Billing & Coding Basics for WHNPs

Essential Skills for Early-Career Success

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The National Association of NURSE PRACTITIONERS in WOMEN'S HEALTH

1

Disclosure

- The speaker has no reported disclosures

2

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3

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4

Purpose

To provide foundational billing and coding skills essential for a successful transition into practice. Many new WHNPs report uncertainty around coding, documentation, and reimbursement requirements. This webinar aims to increase confidence, reduce early-career errors, and enhance long-term professional growth.

5

Objectives

By the end of this session, attendees will be able to:

- Understand key billing and coding terminology relevant to WHNP practice.
- Identify correct CPT, ICD-10, and E/M codes commonly used in women's health.
- Apply documentation requirements to support accurate billing.
- Avoid common coding mistakes made by new graduates.
- Improve reimbursement accuracy and workflow efficiency in clinical practice.
- Know where to access ongoing billing and coding resources.

6

Part 1:
Billing & Coding Basics

7

Why It Matters?

- The **Code of Federal Regulations (CFR)** is the **official, codified collection of all permanent rules and regulations** created by U.S. federal agencies.
- In other words, we have rules, and we must abide by CMS (Federal Government).

8

Key Terms – ICD-10

ICD-10-CM = Diagnosis Codes

- Describes *why* the patient was seen (condition, symptom, injury)
- Required for all HIPAA-covered entities and used for clinical justification

(Source: CMS ICD-10 overview — ICD-10 is required for all HIPAA covered parties)

9

Key Terms – CPT®

CPT® = Procedure Codes

- Describes *what* you did (exams, procedures, services, tests)
- Used for billing, reimbursement, and documenting patient care accurately

(Source: CMS description of standardized coding systems for claims) [acdis.org]

10

Your Responsibilities

- Select **ICD-10** codes that match the clinical assessment.
- Choose **CPT®** codes that accurately reflect the service performed.
- Provide **clear, complete documentation** to support all codes.

11

Role of Payers and Documentation in Reimbursement – What Payers Do

- **Set coverage and payment rules**
  - Payers (Medicare, Medicaid, commercial plans) decide what services are covered and under what circumstances.
- **Require accurate coding for reimbursement**
  - Claims must include correct **ICD-10 diagnoses** and **CPT®/HCPCS procedures** to be processed and paid.
    - *Medicare requires that claims include appropriate diagnostic and HCPCS coding.*
- **Audit and validate claims**
  - Payers review documentation to ensure the service was medically necessary and the codes billed are justified.
    - *CMS denies payment for services when documentation does not support coding and billing requirements.*

12

Role of Payers and Documentation in Reimbursement – Why Documentation Matters

Documentation is Your Legal & Clinical Proof

- **Supports medical necessity**
  - Payers will only pay if the medical record clearly supports *why* the service was needed and *what* was done.
- **Justifies the codes you select**
  - Every CPT® and ICD-10 code must match what's documented in the chart.
- **Protects against audits and denials**
  - Incomplete, vague, or missing documentation leads to denied claims or recoupments.
    - Insufficient documentation is the #1 cause of improper Medicare payments.

13

Role of Payers and Documentation in Reimbursement – Why Documentation Matters

Your Role

- **Document clearly, completely, and specifically**
  - The record should allow a reviewer to understand the diagnosis and why the service was needed.
- **Choose codes that reflect the documentation**
  - Coding must follow—not lead—the medical record.
- **Ensure continuity and compliance**
  - Good documentation improves patient care, supports reimbursement, and aligns with payer rules.

14

Part 2:
Common Women's Health Codes

15

Understanding E/M Coding for Well-Woman Exams

Well-Woman Visits = Preventive Services

- **Use CPT® preventive codes (99381–99397)** — these are for routine, age-appropriate preventive care.
- Preventive visits include:
  - Screening history
  - Risk assessment
  - Education and counseling
  - Preventive labs or screenings
- Preventive codes are **not based on MDM or time**, unlike problem-based E/M.

16

Key Point for NPs

Preventive visits are **not the same** as problem-oriented E/M visits — they follow different coding rules and are often covered differently by payers (e.g., usually no copay for preventive services under ACA).

17

Problem-Oriented E/M During a Well-Woman Exam

When Both Preventive & Problem Visits Occur

If a patient presents for a well woman exam **AND** has a separate, clinically significant issue that requires evaluation:

Use BOTH:

1. A preventive service CPT® code (e.g., 99395)
2. An E/M problem-oriented CPT® code (e.g., 99213)

❖ Add **modifier –25** to the E/M code

18

Documentation Requirements

To bill both on the same day, documentation must clearly show:

- A distinct problem or complaint
- Separate history, exam, and medical decision making
- Additional time and work beyond the routine preventive visit

19

What Counts as a "Problem Visit"?

Use an E/M Code (99202–99215) when:

- The patient presents with **symptoms, complaints, or concerns**
- You perform **medical decision making (MDM)**
- You assess, diagnose, treat, order tests, or prescribe medication
- Follow-up or chronic condition management is performed
- The problem requires **separate documentation** from the preventive exam

20

ICD-10 Coding for Well-Woman vs. Problem Visits

Preventive ICD-10 Codes

These include "encounter for" screening and routine exams:

- **Z00.00** – General adult exam without abnormal findings
- **Z01.411** – Gynecological exam with abnormal findings
- **Z12.4** – Cervical cancer screening

21

ICD-10 Coding for Well-Woman vs. Problem Visits

Problem Related ICD-10 Codes

Use diagnosis codes based on the patient's condition:

- AUB, pelvic pain, infections, breast concerns, contraceptive management, etc.

Tip:

Your ICD-10 must support **each** CPT® code billed that day.

22

Billing Examples

Example 1: Routine Preventive Only

- Service: Annual well-woman exam
- Code: **99395**
- ICD-10: **Z01.419** (GYN exam without abnormal findings)

23

Billing Examples

Example 2: Preventive + Problem Visit

- Preventive exam + evaluation of new pelvic pain
- Codes:
  - **99395** (preventive)
  - **99213-25** (problem visit with modifier 25)
- ICD-10:
  - **Z01.419** (preventive)
  - **R10.2** (pelvic pain)

24

Documentation Checklist for NPs

For Preventive Visit

- Full preventive history
- Lifestyle & risk factors
- Screening recommendations
- Physical exam (age-appropriate)
- Preventive counseling

25

Documentation Checklist for NPs

For Problem Visit (Same Day)

- A **separate problem-focused note**
- Clear assessment & plan
- Medical decision making
- Orders, tests, prescriptions if applicable
- Distinct documentation to justify modifier 25

26

Contraceptive Counseling – What NPs Need to Know

What Contraceptive Counseling Includes

- Discussion of pregnancy prevention goals
- Review of patient's medical, sexual, and reproductive history
- Evaluation of contraindications (per U.S. MEC)
- Counseling on risks, benefits, effectiveness, side effects, and alternatives
- Shared decision-making and patient education

27

Contraceptive Counseling – What NPs Need to Know

Coding for Counseling (No Procedure Performed)

- **Preventive Visit:** Counseling is included in age-appropriate preventive E/M (99381–99397)
- **Problem Visit:** If focused counseling is the *primary reason* for the visit → bill **E/M (99202–99215)** based on MDM or time

28

Contraceptive Counseling – What NPs Need to Know

Common ICD-10 Codes

- **Z30.09** – Counseling for contraceptive management, unspecified
- **Z30.011** – Encounter for initial prescription of contraceptive pills
- **Z30.013** – Encounter for emergency contraception
- **Z30.015** – Encounter for initiation of implant
- **Z30.017** – Encounter for IUD insertion counseling

29

Coding When a Contraceptive Procedure Is Performed

Use CPT® Procedure Codes for Contraceptive Services

IUD

- **58300** – IUD insertion
- **58301** – IUD removal
- **J7296–J7298** – LNG IUDs (device codes)
- **J7300/J7301** – Copper or non-hormonal IUDs

30

Coding When a Contraceptive Procedure Is Performed

Implants

- **11981** – Implanon/Nexplanon insertion
- **11982** – Removal
- **11983** – Removal & reinsertion
- **J7307** – Nexplanon device

Injectables

- **96372** – Administration of Depo-Provera
- **J1050** – Depo-Provera medication

31

Billing Preventive + Procedure on Same Day

If the Patient Is There for a Routine Preventive Exam AND a Contraceptive Procedure

Bill BOTH:

1. **Preventive visit (9939X)**
2. **Procedure code** (e.g., 58300, 11981, 96372)

❖ Add **modifier –25** to preventive E/M **ONLY** if a significant, separate E/M was done beyond preventive care

32

Billing Preventive + Procedure on Same Day

Documentation Must Include:

- Complete preventive visit note
- Separate procedure note (indication, consent, technique, device details, tolerance, follow-up)

33

Documentation Requirements for Contraceptive Procedures

What Must Be Documented

- **Reason for procedure** (e.g., contraception, heavy bleeding, dysmenorrhea)
- **Counseling and consent**
- **Pregnancy-screening verification** (LMP, urine pregnancy test, or criteria for reasonable certainty)
- **Procedure details**
  - Lot number, expiration date
  - Type of device
  - Technique
- **Patient tolerance**
- **Post-procedure instructions**

Tip for NPs: Documentation must support BOTH the ICD-10 code and the CPT® procedure code.

34

ICD-10 Codes for Contraceptive Procedures

Most Common Codes

- **Z30.430** – Encounter for IUD insertion
- **Z30.432** – Encounter for IUD removal
- **Z30.433** – Encounter for IUD removal & reinsertion
- **Z30.017** – Encounter for implant insertion
- **Z30.46** – Encounter for surveillance of implant
- **Z30.49** – Encounter for other contraceptive maintenance
- **Z30.42** – Encounter for injectable contraceptive
- **Z30.40** – General contraceptive management
- **Z30.8** – Other contraceptive management

35

Examples for Teaching NPs

Example 1: IUD Insertion

- CPT®: **58300**
- Device: **J7298**
- ICD-10: **Z30.430**
- E/M: Only if significant counseling beyond the procedure → **99213 25**

36

Examples for Teaching NPs

Example 2: Nexplanon Removal & Reinsertion

- CPT®: **11983**
- Device: **J7307**
- ICD-10: **Z30.017** (reinsertion)
- E/M: Only if separate problem addressed

37

Examples for Teaching NPs

Example 3: Depo-Provera Visit

- CPT®: **96372**
- Drug: **J1050**
- ICD-10: **Z30.42**

38

Amenorrhea??

Is it appropriate to diagnose a potential pregnancy with amenorrhea?

No.

Secondary amenorrhea is the absence of three or more periods in a row by someone who has had periods in the past OR when someone with previously irregular cycles stops menstruating for six months or more.

39

Prenatal Care – What's Included

Components of Routine Prenatal Visits

- Confirmation of pregnancy
- Establishing gestational age
- Review of medical, obstetric & social history
- Risk screening (genetic, medical, psychosocial)
- Physical exam & prenatal labs
- Ongoing assessment of maternal & fetal well-being
- Education on nutrition, warning signs, lifestyle, medications

40

Prenatal Care – What's Included

Frequency of Prenatal Visits

- **Every 4 weeks** until 28 weeks
- **Every 2 weeks** from 28–36 weeks
- **Weekly** from 36 weeks to delivery

41

Coding for Prenatal Visits

Routine Prenatal Care is Billed as a "Package"

- Typically billed **after delivery**, not per visit
- Includes:
  - ✓ All routine prenatal visits
  - ✓ Admission to labor & delivery
  - ✓ Delivery services
  - ✓ Routine postpartum follow-up

42

Coding for Prenatal Visits

When E/M Codes *May* Be Used

Only when:

- The patient **transfers care** late
- There is **no global OB package** with the payer
- The visit is **problem-focused** (e.g., headaches, bleeding, hypertension)

43

Coding for Prenatal Visits

Common ICD-10 Codes

- **Z34.0–Z34.9** – Routine prenatal care (normal pregnancy)
- **O09._** – High risk pregnancy supervision
- **Z3A.XX** – Weeks of gestation (add to all OB visits)

44

Problem-Focused Prenatal E/M Visits

When to Bill Problem E/M (99202–99215)

- Complications: bleeding, decreased fetal movement, UTI, nausea/vomiting
- Chronic condition management: HTN, diabetes, asthma
- Non-OB issues addressed during pregnancy

45

Problem-Focused Prenatal E/M Visits

Documentation Must Include

- Reason for visit (the *problem*)
- History, exam & medical decision making
- Orders, tests, or treatment plan
- Gestational age noted

46

Postpartum Care – What's Included

Routine Postpartum Visit (6–12 Weeks Post Delivery)

- Physical recovery assessment
- Mood screening (PPD)
- Pelvic exam (as indicated)
- Feeding/infant care questions
- Contraceptive planning
- Management of chronic or pregnancy-related conditions
- Support for lactation issues

47

Postpartum Care – What's Included

ICD-10 Codes

- **Z39.1** – Encounter for postpartum care
- **Z39.2** – Routine postpartum follow-up

48

Coding Postpartum Visits

Global OB Package Covers:

- Routine postpartum care up to 6 weeks
- Physical exam
- Screening & counseling
- Contraceptive counseling (but **not all procedures**)

49

Coding Postpartum Visits

When to Bill an E/M Separately

Use **99212–99215** when:

- Managing postpartum complications (mastitis, mood disorders, wound issues)
- Evaluating a medical problem separate from routine postpartum care
- Contraceptive *procedures* performed (e.g., IUD insertion, implant placement)

50

Contraception During Postpartum Visit

Coding Rules

- Counseling → included in routine postpartum care
- **Procedures require separate CPT® charges** (e.g., 58300, 11981)
- Add **modifier –25** to E/M *only* if a separate, significant problem-focused visit occurs

51

Examples for NPs

Example 1: Routine Postpartum Visit Only

- CPT®: Included in global OB package
- ICD-10: **Z39.2**

52

Examples for NPs

Example 2: Postpartum Visit + IUD Insertion

- Global postpartum visit
- CPT®: **58300**
- ICD-10: **Z30.430**
- *No E/M unless separate issues were addressed*

53

Examples for NPs

Example 3: Problem-Focused Postpartum Visit

- Complaint: mastitis
- CPT®: **99213**
- ICD-10: **O91.22X** (mastitis, postpartum)

54

STI Testing – What NPs Need to Know

Common STIs Screened in Primary & Women's Health

- Chlamydia
- Gonorrhea
- Trichomonas
- Syphilis
- HIV
- Hepatitis B & C
- HSV (as clinically indicated)

55

STI Testing – What NPs Need to Know

When to Test

- Symptomatic patients (discharge, pelvic pain, dysuria, lesions)
- Routine screening based on risk factors
- Prenatal care
- Post-exposure concerns
- Partner exposure

56

Coding for STI Screening & Evaluation

E/M Coding for STI Concerns

Use **E/M (99202–99215)** when:

- The visit is for symptoms
- Risk assessment and sexual history are taken
- You evaluate, diagnose, and counsel
- Testing or treatment decisions are made

Coding tip: E/M level should reflect **MDM**, or **time** if selected appropriately.

57

Coding for STI Screening & Evaluation

ICD-10 Codes for Screening

- **Z11.3** – Encounter for screening for STIs
- **Z11.4** – HIV screening
- **Z11.59** – Viral hepatitis screening
- **Z20.2** – Exposure to STIs
- **Z72.51** – High-risk heterosexual behavior
- **Z72.52** – High-risk homosexual behavior

58

Coding for STI Screening & Evaluation

ICD-10 Symptom Codes (If Not Confirmed Yet)

- **N76.0** – Acute vaginitis
- **N89.8** – Vaginal discharge, other
- **R36.9** – Urethral discharge
- **R30.0** – Dysuria
- **R10.2** – Pelvic/perineal pain

59

Common CPT® Codes for STI Tests

Lab Test Codes Commonly Seen (Examples)

(Note: actual CPT® assignment often depends on your lab's billing)

- **87491** – Chlamydia NAAT
- **87591** – Gonorrhea NAAT
- **87661** – Trichomonas test
- **87801** – Infectious agent detection (molecular multiplex)
- **86592 / 86593** – Syphilis (RPR) screening
- **87389** – HIV antigen/antibody combo
- **86803** – Hepatitis C antibody

60

Treatment & Management Coding

If Treatment Is Provided

Bill an **E/M code** based on:

- Assessment for complications
- CDC-recommended treatment
- Partner services counseling
- Treatment plan documentation

61

Treatment & Management Coding

ICD-10 Codes for Diagnosed STIs

- **A56.01 / A56.02** – Chlamydia
- **A54.01 / A54.03** – Gonorrhea
- **A59.0** – Trichomoniasis
- **A51–A53** – Syphilis
- **A60._** – Herpes
- **B20** – HIV disease

62

Counseling & Partner Management

What STI Counseling Should Include

- Transmission education
- Condom and barrier-use counseling
- Treatment adherence
- Partner notification / EPT laws (varies by state)
- Risk-reduction strategies

63

Counseling & Partner Management

Coding for Counseling (If Separate & Significant)

Use **E/M** + modifier **-25** *if counseling is above and beyond the presenting problem.*

64

Example Scenarios for Teaching NPs

Example 1: STI Screening During Preventive Visit

- Preventive: **99395**
- Labs: **87491**, **87591**, **87661**
- ICD-10: **Z11.3**
- *No E/M unless a problem is discussed beyond routine preventive screening.*

65

Example Scenarios for Teaching NPs

Example 2: Symptomatic Patient (Discharge + Pain)

- E/M: **99213–99214** based on MDM
- Labs: **87491**, **87591**, **87661**
- ICD-10: **N89.8**, **R10.2** (symptoms)
- If diagnosed later → add specific "**A**" codes (e.g., A56.02)

66

Example Scenarios for Teaching NPs

Example 3: STI Treatment Visit

- E/M: **99213**
- Injection (if ceftriaxone used): **96372**
- Medication: "**J**" code if applicable
- ICD-10: **A54.01** (gonorrhea)

67

Menopause Visits – Clinical Focus

Common Reasons for Menopause-Related Visits

- Vasomotor symptoms (hot flashes, night sweats)
- Irregular bleeding / perimenopause concerns
- Sleep disturbance
- Mood symptoms
- Vaginal dryness / dyspareunia
- Hormone therapy counseling
- Cardiovascular & bone health risk assessment

68

Menopause Visits – Clinical Focus

ICD-10 Codes

- **N95.1** – Menopausal & perimenopausal disorder
- **N95.0** – Postmenopausal bleeding
- **N95.2** – Postmenopausal atrophic vaginitis
- **Z78.0** – Asymptomatic menopause

69

Menopause Visits – Clinical Focus

E/M Coding (99202–99215)

Use an E/M code when:

- Evaluating symptoms
- Starting/stopping HRT
- Managing abnormal bleeding
- Reviewing risks & labs (thyroid, CBC, FSH when appropriate)

70

Menopause – Coding Tips

When Counseling Is the Main Focus

- Bill E/M based on **time** if the majority of the visit is counseling.
- Document:
  - Symptom burden
  - Treatment options
  - Risks/benefits of HRT
  - Lifestyle management

71

Menopause – Coding Tips

Related Orders

- Bone density: **77080** (DEXA scan)
- Associated labs (panel depends on symptoms)

72

PCOS Visits – Clinical Focus

Core Components of PCOS Evaluation

- Menstrual history & cycle irregularity
- Assessment for hyperandrogenism (acne, hirsutism)
- BMI / metabolic risk assessment
- Screening for insulin resistance
- Fertility concerns
- Psychological impact screening

73

PCOS Visits – Clinical Focus

ICD-10 Codes

- **E28.2** – Polycystic ovarian syndrome
- **N92.6** – Irregular menstruation
- **L68.0** – Hirsutism
- **E66._** – Obesity (if applicable)

74

PCOS Visits – Clinical Focus

E/M Coding (99202–99215)

Bill based on:

- Complexity of medical decision making
- Ordering tests (A1c, lipids, testosterone)
- Treatment planning (OCPs, metformin, spironolactone)

75

PCOS – Coding Tips

What Must Be Documented

- Diagnostic criteria reviewed
- Metabolic screening
- Treatment options discussed
- Fertility implications
- Follow-up plan

76

PCOS – Coding Tips

Related Orders

- Pelvic ultrasound (CPT **76830**, **76856**)
- Endocrine labs (varies by lab coding)

77

Infertility Visits – Clinical Focus

Reasons for Infertility Evaluations

- Trouble conceiving ≥12 months (<35 yrs)
- Trouble conceiving ≥6 months (≥35 yrs)
- Irregular cycles
- Suspected anovulation
- History of endometriosis, PCOS, pelvic infections
- Semen analysis needs for partner
- Preconception counseling

78

Infertility Visits – Clinical Focus

ICD-10 Codes

- **N97.0** – Female infertility associated with anovulation
- **N97.1** – Infertility of tubal origin
- **N97.2** – Infertility of uterine origin
- **N97.8** – Other female infertility
- **Z31.41** – Encounter for fertility testing
- **Z31.69** – Encounter for other procreative management

79

Infertility Visits – Clinical Focus

E/M Coding (99202–99215)

Infertility visits are *always* problem-focused (not preventive).

Bill based on:

- History, exam, diagnostic planning
- Review of prior records
- Counseling and risk assessment

80

Infertility – Coding Tips

Procedure & Testing Codes Commonly Ordered

(Actual CPT® billed by labs or radiology)

- **76830** – Transvaginal ultrasound
- **58340** – Catheterization for HSG
- **74740** – Radiology for HSG
- **89300** – Semen analysis (lab)

81

Infertility – Coding Tips

Key Documentation Points

- Duration of infertility
- Menstrual history
- Prior pregnancies
- Exposure risks
- Testing plan for both partners

82

Example Scenarios for NPs

Example 1: Menopause Symptom Management

- E/M: **99214**
- ICD-10: **N95.1**
- Document: symptom burden, HRT discussion, risk review

83

Example Scenarios for NPs

Example 2: PCOS Evaluation

- E/M: **99204** (new patient)
- ICD-10: **E28.2**, **N92.6**
- Orders: US pelvis, A1c, testosterone

84

Example Scenarios for NPs

Example 3: Infertility Workup

- E/M: **99214**
- ICD-10: **N97.0**, **Z31.41**
- Orders: HSG, ovarian reserve labs, partner SA

85

What Is Urgent/Episodic Care in a WHNP Practice?

Definition

Urgent or episodic care refers to **unplanned, symptom-driven visits** for acute issues requiring prompt evaluation and treatment, but **not** emergency-level intervention.

86

What Is Urgent/Episodic Care in WHNP Practice?

Common Reasons for Episodic Visits

- Pelvic or abdominal pain
- Vaginal bleeding (intermenstrual or early pregnancy)
- Dysuria, urinary symptoms
- Vaginal discharge, itching, odor
- STI exposures, symptoms, or concerns
- Breast pain or masses
- Acute contraception needs (EC, urgent insertion requests)
- Early pregnancy symptoms, concerns, or complications

87

E/M Coding for Urgent or Episodic Visits

- **Always Billed as Problem Focused E/M**
- Use **99202–99215** based on **Medical Decision Making (MDM)** or **Time**.

88

E/M Coding for Urgent or Episodic Visits

When These Visits Are Typically Higher Level

- Multiple differential diagnoses
- Ordering labs/imaging
- New prescription medications
- Acute infection management
- Evaluation involving potential pregnancy complications

89

E/M Coding for Urgent or Episodic Visits

Documentation Must Include

- Onset, duration, severity of symptoms
- Review of systems relevant to complaint
- Focused exam
- Clear assessment & differentials
- Diagnostic plan (labs, imaging)
- Treatment plan & follow-up

90

Common ICD-10 Codes for Urgent WHNP Visits

Symptom-Based Codes (when no confirmed diagnosis yet)

- **R10.2** – Pelvic/perineal pain
- **N93.9** – Abnormal uterine/vaginal bleeding
- **R30.0** – Dysuria
- **N89.8** – Vaginal discharge
- **R39.9** – Urinary symptoms
- **N64.4** – Breast pain
- **R22.2** – Breast lump, unspecified

91

Common ICD-10 Codes for Urgent WHNP Visits

Diagnosis-Based Codes

- **N39.0** – UTI
- **N76.0** – Acute vaginitis
- **A56.02 / A54.01** – STI diagnoses (chlamydia, gonorrhea)
- **O20.0** – Threatened abortion
- **O26.891** – First-trimester pregnancy complications

92

Common Procedures & Relevant Coding

Specimen Collection

- **99000** – Handling/transport of specimen (payer-dependent reimbursement)

Point-of-Care Tests

(Note: often billed by clinic or lab depending on setup)

- **81025** – Urine pregnancy test
- **81002** – UA dipstick, non-automated
- **87880** – Strep test (for clinics that treat general female patients)
- **87800+** – Vaginitis panels / multiplex tests (varies by lab)

93

Common Procedures & Relevant Coding

Pelvic Exam

- Included in E/M—**not billed separately**

Injections

- **96372** – Therapeutic injections (Toradol, ceftriaxone, etc.)

94

Clinical Scenarios NPs Commonly Manage

Pelvic Pain

- Rule out pregnancy (UPT), STI, PID, cysts
- E/M code + labs + consider imaging referral

Acute Bleeding

- Pregnancy test
- Rule out pregnancy complications vs. anovulatory bleeding
- Document stability and follow-up plan

95

Clinical Scenarios NPs Commonly Manage

Urinary Symptoms

- UA + urine culture
- Treat empirically based on symptoms and guidelines
- E/M + POCT + ICD-10 based on findings

STI Exposure or Symptoms

- E/M + labs (GC/CT, trich, HIV, syphilis, hepatitis)
- Provide treatment per CDC guidelines
- Partner management discussion

96

Coding Tips for Urgent/Episodic WHNP Visits

Use MDM to Determine Level

Levels increase with:

- Multiple differentials
- Ordering labs or imaging
- Prescription drug management
- Acute illness with systemic symptoms

97

Coding Tips for Urgent/Episodic WHNP Visits

Modifier –25 May Apply

Add **–25** to E/M **only** when:

- A procedure is performed (e.g., injection, I&D)
- The E/M is **separate and significant**

Avoid Preventive Coding

Urgent/episodic visits are **never preventive**.

98

Example Cases

Example 1 – Dysuria + Frequency

- E/M: **99213**
- POCT: UA (**81002**)
- ICD-10: **R30.0** (if pending labs), or **N39.0** (confirmed UTI)
- Treatment: antibiotic if indicated

99

Example Cases

Example 2 – Pelvic Pain with Negative Pregnancy Test

- E/M: **99214** (due to complexity + differential)
- Labs: GC/CT, UA, trich
- ICD-10: **R10.2**
- Plan: treat based on results + pain management

100

Example Cases

Example 3 – Vaginal Bleeding in Early Pregnancy

- E/M: **99214**
- ICD-10: **O20.0**
- Orders: quantitative HCG, ultrasound (external radiology)

101

Key Takeaways for NPs

- Urgent visits are **problem-based** and rely heavily on **MDM**.
- Documentation must clearly support **acute evaluation + decision making**.
- Use **symptom codes** if diagnosis not yet confirmed.
- Prioritize **patient safety**, **follow-up**, and **return precautions**.
- Know when to **escalate to ER or OB/GYN**.

102

Part 3: Documentation that Supports Your Codes

103

Elements Required for Correct E/M Coding

- **History**
- **Examination**
- **Medical Decision Making (MDM)**

104

Elements Required for Correct E/M Coding

Recent and upcoming rules (2023–2026) shift the emphasis significantly toward MDM as the central element in selecting E/M levels.

Key points from updated 2026 guidance include:

- Coding now **focuses on the complexity of MDM** rather than "checking boxes" for history or exam.
- Providers should document **their clinical reasoning**, **assessment**, and **management plan**.

105

Elements Required for Correct E/M Coding

Under current AMA/CMS rules:

- History and exam are still required, but only to the extent that they are medically appropriate for the patient's condition.
- They are no longer scored components for determining the E/M code level.

This is especially helpful in women's health, where history/exam may vary widely by patient presentation (e.g., contraception counseling vs. pelvic pain vs. prenatal concerns).

106

Time-based Billing

Instead of MDM, clinicians may select the E/M level based on total time spent on the date of the encounter, including:

- Reviewing records
- Performing the exam
- Counseling
- Care coordination
- Documentation

This aligns with the 2026 guidance emphasizing minimum time thresholds and cognitive work.

107

CMS/AMA

Documentation style affects both coding accuracy and audit risk. Current CMS and AMA trends emphasize clinically meaningful, patient specific documentation rather than lengthy or templated text.

108

Templates (Smart Phrases, Checkboxes, Auto-Populate Tools)

Pros:

- Increase efficiency and reduce documentation burden. This was a major goal of the AMA/CMS reforms designed to make E/M documentation "more clinically meaningful" and reduce time spent on documentation tasks. [ama-assn.org]
- Provide consistency across providers and ensure required fields aren't missed.

109

Templates

Cons (and Audit Risks):

- CMS and auditors are increasingly penalizing copy/paste, auto filled, or vague templated entries.
- 2026 audit guidance highlights that over templated notes often fail to clearly connect diagnoses, data, and risk to the billed level. CMS expects documentation to *"accurately reflect patient complexity, rather than documentation volume."*
- Templates are often flagged for "listed but not addressed" conditions, which CMS warns carries higher compliance risk.
- CMS documentation rules confirm that records must be sufficient, specific, and support medical necessity, and they may deny payment for incomplete, illegible, or non-specific templated documentation.

110

Templates

Bottom line:

Templates are helpful, but over reliance on them is a top reason for E/M audit failures in 2026.

111

Detailed, Patient-Specific Documentation

Pros:

- Aligns with 2026 CMS expectations that documentation must clearly support either MDM or time, depending on which is used for code selection.
- Reduces risk of denials by showing clear clinical reasoning, which CMS notes is essential for validating the level of service.
- Demonstrates evaluation, management, and risk consideration for each condition, meeting the raised expectations for MDM clarity in 2026.

112

Detailed, Patient-Specific Documentation

Cons:

- Takes more time without efficient workflows.
- Can be overly verbose if clinicians assume "more words = higher code," which is no longer true—CMS emphasizes clarity over volume.

113

What CMS and AMA Actually Want in 2026

Based on current rules and 2026 updates:

✓ **Clinically relevant, patient specific documentation**
- The emphasis is not on how long the note is, but whether it **"clearly supports the clinical story, decision making, and time spent."**

✓ **Alignment with billing method (MDM vs. Time)**
- CMS now requires strict alignment—no mixing or unclear rationale.

✓ **Fewer checkboxes, more reasoning**
- AMA shows that physicians now spend less time documenting checklists like ROS and HPI after reforms, with documentation being more clinically meaningful.

✓ **Avoid copy/paste and vague template language**
- Auditors actively target templated notes that are duplicative or fail to demonstrate evaluation of each condition.

114

What Is Medical Necessity?

Medical necessity is the foundational requirement for all E/M services.

CMS makes it clear that **services are payable only when the documentation supports that the service was necessary for diagnosing or treating the patient's condition**. Insufficient or unclear documentation can lead to **denial of payment** because there is "no justification for the services or level of care billed.

115

How to Demonstrate Medical Necessity

1. Clearly Describe the Patient's Problem

Your documentation should:

- Explain **why** the patient is presenting today.
- Show the **severity**, **acuity**, or **impact** of the condition.
- Avoid listing diagnoses without evaluating or addressing them — CMS flags this as a compliance risk.

116

How to Demonstrate Medical Necessity

2. Show Your Clinical Reasoning (MDM)

CMS expects documentation to show **what you thought** and **why**.

To demonstrate medical necessity, tie together:

- Problems addressed
- Data reviewed
- Risk of management
- 2026 auditors focus on whether **each documented condition shows evaluation, management, or risk consideration** — merely listing conditions no longer passes scrutiny.

117

How to Demonstrate Medical Necessity

3. Explain Why Certain Tests, Orders, or Referrals Were Needed

CMS documentation requirements stress the necessity of showing that tests or services were **medically needed**—not routine or templated.

If the rationale isn't in the note, CMS may consider it unsupported.

118

How to Demonstrate Medical Necessity

4. Document Risk and Complexity

Risk level helps justify the E/M code. Provide detail on:

- Medication management decisions
- Diagnostic uncertainty
- Co-morbidities impacting your decisions
- Potential for complications

CMS highlights that documentation must reflect **actual patient management risk**, not generic statements.

119

How to Demonstrate Medical Necessity

5. Tie Time or MDM Directly to Medical Necessity

If billing based on **time**, your time must relate to medically necessary activity.

2026 guidance emphasizes excluding:

- Administrative tasks
- Staff time
- Unrelated chart review

120

How to Demonstrate Medical Necessity

6. Ensure Documentation Is Complete and Specific

CMS states that **incomplete or vague documentation can justify denial**, even if the service was truly necessary.

Avoid:

- Templated wording not specific to the patient
- "Copy-forward" histories without updates
- Listing chronic conditions without explaining relevance

121

Putting It All Together (Women's Health Example)

Poor documentation (fails medical necessity):

"Patient here for pelvic pain. Ordered ultrasound. Follow up in 2 weeks."

Strong documentation (demonstrates medical necessity):

"Patient presents with acute right-sided pelvic pain x 3 days, worsened with movement. Concern for ovarian torsion vs. ruptured cyst. Exam: guarding, localized tenderness. Ordered STAT pelvic ultrasound to rule out ovarian torsion. Given severity and diagnostic uncertainty, moderate MDM complexity."

This aligns with CMS expectations for:

- Clear problem description
- Clinical reasoning
- Risk explanation
- Supported MDM level

122

Quick Checklist: How to Demonstrate Medical Necessity

- ✓ **State the reason for visit clearly**
- ✓ **Describe the severity/impact of the condition**
- ✓ **Show your thought process & management decisions**
- ✓ **Connect each diagnosis to its evaluation/plan**
- ✓ **Document risk and complexity**
- ✓ **Justify tests, imaging, or referrals**
- ✓ **Avoid vague or copied templates**
- ✓ **Ensure documentation aligns with MDM or time rules**

123

1. Document *Total Time* Clearly and Specifically

CMS requires documenting the **total time spent on the date of the encounter** by the billing clinician — not staff.

- Must state the **exact number of minutes**.
- Vague statements like “spent significant time” are no longer acceptable.

124

2. Ensure Activities Count Only if CMS Allows Them

CMS limits "countable time" strictly to activities performed by the clinician, on the date of service, that directly relate to patient care.

Countable activities include:

- Reviewing tests, notes, or imaging related to that day's encounter
- Performing a medically appropriate exam
- Counseling and educating the patient/family
- Care coordination (ordering tests, communicating with other providers)
- Documenting the visit

Not allowed:

- Staff time
- Administrative tasks (prior auths, routine forms, scheduling)
- Reviewing unrelated charts

125

3. Time Documentation Must Align With the Selected E/M Code

In 2026, CMS expects strict alignment between:

- the E/M level selected, and
- whether the provider used MDM or time as the basis.

You cannot blend or be vague — the note must clearly indicate time is the determinant.

126

4. List the Activities Performed During the Time Count

CMS emphasizes that documentation must reflect what you actually did during the time spent.

127

5. Ensure Time Only Includes Work Done *by You, That Day*

Auditors now closely review whether time documented truly reflects the provider's personal involvement and is performed on the same date.

Time cannot include:

- Next-day phone calls
- Pre-charting the night before
- Nurse intake time
- MA record gathering

128

6. Avoid Copy-Paste or Templated Time Statements

A major 2026 audit risk is templated or identical time blocks across visits — CMS expects individualized time documentation.

Template red flags include:

- "Total time: 30 minutes" repeated across encounters
- Generic "Time spent counseling" with no details

129

7. Use Time-Based Billing Only When It Yields a Higher Level

Current guidelines allow choosing MDM OR time, whichever supports the higher code — but you must document the chosen method clearly.

130

8. Make Sure Time Documentation Supports Medical Necessity

Even when billing based on time, CMS still requires the visit to be medically necessary, and the activities documented must match the reason for the encounter.

131

Sample Time-Based Documentation (Women's Health NP Example)

"Total time spent personally by NP today: 44 minutes.

Time included: review of patient's outside ultrasound and oncology notes (10 min); pelvic exam and symptom evaluation (8 min); counseling regarding management options for endometriosis flare and discussing risks/benefits of hormonal therapy (18 min); coordination of referral to pain management (3 min); documentation and order entry (5 min).

Time based billing used; total time exceeds requirement for **99214**."

132

Part 4: Common Errors & How to Avoid Them

133

Frequent Pitfalls Among New Graduate Nurse Practitioners

Documentation Errors

- Charting too little or too late
- Not documenting clinical reasoning or differential
- Over-reliance on templates without customization

Time Management Struggles

- Visits taking too long due to incomplete workflows
- Difficulty prioritizing tasks in fast-paced settings
- Carrying documentation home → burnout risk

134

Frequent Pitfalls Among New Graduate Nurse Practitioners

Inconsistent Follow Up & Care Coordination

- Forgetting to track labs, imaging, or referrals
- Unclear communication with multidisciplinary teams
- Inadequate patient instructions for red flags

Management Errors

- Prescribing too conservatively or too aggressively
- Not knowing insurance formularies
- Missing opportunities for deprescribing

135

Frequent Pitfalls Among New Graduate Nurse Practitioners

Burnout From Unrealistic Expectations

- Trying to prove themselves too quickly
- Taking on excessive workloads
- Not setting boundaries around schedule or emotional labor

Limited Understanding of Billing & Coding

- Missing key documentation required for appropriate billing
- Not understanding levels of service
- Revenue loss or compliance issue

136

Under-Coding vs. Over-Coding

Topic	Under-Coding	Over-Coding
Definition	Billing lower level than supported	Billing higher level than supported
Common Cause	Fear, lack of confidence	Misunderstanding guidelines
Risk Level	Revenue loss, undervalued work	Compliance/audit risk
Impact	Under-reports complexity	Financial/legal consequences
Fix	Strengthen documentation & MDM reasoning	Ensure documentation matches true MDM

137

Part 5:
Practical Case Scenarios

138

Scenario 1

Annual Well-Woman Exam + Pap + STI Screening

Patient:

A 32-year-old established patient presents for her routine annual well-woman exam.

She requests Pap with HPV and chlamydia/gonorrhea screening "just to be safe."

No symptoms.

139

Scenario 1 – Correct Coding – CPT®

Service	CPT® Code	Rationale
Preventive visit (established, age 18-39)	**99395**	Age-based preventive service with history, exam, anticipatory guidance
Pap smear – collection only (performed by clinician)	**Q0091**	Medicare/Medicaid accepts **Q0091** for Pap collection; some commercial plans too
Lab tests (sent out to lab)	**88175 / 87624**	Pap cytology + HPV testing (lab bills these; NP does ***not***)
Chlamydia/Gonorrhea NAAT	**87491 + 87591**	Lab bills

140

Scenario 1 – Correct Coding – ICD-10

Diagnosis	ICD-10 Code	Rationale
Encounter for routine gyn exam	**Z01.419**	Well-woman exam, no abnormal findings
Cervical cancer screening	**Z12.4**	Proper diagnosis for Pap/HPV screening
Screening for chlamydia	**Z11.8**	Screening for infectious diseases
Screening for gonorrhea	**Z11.3**	Separate screening diagnosis

141

Scenario 2

Abnormal Uterine Bleeding (Problem Visit)

Patient:

A 44-year-old established patient presents with:

- heavier periods for 3 months
- cycles every 21–24 days
- mild pelvic cramps
- suspects perimenopause

You order CBC, TSH, and a pelvic ultrasound.

142

Scenario 2 – Correct Coding – CPT®

Service	CPT® Code	Rationale
E/M visit (moderate MDM)	**99214**	AUB work-up requires ordered tests + DDx + risk review
Endometrial biopsy (if performed today)	**58100**	Only if done during visit
Point-of-care pregnancy test (if done)	**81025**	Required for AUB evaluation in many clinics

143

Scenario 2 – Correct Coding – ICD-10

Diagnosis	ICD-10 Code	Rationale
Abnormal uterine bleeding	**N93.9**	General AUB when etiology unknown
Perimenopausal symptoms (optional)	**N95.1**	If symptoms support consideration
Pelvic pain (optional)	**R10.2**	If clinically addressed/managed

144

Part 6:
Early-Career Tips for Success

145

What New WHNPs Should Ask Employers

1. Orientation & Preceptorship

- *"How long is the formal orientation period?"*
- *"Will I have a dedicated preceptor or rotating mentors?"*
- *"How is competency assessed before independent scheduling?"*

146

What New WHNPs Should Ask Employers

2. Scheduling Expectations

- *"How many patients per day am I expected to see in the first 3–6 months?"*
- *"Will I have protected admin/documentation time?"*
- *"How quickly will my productivity expectations increase?"*

147

What New WHNPs Should Ask Employers

3. Scope of Practice & Procedures

- *"Which procedures am I expected to perform independently?"* (Pap, IUD/Nexplanon, biopsies, colposcopy, etc.)
- *"Will I receive training and proctoring for procedures?"*

148

What New WHNPs Should Ask Employers

4. Billing & Coding Support

- *"Who reviews or audits my charts?"*
- *"Is there dedicated coding education for NPs?"*
- *"Will someone review my first 50–100 E/M visits for accuracy?"*

149

What New WHNPs Should Ask Employers

5. Supervision & Consultation Structure

- *"Who is my go-to for urgent clinical questions?"*
- *"Are collaborative or supervising physicians readily accessible?"*

150

What New WHNPs Should Ask Employers

6. Professional Development

- *"Will CME funds or WHNP-specific courses be provided?"*
- *"Can I attend colposcopy/IUD workshops or coding courses?"*

151

How to Advocate for Proper Training (New WHNPs)

1. Present Training as a Safety & Compliance Need

Use language employers respect:

- *"Structured onboarding reduces documentation errors."*
- *"Adequate orientation prevents under-coding/over-coding."*
- *"Supported transition improves patient safety and retention."*

152

How to Advocate for Proper Training (New WHNPs)

2. Request Clear Expectations Up Front

- *"Can we outline month by month goals for patient volume?"*
- *"Can my first 4–6 weeks include shadowing + gradually increasing visits?"*

153

How to Advocate for Proper Training (New WHNPs)

3. Ask for Protected Learning Time

- Schedule weekly check-ins with a mentor
- Ask for monthly chart reviews
- Request 30–60 minutes per day of admin time during first months

154

How to Advocate for Proper Training (New WHNPs)

4. Advocate for Procedure Skill-Building

- *"I'd like supervised practice with 5–10 insertions before independent performance."*
- *"Can we create a competency checklist for IUD/Nexplanon/biopsies?"*

155

How to Advocate for Proper Training (New WHNPs)

5. Normalize Asking Questions

- Encourage a culture of "curiosity, not perfection."
- Ask for guidance on referral patterns, red flags, and clinic norms.

156

Recommended Billing/Coding Resources & Tools (Perfect for WHNPs)

1. Essential Coding Tools

- **2026 CPT® Professional Edition (AMA)**
- **ICD-10-CM Code Book (AAPC or Optum)**
- **AMA Guidelines for E/M 2021+** (for MDM-based coding)

157

Recommended Billing/Coding Resources & Tools (Perfect for WHNPs)

2. Online Coding Resources

- **AAPC Coder** – coder-friendly, includes RVUs
- **CMS E/M Resources & Audit Tools**
- **UpToDate Billing Guides** (useful decision trees)
- **Find-A-Code** – excellent for procedure lookups
- **EM University (emuniversity.com)** – gold standard for E/M education

158

Recommended Billing/Coding Resources & Tools (Perfect for WHNPs)

3. Women's Health–Specific Training

- **NPWH (Nurse Practitioners in Women's Health)** billing webinars
- **ASCCP** – colposcopy coding, HPV management
- **ACOG Coding Resources** – excellent WH-specific CPT® guidance

159

Recommended Billing/Coding Resources & Tools (Perfect for WHNPs)

4. Workflow & Documentation Tools

- **EHR SmartPhrases for MDM**
- **WHNP preventive care templates**
- **Symptom-based algorithms (ACOG, CDC STI treatment guidelines)**

160

Recommended Billing/Coding Resources & Tools (Perfect for WHNPs)

5. Recommended Certifications

(Not required, but help new WHNPs build skill)

- Colposcopy basic course
- Nexplanon insertion certification
- Breast and pelvic ultrasonography courses (where allowed)

161

Miscellaneous

162

Sample CPT & ICD-10 Codes Summary

Service	CPT Code	ICD-10 Code
Contraceptive counseling	**99401**	**Z30.011**
Injectable contraception	**96372** + **J1050**	**Z30.013**
IUD insertion	**58300** + **J730x**	**Z30.430**
Initial prenatal visit	**59426**	**Z34.01**
STI screening	**G0445**	**Z11.3**
PCOS management	**99213** + **76830**	**E28.2**
Infertility encounter	**99214**	**N97.0**

163

New Patient E/M

CPT	MDM	2021 Range
99202	Straightforward	15-29 min
99203	Low complexity	30-44 min
99204	Moderate complexity	45-59 min
99205	High complexity	60-74 min

Established Patient E/M

CPT	MDM	2021 Range
99211	NA	NA
99212	Straightforward	10-19 min
99213	Low complexity	20-29 min
99214	Moderate complexity	30-39 min
99215	High complexity	40-54 min

164

Evaluation and Management Updates – New Codes (Synchronous Audio-Video Evaluation and Management Services)

CPT® Codes	Description
98000	Synchronous audio-video visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making. When using total time on the date of the encounter for code selection, **15** minutes must be met or exceeded.
98001	Synchronous audio-video visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **low** medical decision making. When using total time on the date of the encounter for code selection, **30** minutes must be met or exceeded.
98002	Synchronous audio-video visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **moderate** medical decision making. When using total time on the date of the encounter for code selection, **45** minutes must be met or exceeded.
98003	Synchronous audio-video visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **high** medical decision making. When using total time on the date of the encounter for code selection, **60** minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)

165

Evaluation and Management Updates – New Codes (Synchronous Audio-Video Evaluation and Management Services)

CPT® Codes	Description
98004	Synchronous audio-video visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making. When using total time on the date of the encounter for code selection, **10** minutes must be met or exceeded.
98005	Synchronous audio-video visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and **low** medical decision making. When using total time on the date of the encounter for code selection, **20** minutes must be met or exceeded.
98006	Synchronous audio-video visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and **moderate** medical decision making. When using total time on the date of the encounter for code selection, **30** minutes must be met or exceeded.
98007	Synchronous audio-video visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and **high** medical decision making. When using total time on the date of the encounter for code selection, **40** minutes must be met or exceeded. (For services 55 minutes or longer, use prolonged services code 99417)

166

Evaluation and Management Updates – New Codes (Synchronous Audio-Only Evaluation and Management Services)

CPT® Codes	Description
98008	Synchronous audio-only visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making, **and more than 10 minutes of medical discussion**. When using total time on the date of the encounter for code selection, **15** minutes must be met or exceeded.
98009	Synchronous audio-only visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **low** medical decision making, **and more than 10 minutes of medical discussion**. When using total time on the date of the encounter for code selection, **30** minutes must be met or exceeded.
98010	Synchronous audio-only visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **moderate** medical decision making, **and more than 10 minutes of medical discussion**. When using total time on the date of the encounter for code selection, **45** minutes must be met or exceeded.
98011	Synchronous audio-only visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **high** medical decision making, **and more than 10 minutes of medical discussion**. When using total time on the date of the encounter for code selection, **60** minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)

167

Evaluation and Management Updates – New Codes (Synchronous Audio-Only Evaluation and Management Services)

CPT® Codes	Description
98012	Synchronous audio-only visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making, **and more than 10 minutes of medical discussion**. When using total time on the date of the encounter for code selection, **10** minutes must be met or exceeded. (Do not report 98012 for home and outpatient INR monitoring when reporting 93792, 93793) (Do not report 98012 when using 99374, 99375, 99377, 99378, 99379, 99380 for the same call[s]) (Do not report 98012 during the same month with 99487, 99489) (Do not report 98012 when performed during the service time of 99495, 99496)
98013	Synchronous audio-only visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and **low** medical decision making, **and more than 10 minutes of medical discussion**. When using total time on the date of the encounter for code selection, **20** minutes must be met or exceeded. (Do not report 98013 for home and outpatient INR monitoring when reporting 93792, 93793) (Do not report 98013 when using 99374, 99375, 99377, 99378, 99379, 99380 for the same call[s]) (Do not report 98013 during the same month with 99487, 99489) (Do not report 98013 when performed during the service time of 99495, 99496)
98014	Synchronous audio-only visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and **moderate** medical decision making, **and more than 10 minutes of medical discussion**. When using total time on the date of the encounter for code selection, **30** minutes must be met or exceeded. (Do not report 98014 for home and outpatient INR monitoring when reporting 93792, 93793) (Do not report 98014 when using 99374, 99375, 99377, 99378, 99379, 99380 for the same call[s]) (Do not report 98014 during the same month with 99487, 99489) (Do not report 98014 when performed during the service time of 99495, 99496)
98015	Synchronous audio-only visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and **high** medical decision making, **and more than 10 minutes of medical discussion**. When using total time on the date of the encounter for code selection, **40** minutes must be met or exceeded. (Do not report 98015 for home and outpatient INR monitoring when reporting 93792, 93793) (Do not report 98015 when using 99374, 99375, 99377, 99378, 99379, 99380 for the same call[s]) (Do not report 98015 during the same month with 99487, 99489) (Do not report 98015 when performed during the service time of 99495, 99496) (For services 55 minutes or longer, use prolonged services code 99417)

168

Evaluation and Management Updates – New Code (Brief Synchronous Communication Technology Service [e.g., Virtual Check-In])

CPT® Code	Description
98016	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an **established** patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, **5-10** minutes of medical discussion.

169

E/M – 3-Year Rule

New Patient

- Description for "New and Established Patient" 3-year rule:

  "A new patient is one who has not received any professional services from the provider or another provider of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years."

- This rule is retained in the 2021/2023 E/M guidelines.

170

LAY DESCRIPTION VERSION OF THE Level of Medical Decision Making (MDM)

Expansion by AMA Effective January 1, 2023: 99202 - 99215 OFFICE/CLINIC BASED SERVICES

Note: The following is a modification of the original AMA MDM Chart. This chart has been modified to provide more general terms and also include more specifications from the guidelines.

Code	Level of Service (Based on 2 out of 3 Elements of MDM) -OR- Time	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Work Performed & Analyzed During the Encounter *Directions for this column are noted in each area of risk row. This column is the column that requires scoring. Choose the risk area with the highest score.*	Risk of Complications and/or Morbidity or Mortality of Patient Management *NOTE: THIS COLUMN INCLUDES EXAMPLES ONLY!*
99211	Services at this level are provided by ancillary staff. *NOTE: Ancillary staff and providers must be employed by the same TAX ID number to meet supervision requirements			
99202 99212	**Straightforward - or-** 99202: 15 - 29 | 99212: 10 - 19 99242: 20	**Minimal** • **1** negligible or meager problem addressed	**Minimal or none** Minimal infers the typical work of the encounter, but no additional order, review, or otherwise classified work of the provider to be categorized below	**Negligible risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** Example ONLY: • Follow up PRN
99203 99213	**Low** -or- Time: 99203: 30 - 44 99213: 20 - 29 99243: 30	**Low** • **2** or more negligible or meager problem addressed; • **or** • **1** stable chronic problem addressed; **or** • **1** acute, direct or well-defined problem addressed or injury; **or** • **1** stable, acute illness; **or** • **1** acute, direct or well-defined problem addressed or injury requiring inpatient or observation admit	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents (Work commonly associated with E&M services)** • **Documentation noting 2 of the following were performed:** ○ Evaluate external records from an external provider (may not divide per test/per CPT); ○ Example: Review of admission to the ED or IP since previous visit ○ review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; ○ Example: PCP reviews testing ordered and performed by the cardiologist ○ ordering imaging, lab, psychometric, physiologic data testing per CPT ○ Example: If the 26 component is NOT billed by the provider- the order can be allowed. However, the order and independent interpretation could NOT be combined. • **or** **Category 2: Encounter including an additional historian(s)** **Documentation: Who is the historian, information historian provided, and best practices- why historian was required*	**Below average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Medications NOT requiring prescriptive authority • DME • Physical Therapy • Consult/Referral without elaboration
99204 99214	**Moderate** -or- Time: 99204: 45 - 59 99214: 30 - 39 99244: 40	**Moderate** • **1** (or+) chronic complaint(s) that is not stable, or noted as progressing/worsening, or side effects of treatment; **or** • **2** (or+) stable chronic problems addressed; **or** • **1** new problem undiagnosed potentially high risk; **or** • **1** acute complaint with unanticipated symptoms; **or** • **1** acute complex injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following: (REFER TO EXAMPLES ABOVE):** • Evaluate external records from an external provider (may not divide per test/per CPT); • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; • ordering imaging, lab, psychometric, physiologic data testing per CPT; • encounter including an additional historian(s) **or** **Category 2: Independent interpretation of tests** • Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported); ○ Example: Provider request Chest Xray- reviews the images and provides an interpretation within the E&M at the time of service that impacts care. Radiology will provide an over-read at a later time which will be billed. **or** **Category 3: Discussion of management or test interpretation** • Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed) ○ Example: Provider makes the decision to send the patient to the ED. The provider calls the ED provider to discuss	**Average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Initiation, continuation, discontinuation, modification of a medication that requires prescriptive authority • Decision or consideration of a minor* procedure with documented patient or procedure risk factors. • Decision or consideration of a major* procedure without documented patient or procedure risk factors. • Documentation indicates that the patients economic or social conditions impact appropriately treating or diagnosing the patient • Documentation indicates a consult/referral is required for consideration of an average risk/moderate risk management option *AMA: Minor and Major are at the discretion of the provider as documented *CMS: Minor 0-10 global | Major 90 day global
99205 99215	**High** -or- Time: 99205: 60 - 74 99215: 40 - 54 99245: 55	**High** • **1** (or +) chronic problem(s) severely triggered, progression, or side effects of treatment; **or** • **1** acute or chronic problem or injury that places danger/ risk to life or bodily function	**Extensive (REFER TO EXAMPLES ABOVE):** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: • Evaluate external records from an external provider (may not divide per test/per CPT); • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; • ordering imaging, lab, psychometric, physiologic data testing per CPT; • encounter including an additional historian(s) **or** **Category 2: Independent interpretation of tests** • Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed)	**Above average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Long/short term *intensive* monitoring to prevent toxicity (NOT monitoring efficacy) • Decision or consideration of a major* procedure with documented patient or procedure risk factors. • Decision or consideration of an major* surgery performed with minimal delay/immediate • Decision or consideration for hospitalization or alternative levels of care • Documentation of election or consideration of DNR status and/or de-escalate due to a low chance of recovery • Administration of controlled substance via IM, IV, or SubQ *AMA: Minor and Major are at the discretion of the provider as documented *CMS: Minor 0-10 global | Major 90 day global

171

LAY DESCRIPTION VERSION OF THE Level of Medical Decision Making (MDM)

Expansion by AMA Effective January 1, 2023: INPATIENT PLACE OF SERVICE

Note: The following is a modification of the original AMA MDM Chart. This chart has been modified to provide more general terms and also include more specifications from the guidelines.

Code	Level of Service (Based on 2 out of 3 Elements of MDM) -OR- Time	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Work Performed & Analyzed During the Encounter *Directions for this column are noted in each area of risk row. This column is the column that requires scoring. Choose the risk area with the highest score.*	Risk of Complications and/or Morbidity or Mortality of Patient Management *NOTE: THIS COLUMN INCLUDES EXAMPLES ONLY!*
	No IP Services fall under "minimal". There are other services that fall under SF, but they also fall under Low Level of Complexity as well. The same requirements are required with the exception of 99252 which has a time value of 35 minutes. Refer to the Low Complexity guidelines below.			
99252	**Straightforward - or- 35 Minutes**	**Minimal** • **1** negligible or meager problem addressed	**Minimal or none** Minimal infers the typical work of the encounter, but no additional order, review, or otherwise classified work of the provider to be categorized below	**Negligible risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** Example ONLY: • Will Follow up on patient tomorrow | Patient awaiting Discharge
99221 99231 99234 99253	**Low** **- or -** **99221 = 40 minutes** **99231 = 25 minutes** **99234 = 45 minutes** **99253 = 45 minutes**	**Low** • **2** or more negligible or meager problem addressed; • **or** • **1** stable chronic problem addressed; **or** • **1** acute, direct or well-defined problem addressed or injury; **or** • **1** stable, acute illness; **or** • **1** acute, direct or well-defined problem addressed or injury requiring inpatient or observation admit	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents (Work commonly associated with E&M services)** • **Documentation noting 2 of the following were performed:** ○ Evaluate external records from an external provider (may not divide per test/per CPT); ○ Example: Review of previous admission IP ○ review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; ○ Example: Cardiology reviews testing ordered by the hospitalist ○ ordering imaging, lab, psychometric, physiologic data testing per CPT ○ Example: If the 26 component is NOT billed by the provider- the order can be allowed. However, the order and independent interpretation could NOT be combined. • **or** **Category 2: Encounter including an additional historian(s)** **Documentation: Who is the historian, information historian provided, and best practices- why historian was required*	**Below average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Medications NOT requiring prescriptive authority • DME • Physical Therapy • Consult/Referral without elaboration • Awaiting discharge without further treatment plan
99222 99232 99235 99254	**Moderate** **- or -** **99222 = 55 minutes** **99232 = 35 minutes** **99235 = 70 minutes** **99254 = 60 minutes**	**Moderate** • **1** (or+) chronic complaint(s) that is not stable, or noted as progressing/worsening, or side effects of treatment; **or** • **2** (or+) stable chronic problems addressed; **or** • **1** new problem undiagnosed potentially high risk; **or** • **1** acute complaint with unanticipated symptoms; **or** • **1** acute complex injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following: (REFER TO EXAMPLES ABOVE):** • Evaluate external records from an external provider (may not divide per test/per CPT); • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; • ordering imaging, lab, psychometric, physiologic data testing per CPT; • encounter including an additional historian(s) **or** **Category 2: Independent interpretation of tests** • Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported); ○ Example: Provider requests Chest Xray- reviews the images and provides an interpretation within the E&M at the time of service that impacts care. Radiology will provide an over-read at a later time which will be billed. The need for independent interpretation (medical necessity) should be included **or** **Category 3: Discussion of management or test interpretation** • Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed) ○ Example: Provider request consult and calls requesting services and discuss the patient with the on call provider	**Average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Initiation, continuation, discontinuation, modification of a medication that requires prescriptive authority • Decision or consideration of a minor* procedure with documented patient or procedure risk factors. • Decision or consideration of a major* procedure without documented patient or procedure risk factors. • Documentation indicates that the patients economic or social conditions impact appropriately treating or diagnosing the patient • Documentation indicates a consult/referral is required for consideration of an average risk/moderate risk management option • Leaving AMA without high complexity risk documented
99223 99233 99236 99255	**High** **- or -** **99223 = 75 minutes** **99233 = 50 minutes** **99236 = 85 minutes** **99255 = 80 minutes**	**High** • **1** (or +) chronic problem(s) severely triggered, progression, or side effects of treatment; **or** • **1** acute or chronic problem or injury that places danger/ risk to life or bodily function	**Extensive (REFER TO EXAMPLES ABOVE):** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: • Evaluate external records from an external provider (may not divide per test/per CPT); • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; • ordering imaging, lab, psychometric, physiologic data testing per CPT; • encounter including an additional historian(s) **or** **Category 2: Independent interpretation of tests** • Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed)	**Above average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Long/short term *intensive* monitoring to prevent toxicity (NOT monitoring efficacy) • Decision or consideration of a major* procedure with documented patient or procedure risk factors. • Decision or consideration of an major* surgery performed with minimal delay/immediate • Decision or consideration for hospitalization or alternative levels of care • Documentation of election or consideration of DNR status and/or de-escalate due to a low chance of recovery • Administration of controlled substance via IM, IV, or SubQ

-AMA: Minor and Major are at the discretion of the provider as documented
-CMS: Minor 0-10 global \| Major 90 day global

172

Medical Decision Making (MDM) Level Tool: EMERGENCY DEPARTMENT SERVICES

EFFECTIVE FOR USE: JANUARY 1, 2023

Note: The following is a modification of the original AMA MDM Chart. This chart has been modified to be specific to the ED, add examples to the chart, as well as provide more general terms from the guidelines.

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Work Performed & Analyzed During the Encounter *Directions for this column are noted in each area of risk row. This column is the column that requires scoring. Choose the risk area with the highest score.*	Risk of Complications and/or Morbidity or Mortality of Patient Management ***NOTE: THIS COLUMN INCLUDES EXAMPLES ONLY!***
99281	Services at this level are provided by ancillary staff. *NOTE: Ancillary staff and providers would need to be employed by the same TAX ID number due to supervision rules			
99282	**Straightforward** Time-based services are NOT allowed in this place of service	**Minimal** • **1** negligible or meager problem addressed	**None**	**Negligible risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** Example ONLY: • Follow up with PCP without elaboration
99283	**Low** Time-based services are NOT allowed in this place of service	**Low** • **2** or more negligible or meager problem addressed; • **or** • **1** stable chronic problem addressed; **or** • **1** acute, direct or well-defined problem addressed or injury; **or** • 1 stable, acute illness; **or** • 1 acute, direct or well-defined problem addressed or injury requiring inpatient or observation admit	**Limited** *(Must meet the requirements of **at least 1 of the 2 categories**)* **Category 1: Tests and documents (Work commonly associated with E&M services)** • **Documentation noting 2 of the following were performed:** • Evaluate external records from an external provider (may not divide per test/per CPT); ○ Example in ED: previous admissions to the IP or ED • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; ○ Example in ED: previous labs/imaging/diagnostics from other dates of service • ordering imaging, lab, psychometric, physiologic data testing per CPT (standing orders MUST be documented) ○ Example in ED: Most test the ED physician does not bill the TC component. If the TC is not billed by the provider- the order can be allowed. However, the order and independent interpretation could **NOT** be combined **or** **Category 2: Encounter including an additional historian(s):** *(In Moderate & High, this moves to Category 1)* ○ Documentation: Who is the historian, information historian provided, and best practices- why historian was required	**Below average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Medications NOT requiring prescriptive authority • DME such as a splint • Consult/Referral without elaboration • Leaving AMA without elaboration
99284	**Moderate** Time-based services are NOT allowed in this place of service	**Moderate** • **1** (or+) chronic complaint(s) that is not stable, or noted as progressing/worsening, or side effects of treatment; **or** • **2** (or+) stable chronic problems addressed; **or** • **1** new problem undiagnosed potentially high risk; **or** • 1 acute complaint with unanticipated symptoms; **or** • **1** acute complex injury	**Moderate** *(Must meet the requirements of **at least 1 out of 3 categories**)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following (REFER TO EXAMPLES ABOVE):** • Evaluate external records from an external provider (may not divide per test/per CPT); • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; • ordering imaging, lab, psychometric, physiologic data testing per CPT; • encounter including an additional historian(s) **or** **Category 2: Independent interpretation of tests** • Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported); ○ Example: ED provider request Chest Xray- reviews the images and provides an interpretation within the E&M at the time of service that impacts care. Radiology will provide an over-read at a later time which will be billed. **or** **Category 3: Discussion of management or test interpretation** • Documentation identifying dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed) ○ Example in ED: ED provider Discuss an patient admission with the hospitalist	**Average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Initiation, continuation, discontinuation, modification of a medication that requires prescriptive authority • Decision or consideration of a minor* procedure with documented patient or procedure risk factors. • Decision or consideration of a major* procedure without patient or procedure risk factors. • Documentation indicates that the patients economic or social conditions impact appropriately treating or diagnosing the patient • Documentation indicates a consult/referral is required for consideration of an average risk/moderate risk management option *AMA: Minor and Major are at the discretion of the provider as documented *CMS: Minor 0-10 global | Major 90 day global
99285	**High** Time-based services are NOT allowed in this place of service	**High** • **1** (or +) chronic problem(s) severely triggered, progression, or side effects of treatment; **or** • **1** acute or chronic problem or injury that places danger/ risk to life or bodily function	**Extensive (REFER TO EXAMPLES ABOVE):** *(Must meet the requirements of **at least 2 out of 3 categories**)* • **Any combination of 3 from the following: Category 1: Tests, documents, or independent historian(s)** • Evaluate external records from an external provider (may not divide per test/per CPT); • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider; • ordering imaging, lab, psychometric, physiologic data testing per CPT; • encounter including an additional historian(s) **or** **Category 2: Independent interpretation of tests** • Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed)	**Above average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** **Examples ONLY:** • Long/short term *intensive* monitoring- for high risk meds or the consideration of to prevent toxicity (NOT monitoring efficacy) • Decision or consideration of a major* procedure with documented patient or procedure risk factors. • Decision or consideration of an major* surgery performed with minimal delay/immediate • Decision or consideration for hospitalization • Documentation of election or consideration of DNR status and/or de-escalate due to a low chance of recovery • Administration of controlled substance via IM, IV, or SubQ *AMA: Minor and Major are at the discretion of the provider as documented *CMS: Minor 0-10 global | Major 90 day global

173

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QUESTIONS??

174