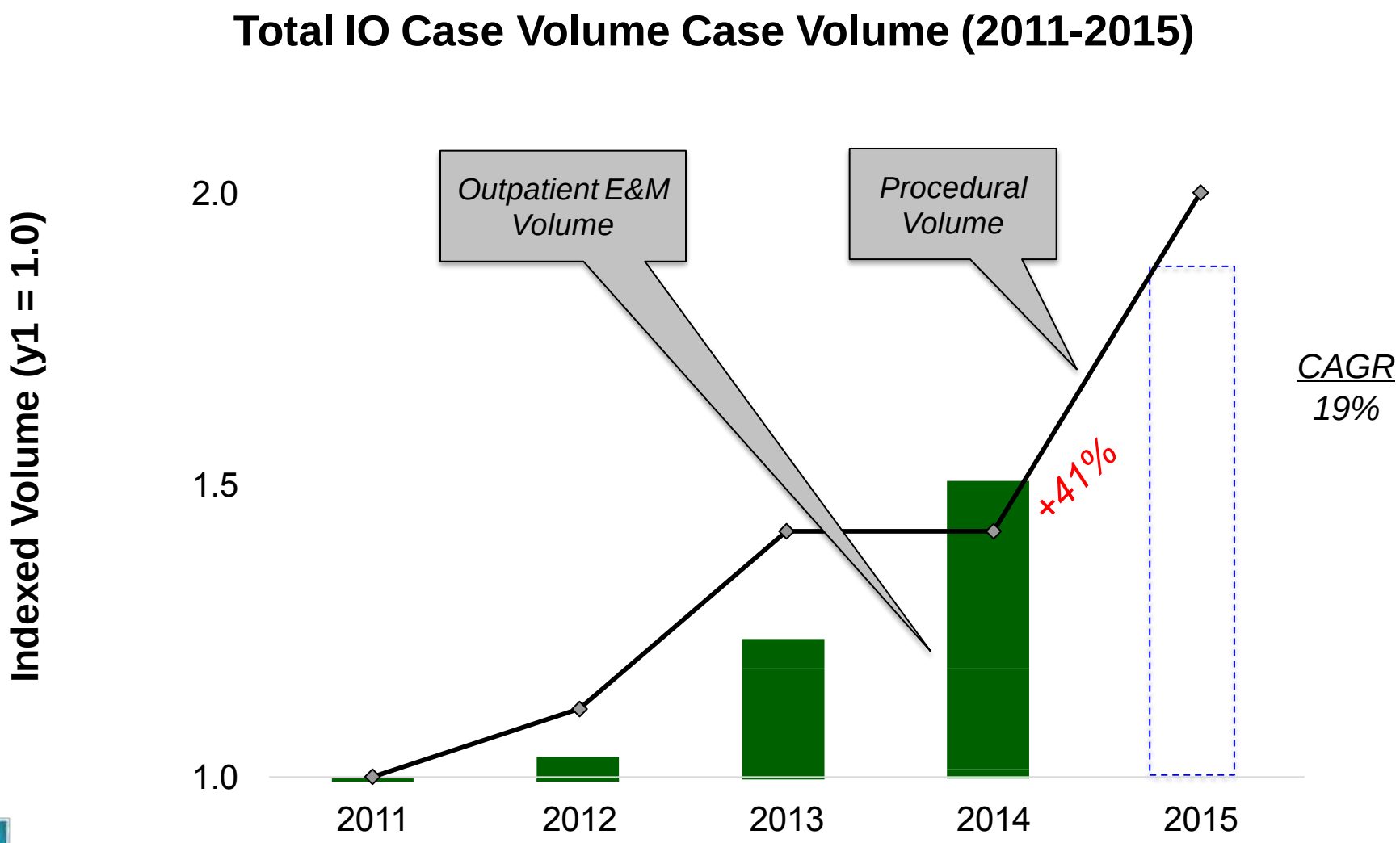
Outpatient E&M Volume (2011-2014)



…with commensurate growth in procedures…



…especially in interventional oncology



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Why Does E&M Coding Matter?

E&M Case Scenarios

General E&M guidelines

- Understanding correct level of coding is a requirement to maximizing reimbursement

- Coding level must be supported by approriate documentation

- E&M levels dependent on either component documentation or time

Time component can be a "shortcut," but has its own requirements

Entire time is face to face with patient, and at least 50% of that time must be used for "**counseling and coordination of care**"

Counseling & Coordination of Care

Setting	Where	What
Outpt.	Face to face time with MD and patient/family members	• Prognostic conversation • Discuss imaging results • Smoking cessation • Risks/benefits of treatment • Instructions for follow up • Family education
Inpt.	Floor/Unit time	

History component itself has four different elements

HPI	ROS	Past, Family, Social History	Categorization
Brief	N/A	N/A	**Problem focused**
Brief problem	Problem pertinent	N/A	**Focused expanded problem**
Extended	Extended	Pertinent	**Detailed**
Extended	Complete	Complete	**Comprehensive**

Medical decision making has four levels

# of diagnostic/management options	Amount of data to review	Risk of complications	Type of decision making
Minimal	Minimal/none	Minimal	**Straightforward**
Limited	Limited	Low	**Low complexity**
Multiple	Moderate	Moderate	**Moderate complexity**
Extensive	Extensive	High	**High complexity**

E&M office visit can fall into one of two categories

New			
Level	Code	Time (min)	$$
Level I	99201	-	$20
Level II	99202	10	$75
Level III	99203	30	$108
Level IV	99204	45	$166
Level V	99205	60	$207

Established			
Level	Code	Time (min)	$$
Level I	99211	-	$20
Level II	99212	10	$44
Level III	99213	15	$73
Level IV	99214	25	$108
Level V	99215	40	$144

3/3 component documentation

2/3 component documentation

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E&M inpatient care also falls into one of two categories

Initial Hospital Care			
Level	Code	Time (min)	$$
Level I	99221	30	$102
Level II	99222	50	$138
Level III	99223	70	$204

Subsequent Hospital Care			
Level	Code	Time (min)	$$
Level I	99231	15	-
Level II	99232	25	$72
Level III	99233	35	$104

3/3 component documentation

2/3 component documentation

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Case 1: New consult for GI bleed

- 3/3 of detailed history, detailed exam, straightforward/low complexity medical decision making
  - Or 30 minutes of face to face time

- ICD-10: K92.2
  - Bleeding in any segment of the GI tract from esophagus to rectum

- E&M Initial Hospital Care, Level I, 99231

Case 2: Inpatient followup after PCN placement

- 2/3 of either expanded problem focused history, expanded problem focused exam, moderate complexity medical decision making
  - Or 25 minutes of face to face time
- ICD-10: N 13.2
  - Hydronephrosis with renal and ureteral calculous obstruction
- E&M: Level II, 99232

Level	E&M	History	PE	MDM	Time
1	99231	Problem focused	Problem focused	Straightforward/Low	15
2	99232	EPF	EPF	Moderate	25
3	99233	Detailed	Detailed	High	35

Case 3: New visit for varicose veins

- 3/3 of detailed history, detailed exam, and straightforward/low complexity medical decision making
  - Or 30 minutes of face to face time

- ICD-10: K 92.2
  - Bleeding in any segment of the GI tract from the esophagus to the rectum

- E&M: New office visit, level I: 99203

Documentation is key since consequences of false coding are real

Adventist Health System to Pay $118.7 Million to Settle False Claims Charge

By **Editor** Filed in **News** September 21st, 2015 @ 4:39 pm

Adventist Health System will pay a total of $118.7 million to the federal government and four states to settle a whistleblower lawsuit filed in December 2012 by three former employees.

Summary

- The rewards of a strong clinical practice are great but require real time and effort
- A clear financial benefit can be seen with a robust clinical practice
- The devil is in the details of E&M coding and require compliant documentation

Thank you

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