

Rheumatology Coding Manual

Rheumatology-specific information to help code with confidence



**AMERICAN COLLEGE
OF RHEUMATOLOGY**
EDUCATION • TREATMENT • RESEARCH

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The most current CPT® is available from the American Medical Association.

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Some sections found in the appendix of this publication are taken from the Medicare Carrier Review: What Every Physician Should Know About "Medically Unnecessary" Denials. It describes the Medicare carrier review process in detail and is copyrighted by the American Medical Association. The documentation guidelines outlined in Chapter Two incorporate information and materials developed by the American Medical Association, the Centers for Medicare and Medicaid Services and the American College of Physicians.

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Introduction

This reference is a practical guide for rheumatologists and their staff to communicate effectively with third party payors regarding the medical services provided to patients. The American College of Rheumatology has developed this reference guide for rheumatologists as an adjunct to the American Medical Association's Current Procedural Terminology manual. It provides an overview of the codes most applicable to rheumatology practices as well as their effective and appropriate use. It should not be regarded as a substitute for an understanding of the entire CPT® coding system. Rather, it is meant to increase understanding of the system and to enhance its usefulness to rheumatologists and their staffs. The revisions of the CPT® codes published in this reference guide have been adopted by Medicare and by most private insurance carriers.

It is extremely important that the communication about this information be both precise and timely in light of CPT® coding changes which take place each year. It is important to remain abreast of these changes to ensure accurate coding and appropriate reimbursement.

Themes

Throughout this manual, you will note recurring themes. They are summarized below:

1. Precise and accurate coding is the most important factor in the CPT® evaluation and management codes.
2. Regardless of the level or intensity of service provided by the physician, one of the critical elements in justifying a CPT® code is documentation of the service provided. The physician's record must accurately document the components of all the services provided. Documentation is critical and should be legible. One caveat: No matter how well you document the services provided, if Medicare (or other payor) deem that the services were not medically necessary, you will not be reimbursed for the service.
3. The CPT® system is a communication service in which codes serve as symbols indicating the service provided to patients. The symbols also communicate to third party payors the level and intensity of the services. Fee schedules are developed independently by the rheumatologist who assigns a separate fee for each service and code in CPT®. The same fee should not be used for different CPT® codes within a series. To do so would not reflect the resource-based amount of work required for increasing intensity of service. It should also be noted that charging different fees for the same CPT® code should be avoided. You may choose to accept less than your fee for a particular plan, but this should not affect what you have chosen as your fee. On the other hand, if you charge the same payor different fees for a particular code, then a modifier should be added to explain a reason for that difference.
4. The importance of establishing communication between your office and local carriers cannot be underestimated. By doing so, you will save time and avoid frustrations with coding problems down the road.



We hope this reference guide is of benefit. It is important that you and your staff attend CPT® workshops and talk with your colleagues about coding issues. Please be accurate in coding your visits, and use the examples in this manual only as a guide.

Educational Resources from the American College of Rheumatology:

- If you have a coding question, contact the ACR coding and reimbursement specialist Melesia Tillman, CPC, CRHC, CHA at (404) 633-3777 ext. 820 or at mtillman@rheumatology.org.
- States societies can join the Affiliate Society Council - The ACR Affiliate Society Council is designed to address the practical needs of community rheumatologists by offering a range of services to state/local affiliates. The program includes state/local rheumatology groups who benefit from the ACR on ways to strengthen their organizations, enhance their educational activities, and provide support for their members. Each state/local affiliate serves as a bridge between local rheumatologists and the ACR.

Benefits of joining include:

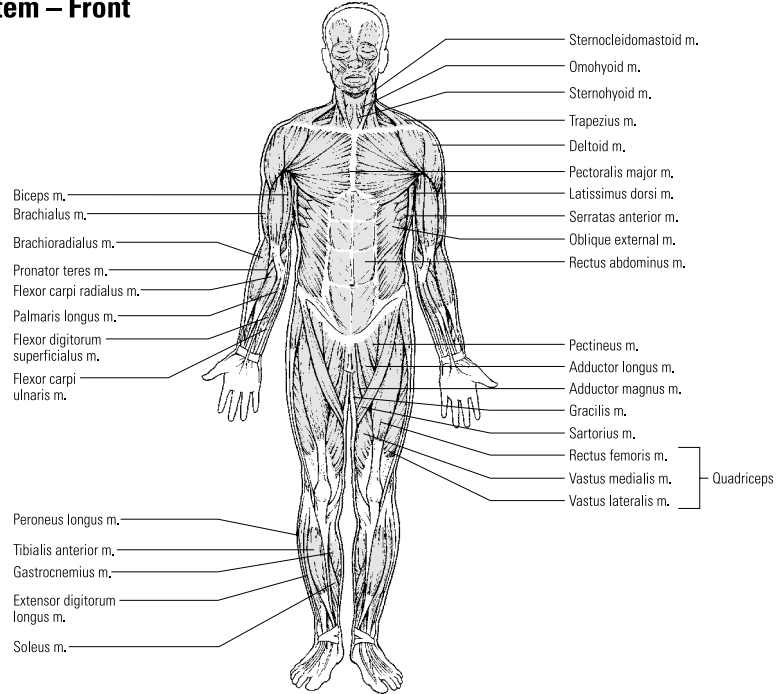
- Yearly presentation from the ACR Certified Professional Coder
- Yearly presentation from an ACR Board member providing an ACR update
- Policy analysis from the Health Policy department
- Information on Federal legislation
- Access to the ACR's Certified Professional Coder regarding reimbursement and insurance issues
- Assistance in model bylaws for associations that are being established
- List serve for the society
- State or local specific mailing labels once per year
- Website development using the ACR designed template
- Complimentary health professional speakers/materials available for your state and local society meetings

For more information on the affiliate program, visit the ACR website at www.rheumatology.org/practice.

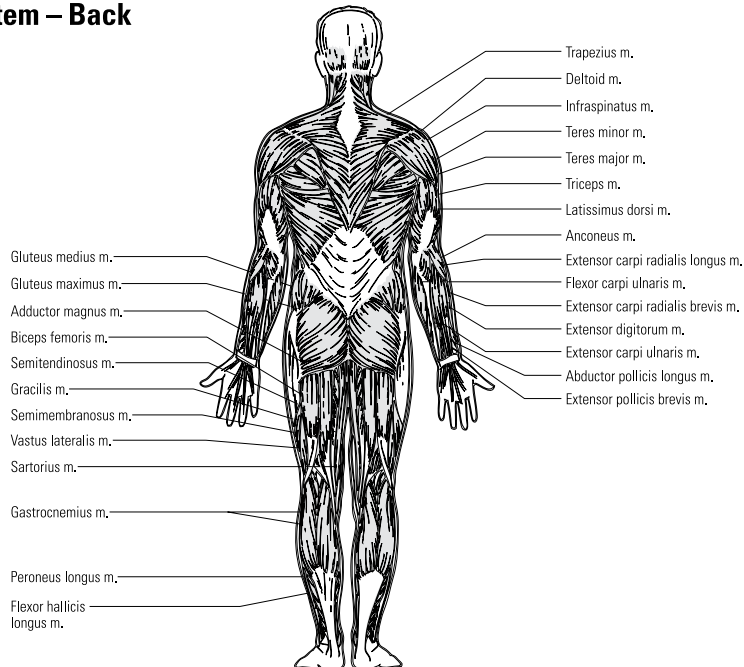


Illustrated Anatomy and Physiology

Muscular System – Front

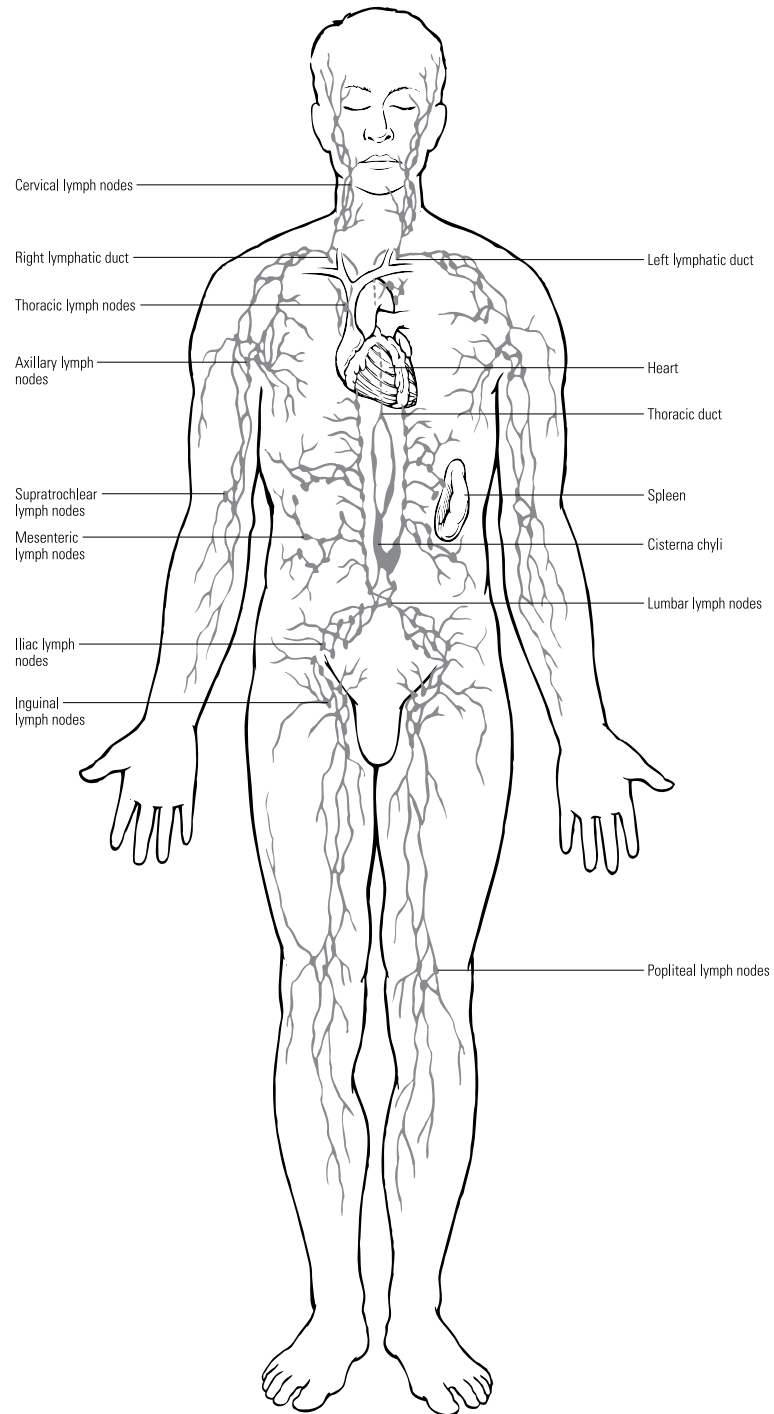


Muscular System – Back



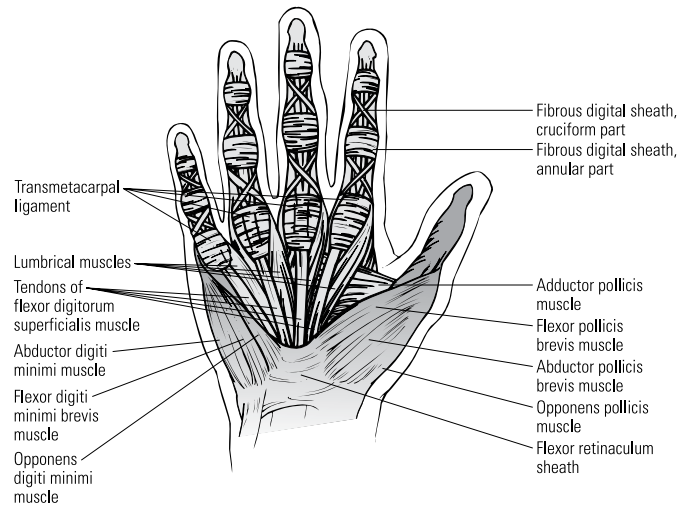
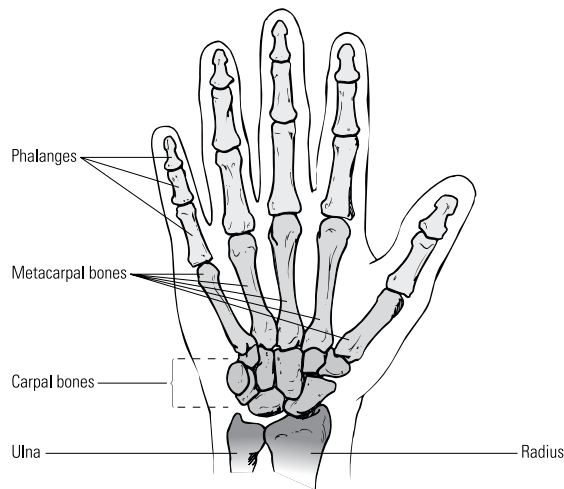


Lymphatic System

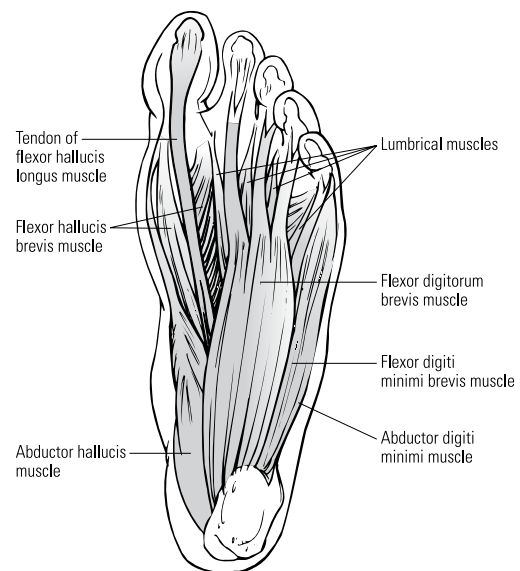
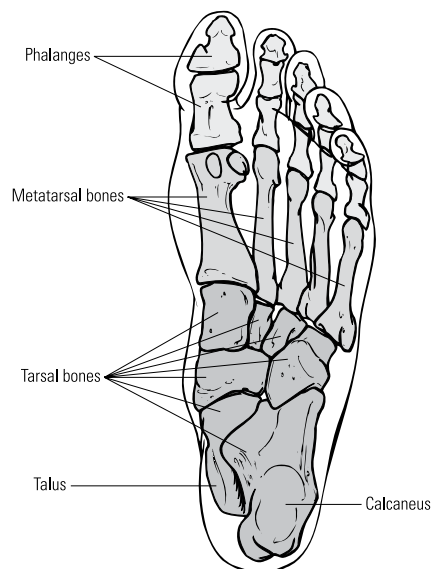




Bones, Muscles, and Tendons of Hand

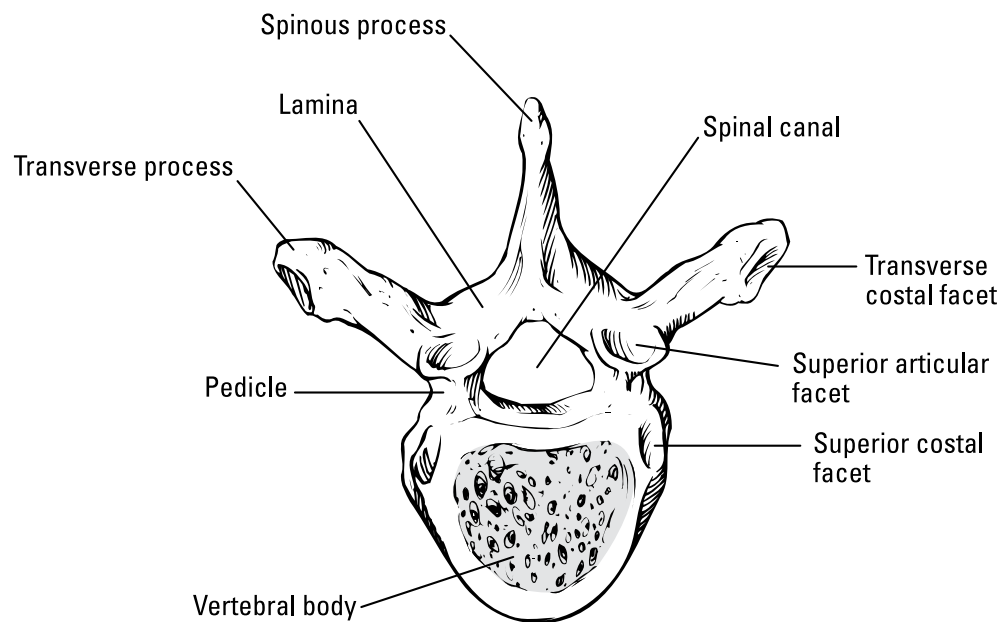


Bones and Muscles of Foot



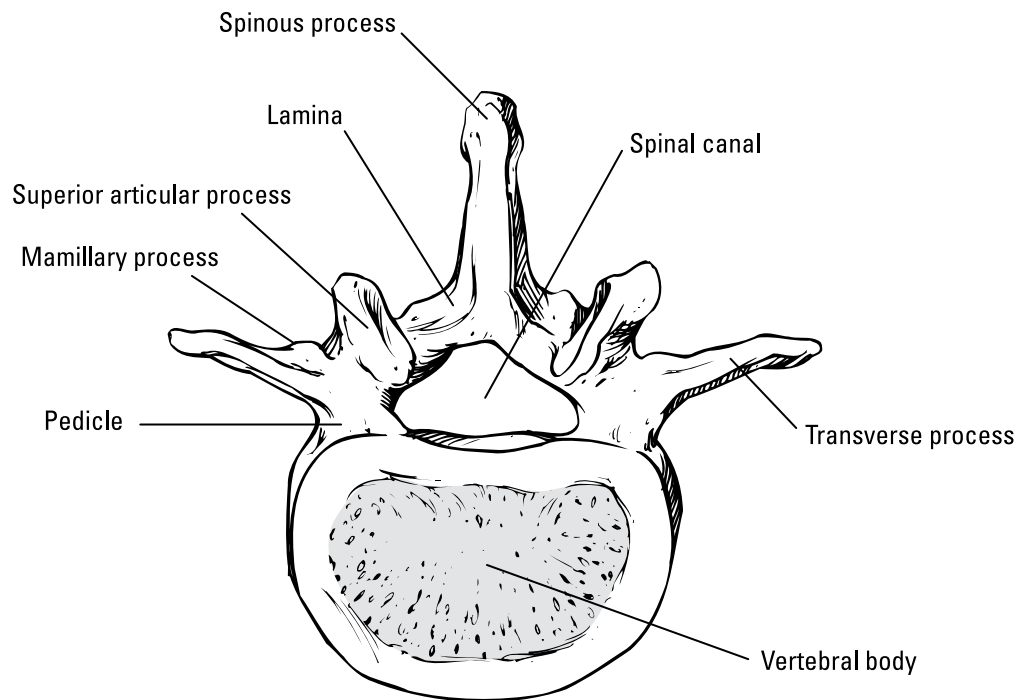


Thoracic Vertebra—Superior View



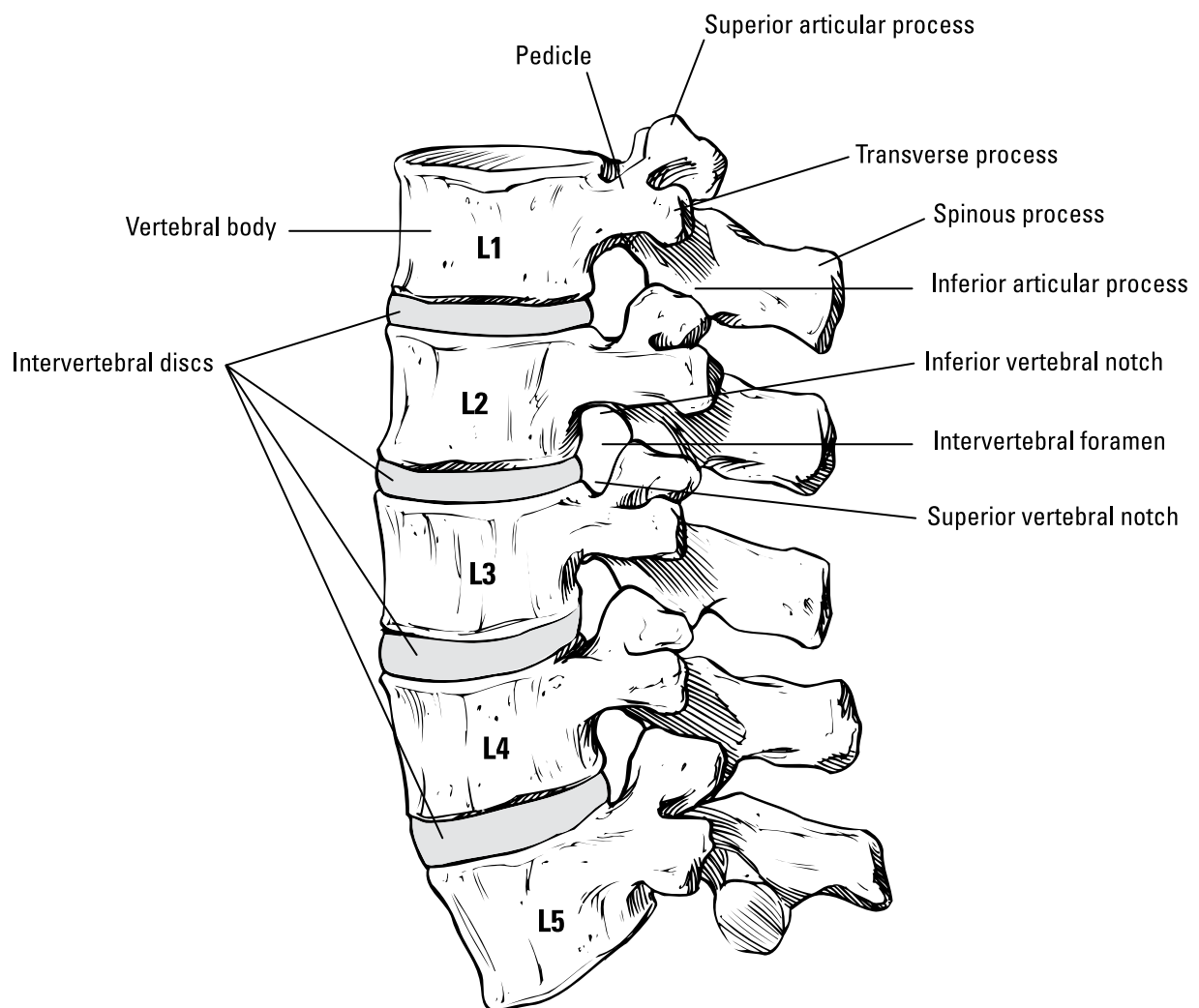


Lumbar Vertebra—Superior View





Lumbar Vertebrae—Lateral View





Chapter One

Coding 101

CPT® is a set of codes, descriptions, and guidelines that were created to describe procedures services performed by physicians and other health care professionals. Each procedure and/or service is identified by a five-digit code and simplifies the reporting of these services. CPT® is a trademark of the American Medical Association.

The CPT® codes were created to have a universal language for health care providers to properly communicate with insurance companies. Health care providers are reimbursed based on the codes that are submitted for services rendered to a beneficiary.

Coding Guidelines

CPT® guidelines are regularly updated to reflect the changes in medical practice. It is very important that physician coders and billers are familiar with the manual and any changes to verify correct coding for procedures.

The AMA updates the CPT® manual annually so please refer to your CPT® book for additions, deletions and revisions. The AMA has assigned certain symbols throughout the manual to easily recognize changes and updates.

Important Symbols:

- – Indicates a new code and will be placed before the code number
- ▲ – Indicates a code revision that has substantially altered the description of the code
- +
- Indicates an add-on code (can only be used with primary codes and should never be reported alone)
- ▶◀ – Indicates new and revised text other than the procedure descriptor

There are two types of code sets in the CPT® manual: evaluation and management service codes and procedural codes. At the beginning of each section in the manual are specific guidelines to help you appropriately interpret and report the procedure and services contained in each section.



Documentation

Concise documentation in a patient's medical records is critical to provide quality care as well as to receive accurate and timely reimbursement for services rendered. It chronologically documents the care of the patient and is required to record relevant facts, findings and observations about the patient's health history including past and present illnesses, examinations, tests, treatments and outcomes. Medical record documentation assists physicians and other health care professionals in evaluating and planning treatment of the patient as well as monitoring his or her health and care over time.

Payors sometimes require rationale that services rendered to patients are consistent with the insurance coverage provided in order to validate:

- The site of service – the place of service
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- That services furnished have been accurately reported

To ensure the documentation in a medical record is accurate, adhere to following principles:

- Medical records should be complete and legible
- The documentation of each patient encounter should include:
 - Reason for the encounter
 - Relevant history, physical examination findings, and prior diagnostic test results
 - Diagnosis, assessment or clinical impression
 - Medical plan of care
 - Date and legible identity of the observer
- If no documentation, the rationale for ordering diagnostic and other ancillary services should be inferred
- Past and present diagnoses should be accessible to the treating and/or consulting physician
- The patient's progress, response to and changes in treatment, and the revision of diagnosis should be documented
- The CPT® and ICD-9 codes should be reported on the health insurance claim form or the billing statement should be supported by the documentation in the medical record



"If it isn't documented, it hasn't been done" is an old adage that is frequently heard in the health care setting.



Guidelines for Residents and Teaching Physicians

Both residents and teaching physicians may document physician services in the patient's medical record.

The documentation must be dated and contain a legible signature or identity and may be:

- Dictated and transcribed
- Typed
- Hand-written
- Computer-generated

For a given encounter, the selection of the appropriate level of E/M services is determined according to the code of definitions in the American Medical Association's CPT® book and any applicable documentation guidelines.

When teaching physicians bill E/M services, they must personally document at least the following:

- That he or she performed the service or was physically present during the critical or key portions of the service furnished by the resident; and
- His or her participation in the management of the patient.

On medical review, the combined entries into the medical record by the teaching physician and resident constitute the documentation for the service and together must support the medical necessity of the service. Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.



Generally, the teaching physician must be present during all critical or key portions of the procedure, and immediately available to furnish services during the entire service in order for the service to be payable under the Medical Physician Fee Schedule.

Advance Beneficiary Notice

An Advance Beneficiary Notice is a form that a physician must have a Medicare patient sign alerting the patient of the following:

- That Medicare will probably deny payment for that specific service or item in the specific case.
- The reason the physician, provider, or supplier expects Medicare to deny payment.
- That the patient will be personally and fully responsible for payment if Medicare denies payment.

If there is a signed ABN on file the charge must be billed with a modifier GA. This will indicate to Medicare that a waiver of liability statement is on file. A copy of the ABN is in the reference section of this manual.



Medical Necessity

Medical necessity demonstrates that what was done to a patient is reasonable, necessary, and/or appropriate. This is based on evidence-based clinical standards of care. To determine a carrier's definition of medical necessity for a service, refer to the carrier's medical policy, usually available on the carrier's website.

CMS maintains a listing of all Medicare carriers' medical policies on the CMS website at www.cms.hhs.gov/DeterminationProcess/04_LCDs.asp.

Medicare refers to their medical policies as "Local Coverage Determinations" or LCDs. Upon reviewing an LCD – it will specify the correct HCPCS code(s), ICD-9 codes that support medical necessity, documentation requirements and utilization guidelines.

Below is a sample LCD for the administration of infliximab.

Contractor Name

Your State's Medicare Carrier

Contractor Number

XXXXXX

Contractor Type

MAC - Part B

LCD Information

LCD ID Number

LXXXXXX



LCD Information

LCD Title

Infliximab (Remicade)

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CMS National Coverage Policy

Your State

Oversight Region

Region XX

Original Determination Effective Date

For services performed on or after 02/01/2008

Original Determination Ending Date



LCD Information

Revision Effective Date

For services performed on or after 08/01/2009

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

Infliximab is a chimeric monoclonal antibody which binds specifically to tumor necrosis factor alpha. Its clinical efficacy is in patients with moderate to severe Crohn's disease who have failed to respond to prior conventional therapies. FDA approval was given August 1998.

1. Treatment of moderately to severely active Crohn's disease, for the reduction of the signs and symptoms, in patients who have an inadequate response to conventional therapy (corticosteroids, 5-aminosalicylates, and/or mercaptopurine/azathioprine). The recommended dose is 5 mg/kg given as a single intravenous infusion over at least two hours, following with additional doses at two and six weeks after the first infusion. Maintenance regimen of 5 mg/kg of body weight should be given every 8 weeks thereafter. For patients responding and then losing their response, consideration may be given to 10 mg per kg of body weight. Patients not responding by week 14 are unlikely to respond with continued dosing and treatment with Infliximab should be discontinued.

2. Treatment of patients with fistulizing Crohn's disease for the reduction in the number of draining and rectovaginal enterocutaneous fistula(s) and maintaining fistula closure. The recommended dose is an initial 5 mg/kg as an intravenous infusion over at least two hours with additional doses of 5 mg/kg at two and six weeks after the first infusion. Maintenance regimen of 5 mg/kg of body weight should be given every 8 weeks thereafter. For patients responding and then losing their response, consideration may be given to 10 mg per kg of body weight. Patients not responding by week 14 are unlikely to respond with continued dosing and treatment with Infliximab should be discontinued.



LCD Information

3. FDA approval was given November 10, 1999 for Infliximab to reduce signs and symptoms of rheumatoid arthritis in adults in combination with methotrexate. The recommended dose is 3 mg/kg as an infusion over at least two hours at two and six weeks after the initial infusion and then every eight weeks. For patients who have an incomplete response, consideration may be given to 10 mg per kg of body weight or treating as often as every four weeks.

4. Infliximab is indicated for reducing signs and symptoms in patients with active ankylosing spondylitis. The recommended dose is 5 mg/kg as an IV infusion with similar doses at 2 and 6 weeks after the first infusion, then every 6 weeks thereafter.

5. Infliximab is indicated for the treatment of psoriatic arthritis. The recommended dose is 5 mg/kg as a single IV infusion over at least two hours, followed with additional doses at two and six weeks after the first infusion then every 8 weeks thereafter. Infliximab can be used with or without methotrexate.

6. Infliximab is indicated for the treatment of psoriasis. The recommended dose is 5 mg/kg as a single IV infusion over at least two hours, followed with additional doses at two and six weeks after the first infusion then every 8 weeks thereafter.

7. Infliximab is indicated for the treatment of reactive arthritis. The recommended dose is 5 mg/kg as a single IV infusion over at least two hours, followed with additional doses at two and six weeks after the first infusion then every 8 weeks thereafter.

8. Infliximab is indicated for the treatment of inflammatory bowel disease arthritis. The recommended dose is 5 mg/kg as a single IV infusion over at least two hours, followed with additional doses at two and six weeks after the first infusion then every 8 weeks thereafter.

9. Infliximab is indicated for reducing signs and symptoms, achieving clinical remission and mucosal healing, and eliminating corticosteroid use in patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy. 5 mg/kg of body weight given as an induction regimen at 0, 2, and 6 weeks followed by a maintenance regiment of 5 mg per kg of body weight given every 8 weeks thereafter.

Trials are ongoing to determine the safety and efficacy of long term use or retreatment for relapse. Some investigators also prescribe Imuran for patients receiving long-term therapy or retreatment with Infliximab to decrease the possibility of antibody reactions to the monoclonal antibody.



LCD Information

Infliximab use in pediatric patients with Crohn's Disease did not have FDA approval prior to May 19, 2006. For moderately to severely active Crohn's Disease is patients having an inadequate response to conventional therapy 6 years of age or older, IV induction regiment of 5 mg/kg given at 0, 2, and 6 weeks followed by a maintenance regiment of 5 mg/kg of body weight every 8 weeks.

The safety and efficacy has not been established for ankylosing spondylitis, psoriatic arthritis, ulcerative colitis, or rheumatoid arthritis in pediatric patients. The safety and efficacy has not been established in children less than 6 years of age.

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.



Coding Information

CPT®/HCPCS Codes

J1745 INJECTION INFlixIMAB, 10 MG

ICD-9 Codes that Support Medical Necessity

555.0 REGIONAL ENTERITIS OF SMALL INTESTINE

555.1 REGIONAL ENTERITIS OF LARGE INTESTINE

555.2 REGIONAL ENTERITIS OF SMALL INTESTINE WITH LARGE INTESTINE

555.9 REGIONAL ENTERITIS OF UNSPECIFIED SITE

556.0 ULCERATIVE (CHRONIC) ENTEROCOLITIS

556.1 ULCERATIVE (CHRONIC) ILEOCOLITIS

556.2 ULCERATIVE (CHRONIC) PROCTITIS

556.3 ULCERATIVE (CHRONIC) PROCTOSIGMOIDITIS

556.4 PSEUDOPOLYPOSIS OF COLON

556.5 LEFT-SIDED ULCERATIVE (CHRONIC) COLITIS

556.6 UNIVERSAL ULCERATIVE (CHRONIC) COLITIS

556.8 OTHER ULCERATIVE COLITIS

556.9 ULCERATIVE COLITIS UNSPECIFIED

565.1* ANAL FISTULA

569.81* FISTULA OF INTESTINE EXCLUDING RECTUM AND ANUS



Coding Information

696.0	PSORIATIC ARTHROPATHY
696.1	OTHER PSORIASIS AND SIMILAR DISORDERS
711.10	ARTHROPATHY SITE UNSPECIFIED ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.11	ARTHROPATHY INVOLVING SHOULDER REGION ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.12	ARTHROPATHY INVOLVING UPPER ARM ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.13	ARTHROPATHY INVOLVING FOREARM ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.14	ARTHROPATHY INVOLVING HAND ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.15	ARTHROPATHY INVOLVING PELVIC REGION AND THIGH ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.16	ARTHROPATHY INVOLVING LOWER LEG ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.17	ARTHROPATHY INVOLVING ANKLE AND FOOT ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.18	ARTHROPATHY INVOLVING OTHER SPECIFIED SITES ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
711.19	ARTHROPATHY INVOLVING MULTIPLE SITES ASSOCIATED WITH REITER'S DISEASE AND NONSPECIFIC URETHRITIS
713.1	ARTHROPATHY ASSOCIATED WITH GASTROINTESTINAL CONDITIONS OTHER THAN INFECTIONS
713.3	ARTHROPATHY ASSOCIATED WITH DERMATOLOGICAL DISORDERS



Coding Information

713.7 OTHER GENERAL DISEASES WITH ARTICULAR INVOLVEMENT

714.0 RHEUMATOID ARTHRITIS

720.0 ANKYLOSING SPONDYLITIS

*ICD-9-CM codes 569.81 and 565.1 are secondary diagnoses and must be used with one of the codes indicating Crohn's disease.

Diagnoses that Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

General Information

Documentation Requirements

*1. The medical record must contain duration, dosage, and response to methotrexate administration for rheumatoid arthritis patients. *For patients that are unable to tolerate methotrexate, the notes should reflect the use of other disease modifying anti-rheumatic drugs and be available for review. The presence and location of fistulas must be recorded.



Coding Information

*2. The diagnosis of RA must be unequivocal. We recommend the use of American College of Rheumatology criteria for establishing a diagnosis. ACR 20 or equivalent must be one of the criteria used for documenting improvement. In patients with RA, improvement, as judged by ACR 20 criteria, or equivalent should be noticeable at week 30 follow-up. If no improvement occurs, then Medicare will not cover continued treatment. For continued treatment beyond 30 weeks, there must be documentation of demonstrable improvement.

3. Diagnosis(es) correlating to the patient's condition must be present on any claim submitted, and must be coded to the highest level of specificity.

Appendices

Utilization Guidelines

Sources of Information and Basis for Decision

WPS has consolidated the existing LCDs for MAC Jurisdiction 5 according to the instructions provided by CMS so that they are the same throughout the jurisdiction. In the vast majority of cases, one least restrictive LCD was selected as the jurisdictional LCD. In some cases, appropriate revisions, such as combining sections of LCDs that only addressed a portion of a general topic into a single, more complete document, were made to improve the clinical appropriateness of the LCD while keeping with the least restrictive requirement.

In situations where one or more of the states in the jurisdiction does not have an LCD on a topic, then the existing LCDs were reviewed and, based on the merits of the LCD, a decision was made to make the LCD jurisdictional or to have no LCD on that topic with the approval of CMS.

Some revisions of the existing LCDs were necessary to remove references to the former contractor and to update the Sources of Information and Basis for Decision. CPT®, HCPCS and ICD-9 codes will be updated as necessary.



Coding Information

According to the J5 MAC contract, the J5 consolidated LCDs are posted on the web site for the 45 day final notification period prior to the policy implementation date. The MAC contractor is not required to utilize the formal notice and comment revision process specified in Chapter 13 of the Program Integrity Manual (PIM) until the consolidation process is final. However, WPS welcomes provider input regarding the J5 consolidated LCDs. Based on the comments received; LCDs will be revised as necessary during the transition from the existing to new contractor.

This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in consideration of the active LCDs maintained by the preceding Medicare contractors for Jurisdiction X.



Chapter Two

Documentation Guidelines

What are E/M Codes?

Evaluation and Management services refer to visits and consultations provided by a physician or health care professional in the hospital or physician office setting. E/M codes are the most frequently used codes in Physician practices and they are simply the documentation of patient visits. These are the codes that utilized when the physician speaks with the patient and is determining a diagnosis. They are divided into wide-ranging categories such as office visits, hospital visits, and consultations, and will always begin with “99...”.

To bill a patient visit conducted at a clinic, office, or hospital, the physician or health care professional must select an E/M code that best represents the services provided. E/M codes are categorized first by place of service and then level.

Also, there are three key components of every patient visit or consultation:

1. Patient history
2. Examination
3. Medical Decision Making

NOTE: Documentation guidelines for E/M services can be downloaded at www.cms.hhs.gov/MLNEDWebguides/25EMDOC.asp.

Factors for Reporting E/M Services

Assigning an E/M code begins by determining the place of service, type of service and the patient’s status. Once a coder can determine these factors, the appropriate level of E/M code can be assigned to a visit.

Step 1: Place of service

Generally, the place of service for rheumatologists will be in the office/outpatient or inpatient setting. It is very important for all coders or billers in the rheumatology office identify where the physician services were rendered for accurate and timely claim filing. The place of service is identified with a two digit number.



Below is a list of the place of service, or POS, codes most commonly used by rheumatology practices:

Place of Service Codes	Place of Service Name	Place of Service Description
11	Office	Location, other than hospital, skilled nursing facility, military treatment facility community health center, state or local public health clinic, or intermediate care facility, where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
21	Inpatient Hospital	A facility, other than psychiatric, that primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization.
23	Emergency room-hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician office, where surgical and diagnostic services are provided on an ambulatory basis.
31	Skilled nursing facility	A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
72	Rural health clinic	A certified facility located in a rural, medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

Step 2: Type of service

There are three types of services; office visit (new or established), consultation, or inpatient hospital.

1. **Office Visit:** an office visit is a face-to-face encounter between the physician and a patient to allow for management and care of a patient's health.



- 2. Consultation:** a consultation is an E/M service provided by a physician whose opinion or advice regarding evaluation and management of a specific problem is requested by another physician or other appropriate source. The verbal or written request for a consult must be documented in the patient's medical record along with the consultant's opinion and any services that are ordered or performed. The consulting physician must also communicate his/her opinion or advice to the requesting physician by written report. A sample of the request form can be found on the ACR website www.rheumatology.org/practice/office/documentation/index.asp under Consultations and Referrals.

NOTE: *As of January 1, 2010 the Centers for Medicare & Medicaid Services eliminated both inpatient and outpatient consultations codes. For coding outpatient services to CMS, rheumatology practices should use the new patient E/M codes (99201 – 99205) to replace outpatient consult codes (99241 – 99245). For inpatient services per CMS there is no simple one-to-one correspondence between the consultation codes and the appropriate inpatient E/M codes. For inpatient consultation services, CMS has stated that physicians may bill the initial hospital care service codes (99221 – 99223) and the initial nursing facility care codes (99304 – 99306), where those codes appropriately describe the level of service provided. The general guideline is that physicians should apply the most appropriate E/M code to bill Medicare for services that were previously billed using the consultation codes.*

- 3. Inpatient Services:** Patients will sometimes need to be admitted to the hospital for additional care or work up. When a patient is admitted to the hospital as an inpatient, in the course of an encounter in another site of service (e.g., physician's office setting, emergency room) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care and cannot be billed separately.

Step 3: Patient Status

The status of a patient must be verified for correct coding and billing. There are four categories:

- 1. New:** A new patient is someone who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.
- 2. Established:** An established patient is someone who has received any professional service from a physician in group or same specialty within the past three years. (See Decision Tree on page 29.)



1. *New patients, consultations, inpatient and emergency room visits **MUST** have all **three key components** (e.g., History, Examination and Medical Decision Making) to meet an E/M level of service.*
2. *Established patients and subsequent inpatient visit **MUST** have **two out of three key components** (e.g., History, Examination and Medical Decision Making) to meet the appropriate level of E/M service.*

3. Outpatient

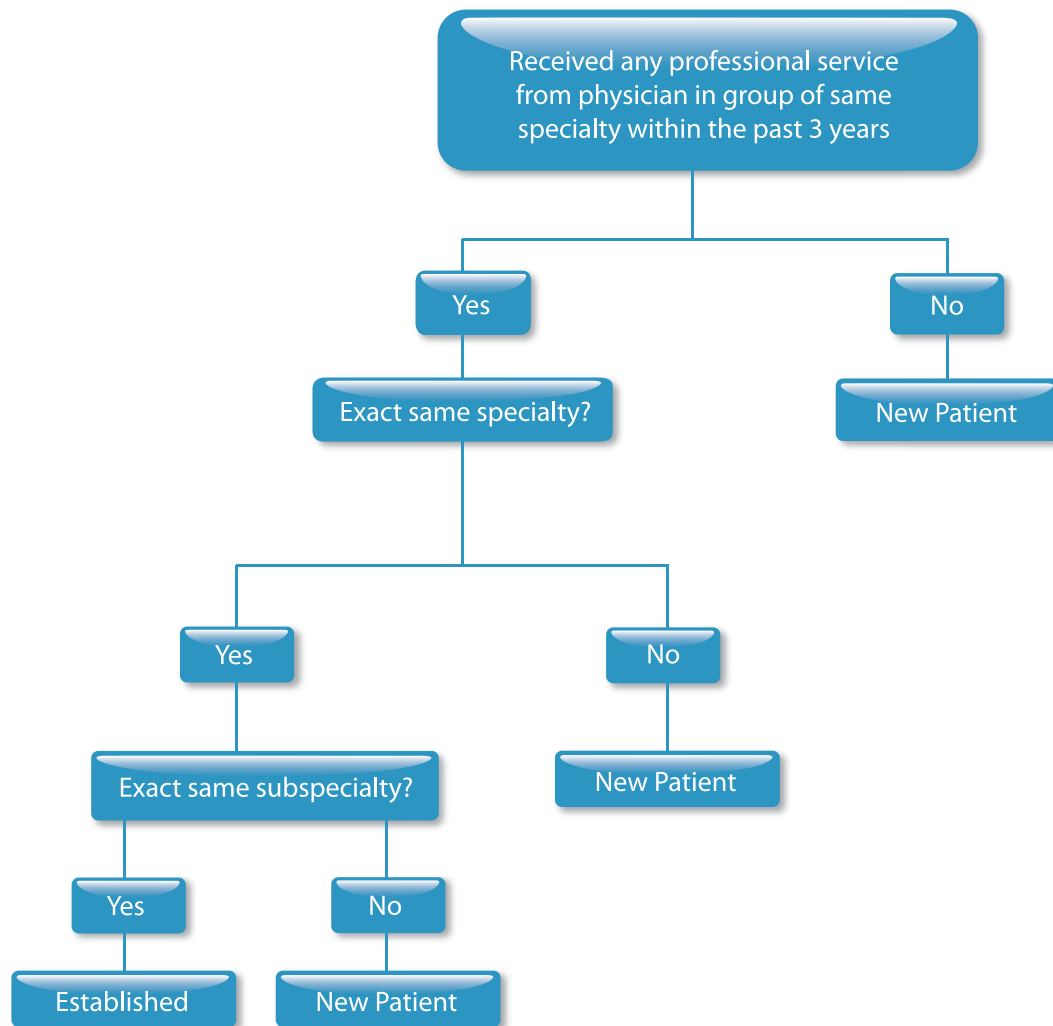
An outpatient is a person who is seen in a physician practice who has not been formally admitted to a health care facility.

4. Inpatient

An inpatient is a person who has been formally admitted to an inpatient facility and also receives services in a hospital setting.



DECISION TREE: NEW VS. ESTABLISHED PATIENTS



Levels of E/M Services

There are three to five levels of E/M services available to report for a patient encounter. The levels of E/M services are not interchangeable among the different categories of services and are based on the documentation located in the patient's medical records. This includes the various amounts of skill, effort, time, responsibility, and medical knowledge required for prevention or diagnosis and treatment to promote optimal health.

The levels of E/M services are based on seven components, six are used to define the levels of service and one is a contributory factor. The first three are considered to be the key components, which are history, examination and



medical decision making. The following three are the contributory factors, which include counseling, coordination of care and nature of presenting problem.

Time is the next component. The use of time as a factor in E/M coding is there to assist physicians in selecting the most appropriate level of service. When counseling and /or coordination of care dominates (more than 50%) the physician/patient face-to-face time, then time may be considered the key or controlling factor to qualify for a particular level of E/M services.

The Components

History

The patient's history is the information that is supplied to the physician on the nature of the presenting problem.

NOTE: All four factors of the history **MUST** be done to have a complete history – chief complaint, history of present illness, review of systems, and past family social history.

Chief Complaint

All E/M codes must have a chief complaint documented in order for the visit to be considered medically necessary. A chief complaint is a succinct statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter. This information will come from the patient.

History of Present Illness

This is a chronological description of the development of the patient's present illness from the first sign and/or symptom to the present.



The chief complaint can be documented in the patient's medical record when the patient calls in to schedule an appointment.

The HPI includes the following descriptions:

- Location – Where is the problem?
- Duration – How long has the problem been there?
- Severity – How would you rate the pain on a scale of one to ten?
- Quality – Describe the quality of the pain (e.g., sharp, dull)?
- Context – Did the pain start gradually over time or is getting better?
- Modifying factors – What makes the pain better (e.g., ibuprofen, aspirin)?
- Associated signs and symptoms – Are there other signs associated with the main problem such as numbness?
- Timing – When do the symptoms occur?



There are two types of HPIs –

- **Brief** which consists of one or two of the elements on page 30.
- **Extended** which consists of four or more of the above elements (1995) or status of three chronic or inactive conditions (1997).

NOTE: The HPI MUST be taken and documented in the patient's medical record every visit by the physician only.

Review of Systems

An inventory of body systems obtained through questions from the physician or office staff seeking to identify signs and/or symptoms the patient may be experiencing or has experienced. The ROS consists of the following systems:

- Constitutional (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic



*The ROS can be taken by the office staff, but the physician **MUST** document that he/she has reviewed it.*

There are three levels of ROS:

- **Problem Pertinent** which relates directly patient's problem (one system).
- **Extended** is a review of two to nine systems.
- **Complete** is a review of at least ten systems.

The patient's positive responses and pertinent negatives for the system related to the problem should be documented.

Keep in mind when documenting the ROS - It is acceptable to document pertinent positive or negative findings for specific areas and then say: "All other systems were reviewed and are negative."



Past, Family and/or Social History

This is a review of the patient's past, family and/or social information that can assist the physician or health professionals with the encounter. The PFSH is a review of three areas:

- Past history – patient's past medical illness, operation, and injuries.
- Family history – patient's family history including hereditary diseases.
- Social history – patient past and current activities.

NOTE: The PFSH only has to be documented once and can be referred back to if there is no change. No documentation of the PFSH is a common reason for visits to be down coded.

Types of History

There are four levels of history based on the extent of the history that is dependent on clinical judgment and on the nature of the presenting problem(s). There are four types of history that are recognized for E/M services:

- **Problem-focused** – brief HPI, no ROS and no PFSH.
- **Expanded problem-focused** – brief HPI, pertinent to problem ROS and no PFSH.
- **Detailed** – extended HPI, extended ROS (two to nine systems) and one area of the PFSH.
- **Comprehensive** – extended HPI, complete ROS (ten or more systems), and complete PFSH.

Chief complaint plus all of these elements

Type of History	HPI	ROS	PFSH
Problem-focused	Brief (1-3)	N/A	N/A
Expanded Problem-focused	Brief (1-3)	Problem Pertinent (1 system)	N/A
Detailed	Extended (4+)	Pertinent (2-9 systems)	Pertinent (1 factor)
Comprehensive	Extended (4+)	Complete (10 systems)	Complete (based on ICD-9 code)



Examination

As stated previously, the documentation of the examination can be either under the 1995 version or the 1997 version. The 1995 examination is very broad and somewhat vague when it comes to determining the level of the expanded problem-focused level and a detailed level. The 1997 version is very specific and detailed and it is based on bullet points.

Under both versions there are four levels of history:

- **Problem-focused** – a limited examination of the affected body area or organ system.
- **Expanded problem-focused** – a limited examination of the affected body area or organ system and other symptomatic or related organ system(s) (2 – 7 systems).
- **Detailed** – an extended examination of the affected body area(s) and other symptomatic or related organ system(s) (2 – 7 systems).
- **Comprehensive** – a general multi-system examination or complete examination of a single organ system (8 or more systems).

An examination may involve several organ systems or a single organ system. The extent of the examination performed is based upon clinical judgment, the patient's history, and nature of the presenting problem.

The chart on page 34 depicts the body areas and organ systems that are recognized according to the Current Procedural Terminology (CPT®) book.



A simple notation of “abnormal” is not sufficient without further details of the problem. But, it is sufficient to have a simple documentation of “negative” or “normal.”



Using the 1995 Guidelines

BODY AREAS	ORGAN SYSTEMS
<ul style="list-style-type: none">• Head, including face• Neck• Chest, including breasts and axilla• Abdomen• Genitalia, groin, buttocks• Back• Each extremity	<ul style="list-style-type: none">• Constitutional (e.g., vital signs, general appearance)• Eyes• Ears, Nose, Mouth and Throat• Cardiovascular• Respiratory• Gastrointestinal• Genitourinary• Musculoskeletal• Skin• Neurologic• Hematologic/Lymphatic/Immunologic• Psychiatric

Using the 1997 Guidelines

This version has two types of examination, the general multi-system and the single organ system. Listed below are the examinations classified as either a general multi-system or a single organ system:

- | | |
|---------------------------------------|-------------------|
| • Cardiovascular | • Musculoskeletal |
| • Ears, Nose, Mouth, and Throat | • Neurological |
| • Eyes | • Psychiatric |
| • Genitourinary (Female) | • Respiratory |
| • Genitourinary (Male) | • Skin |
| • Hematologic, Lymphatic, Immunologic | |



General Multi–System Examination

This involves the examination of one or more organ systems or body areas.

Level of Exam	Perform and Document
Problem-focused	One to five elements identified by a bullet.
Expanded Problem-focused	At least six elements identified by a bullet.
Detailed	At least two elements identified by a bullet from each of six areas/systems OR at least twelve elements identified by a bullet in two or more areas/systems .
Comprehensive	Perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems .

Musculoskeletal Examination

This examination involves a more extensive examination of the specific organ system.

Level of Exam	Perform and Document
Problem-focused	One to five elements identified by a bullet.
Expanded Problem-focused	At least six elements identified by a bullet.
Detailed	At least twelve elements identified by a bullet.
Comprehensive	Perform all elements identified by a bullet; document every element in each box with a shaded border and a least one element in each box with an unshaded border .

Complexity of Medical Decision Making

Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option. There are four levels to medical decision making: straightforward, low complexity, moderate complexity, and high complexity.



The MDM is determined by considering the following factors:

1. the number of possible diagnoses and/or the number of management options that must be considered;
2. the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
3. the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

*The chart below depicts the elements for each level of medical decision making. **NOTE** that to qualify for a given type of medical decision making, two of the three elements must either be met or exceeded.*

TYPE OF DECISION MAKING	NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED	RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Time

Time can be the controlling factor to qualify for a particular level of E/M visit. This can occur when counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face in the office or outpatient setting, floor/unit time in the hospital or nursing facility).

For example, if 25 minutes was spent face-to-face with an established patient in the office and more than half of that time was spent counseling the patient or coordinating his or her care, CPT® code 99214 should be selected.

NOTE: Counseling or coordination of care must be documented separately from the information recorded in the medical decision making and should be identified independently.



Chapter Three

Evaluation and Management

Office or Other Outpatient Services

New Patient

E/M codes are divided into two categories, new or established patient for office visits. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires the following three key components:

1. A problem-focused history
 - Chief complaint
 - Brief history of present illness or problem
2. A problem-focused examination
 - A limited exam of affected body area or organ system
3. Straightforward medical decision making
 - Minimal number of diagnoses/management options
 - Minimal (or no) amount/complexity of data obtained, reviewed and analyzed
 - Minimal risk of complications/morbidity/mortality



If a physician is on call or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.



Example: A 45-year-old, who is self-referred, comes complaining of pain in her left big toe. The rheumatologist examination is unremarkable except for bony enlargement consistent with a bunion in her first metatarsophalangeal joint. Local treatment is prescribed.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires the following three key components:

1. An expanded problem-focused history
 - Chief complaint
 - Brief history of present illness
 - Problem pertinent system review
2. An expanded problem-focused examination
 - A limited exam of affected body area or organ system and other symptomatic/related organ system(s)
3. Straightforward medical decision making
 - Minimal number of diagnoses/management options
 - Minimal (or none) amount/complexity of data obtained, reviewed and analyzed
 - Minimal risk of complications/morbidity/mortality

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

Example: A 20-year-old male comes in for an initial visit. He is complaining of pain in his right elbow. The pain has been there for two weeks. A brief history, review of system, and exam is performed. The patient is given an elbow splint and non-steroidal anti-inflammatory medication prescribed, along with education as to cause and prognosis of "tendinitis."

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires the following three key components:

1. A detailed history
 - Chief complaint
 - Extended history of present illness
 - Problem pertinent system review extended to include a review of a limited number of additional systems
 - Pertinent past, family and/or social history directly related to the patient's problems



2. A detailed examination

- Extended exam of affected body area(s) and other symptomatic/related organ system(s)

3. Medical decision making of low complexity

- Limited number of diagnoses/management options
- Limited amount/complexity of data obtained, reviewed and analyzed
- Low risk of complications/morbidity/mortality

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

Example: *This is an initial office visit for obese 52-year-old man and he has a complaint of gouty arthritis. There was a detailed history, review of system, and examination performed. A treatment plan was discussed, medication was prescribed and appropriate laboratory testing order.*

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires the following three key components:

1. A comprehensive history

- Chief complaint
- Extended history of present illness
- Review of systems which is directly related to the problem(s) identified in the history of present illness plus a review of all additional body systems
- Complete past, family and/or social history

2. A comprehensive examination

- A general multi-system exam, or
- A complete exam of a single organ system

3. Medical decision making of moderate complexity

- Multiple number of diagnoses/management options
- Moderate amount/complexity of data obtained, reviewed and analyzed
- Moderate risk of complications/morbidity/mortality



Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

Example: *Initial office visit for 32 year-old female, self-referred for complaint of pain, numbness and color changes in fingers when exposed to cold. Patient reports that her right distal index and 4th right fingers and left distal index finger will turn white and then blue when exposed to cold temperatures with pain and numbness in the digits. These symptoms have been occurring for the past year, but have increased in frequency in past two months. Patient reports that fingers return to normal color and pain and numbness resolve after rewarming hands. Patient reports that she has developed a "sore" on her distal left index finger. Patient reports fingers sometimes feel stiff when cold. Patient denies any other musculoskeletal pain or stiffness and denies any joint swelling. Patient denies fatigue, weight loss, recurrent fevers, rashes, chest pain, dyspnea, cough, palpitations, hypertension, unusual bruising, menorrhagia, dysuria or frequency, abdominal pain, vomiting, diarrhea, constipation, dysphagia, hematochezia, headaches, memory difficulties, insomnia, depression, or weakness. She has no known allergies.*

Past Family Social Medical History: Her family is significant for rheumatoid arthritis in mother. No other comorbidities. No surgeries or hospitalizations. The patient lives alone and does not drink or smoke.

On examination, patient was alert and oriented. Vital signs normal. Height 5'7", weight 140 lbs, BMI 21.9. HEENT exam is normal. No lymphadenopathy. Lungs clear. Heart RRR, no murmurs or friction rubs. Good peripheral pulses. Her abdomen is soft, nontender, no mass or HSM. There was no CVA tenderness on percussion. Skin no rashes. Demonstrated mild cyanosis in distal digits of right index & 4th fingers and left index finger. There was shallow ulcer on distal fingertip of left index finger. Musculoskeletal exam: Her gait is normal. Good muscle strength in upper & lower extremities, both proximally and distally. All joints are unremarkable with FROM and no evidence of synovitis.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires the following three key components:

1. A comprehensive history
 - Chief complaint
 - Extended history of present illness
 - Review of systems which is directly related to the problem(s) identified in the history of present illness plus a review of all additional body systems
 - Complete past, family and/or social history



2. A comprehensive examination

- A general multi-system exam or a complete exam of a single organ system

3. Medical decision making of high complexity

- Extensive number of diagnoses/management options
- Extensive amount/complexity of data obtained, reviewed and analyzed
- High risk of complications/morbidity/mortality

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Example: *This is an initial visit for a 28-year-old woman with systemic lupus erythematosus, fever and a history of seizures and thrombocytopenia. She has severe painful and swollen joints. She has been taking over the counter medication to get some mild relief. A comprehensive history, review of system and examination was preformed. Her medical decision making is of high complexity; based on laboratory and X-rays ordered.*

Established Patient

99211 Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.

Example: *A patient returns to the office three days later to have PPD test evaluated and for instructions on self-administration of TNF-alpha inhibitor. The RN evaluates the PPD test and informs the rheumatologist that it is negative. The rheumatologist instructs RN to proceed with teaching patient self-administration of TNF-alpha inhibitor and provides RN with prescription for TNF-alpha inhibitor to give to patient. RN instructs patient on self-administration of TNF-alpha inhibitor and patient is scheduled to return to office next week to give self TNF-alpha inhibitor injection under supervision of RN. The patient will return for routine E/M follow-up visit in one month. The physician does not personally see patient during this visit, but is present in the office suite.*

BILL THIS CODE if a patient comes in for a blood pressure check or TB results.

DO NOT BILL 99211 for teaching a patient how to give themselves an injection or for doing a preauthorization.



99212 Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components:

1. A problem-focused history
 - Chief complaint
 - Brief history of present illness
2. A problem-focused examination
 - A limited exam of affected body area or organ system
3. Straightforward medical decision making
 - Minimal number of diagnoses/management options
 - Minimal (or no) amount/complexity of data obtained, reviewed and analyzed
 - Minimal risk of complications/morbidity/mortality

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Example: *This is a follow-up visit for a 35-year-old male seen before for pain and loss of motion in his right shoulder. He returns for follow-up after a course of medication, an intraarticular injection and physical therapy. Review of test results and a physical examination reveal that the patient is now better. The patient is told to return only if a new problem occurs.*

99213 Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components:

1. An expanded problem-focused history
 - Chief complaint
 - Brief history of present illness
 - Problem pertinent system review
2. An expanded problem-focused examination
 - A limited exam of affected body area or organ system and other symptomatic or related organ systems
3. Medical decision making of low complexity
 - Limited number of diagnoses/management options
 - Limited amount/complexity of data obtained, reviewed and analyzed
 - Low risk of complications/morbidity/mortality



Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Example: A 68-year-old woman comes in for a follow-up office visit; she has polymyalgia rheumatica maintained on chronic low-dose corticosteroids. The history reveals no increase in the shoulder or hip pain. There has been some mild weight gain and bruising while on the medication. A limited examination was performed. The patient was instructed on long-term prognosis of PMR and steroid side effects. Laboratory tests were ordered.

99214 Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components:

1. A detailed history
 - Chief complaint
 - Extended history of present illness
 - Problem pertinent system review extended to include a review of a limited number of additional systems
 - Pertinent past, family, and/or social history directly related to the patient's problems
2. A detailed examination
 - Extended exam of affected body area(s) and other symptomatic/related organ system(s)
3. Medical decision making of moderate complexity
 - Multiple number of diagnoses/management options
 - Moderate amount/complexity of data reviewed
 - Moderate risk of complications/morbidity/mortality

Counseling and/or coordination of care with other providers or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.



Example: A 38-year-old female returns for a routine follow-up office visit for rheumatoid arthritis. Patient is on celecoxib, methotrexate, folic acid and lansoprazole. The patient reports moderate pain, swelling and stiffness in her wrists and most finger joints every day, which is interfering with activities such as opening jars, buttoning clothing, using a computer keyboard, etc. The patient reports generalized morning joint stiffness lasting from 1 to 3 hours on most days of the week and easy fatigue. The patient has history of GERD, but denies dyspepsia or abdominal complaints. The patient denies fevers, headaches, chest pain, dyspnea, cough, oral ulcers, Raynaud's phenomenon, rashes, hematochezia, insomnia or depression. The patient is a secretary in a law firm, is married and has two young children, ages 3 and 5 years.

On examination, patient is alert and oriented with normal vital signs, height 5'6", weight 135 lbs, BMI 21.8 HEENT exam normal. No lymphadenopathy. Lungs clear. The heart has RRR, no murmurs, friction rubs. The abdomen is soft, nontender, no mass or HSM. Her skin is good color and turgor, no rashes. Musculoskeletal exam: Gait slightly stiff. Patient had warmth, swelling, irritability and decreased range of motion in bilateral wrists; swelling, irritability, bony proliferation and decreased range of motion in bilateral 2nd through 3rd MCP joints and bilateral 2nd through 4th PIP joints and is beginning to develop swan neck deformities. Patient had synovial thickening and bony proliferation in bilateral knees and large effusions in bilateral ankles with warmth and slight decreased dorsiflexion and plantar flexion. All other joints are unremarkable with FROM and no evidence of active synovitis.

Diagnosis: Rheumatoid arthritis with active disease.

Plan: Review of labs done 6 weeks prior showed mild anemia and elevated ESR and CRP. Other labs were normal. Therapeutic options were discussed with patient and decision was made to add TNF-alpha inhibitor. Actions, side effects and administration of TNF-alpha inhibitors were reviewed with patient. Laboratory studies were ordered along with a chest x-ray. PPD test was placed on patient's right forearm. Patient was continued on celecoxib, methotrexate, folic acid and lansoprazole. Patient was given prescription for occupational therapy evaluation and treatment to include finger splints. Patient scheduled to return to office in 3 days to have PPD read and for patient education visit with RN to learn self-administration of TNF-alpha injections.

99215 Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components:

1. A comprehensive history
 - Chief complaint
 - Extended history of present illness
 - Review of systems which is directly related to the problem(s) identified in the history of present illness plus a review of all additional body systems
 - Complete past, family, and/or social history



2. A comprehensive examination

- A general multi-system exam or a complete exam of a single organ system

3. Medical decision making of high complexity

- Extensive number of diagnoses/management options
- Extensive amount/complexity of data obtained, reviewed and analyzed
- High risk of complications/morbidity/mortality

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Example: 30-year-old female patient comes in for a follow-up visit for undifferentiated connective tissue disease. She has a fever, rash and increasing joint difficulties. A comprehensive examination was consistent with a diagnosis of systemic lupus erythematosus. Tests were ordered to confirm the diagnosis.

Consultations and Special Services

The AMA CPT® manual defines a consultation as a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. There are two subcategories of consultations: office (outpatient) and inpatient.

The difference between consultations and new patient visits is often a source of confusion. The difference in reimbursement is sometimes dramatic, so it is important for rheumatologists to understand the distinction.

A consultant may initiate diagnostic and/or therapeutic services at the initial consultation without losing consultant status. If the rheumatologist consultant subsequently assumes responsibility for management of a portion or all of the patient's condition, the established patient office visit codes (99211-99215) must be used for follow-up visits.

NOTE that Medicare carriers interpret national policies in different ways, particularly related to the initiation of therapeutic services. If you have questions, contact the carrier.

If an additional request for opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes (99241-99245) may be reported again by the rheumatologist consultant. Any specifically identifiable procedure (e.g., identified with a specific CPT® code) performed on or subsequent to the date of the initial consultation should be reported separately.



A “consultation” initiated by a non-physician (patient, patient’s family, third party payor, etc.) for a second or third opinion is reported using new patient office visit codes (99201-99205), as appropriate. If the confirmatory consultation is required by a third party payor, then the modifier “-32” or 09932 (mandated services), should be added to the appropriate confirmatory consultation code.

The Centers for Medicare and Medicaid Services released the claims processing transmittal regarding the consultation services payment policy for physicians to bill for both inpatient and outpatient on January 1, 2010 because of the elimination of all consultation codes for inpatient and office/outpatient visits. Physicians should code patient visit with the E/M code that represents where the visit occurred and identify the complexity of the visit performed.

Outpatient Services

Bill the appropriate new or established outpatient visit codes in the office and other outpatient settings using CPT® codes 99201-99205 or 99211-99215.

Inpatient Services

For inpatient services, physicians and other non-physician practitioners who perform the initial evaluation and management may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304-99306). As a result of this change, multiple billings of initial hospital and nursing home visit codes could occur even in a single day.

So as to define the admitting physician, CMS has created the “AI” modifier which is to be used by the admitting or attending physician who oversees the patient’s care, as distinct from other physicians who may be furnishing specialty care. The “AI” modifier is defined as “Principal Physician of Record.”

The admitting or attending physician must append modifier “-AI” in addition to the initial visit code. All other physicians who perform an initial evaluation on this patient should only bill the E/M code for the complexity level performed.

NOTE: The primary purpose of this modifier is to identify the principal physician of record on the initial hospital and nursing home visit codes.

CMS indicated that it is not necessary to reject claims that include the “-AI” modifier on codes other than the initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes).

Follow-up visits in the facility setting should be billed as subsequent hospital care visits and subsequent nursing facility care visits as is the current policy. In all cases, physicians should bill the available code that most appropriately describes the level of the services provided.

The transmittal can be reviewed at www.cms.hhs.gov/transmittals.



Office or Other Outpatient Consultations

New or Established Patient

The following CPT® codes are used to report consultations provided in the physician's office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, custodial care or an emergency department. Each example for the codes implies that the rheumatology consultant communicates (orally or in written form) with the requesting physician about the patient work-up, differential diagnosis and potential treatment options.

To find consultation and referral forms to help your office document requests for consultations, visit www.rheumatology.org/practice and click on Office Support.

99241 Office Consultation for a new or established patient, which requires the following three key components:

1. A problem-focused history
2. A problem-focused examination
3. Straightforward medical decision making

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with patient and/or family.

Example: Initial Office Consultation for a 27-year-old office worker with a painful "catching" index finger. Brief history taken and limited examination completed. Treatment options for trigger finger discussed. NSAIDs prescribed.

99242 Office consultation for a new or established patient, which requires the following three key components:

1. An expanded problem-focused history
2. An expanded problem-focused examination
3. Straightforward medical decision making

Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.



*Consultation codes are now one of the highest overpayments. A referral is **not** the same as a request for a consultation. Make sure that a request for a referral is a request for the physician's medical **opinion or advice**.*



Example: Office consultation with a 66-year-old female with wrist and hand pain and finger numbness secondary to suspected carpal tunnel syndrome. History and examination completed. Laboratory tests were ordered. Medication and splint prescribed.

99243 Office consultation for a new or established patient, which requires the following three key components:

1. A detailed history
2. A detailed examination
3. Medical decision making of low complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Example: A 58-year-old female comes in for an office consultation; she has progressive pain and swelling in both knees. A detailed history and examination was completed. Radiographs and laboratory tests were ordered. The patient was given information regarding osteoarthritis. Medications prescribed with appropriate warnings regarding toxicity.

99244 Office consultation for a new or established patient, which requires the following three key components:

1. A comprehensive history
2. A comprehensive examination
3. Medical decision making of moderate complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with patient and/or family.

Example: A 44-year-old female patient comes in for an initial consultation. She presents with diabetes mellitus, hypertension, diffuse psoriasis and arthritis unresponsive to anti-inflammatory medications. A comprehensive history is taken. A comprehensive physical exam is performed. Radiographs and laboratory tests are ordered. A treatment for psoriatic arthritis, drug toxicity and prognosis is discussed with the patient.

**99245 Office consultation for a new or established patient, which requires the following three key components:**

1. A comprehensive history
2. A comprehensive examination
3. Medical decision making of high complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

Example: A 12-year-old female sent by primary care provider for an initial office visit, he requested a pediatric rheumatology consultation. Patient was found to have 3+ proteinuria and anemia (Hgb 8.9) on routine physical exam. Repeat U/A on first morning urine specimen had 3+ proteinuria and 1+ blood. ANA was 1:2560. Patient is accompanied to rheumatology office by her mother, who reports that the child has been more fatigued for the past six months and has had recurring fevers to 101.4° approximately 1-3 times per week for the past two weeks. Parent reports that the child was noted to have lost five lbs. from her previous well-child exam. The patient has had periorbital edema in the mornings for the past month, which the parent had attributed to "allergies". The patient reports that her socks often leave indentations above her ankles when she removes them at night. The patient reports generalized musculoskeletal pain on most days, which she rated at a 6 on a Faces Scale of 0-10. She especially has pain and stiffness in her hands and sometimes her rings are "too tight", especially in the mornings. The patient has had an intermittent raised red rash across her cheeks for the past three months, more prominent after being outdoors in sunlight. The parent reports that the child's hair has been thinning, but denied patchy alopecia. The child reports new onset daily frontal and parietal headaches for the past two weeks, which do not wake her from sleep. She rates headaches at 10 on Faces Scale 0-10. The patient denied nausea or photophobia. The parent reports that the child seems to be more forgetful recently and her teachers have reported that she has not been completing her school assignments. The patient reports she has sometimes has difficulty remembering her school assignments. Parent denies patient has exhibited any other behavior changes. The child denies oral or nasal ulcers, visual disturbances, swollen or tender lymph nodes, Raynaud's phenomenon, chest pain, dyspnea, cough, epistaxis, unusual bruising, dysuria, insomnia, tremors, seizures, hallucinations, abdominal pain, vomiting, diarrhea, constipation or hematochezia. The patient is premenarche. The patient is not on any prescribed medications, but takes Tylenol for headaches or musculoskeletal pain with occasional relief. She has no known allergies.

Past Medical History: Born at term to a G1P1 mother by NSVD. No prenatal or postnatal complications. Her growth and development is normal. No surgeries or hospitalizations. No comorbidities. Immunizations are UTD. She had chickenpox at three years of age.

Family Medical History: Significant for rheumatoid arthritis in paternal grandmother, hypothyroidism and migraine headaches in mother, and type II diabetes mellitus in maternal grandfather. No family history of childhood arthritis, lupus, cancer, IBD, psoriasis, or blood disorders.



Social History: Lives with parents and nine year-old brother. Pets: one dog. Father is engineer and mother is social worker, who works part-time. No smoking or firearms in home. Patient is in 7th grade and was doing well in school until the past 6 weeks.

On examination, patient was alert and oriented to time, place & person. Short term and long term memory is grossly intact. BP 129/87, HR 100, RR 20, temp 36.80C. Height is 154.9 cm, weight 44.5 kg, BMI 18.5 HEENT exam remarkable for mild periorbital edema and a small ulcer on hard palate. Fundoscopic exam is normal. Her skin is slightly pale with erythematous maculopapular malar rash. She has mildly enlarged nontender cervical and inguinal nodes. Lungs clear. Heart RRR, no murmurs or friction rubs. Her abdomen is soft, nontender, no mass or HSM. Breasts and pubic hair early Tanner stage II. Musculoskeletal exam: Gait steady. Good muscle strength in upper & lower extremities, proximally & distally. The spine shows normal curvature, FROM. Patient had mild swelling and irritability in right wrist and right 2nd and 3rd PIP joints. All other joints are unremarkable with FROM and no evidence of active synovitis. DTRs are normal.

Diagnoses:

- 1. Proteinuria, anemia, fatigue, rash & positive ANA*
- 2. Mild hypertension*
- 3. Headaches & memory difficulties*
- 4. Probable SLE with lupus nephritis*
- 5. R/O CNS vasculitis*
- 6. R/O other autoimmune connective tissue disease*

Plan: A lengthy discussion was had with the parent and patient regarding clinical findings, differential diagnoses, further diagnostic workup and potential therapies. Laboratory studies ordered for lupus evaluation. MRI/MRA of brain ordered to evaluate for CNS vasculitis. Nephrology consult requested. Her nephrologist contacted and arrangements made for patient to be evaluated by nephrologist later the same day. Advised parent that renal biopsy will probably be needed. Advised patient to adhere to low sodium diet and copy of diet given and reviewed with patient and parent. Advised that patient must limit sun exposure to the extent possible & use sunscreen with SPF >45 when she must be outdoors in sunlight. Parent to call clinic after patient sees nephrologist to review initial lab results, determine medication therapy and follow up appointment. Report on clinical findings, impression and plan dictated to patient's primary care provider.

This encounter was an outpatient consultation as there was a formal consultation request from the patient's primary care provider as there was a formal consultation request from the patient's primary care provider for rheumatology evaluation and opinion regarding patient's symptoms and the NP/PA provided a written report of his/her findings and plan to the patient's primary care provider.



This was a high-complexity consultation as it included:

Services for Inpatient Visits

Hospital visits can be separated into two broad groups: (1) visits for which the physician is the primary attending and (2) visits for which the physician is the consultant. Pages 47-51 contain a detailed explanation of office consultations. In this section, it is important to understand that consultations are regarded differently in the hospital than in the office.

Visits for which the rheumatologist is the primary attending will be addressed first. The relevant CPT® codes are divided into initial observation care, initial hospital care and subsequent hospital care with three levels of services.

Initial Observation Care

New or Established Patient

Initial observation care codes (99218-99220) are used to report the first encounter by the supervising physician with the patient when designated as “observation status.” This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic assessment. It is not necessary that the hospital have a designated area in which observation services are performed.

If such an area does exist in a hospital (as a separate unit in the hospital, or in the emergency department, etc.), these codes are to be used if the patient is placed there. If the hospital does not have a designated “observation area” then you are to code to the location of the service (i.e., emergency room, ambulatory surgery center).

Only the supervising physician admitting the patient to “observation status” may use these codes. If a consultation is requested by this admitting physician, the consulting physician would use outpatient consultation codes (99241-99245).

If a patient is seen in “observation status” and admitted to the hospital the same day, an initial hospital care code (99221-99223), which includes the work of the combined E/M services, should be used.

If a patient is seen in “observation status” today and admitted to the hospital tomorrow, an initial observation care code (99218-99220) should be used to bill for today’s services, and an initial hospital care code (99221-99223) should be used for tomorrow’s services.

Initial observation care codes may not be used for post-operative recovery if the procedure is considered part of a global surgical package. Also note that these codes apply to all E/M services that are provided on the same day of patient admission to “observation status.”



If a patient sees their rheumatologist in the emergency room and later admitted the patient to observation status on the same date of service, the emergency room visit from the morning would have to be combined with the observation code done later that day.



An initial history and physical should be performed on each patient admitted to “observation status.” This is true even if the admitting physician also performed a history and physical in the hospital emergency department. Physicians should note the date and time of the history and physical to make it clear to auditors that the physical was performed after the patient was admitted to “observation status.”

99218 Initial observation care, per day, for the evaluation and management of a patient which requires the following three key components:

1. A detailed or comprehensive history
2. A detailed or comprehensive examination
3. Medical decision making that is straightforward or of low complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the problem(s) requiring admission to “observation status” are of low severity.

99219 Initial observation care, per day, for the evaluation and management of a patient which requires the following three key components:

1. A comprehensive history
2. A comprehensive examination
3. Medical decision making of moderate complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the problem(s) requiring admission to “observation status” are of moderate severity.

99220 Initial observation care, per day, for the evaluation and management of a patient which requires the following three key components:

1. A comprehensive history
2. A comprehensive examination
3. Medical decision making of high complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the problem(s) requiring admission to “observation status” are of high severity.



Observation Care Discharge Services

CPT® code 99217 is to be used to report all services provided to a patient on discharge from “observation status” if the discharge is on a day other than the initial date of “observation status.” Discharge of a patient from “observation status” includes final examination of the patient, discussion of the hospital stay, instructions for continuing care and preparation of discharge records.

Initial Hospital Care

New or Established Patient

Most third-party payors will not reimburse for more than one medical visit by the same provider per day. If a patient is seen in the office and admitted to the hospital the same day, a single code must be assigned to the E/M services provided if they were for the same diagnosis. In such cases, billing the code for the initial hospital care should reflect the work of these combined services because, in general, initial hospital codes will provide the appropriate reimbursement for the services rendered since these codes assume time spent in reviewing radiographs and give credit for physician “floor time.”

If the diagnosis is different for the E/M services provided on the same day, then two codes, one reflecting office service and the other reflecting admission service, are appropriate. Selection of the CPT® and ICD-9-CM codes and subsequent documentation should indicate why the second visit was appropriate.

NOTE: For **Medicare** billing purposes, if an admission and office visit are performed on the same day, bill only the admission. As of January 1, 2010, inpatient physicians and other non-physician practitioners who perform an initial evaluation and management may bill the initial hospital care codes (99221 – 99223). As a result of this change, multiple billings of initial hospital codes could occur even in a single day. So as to define the admitting physician, CMS has created the “AI” modifier which is to be used by the **admitting or attending physician** who oversees the patient’s care, as distinct from other physicians who may be furnishing specialty care. The “AI” modifier is defined as “Principal Physician of Record.”

For all of carriers, if two hospital visits are billed on the same day, only one will be reimbursed unless the second one is for an emergency situation (e.g., the patient is admitted with a stable condition that becomes unstable later in the day). Carriers will consider payment for the second visit on a post-payment basis.



There are two types of inpatient hospital codes: initial and subsequent.



When the patient is admitted to the hospital as an inpatient, in the course of an encounter in another site of service (e.g., hospital emergency department, observation status in a hospital, physician's office, nursing facility), all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission that he/she provided in the other sites of service as well as in the inpatient setting.

Evaluation and management services on the same date provided in sites other than the hospital that are related to the admission should not be reported separately.

99221 Initial hospital care, per day, for the evaluation and management of a patient which requires the following three key components:

1. A detailed or comprehensive history
2. A detailed or comprehensive examination
3. Medical decision making that is straightforward or of low complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

Example: *A rheumatologist is called to the hospital see a 60-year-old male patient with rheumatoid arthritis two days following an uncomplicated total knee replacement. The patient is expected to be discharged the following day but the knee is still slightly swollen. The patient reports having some discomfort in the operative knee when pressure is placed on it. He states the pain is tolerable with some oral hydrocodone/acetaminophen and denies any other complaints. He shows signs of weight loss since his last visit with the rheumatologist. His nonsteroidal anti-inflammatory drugs and methotrexate were discontinued one week preoperatively. Currently, he is on aspirin for thrombosis prophylaxis and an intermittent pneumatic compression device, ordered by the orthopedic surgeon. The orthopedic surgeon has ordered a visiting nurse and physical therapy after discharge.*

At the time of the examination, patient is alert and oriented. His vital signs are normal. Lungs are clear. His heart is regular rate and rhythm, no murmurs or friction rubs. He has good peripheral pulses. His abdomen is soft, nontender, no masses or hepatosplenomegaly. The surgical dressing on his right knee is dry and intact with a knee immobilizer and intermittent pneumatic compression device in place. The patient has slight decreased extension in right elbow, bony proliferation and mild boutonniere's deformities in fingers.

He was instructed to schedule a follow-up office visit in three weeks with his rheumatologist, and will restart NSAID and methotrexate once cleared by the orthopedic surgeon.



99222 Initial hospital care, per day, for the evaluation and management of a patient, which requires the following three key components:

1. A comprehensive history
2. A comprehensive examination
3. Medical decision making of moderate severity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

Example: *This is a hospital admission of a 19-year-old female with fever, rash and acute monoarthritis. A comprehensive history and examination is performed. Appropriate cultures, radiographs and laboratory are ordered. A joint aspiration is done. Antibiotics are instituted for presumed gonococcal arthritis. The patient is educated as to etiology of the illness.*

99223 Initial hospital care, per day, for the evaluation and management of a patient, which requires the following three key components:

1. A comprehensive history
2. A comprehensive examination
3. Medical decision making of high complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

Example: *This is a 66-year-old female patient admitted to the hospital for multisystem disease and a positive ANCA. The patient has a history of diabetes, hypertension, pulmonary hypertension, splenectomy and chronic renal insufficiency. She was admitted to the hospital because of left foot pain and swelling. She reports that three weeks prior to admission, she hit her foot on a wheelchair in a store, and then she developed a blister with swelling, erythema, and pain. Additionally, she has had some left ear pain for five days with subsequent bleeding out of the left ear with some hearing loss. She has mucosal bleeding from the mouth and eyes.*

She states that she has lost 30 pounds since October. She also is complaining of chills, low-grade fever, shortness of breath and a cough. The patient was started on Coumadin because of pulmonary emboli. She has been off Coumadin since her admission. She was noted to have acute renal failure at the time of admission, but her creatinine level has improved although it is not normal. She has skin lesions on her right hand on both legs, but does not know how long they have been there. She has nasal bleeding. She denies any numbness or tingling. She denies any changes in color of her fingers. She denies any nausea, vomiting, constipation, or diarrhea. She denies any change in urination or dysuria.



Past medical history: Type two diabetes, insulin dependent, systemic hypertension, pulmonary hypertension, depression, atrial fibrillation, hyperlipidemia, chronic renal insufficiency, and pulmonary embolus.

Social history: She lives with her daughter. Denies tobacco or alcohol use.

Family history: No known autoimmune disease but history of CVA, breast cancer, and hypertension.

Examination:

General: An ill- appearing female in no acute distress.

Vital signs: She is afebrile. Patient on nasal cannula O2 with good oxygen saturation and normotensive.

HEENT: Pupils equal, round, and reactive to light and accommodation. Extra ocular movements are intact. She does have severely dry mucous membranes. She has some dried blood surrounding her eyes and some sclera hemorrhage. She does have some dried blood in the mouth and at the nares. She has evidence of a bleeding ulcer at the right ear.

Neck: Supple. No lymphadenopathy. No thyromegaly.

Heart: Regular rate and rhythm. No murmurs, rubs or gallops.

Lungs: She does have some diffuse decreased breath sounds. Exam is anterolateral and unable to appreciate rales, rhonchi, or rubs.

Abdomen: Soft, nontender, nondistended. No hepatosplenomegaly.

Extremities: No cyanosis, clubbing or edema.

Skin: She does have evidence of a punch biopsy on the palm of the left hand. She has some small, punctuate, erythematous lesions on the palm of her left hand. She has an approximately 2cm bullous lesion on the right thigh and hemorrhagic, bullous appearing lesion measuring approximately 3cm on the anterior left tibia. The left foot has an extensive dressing that is in place and was not removed to evidence of active bleeding.

Musculoskeletal: No synovitis. There is full range of motion of all joints.

Neurologic: She is not oriented to year does not know the president. She does know her name and that she is in the hospital. No evidence of abnormal reflexes. Difficult to get a good strength exam due to her poor cooperation, but appears to move all extremities, and does not have apparent sensory deficit but does not fully cooperate with the sensory exam.

Laboratory data: Extensive data are reviewed off the portal, including lab data over the last three months and all imaging studies for the last three months.

Assessment: Pulmonary infiltrate, pulmonary hypertension, Ethmoid sinusitis, frontal sinusitis, maxillary sinusitis, bullous skin lesions, oropharyngeal hemorrhage, acute renal failure on baseline renal insufficiency, positive C-ANCA/ positive T-ANCA significant titers, Coumadin toxicity, diabetes, hypertension, atrial fibrillation, and depression.



Recommendations: I have discussed the patient's situation in detail with hematology and Renal. I will hold a conference with the family to discuss patient's condition.

Certainly, this is most consistent with Wegener's granulomatosis. Other possibility would be microscopic polyangiitis. At this point, I think she is at high risk for any type of biopsy. Renal biopsy will be low yield. Open lung biopsy will put her at significant risk for a bad outcome. I do not believe that we will obtain significant information from a skin biopsy to change her prognosis or treatment course. I would recommend that we do another CT scan of her chest to get a more detailed assessment of the pulmonary lesions. I would recommend high dose steroids. The patient is at high risk from steroid and Cytoxan use because of her high risk of infection and high risk from bone marrow suppression. Also, may consider discussing with Pulmonary whether they can do a BAL to rule out infection before starting cytotoxic agents. We will discuss in detail with the family and continue to discuss with the other consultants. Her prognosis is poor without treatment. Also her prognosis is poor from treatment due to the potential for complications.

Time invested in this visit was greater than 120 minutes.

Subsequent Hospital Care

Coding for subsequent hospital care should reflect the level and intensity of service required for the individual patient on a particular day. Codes for daily care may vary depending on the possible development of new problems or worsening of existing problems. These codes are meant to be used for all care provided on a given day. If the rheumatologist visits or sees a hospital inpatient more than once a day, all such encounters and all care rendered for the patient on that day should be combined in one level of service code. For payment purposes, Medicare will combine both the office and admission services into a single hospital visit. The only time it will not is if the later visit is for emergency purposes – then it will only pay on a post payment basis. The exceptions are a return visit for complications constituting critical care or for a second distinct problem which requires a different ICD-9-CM code. In the former case, both a hospital care code (for non-critical care) and a critical care code should be used with supporting documentation to show that both services were necessary.

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (e.g., change in history, physical condition and response to management) since the last assessment by the physician.

99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of the following three key components:

1. A problem-focused interval history
2. A problem-focused examination
3. Medical decision making that is straightforward or of low complexity



Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

Example: *Follow-up hospital visit for a 55-year-old female with rheumatoid arthritis, three days following an uncomplicated joint replacement. The patient's general medical care is being managed by her internist. A brief examination and chart review was completed.*

99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of the following three key components:

1. An expanded problem-focused interval history
2. An expanded problem-focused examination
3. Medical decision making of moderate complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

Example: *The rheumatologist sees a 58-year male with Wegener's granulomatosis, hospitalized for acute hemoptysis and progressive dyspnea, in the morning of the patient's third hospital day. The rheumatologist performs and documents an expanded problem-focused history, detailed examination and moderate complexity medical decision making. The rheumatologist in the same practice as the PA, sees the patient later that day, reviews the patient's laboratory results drawn that morning, auscultates the patient's heart and lungs findings and documents her findings.*

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of the following three key components:

1. A detailed interval history
2. A detailed examination
3. Medical decision making of high complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.



Example: *This is a follow-up hospital visit for a 55-year-old female with rheumatoid arthritis, and three days of postoperative leg pain and swelling from total hip replacement. The patient's general medical care is being managed by the rheumatologist. She denies chest pain, shortness of breath or a flare of rheumatoid arthritis. An expanded problem-focused examination is performed. Anticoagulant therapy is instituted for presumed deep venous thrombosis. A venous study is ordered. The rheumatologist discussed the plan with the orthopedic surgeon.*

Hospital Discharge Services

The hospital discharge day management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the physician on that date is not continuous. Instructions for continuing care are given to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms is completed. The patient does not have to be seen, but services have to be provided on the date billed.

99238 Hospital discharge day management, 30 minutes or less.

99239 Hospital discharge day management, more than 30 minutes.

To report services for a patient who is admitted as an inpatient and discharged on the same day, use only the codes for observation or inpatient care services, including admission and discharge services (99234-99236). To report concurrent care services provided by a physician(s) other than the attending physician, use subsequent hospital care codes (99231-99233).

Hospital Consultations

New or Established Patient

Different codes are used for inpatient and outpatient consultations. The Harvard Resource-based Relative Value Scale study shows that inpatient work and overhead were quite different from outpatient work and overhead for consultations. Consequently, different descriptors are used for inpatient consultations.

The following codes are used to report physician consultations provided to hospital inpatients, residents of nursing facilities or patients in a partial hospital setting. Only one initial consultation should be reported by a consultant per admission. There are no longer codes for follow-up in-patient consultations. Subsequent services during the same admission should be reported as Subsequent Hospital Care.

NOTE: *Reminder as of January 1, 2010 Medicare eliminated inpatient consultations codes. For inpatient physicians and other non-physician practitioners who perform an initial evaluation and management may bill the initial hospital care codes (99221-99223) or nursing facility care codes (99304-99306). As a result of this change, multiple billings of initial hospital and nursing home visit codes could occur even in a single day.*



99251 Initial inpatient consultation for a new or established patient, which requires the following three key components:

1. A problem-focused history
2. A problem-focused examination
3. Straightforward medical decision making

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

Example: Hospital consultation for a 65-year-old female osteoarthritis patient admitted for kidney stones. Medication is adjusted accordingly.

99252 Initial inpatient consultation for a new or established patient, which requires the following three key components:

1. An expanded problem-focused history
2. An expanded problem-focused examination
3. Straightforward medical decision making

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

Example: This is a hospital consultation for a 72-year-old male patient recovering from angioplasty who develops an acute bursitis of the left shoulder. The rheumatologist had seen the patient four years previously for an episode of pseudo gout in the right knee. The patient is on antihypertensive and lipid lowering drugs. He is afebrile and otherwise has made an uneventful recovery.

99253 Initial inpatient consultation for a new or established patient which requires the following three key components:

1. A detailed history
2. A detailed examination
3. Medical decision making of low complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.



Example: This is a hospital consultation for an obese female hospitalized for an endoscopic removal of her gallbladder. She is making an apparently uneventful recovery from a moderately difficult procedure. On the third day (which was going to be her discharge day), she develops a right Podagra and pain in multiple joints. In addition to a bright red first toe, she has warmth and an effusion in her left knee. The rheumatologist is consulted. The family is present and is anxious about this complication; they remind the rheumatologist that the patient's brother was seen by the rheumatologist for gout. Records reviewed, x-rays ordered and knee aspirated, and the fluid was sent to the laboratory. Gout crystals found, and therapy was initiated. The rheumatologist informs the family that the patient will be seen the next day for review.

99254 Initial inpatient consultation for a new or established patient which requires the following three key components:

1. A comprehensive history
2. A comprehensive examination
3. Medical decision making of moderate complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

Example: This is a hospital consultation for a 68-year-old woman, who was admitted for a six-month history of severe polyarthritis. The arthritis is unresponsive to initial therapy. The patient's family is present. A comprehensive history and musculoskeletal examination is performed. A review of laboratory studies, chart and x-rays were completed with patient and family. The results were consistent with rheumatoid arthritis. Treatment options, drug toxicity, and long-term prognosis discussed with the patient and family. The addition of "second-line" anti-rheumatic therapy instituted and a physical therapy consultation was arranged.

99255 Initial inpatient consultation for a new or established patient which requires the following three key components:

1. A comprehensive history
2. A comprehensive examination
3. Medical decision making of high complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.



Example: A 22-year-old steroid-dependent woman is seen for an initial hospital consultation; she presents with systemic lupus erythematosus, arthritis and glomerulonephritis. The patient is re-evaluated for loss of consciousness and chest pain. A comprehensive examination is performed. A review of x-rays, cardiac echo cardiogram, laboratory studies and chart was completed. The case was discussed with the patient and her nephrologist and cardiologist. Appropriate diagnostic studies were ordered. Steroid dosage was adjusted along with institution of anticoagulation.

Critical Care Services

As defined by the AMA CPT® manual, critical care includes the care of critically ill or unstable, critically injured, patients who require the constant attention of the physician. (**NOTE:** Medicare's definition is critically ill and unstable.) The critical care unit is an area where the time required to provide the services is an important determinant of which code to use. CPT® code 99291 is used to report the first hour of critical care on a given day. It should be used only once per day even if the time spent by the physician is not continuous on that day. Critical care of less than 30 minutes should be reported with the appropriate E/M service code. CPT® code 99292 is used to report each additional 30 minutes beyond the first hour. There are no subsequent follow up critical care codes. Services for a patient who is not critically ill but happens to be in a critical care unit are reported using subsequent hospital care codes (99231-99233) or hospital consultation codes (99251-99255). For further guidelines, please refer to the AMA CPT® manual.

Prolonged Services

There are two types of prolonged service rheumatologists may bill for when care is beyond the normal time frame during either an inpatient or outpatient visit. These services must be billed along with an E/M visit. They are known as add on codes.

With Direct (Face-to-Face) Patient Contact

- + **99354** Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour (List separately in addition to code for office other outpatient Evaluation and Management service)
- + **99355** each additional 30 minutes (List separately in addition to code for prolonged physician service)
- + **99356** Prolonged physician service in the inpatient setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)
- + **99357** each additional 30 minutes (List separately in addition to code for prolonged physician service)



Without Direct (Face-to-Face) Patient Contact

- + 99358** Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g. review of extensive records and tests, communication with other professionals and/or the patient/family); first hour (List separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient Evaluation and Management service)
- + 99359** each additional 30 minutes (List separately in addition to code for prolonged physician service)

Telephone Services

There are two types of codes for telephone services: non-face-to-face physician and non-face-to-face nonphysician. These codes are used to report care done by a qualified health professional for an established patient or guardian of an established patient.

Below is a list of both types of telephone services codes:

Non-Face-to-Face Physician Services

- 99441** Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5 – 10 minutes of medical discussion
- 99442** 11 – 20 minutes of medical discussion
- 99443** 21 – 30 minutes of medical discussion

Non-Face-to-Face Nonphysician Services

- 98966** Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5 – 10 minutes of medical discussion
- 98967** 11 – 20 minutes of medical discussion
- 98968** 21 – 30 minutes of medical discussion

Medicare and many private carriers will not reimburse for either prolonged services or telephone services. When billing to CMS, an Advance Beneficiary Notice must be signed and dated prior to the service. It is recommended that your practice verify with each carrier its policy on these charges.

NOTE: It is acceptable to bill these charges directly to the patient. Just make sure you notify patients both in writing and on signage that is prominently displayed in the office.



Chapter Four

Rheumatology Technical Procedures

Minor Surgical Procedures

In addition to the major global surgeries in the Surgery section of the AMA CPT® manual, there are a number of minor surgeries. These minor surgeries involve a readily identifiable surgical procedure but include variable preoperative and postoperative services (e.g., injection of a tendon sheath and manipulation of a joint under anesthesia). Because of the indefinite preoperative and postoperative services, they are not traditionally paid using a global surgery policy.

- 20526** Injection, therapeutic (e.g., local anesthetic corticosteroid), carpal tunnel
- 20550** Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar “fascia”)
- 20551** single tendon origin/insertion
- 20552** Injection(s); single or multiple trigger point(s), one or two muscle(s)
- 20553** single or multiple trigger point(s), three or more muscle(s)
- 20600** Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes)
- 20605** intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
- 20610** major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)



Trigger point injections are coded based on the number of muscles, not the number of injections. You may not bill for both 20552 and 20553. For example, if a patient comes in for trigger point injections in six different muscles, you bill code 20553 only.

NOTE: When billing two joints of the same size and it is not bilateral, you may want to use modifier -59 to ensure that the carrier realizes you are performing two separate joints. In some cases, there have been denials of the second code because it was thought the practices were billing for the aspiration and the injection. This is not allowed; the joint injection is for both aspiration and/or injection.

(If imaging guidance is performed, see 76942, 77002, 77012, or 77021. See page 71.)



64490 Injection(s) diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

+64491 second level (List separately in addition to code for primary procedure)

+64492 third and any additional level(s) (List separately in addition to code for primary procedure)

– (Do not report 64492 more than once per day) –

– (Use 64491, 64492 in conjunction with 64490) –

64493 Injection(s), diagnostic therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

+64494 second level (List separately in addition to code for primary procedure)

+64495 third and any additional level(s) (List separately in addition to code for primary)

– (Do not report 64495 more than once per day) –

– (Use 64494, 64495 in conjunction with 64493) –

- Image guidance (fluoroscopy or CT) and any injection of contrast are inclusive components of 64490-64495. Imaging guidance and localization are required for the performance of paravertebral facet joint injection described by codes 64490-64495. If imaging is not used; report 20550-20553. If ultrasound guidance is used, report 64999.
- For bilateral procedures, use modifier 50.
- For injection of the T12-L1 joint, or nerves innervating that joint, use 64493.

Drug Administration

Following are the most common drug administration codes used in rheumatology practices for the injection and infusion of medications. The codes are broken down by categories: hydration, therapeutic, prophylactic and diagnostic.

When coding from the drug administration group it is important to know the guidelines. It is significant to know that only one “initial” code from this group can be billed. The term “initial” refers to the first code within the family of codes during a patient’s encounter. When multiple drugs or other agents are administered, the additional sequential codes should be used.

NOTE: It may be appropriate in some instances for the initial code to be a chemotherapy code and the additional sequential code to be a non-chemotherapy code.

A number of these codes are based on time. Two types of these codes in this group are infusions and IV pushes. Accurate documentation of the time is very important. The time begins when the medicine is started in the line and it should be stopped when the medicine is finished.



The first hour of an infusion must be at least 16 minutes in order to be considered for the initial hour of an infusion. If it is 15 minutes or less it should be coded as an IV push. Each additional hour must be at least 31 minutes into that additional hour. Anything less than the 31 minutes will not count toward an additional hour of infusion.

Example 1: The infusion time of a chemotherapy drug was 91 minutes it would be coded as 96413 and 96415.

Example 2: The infusion time of a chemotherapy drug was 90 minutes it would be coded as 96413 only.

The billing of local anesthesia, IV start, access to indwelling IV, subcutaneous catheter or port, flushing at the conclusion of the infusion, or the standard tubing, syringes, and supplies is not allowed – all of these items are built into the code.



Time does not start when the IV is put into the patient nor does it begin when the saline is infused – only when the actual medicine is infused. This is a common documentation error.

NOTE: CPT® code 99211 cannot be billed with any drug administration code. This code has been built into the Relative Value unit for these codes.

- 96360** Intravenous infusion, hydration; initial, up to 1 hour (Do not report 90760 if performed as a concurrent infusion service)
- 96361** Each additional hour, up to 8 hours (List separately in addition to code for primary procedure)

NOTE: Codes 96360 and 96361 should not be billed for the infusion of saline if it is used to administer the drug. Either code should only be billed if the saline is used to flush out the drug in a patient's system. In that case you would bill the 96360 or the 96361 with a modifier 59 to indicate that the hydration was not used to facilitate the drug.

- 96365** Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
- 96366** each additional hour, up to 8 hours (List separately in addition to code for primary procedure)
- 96372** Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
- 96374** intravenous push, single or initial substance/drug
- 96375** each additional sequential intravenous push a new substance/drug (List separately in addition to code for primary procedure)

NOTE: Chemotherapy administration codes 96401, 96413 and 96415 apply to a parenteral administration of non-radionuclide Antineoplastic drugs; and also to anti-neoplastic agents provided for the treatment of noncancer diagnosis (e.g., cyclophosphamide for auto-immune conditions) or to substance such as certain monoclonal antibody agents, and other biologic response modifiers.



- 96401** Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
- 96413** Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
- 96415** each additional hour, 1 to 8 hours (List separately in addition to code for primary procedure)

Modifiers

There are two types of modifiers: functional/pricing modifiers and informational modifiers. Functional/pricing modifiers do exactly what they state — control the money. Without the correct modifier, the charge could be rejected or lumped in with another charge. Informational modifiers provide information to the carrier such as body area (e.g., LT for left or RT for right). It could also provide information as to whether or not the patient is aware of his or her liability (e.g., GA to notify CMS that there is a signed Advance Beneficiary Notice on file).

Functional/Pricing Modifier

- Modifier 25 - Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.
- Modifier 50 - Bilateral procedure

NOTE: Carrier will often tell you that a separate diagnosis is needed for this modifier. This is incorrect per the 2010 CPT®; “As such, different diagnoses are not required for reporting of the E/M service on the same date.” It is recommended that the documentation for the E/M visit should be totally separate from the document for the procedure done that same day.

- Modifier 26 - Professional component

NOTE: This modifier should only be used if the rheumatologist is reading and writing a report of his findings of the X-ray. If the physician is reading and performing the X-ray no modifier is needed. You would just bill the X-ray procedure with no modifier to show that it was done as a global procedure.



- Modifier LT – Left side
- Modifier RT – Right side

NOTE: Modifier 50 will be reimbursed at 150 percent, not at 100 percent and 100 percent for the two procedures. You should verify with your carrier on how they want this modifier used. You may be asked to:

- Bill it as one line with both procedure charge amount on it with the 50 modifier and one in the unit field.
- Bill the procedures on two lines with the 50 modifier on the second procedure with one in the unit field for each procedure.
- Bill it with modifiers on two lines, with the modifier LT on first procedure and RT on the second procedure with one in the unit field for each procedure.

- Modifier 51 - Multiple procedures
- Modifier 59 - Distinct procedural service

NOTE: This modifier should be used when you are trying to demonstrate that two separate and different sites or sessions.

Example: If you two large joints are being injected, such as a shoulder and a knee, you would place a modifier 59 on the second 20610 to show that there was two different joints injected and the practice is not billing for the injection and aspiration of the same joint.

- Modifier 76 - Repeat procedure or service by same physician
- Modifier 90 - Reference (outside) laboratory
- Modifier 91 - Repeat clinical diagnostic laboratory test



Chapter Five

Radiologic Examination

Several codes are available for each radiologic examination depending on the number of views obtained. To ensure proper reimbursement, the correct code reflecting the total number of procedures performed should be chosen. Specific codes for radiologic tests (single and multiple views) can be found in the AMA CPT® manual. Physician should report these codes when a radiologic procedure is performed and/or read.

A word of caution is offered here regarding patients covered by Medicare. If radiologic studies are personally performed by the physician or by the physician's employees under appropriate supervision and that physician provides the interpretation, the radiologic studies may be billed routinely as a global service (both technical and professional component).

However, if a radiologic study is obtained that the physician did not actually perform or supervise, then billing and reimbursement fall under the "purchased service" provision. The purchased service may be billed directly to the Medicare carrier by the provider of the technical component, or the physician can bill for it. If the physician bills for it, he or she must check "Yes" in Block 20 of the claim to indicate the technical component was purchased and indicate the actual amount paid for the service. In addition, a "Yes" requires completion of Block 32 with the name, address and Medicare billing number of the provider providing the purchased service. A "No" in Block 20 tells the Medicare carrier that there are no purchased services on the claim.

Certain procedures, including many radiographs and bone density scans, are a combination of professional and technical services. Use of the modifier "-26" with these codes indicates that only the professional service (interpreting the data) was provided. The modifier "-26" is used by rheumatologists who provide a written interpretation on a radiograph or bone density scan from an outside diagnostic center. Rheumatologists who only review a radiograph from an outside diagnostic center and do not provide written interpretation would not use modifier "-26" as this work is considered part of the E/M service.

If a rheumatologist performs or supervises a radiograph in the office and provides written interpretation, then the usual radiologic procedure code, such as CPT® 73100, is used. If another physician requests a report on a film done elsewhere, then CPT® 76140 (consultation on radiographic examination made elsewhere, written report) is used. A written report is required. This code is not applicable when the physician requesting the report is from the same institution or practice.



Magnetic Resonance Imaging

Upper Extremities

- 73221** Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material(s)
- 73222** with contrast material(s)
- 73223** without contrast material(s), followed by contrast material(s) and further sequences

Lower Extremities

- 73721** Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material(s)
- 73722** with contrast material(s)
- 73723** without contrast material(s), followed by contrast material(s) and further

There are several CPT® codes for bone densitometry. Dual energy X-ray absorptiometry has separate codes for axial, peripheral scans, and vertebral fracture assessment.

- 77080** Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)
- 77081** appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
- 77082** vertebral fracture assessment

NOTE: CMS has very strict guidelines for DXAs. You can find any carriers' local coverage determination at www.cms.hhs.gov/DeterminationProcess/04_LCDs.asp.



Radiologic Guidance

There are three types of radiologic guidance that rheumatologists would use along with some minor surgical procedures: ultrasound, fluoroscopic, computed tomography and magnetic resonance.

- 76942** Ultrasound guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation

NOTE: There has been a significant rise in the usage of code 76492. Because of this, the Office of the Inspector General has placed this code on the OIG watch list. Your practice should be prepared to show documentation of medical necessity for this code.

- 77033** Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction
- 77012** Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation

Ultrasound

- 76800** Ultrasound, spinal canal and contents
- 76880** Ultrasound, extremity, nonvascular, real time with image documentation



Chapter Six

Pathology and Laboratory

Laboratory codes have nuances that may promote confusion. Most codes for specific analyte/method and specimen source/analyte combinations have been eliminated. The rheumatologist must be certain that the correct code is applied to ensure proper reimbursement. Offices that process laboratory tests should follow the guidelines listed below:

1. If you do the testing in your own laboratory, bill for the test using the appropriate laboratory code number, in addition to the office visit.
2. If you collect the specimen and send it to an outside laboratory, bill for the office visit and a handling fee (CPT® codes 99000-99002) or add the modifier “-90” (or the five digit modifier 09990) with the code for the test performed. This alerts third-party payors that an outside laboratory performed the tests and supports the billing by both the rheumatologist and the laboratory.

NOTE: Medicare does pay for 36415 (venipuncture) to draw the blood specimen, but does not pay for 99000-99002. However private payor payments vary.

3. If the laboratory bills you for the tests, bill the patient using the appropriate code from the laboratory section. This applies only to non-Medicare patients. Medicare patients who have laboratory tests performed by an outside laboratory must be billed directly by the outside laboratory. It should be pointed out that, at least in a few states, Medicaid and other third-party payors stipulate the same requirements.
4. If you are unable to locate a specific code for a test in the AMA CPT® manual, try to find it based on the method of performing the test.
5. The allowable laboratory tests reimbursed for particular diagnoses are carefully monitored. You should consult your Medicare carrier’s bulletin to identify the laboratory tests that will be reimbursed only if it corresponds with the medically necessary diagnosis list.



Blood Counts

Not only are there codes for manual and automated performances of complete blood counts, there are also codes for each component. Refer to the index in the AMA CPT® manual for the appropriate list of codes. The most frequently used codes done in rheumatology offices are listed below:

- 85014** hematocrit (HCT)
- 85018** hemoglobin (Hgb)
- 85025** complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
- 85027** complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
- 85032** manual cell count (erythrocyte, leukocyte, or platelet)
- 85049** platelet, automated
- 85651** Sedimentation rate, erythrocyte; non-automated

Urinalyses

Urinalyses can be listed as a complete routine (with pH, specific gravity, protein, reducing substance and microscopy) or by constituent subsets (complete microscopy) or qualitative chemical analysis with any number of constituents.

- 81000** Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, keton, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
- 81001** automated, with microscopy
- 81002** non-automated, without microscopy
- 81003** automated, without microscopy
- 81005** Urinalysis; qualitative or semiquantitative, except immunoassays

Cultures

Body fluids cultures may be described using CPT® codes 87040-87999, depending on the site or origin and the type of culture obtained. Urine cultures are usually performed in a quantitative manner with colony counts.

- 87086** Culture, bacterial; quantitative colony count, urine
- 87088** with isolation and presumptive identification of each isolate, urine



Immunology

The branch of biomedicine that is concerned with the structure and function of the immune system, innate and acquired immunity, and laboratory techniques involving the interaction of antigens with antibodies.

- 86255** Fluorescent noninfectious agent antibody; screen, each antibody
- 86256** titer, each antibody
- 86430** Rheumatoid factor, qualitative
- 86431** quantitative
- 86480** Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response
- 86580** tuberculosis, intradermal (skin test)

NOTE: There have been some denials of the PPD test done before a patient starts biologics. Medicare does not pay for screening, it has been reported that carriers will accept V01.01 – contact with or exposure to communicable disease.

Tissue Typing

Tissue typing can be coded as a single antigen, e.g., HLA B27, or multiple antigens. A separate code is utilized for HLA DR/DQ typing, with codes for single antigen and for multiple antigens.

- 86812** HLA typing; A, B, or C (e.g., A10, B7, B27), single antigen
- 86813** A, B, or C, multiple antigens
- 86816** DR/DQ, single antigen
- 86817** DR/DQ, multiple antigens

Synovial Fluid Examination

Synovial fluid examinations should be coded as follows:

- 85810** Viscosity
- 89050** Cell count, miscellaneous body fluids (e.g., cerebrospinal fluid, joint fluid), except blood;
- 89051** with differential count
- 89060** Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)
- 82947** Glucose; quantitative, blood (except reagent strip)

Gross examination

- Viscosity
- Color
- Clarity



Drug Monitoring

Medicare carefully monitors follow-up testing. Listing disease-specific diagnosis codes will not be sufficient to prove medical necessity for drug monitoring. You must also list the ICD-9-CM codes that support medical necessity for high-risk medications. These include:

- V58.65 Glucocorticoids
- V58.69 Long-term (current) use of other (high-risk) medications.
- V67.51 Following completed treatment with high-risk medications

CLIA

The Clinical Laboratory Improvement Amendments were passed by Congress in 1988 to improve the quality of testing in all laboratories nationwide. These health assessment tests examine diagnoses, prevention and treatment of the human body. The basis of the complexity of CLIA tests are categorized into three levels, waived tests, moderate and high complexity.

Waived Tests

Waived tests include any test listed in the regulation (process of categorizing and re-categorizing of tests), any test in which the manufacturer instructions allow inspections and random compliance checks, and tests cleared by the FDA for home usage. When billing for waived tests approved on or after January 23, 1996, laboratories must use QW modifier. It is not mandatory for tests approved before January 23, 1996.

The specified tests that are listed in the FDA regulation as waived are:

1. Dipstick or tablet reagent urinalysis (non-automated) for the following:
 - Bilirubin
 - Glucose
 - Hemoglobin
 - Ketone
 - Leukocytes
 - Nitrite
 - pH
 - Protein
 - Specific gravity
 - Urobilinogen



2. Fecal occult blood
3. Erythrocyte sedimentation rate – non-automated
4. Hemoglobin-copper sulfate – non-automated
5. Blood glucose by glucose monitoring devices cleared by the FDA specifically for home use
6. Spun microhematocrit
7. (Added 1/19/93) Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout

Moderate and High Complexity Tests

Moderate and high complexity tests must meet requirements for proficiency testing, patient test management, quality assurance/control and personnel. Waived tests are exempted from these requirements.

Proficiency testing evaluates the laboratory's performance mandated by CLIA. Moderate and high complexity tests are required to enroll in an approved proficiency testing program for specialties in which certification is sought. Regulations create rules for PT providers that include sample problem solving, distribution, preparation, result reporting and records.

Patient test management must maintain and establish a system to ensure identification and reliability of specimens during the testing process and correct handling of the results. Requirements for the submission and handling, specimen referral, test applications, test records and reports are stipulated by the regulations.

Quality assurance/control ensures that every laboratory must create quality control procedures that oversee and assess every test technique to guarantee precise and dependable results. Each laboratory must ascertain written policies and procedures for a QA program intended to oversee and assess the complete testing process.

Personnel requirements tie into the complexity of testing. The condition differs for personnel who execute moderate and high complexity testing and are identified individually. Qualifications for a precise mixture of positions and define accountability for people who fill the position.

All laboratories must have one of the below certifications from CLIA to perform clinical testing on specimens:

- a) **Certificate of Waiver** is issued to a laboratory to perform waived tests only.
- b) **Certificate of Provider-Performed Microscopy Procedures** is issued to a laboratory in which a mid-level practitioner, physician or dentist can perform microscopy procedures. Waived tests may also be performed.
- c) **Certificate of Registration** is issued to a laboratory that performs moderate and/or high complexity testing until it is determined by a survey to be in compliance with CLIA regulations.



- d) **Certificate of Compliance** is issued to a laboratory after an inspection determines that it is compliant with CLIA requirements.
- e) **Certificate of Accreditation** is issued to a laboratory based on the accreditation of an organization approved by CMS.

How to Apply for a CLIA Certificate of Waiver

Obtaining a Certificate of Waiver is usually a straightforward process. An application (Form CMS-116) can be obtained on the CMS website at www.cms.gov/clia/cliaapp.asp or from your state health department. The application requests the following information that you must complete:

- I. **General Information** – provide information about your organization, including street address, name of director, and federal tax identification number. Don't fill out the CLIA identification number if this is an initial application.
- II. **Type of Certificate Requested** – request a Certificate of Waiver.
- III. **Type of Laboratory** – indicate the facility or setting in which you will perform the rapid test, e.g., community clinic, health fair, mobile laboratory (van). If none of the categories apply to your setting, check "other."
- IV. **Hours of Laboratory Testing** – indicate the times you plan to do testing.
- V. **Multiple Sites** – indicate if you will be doing testing at more than one site. If you will have multiple sites, provide the number of sites and complete the remainder of this section. In general, a mobile van is considered a multiple site if it is not in a fixed location and moves from site to site for testing. If that is the case, the name and address of the testing site for that van would be the same as the organization it operates under or the physical location where the van is housed.
- VI. **Waived Testing** – estimate the number of tests you will be performing annually.
- VII. **Non-Waived Tests** – skip this section if you are performing a waived test only.
- VIII. **Type of Control** – check the type of organization for which you are making this application (private nonprofit, for-profit, government).
- IX. **Director Affiliation With Other Laboratories** – provide the name and address of other laboratories (facilities) that your director also directs. CLIA regulations allow a director to direct a maximum of five laboratories.
- X. **Individuals Involved in Laboratory Testing** – indicate the total number of individuals involved in testing — those who are directing, supervising, consulting or testing. Include counselors only if they will perform or supervise testing.
- XI. **Consent and Signature** – carefully read the consent information at the bottom of page four before signing and dating.



Chapter Seven

Diagnostic Codes for Rheumatology

ICD-9 Clinical Modification – Diagnostic Codes

Abdomen, abdominal – see *also* condition

[0-7, 9] Abdominal pain 789.0_

NOTE: The following fifth-digit subclassification is to be used for codes 789.0, 789.3, 789.4, 789.6

- 0 unspecified site
- 1 right upper quadrant
- 2 left upper quadrant
- 3 right lower quadrant
- 4 left lower quadrant
- 5 periumbilic
- 6 epigastric
- 7 generalized
- 9 other specific site
- multiple sites

Albuminuria, albuminuric (acute) (chronic)
(subacute) 791.0

Anemia 285.9

Angiitis 447.6

hypersensitivity 446.20

Angina (attack) (cardiac) (chest) (effort) (heart)
(pectoris) (syndrome) 413.9

Arteritis 447.6

giant cell 446.5

necrosing or necrotizing 446.0

temporal 446.5

Arthritis, arthritic (acute) (chronic) (subacute)

716.9_

meaning Osteoarthritis – see *also* Osteoarthritis

NOTE: Use the following fifth-digit subclassification with categories 711-712, 715-716:

- 0 site unspecified
- 1 shoulder region
- 2 upper arm
- 3 forearm
- 4 hand
- 5 pelvic region and thigh
- 6 lower leg
- 7 ankle and foot
- 8 other specified sites
- 9 multiple sites

crystal (-induced) – see Arthritis, due to crystals

due to or associated with

bacterial disease NEC 040.89 [711.4]

crystals (*see also* Gout)

dicalcium phosphate 275.49 [712.1]

pyrophosphate 275.49 [712.2]

specified NEC 275.49 [712.8]

dermatological disorder NEC 709.9 [713.3]

gastrointestinal condition NEC 569.9 [713.1]



Reiter's disease 099.3 [711.1]
 sarcoidosis 135 [713.7]
 viral disease NEC 079.99 [711.5]
 gonococcal 098.50
 gouty 274.00
 acute 274.01
 hypertrophic (*see also* Osteoarthritis) 715.9_
 spine 721.90
 with myelopathy 721.91
 idiopathic, blennorrhoeal 099.3
 inflammatory NEC 714.9
 juvenile rheumatoid (chronic) (polyarticular)
 714.30
 acute 714.31
 monoarticular 714.33
 pauciarticular 714.32
 lumbar (*see also* Spondylosis, lumbar) 721.3
 postrheumatic, chronic (Jaccoud's) 714.4
 psoriatic 696.0
 primary progressive 714.0
 spine 720.9
 rheumatic 714.0
 acute or subacute – *see* Fever, rheumatic
 chronic 714.0
 spine 720.9
 rheumatoid (nodular) 714.0
 with
 splenadenomegaly and leukopenia
 714.1
 visceral or systemic involvement 714.2
 juvenile (chronic) (polyarticular)
 714.30
 acute 714.31
 monoarticular 714.33
 pauciarticular 714.32
 septic 711.0_

Arthropathy – *see also* Arthritis 716.9_

NOTE: Use the following fifth-digit subclassification with categories 711-712, 716:

- 0 site unspecified
- 1 shoulder region
- 2 upper arm
- 3 forearm
- 4 hand
- 5 pelvic region and thigh

Behçet's 136.1 [711.2]
 crystal (-induced) – *see* Arthritis, due to crystals
 gouty 274.00
 postrheumatic, chronic (Jaccoud's) 714.4

Arteriosclerosis, arteriosclerotic (artery) (deformans) (diffuse) (disease) (endarteritis) (general) (obliterans) (obliterative) (occlusive) (senile) (with calcification) 440.9
 coronary (artery) 414.00

Atherosclerosis – *see* Arteriosclerosis

Autoimmune

disease NEC 279.49

Backache (postural) 724.5

Baker's

cyst (knee) 727.51

Behçet's syndrome 136.1

Bronchitis (diffuse) (hypostatic) (infectious) (inflammatory) (simple) 490
 acute or subacute 466.0
 chronic 491.9

Bursitis NEC 727.3

ankle 726.79
 elbow 726.33
 finger 726.8
 foot 726.79
 hand 726.4



hip 726.5
knee 726.60
olecranon 726.33
pes anserinus 726.61
prepatellar 726.65
shoulder 726.10
trochanteric area 726.5
wrist 726.4

Capsulitis (joint) 726.90

adhesive (shoulder) 726.0

Carpal tunnel syndrome 354.0

Cervicalgia 723.1

Chest – see condition

Chondrocalcinosis (articular) (crystal deposition)
(dihydrate) – (see *also* Arthritis, due to, crystals)
275.49 [712.3]

due to

calcium pyrophosphate 275.49 [712.2]

dicalcium phosphate crystals 275.49 [712.1]

pyrophosphate crystals 275.49 [712.2]

Chondromalacia 733.92

patella, patellae 717.7

Colitis (acute) (catarrhal) (croupous) (ccystica
superficialis) (exudative) (hemorrhagic) (noninfectious)
(phlegmonous) (presumed noninfectious) 558.9
ulcerative (chronic) (idiopathic) (nonspecific) 556.9

Constipation 564.00

Contusion (skin surface intact) 924.9

with

ankle 924.21

back 922.31

buttock 922.32

foot (with ankle) (excluding toe(s)) 924.20

hip 924.01

with thigh 924.00

knee 924.11

leg 924.5

lower (with knee) 924.10

Cramp(s)

muscle (extremity) (general) 729.82

Cyst (mucus) (retention) (serous) (simple)

Baker's (knee) 727.51

Cystitis (bacillary) (colli) (diffuse) (exudative)
(hemorrhagic) (purulent) (recurrent) (septic)
(suppurative) (ulcerative) 595.9
acute 595.0

Degeneration, degenerative

articular cartilage NEC (see *also* Disorder,
cartilage, articular) 718.0_

elbow 718.02

knee 717.5

patella 717.7

shoulder 718.01

spine (see *also* Spondylosis) 721.90

intervertebral disc 722.6

with myelopathy 722.70

cervical, cervicothoracic 722.4

with myelopathy 722.71

lumbar, lumbrosacral 722.52

with myelopathy 722.73

thoracic, thoracolumbar 722.51

with myelopathy 722.72

de Quervain's disease (tendon sheath) 727.04
syndrome 259.51

Derangement

ankle (internal) 718.97

cartilage (articular) NEC (see *also* Disorder
cartilage, articular) 718.0

knee 717.9

recurrent 718.36

elbow (internal) 718.92

hip (joint) (internal) (old) 718.95

current injury (see *also* Dislocation, hip) 835.00

recurrent 718.35

joint (internal) 718.90

ankle 718.97

elbow 718.92

foot 718.97

hand 718.94

hip 718.95



knee 717.9
 multiple sites 718.99
 pelvic region 718.95
 recurrent 718.30
 ankle 718.37
 elbow 718.32
 foot 718.37
 hand 718.34
 hip 718.35
 knee 718.36
 multiple sites 718.39
 pelvic region 718.35
 shoulder region 718.31
 specified site NEC 718.38
 wrist 718.33
 shoulder region 718.91
 specified site NEC 718.98
 wrist 718.93
 knee (cartilage) (internal) 717.9

Dermatomyositis (acute) (chronic) 710.3

Diabetes, diabetic (brittle) (congenital) (familial)
 (mellitus) (severe) (slight) (without complication) 250.0_

NOTE: Use the following fifth-digit subclassification with category 250:

- 0 type II or unspecified type, not stated as uncontrolled
 Fifth-digit 0 is for use for type II patients, even if the patient requires insulin
- 1 type I [juvenile type], not stated as uncontrolled
- 2 type II or unspecified type, uncontrolled
 Fifth-digit 2 is for use for type II patients, even if the patient requires insulin
- 3 type I [juvenile type], uncontrolled

Diarrhea, diarrheal (acute) (autumn) (bilious) (bloody)
 (catarrhal) (choleraic) (chronic) (gravis) (green) (infantile)
 (lienteric) (noninfectious) (presumed noninfectious)
 (putrefactive) (secondary) (sporadic) (summer)
 (symptomatic) (thermic) 787.91

Disease, diseased – *see also* Syndrome

autoimmune NEC 279.49
 cerebrovascular NEC 437.9
 connective tissue, diffuse (*see also* Disease, collagen) 710.9
 de Quervain's (tendon sheath) 727.04
 Kawasaki 446.1
 kidney (functional) (pelvis) (*see also* Disease, renal) 593.9
 chronic 585.9
 Lyme 088.81
 pulmonary – *see also* Disease, lung
 obstructive diffuse (chronic) 496
 Reiter's 099.3
 Use additional code for associated:
 arthropathy (711.1)
 renal (functional) (pelvis) (*see also* Disease, kidney) 593.9
 end-stage 585.6

Still's (juvenile rheumatoid arthritis) 714.30

Takayasu's (pulseless) 446.7

Tietze's 733.6

Disorder – *see also* Disease

bone NEC 733.90
 specified NEC 733.99
 bursa 727.9
 shoulder region 726.10
 cartilage NEC 733.90
 ankle 718.07
 elbow 718.02
 foot 718.07
 hand 718.04



hip 718.05
knee 717.9
multiple sites 718.09
pelvic region 718.05
shoulder region 718.01
specified

site NEC 718.08
type NEC 733.99

wrist 718.03

immune mechanism (immunity) 279.9
single component (C11-C99) 279.8
specified type NEC 279.8

metabolism NEC 277.9

with

calcium 275.40
plasma protein 273.9
specified type NEC 273.8

Displacement, displaced

NOTE: For acquired displacement of bones, cartilage, joints, tendons, due to injury, see also Dislocation.

Displacements at ages under one year should be considered congenital, provided there is no indication the condition was acquired after birth.

intervertebral disc (with neuritis, radiculitis, sciatica, or other pain) 722.2
cervical, cervicodorsal, cervicothoracic 722.0

lumbar, lumbosacral 722.10

with myelopathy 722.73

thoracic, thoracolumbar 722.11

Dizziness 780.4

Dyspepsia (allergic) (congenital) (fermentative) (flatulent) (functional) (gastric) (gastrointestinal) (neurogenic) (occupational) (reflex) 536.8

Dystrophy, dystrophia 783.9

sympathetic (posttraumatic) (reflex) 337.20
lower limb 337.22
specific site NEC 337.29
upper limb 337.21

Edema, edematous

connective tissue 782.3
joint (*see also* Effusion, joint) 719.0_
legs 782.3
lower extremities – *see* Edema, legs

Effect, adverse

drugs and medicinal 995.20

Effusion

joint 719.00

Enteritis

regional (of) 555.9

Epicondylitis (elbow) (lateral) 726.32

medial 726.31

Erythema, erythematosis (generalized)

nodosum 695.2

Failure, failed

heart (acute) (sudden) 428.9
congestive (compensated) (decompensated) (*see also* Failure, heart) 428.0

Fasciitis 729.4

plantar 728.71

Fatigue 780.79

Fever 780.60

Fatigue 780.79

chronic, syndrome 780.71

Fibrillation

atrial (established) (paroxysmal) 427.31

Fibromyalgia 729.1

Fibrositis (periarticular) (rheumatoid) 729.0

Findings, (abnormal), without diagnosis (examination) (laboratory tests) 796.4

antibody titers, elevated 795.79



antigen-antibody reaction 795.79

C-reactive protein (CRP) 790.95

crystals, urine 791.9

sedimentation rate, elevated 790.1

skin test, positive 795.79

Fracture (abduction) (adduction) (avulsion)
(compression) (crush) (dislocation) (oblique) (separation)
(closed) 829.0

NOTE: For fracture of any of the following sites with fracture of other bones- see Fracture, multiple.

“Closed” includes the following descriptions of fractures, with or without delayed healing, unless they are specified as open or compound:

comminuted	linear
depressed	simple
elevated	slipped epiphysis
fissured	spiral
greenstick	unspecified

pathologic (unknown) 733.10

ankle 733.16

femur (neck) 733.14

specified NEC 733.15

fibula 733.16

hip 733.14

humerus 733.11

radius (distal) 733.12

specified site NEC 733.19

tibia 733.16

ulna 733.12

wrist 733.12

Gastritis 535.5_

NOTE: Use the following fifth-digit subclassification for category 535:

0	without mention of hemorrhage
1	with hemorrhage

acute 535.0

Gastroenteritis (acute) (catarrhal) (congestive)
(hemorrhagic) (noninfectious) (see also Enteritis) 558.9

Giddiness 780.4

Gout, gouty 274.9

arthritis 274.00

acute 274.01

arthropathy 274.00

acute 274.01

chronic (without mention of tophus (tophi)) 274.02

with tophus (tophi) 274.03

tophi 274.03

ear 274.81

specified site NEC 274.82

Granulomatosis NEC 686.1

Wegener's (necrotizing respiratory) 446.4

Headache 784.0

Hernia, hernial

esophageal hiatus (sliding) 553.3

Hypercholesterolemia

pure 272.0

Hypertension, hypertensive

unspecified 401.9

Hypertrophy, hypertrophic

bone 733.99

prostate, benign 600.00

Hyponatremia 276.1

Hypopotassemia 276.8

Hypothyroidism (acquired) 244.9

Infection, infected, infective

respiratory 519.8

upper (acute) (infectious) NEC 465.9

urinary (tract) NEC 599.0

Insufficiency, insufficient

venous (peripheral) 459.81

Keratoconjunctivitis – (see also Keratitis) 370.40

sicca (Sjögren's syndrome) 710.2

not in Sjögren's syndrome 370.33



Kidney – see condition

Lupus 710.0

- discoid (local) 695.4
- erythematodes (discoid) (local) 695.4
- erythematosus (discoid) (local) 695.4
 - disseminated 710.0
 - systemic 710.0
- nephritis 710.0 [583.81]
 - acute 710.0 [580.81]
 - chronic 710.0 [582.81]

Malaise 780.79

Melena 578.1

Metatarsalgia 726.70

Monoarthritis 716.60

- ankle 716.67
- arm 716.62
 - lower (and wrist) 716.63
 - upper (and elbow) 716.62
- foot (and ankle) 716.67
- forearm (and wrist) 716.63
- hand 716.64
- leg 716.66
 - lower 716.66
 - upper 716.65

- pelvic region (hip) (thigh) 716.65
- shoulder (region) 716.61
- specified site NEC 716.68

Myalgia (intercostals) 729.1

Myositis 729.1

- rheumatic 729.1
- rheumatoid 729.1
- traumatic (old) 729.1

Nausea – (see also Vomiting) 787.02

- with vomiting 787.01

Nephritis, nephritic (albuminuric) (azotemic) (congenital) (degenerative) (diffuse) (disseminated) (epithelial) (familial) (focal) (granulomatous) (hemorrhagic) (infantile) (nonsuppurative, excretory) (uremic) 583.9

lupus 710.0 [583.81]

acute 710.0 [580.81]

chronic 710.0 [582.81]

Neuropathy, neuropathic- (see also Disorder, nerve) 355.9

hereditary 356.9

peripheral 356.0

Osteoarthritis – (see also Osteoarthritis) 715.9_

Osteoarthopathy (see also Osteoarthritis) 715.9_

chronic idiopathic hypertrophic 757.39

familial idiopathic 757.39

hypertrophic pulmonary 731.2

secondary 731.2

idiopathic hypertrophic 757.39

primary hypertrophic 731.2

pulmonary hypertrophic 731.2

secondary hypertrophic 731.2

Osteoarthritis (degenerative) (hypertrophic) (rheumatoid) 715.9_

NOTE: Use the following fifth-digit subclassification with categories 715:

- 0 site unspecified
- 1 shoulder region
- 2 upper arm
- 3 forearm
- 4 hand
- 5 pelvic region and thigh
- 6 lower leg
- 7 ankle and foot
- 8 other specified sites except spine
- 9 multiple sites



generalized 715.0 [0,4,9]

 localized 715.3_

 idiopathic 715.1_

 primary 715.1_

 secondary 715.2_

multiple sites, (not generalized) 715.89

polyarticular 715.09

spine (*see also* Spondylosis) 721.90

temporomandibular joint 524.6

Osteomyelitis (general) (infective) (localized) (neonatal) (purulent) (pyogenic) (septic) (staphylococcal) (streptococcal) (suppurative) (with periostitis) 730.2_ sicca 730.1_

Osteoporosis (generalized) 733.00

Overload

 fluid 276.6

Pain(s) – (*see also* Painful) 780.96

 abdominal 789.0

 chest (central) 786.50

 hand 729.5

 joint 719.40

 ankle 719.47

 elbow 719.42

 foot 719.47

 hand 719.44

 hip 719.45

 knee 719.46

 multiple sites 719.49

 pelvic region 719.45

 shoulder (region) 719.41

 specified site NEC 719.48

 wrist 719.43

 limb 729.5

Palindromic, arthritis – (*see also* Rheumatism, palindromic) 719.3_

Palpitation (heart) 785.1

Paresthesia – (*see also* Disturbance, sensation) 782.0

 Berger's (paresthesia of lower limb) 782.0

Parkinsonism (arteriosclerotic) (idiopathic) (primary) 332.0

Periarthritis (joint) 726.90

 shoulder 726.2

 wrist 726.4

Pharyngitis (acute) (catarrhal) (gangrenous) (infective) (malignant) (membranous) (phlegmonous) (pneumococcal) (pseudomembranous) (simple) (staphylococcal) (subacute) (suppurative) (ulcerative) (viral) 462

Polyarteritis (nodosa) (renal) 446.0

Polyarthralgia 719.49

 psychogenic 306.0

Polyarthritis, polyarthropathy NEC 716.59

 inflammatory 714.9

Polychondritis (atrophic) (chronic) (relapsing) 733.99

Polymyalgia 725

 rheumatica 725

Polymyositis (acute) (chronic)

 (hemorrhagic) 710.4

with involvement of

 lung 710.4 [517.8]

 skin 710.3

Proteinuria – (*see also* Albuminuria) 791.0

Purpura

 Schönlein (-Henoch) (allergic) 287.0

 thrombocytopenic thrombotic 446.6

Radiculitis (pressure) (vertebrogenic) 729.2

 cervical NEC 723.4

 leg 724.4

 lumbar NEC 724.4

 lumbosacral 724.2

 rheumatic 729.2

 thoracic (with visceral pain) 724.4

Radiculopathy – (*see also* Radiculitis) 729.2

Raynaud's

 disease or syndrome (paroxysmal digital cyanosis) 443.0



Retention, retained

fluid 276.6

Rheumatism, rheumatic (acute NEC) 729.0

adherent pericardium 393

arthritis

acute or subacute – *see* Fever, rheumatic

chronic 714.0

spine 720.0

articular (chronic) NEC (*see also* Arthritis)

716.9_

acute or subacute – *see* Fever, rheumatic

back 724.9

blennorrhagic 098.59

carditis – *see* Disease, heart, rheumatic

cerebral – *see* Fever, rheumatic

chorea (acute) – *see* Chorea, rheumatic

chronic NEC 729.0

coronary arteritis 391.9

chronic 398.99

degeneration, myocardium (*see also*

Degeneration, myocardium with

rheumatic fever) 398.0

desert 114.0

gonococcal 098.59

gout 274.00

inflammatory (acute) (chronic) (subacute) *see*

Fever, rheumatic

joint (chronic) NEC (*see also* Arthritis)

716.9_

Rheumatoid – *see also* condition

lung 714.81

Sarcoidosis 135

Sciatica (inflectional) 724.3

due to

displacement of intervertebral disc 722.10

Scleroderma, sclerodermia (acrosclerotic) (diffuse)

(generalized) (progressive) (pulmonary) 710.1

circumscribed 701.0

linear 701.0

localized (linear) 701.0

newborn 778.1

Sclerosis, sclerotic

systemic (progressive) 710.1

Scoliosis (acquired) (postural) 737.30

due to or associated with

osteoporosis (*see also* Osteoporosis)

733.00[737.43]

Spondylitis 720.9

ankylosing (chronic) 720.0

Spondylolisthesis (congenital) (lumbosacral) 756.12

acquired 738.4

degenerative 738.4

traumatic 738.4

Spondylolysis (congenital) 756.11

acquired 738.4

cervical 756.19

lumbosacral region 756.11

Spondylopathy

inflammatory 720.9

Spondylosis 721.90

with

myelopathy NEC 721.91

cervical, cervicodorsal 721.0

with myelopathy 721.1

inflammatory 720.9

lumbar, lumbosacral 721.3

with myelopathy 721.42

thoracic 721.2

with myelopathy 721.41

traumatic 721.7

Sprain, strain (joint) (ligament) (muscle) (tendon) 848.9

ankle 845.00

and foot 845.00

elbow 841.9



foot 845.10
 hand 842.10
 hip 843.9
 and thigh 843.9
 knee 844.9
 and leg 844.9
 old 717.5
 leg 844.9
 and knee 844.9
 low back 846.9
 lumbosacral 846.0

 chronic or old 724.6

Stenosis (cicatricial) – *see also* Stricture

spinal 724.00
 cervical 723.0
 lumbar region, without neurogenic claudication
 724.02
 Lumbar region NOS
 lumbar region, with neurogenic claudication
 724.03
 specified region NEC 724.09
 thoracic, thoracolumbar 724.01

Swelling 782.3

ankle 719.07
 arm 729.81
 extremity (lower) (upper) 729.81
 finger 729.81
 foot 729.81
 hand 729.81
 joint (*see also* Effusion, joint) 719.0
 leg 729.81
 limb 729.81
 muscle (limb) 729.81
 neck 784.2
 pelvis 789.3_
 toe 729.81

Syndrome – *see also* Disease

carpal tunnel 354.0
 de Quervain's 259.51
 eosinophilia myalgia 710.5
 fatigue NEC 300.5
 chronic 780.71
 Felty's (rheumatoid arthritis with
 splenomegaly and leukopenia) 714.1
 Goodpasture's (pneumorenal) 446.21
 irritable bowel 564.1
 nephrotic (*see also* Nephrosis) 581.9
 diabetic 250.4_ [581.81]
 Raynaud's (paroxysmal digital cyanosis) 443.0
 restless leg (RLS) 333.94
 sicca (keratoconjunctivitis) 710.2
 Sjögren (-Gougerot) (keratoconjunctivitis
 sicca) 710.2
 with lung involvement 710.2 [517.8]
 thoracic outlet (compression) 353.0

System, systemic – *see also* condition disease,
 combined – *see* Degeneration, combined
 lupus erythematosus 710.0

Takayasu (-Onishi) disease or syndrome (pulseless
 disease) 446.7

Tendinitis, tendonitis – (*see also* Tenosynovitis) 726.90

calcific 727.82
 shoulder 726.11
 pes anserinus 726.61
 trochanteric 726.5

Tenosynovitis (*see also* Synovitis) 727.00

 bicipital (calcifying) 726.12

Thrombosis, thrombotic (marantic) (multiple)
 (progressive) (vein) (vessel) 453.9



Tietze's disease or syndrome 733.6

Trigger finger (acquired) 727.03

congenital 756.89

Ulcer, ulcerated, ulcerating, ulceration, ulcerative

707.9

peptic (site unspecified) 533.9

NOTE: Use the following fifth-digit subclassification with categories 531 – 534:

0 without mention of obstruction

1 with obstruction

Vasculitis 447.6

Weight

gain (abnormal) (excessive) 783.1

loss (cause unknown) 783.21

-
- (a) ICD-9-CM codes must be listed in priority order. Narrative descriptions of diagnoses will not suffice.
 - (b) ICD-9-CM codes must be recorded at the highest level of specialty.
 - (c) Nonspecific codes may be appropriate for an initial visit for a problem but greater specificity, if known should be coded. Try to minimize use of .8 or .9 unless additional information is not available.
 - (d) An underline () indicates the diagnosis requires a fifth digit which should be identified to indicate site of involvement.
 - (e) "And" indicates that an additional code is required for the diagnosis.
 - (f) For diagnoses not listed, refer to ICD-9-CM, Ninth Revision, Vols. 1 and 2.
 - (g) **BOLD** and *Italic* represents new and revised ICD-9-CM codes.



HCPSC Codes for Rheumatology

A list has been compiled of the most common ICD-9 and HCPSC codes. Please take the time to review this list it can be a quick reference guide to assist in coding claims correctly. All new CPT®/HCPSC are effective. Please be certain you are using the most updated information. All deleted codes should be discontinued.

J0129	Injection, abatacept, 10mg - *96413
J0718	Injection, certolizumab pegol, 1 mg - *96372
J1020	Depomedral, injection, methylprednisolone acetate, 20mg - *96372, 96373
J1030	Depomedral, injection, methylprednisolone acetate, 40mg- *96372, 96373
J1040	Depomedral, injection, methylprednisolone acetate, 80mg - *96372, 96373
J1200	Diphenhydramine (Benadryl), injection, up to 50mg - *96372, 96373
J1740	ibandronate sodium (IV Boniva), 1mg - *96374, 96375
J1745	Infliximab (Remicade), injection, 10mg - *96413, 96415
J3488	Injection, zoledronic acid (Reclast), 1mg - *96365
J2430	Pamidronate disodium (Aredia), 30mg - *96365, 96366
J2920	Methylprednisolone (Solu-Medrol) - *96374, 96375
J2930	Methylprednisolone (Solu-Medrol) - *96374, 96375
J7030	Normal saline solution infuse, 1000cc - *96360, 96361
J7040	Normal saline solution infuse, 500mL - *96360, 96361
J7042	5% dextrose/normal saline, 500mL - *96360, 96361
J7050	Normal saline solution infuse, 250cc - *96360, 96361
J7051	Sterile saline/water, 5cc - *96360, 96361
J7321	Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose - *20610
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose - *20610
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose - *20610
J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, per dose - *20610



J9070	Cyclophosphamide, 100mg - *96413, 96415
J9080	Cyclophosphamide, 200mg - *96413, 96415
J9090	Cyclophosphamide, 500mg - *96413, 96415
J9091	Cyclophosphamide, 1g - *96413, 96415
J9092	Cyclophosphamide, 2g - *96413, 96415
J9093	Cyclophosphamide, lyophilized, 100mg - *96413, 96415
J9094	Cyclophosphamide, lyophilized, 200mg - *96413, 96415
J9250	Methotrexate sodium injection, 5mg - *96041
J9260	Methotrexate sodium injection, 50mg - *96401
J9310	Injection, rituximab (RituXan), 100mt - *96413



Chapter Eight

Resource-Based Relative Value Scale

In 1992, the Resource-Based Relative Value Scale was put into place. This system is a way to compare the relative work of a large number of medical episodes to one another. The RBRVS is the payment scale used by Medicare. And by using the formula below, a physician can determine how much Medicare will reimburse for a physician services.

The American Medical Associates created the Relative Value Update Committee. The RUC is compiled of 26 voting specialties that are in charge of processing the value of 7,000+ CPT® codes, along with assigning value to new codes. This is done by assigning a relative value unit on each code.

The Medicare payment schedule's impact on a physician's Medicare payments is primarily a function of three key factors:

- The resource-based relative value scale
 - This is where physicians can find their states RVU – they are in three parts:
 1. Work
 2. Physician expense
 3. Malpractice expense
 - Members can find their states RVU on our website at www.rheumatology.org/practice.
- The geographic practice cost indexes – they are in three parts:
 1. Work
 2. Physician expense
 3. Malpractice expense
 - Members can find their states GPCI at www.rheumatology.org/practice.



- The monetary conversion factor - the formula for calculating Medicare payments is:

Non-Facility Pricing Amount =

$[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Transitioned Non-Facility PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})] \times \text{Conversion Factor}$

Facility Pricing Amount =

$[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Facility PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})] \times \text{Conversion Factor}$

Conversion Factor for 2010 = \$36.0846

Example: 99214 for Alabama for non-facility

$$1.50 \times 0.982 = 1.473$$

$$1.15 \times 0.853 = 0.98095$$

$$0.08 \times 0.496 = 0.03968$$

$$1.473 + 0.98095 + 0.03968 = 2.49363 \times \$36.0846 = \$89.98$$

Average Sales Price

The Average Sales Price is the manufacturer's reporting of the country's average sale prices on drugs. The ASP data is reported quarterly. Medicare ASP fee schedule is the average sale price plus six percent. A list of drugs most commonly used by rheumatologists is available at www.rheumatology.org/practice.



Chapter Nine

Physician Quality Reporting Initiative

The 2006 Tax Relief and Health Care Act (P.L. 109-432) requires the founding of a physician quality reporting system. This program includes an incentive payment for eligible professional who suitably report data on quality measures for covered professional services performed on Medicare indemnity beneficiaries.

Starting January 1 of every year physicians can start reporting PQRI measures. There are a total of 175 PQRI measures, 20 measures of which affect rheumatology practices. The incentive bonus pay for successfully reporting will be two percent of the allowable Medicare Part B Fee for Service with no cap.

As stated before there are a total of 20 PQRI measures that affect rheumatology:

- 24 – (OP): Communication with the Physician Managing Ongoing Care Post Fracture
- 39 – (OP): Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
- 40 – (OP): Osteoporosis: Management Following Fracture
- 41 – (OP): Pharmacologic Therapy
- 108 – Rheumatoid Arthritis (RA): Disease Modifying Anti-rheumatic Drug Therapy in Rheumatoid Arthritis
- 109 – Osteoarthritis (OA): Function and Pain Assessment
- 124 – Health Information Technology (HIT): Adoption/Use of Electronic Health Information (EHR)
- 131 – Pain Assessment Prior to Initiation of Patient Therapy and Follow-up
- 142 – Osteoarthritis (OA): Assessment for Use of Anti-inflammatory or Analgesic Over-the Counter (OTC) Medications
- 148 – Back Pain: Initial Visit
- 149 – Back Pain: Physical Exam
- 150 – Back Pain: Advice for Normal Activities
- 151 – Back Pain: Advice Against Bed Rest
- 154 – Falls: Risk Assessment
- 155 – Falls: Plan of Care
- 176 – Rheumatoid Arthritis (RA): Tuberculosis Screening



- 177 – Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
- 178 – Rheumatoid Arthritis (RA): Functional Status Assessment
- 179 – Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
- 180 – Rheumatoid Arthritis (RA): Glucocorticoid Management

Currently there are two options of reporting PQRI: registry or claims-based. The registry-based reporting registration can be found at www.rheumatology.org/practice. Claims-based reporting can be either individual measures or for measures groups.

Individual Measures Reporting Options

Registry-Based – Rheumatology Clinical Registry: (Options for Mid-Year PQRI Start)

- Successfully report three or more measures for a minimum of 80 percent of applicable Medicare Part B FFS patients between January 1 - December 31
- or -
- Successfully report three or more measures for a minimum of 80 percent of applicable Medicare Part B FFS patients between July 1 - December 31

Claims-Based: (January 1 Start Date)

- Successfully report three or more measures for a minimum of 80 percent of applicable Medicare Part B FFS patients between July 1 - December 31

Measures Group Reporting Options (Including RA)

The Measures Group-based measure that would affect rheumatologists is the Rheumatoid Arthritis Measure Group and the Back Pain Measure Group. The RA Measure Group includes six measures:

- 108 – Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy
- 176 – Tuberculosis Screening
- 177 – Periodic Assessment of Disease Activity
- 178 – Functional Status Assessment
- 179 – Assessment and Classification of Disease Prognosis
- 180 – Glucocorticoid Management



The Back Pain Measure Group is the only measure group that has measures that cannot be reported as individual measures. The Back Pain Measure Group contains four measures:

- 148 – Back Pain: Initial Visit
- 149 – Back Pain: Physical Exam
- 150 – Back Pain: Advice for Normal Activities
- 151 – Back Pain: Advice Against Bed Rest

Registry-Based – Rheumatology Clinical Registry: (Options for Mid-Year PQRI Start)

- Successfully report on a minimum of 30 patients in the group between January 1 - December 31 (Medicare and non-Medicare patients allowed; must have at least two Medicare patients)

OR choose one of the following two options:

- Successfully report on a minimum of 80 percent of patients in the group with a minimum of 30 patients January 1 - December 31 (Medicare patients only)
- or -
- Successfully report on a minimum of 80 percent of patients in the group with a minimum of 15 patients between July 1 - December 31 (Medicare patients only)

NOTE: For reporting options that include a minimum 80 percent requirement, this means that providers must report successfully for at least 80 percent of their patients to which the measure applies in the given time period. Providers who choose to report on only 80 percent of their patient population for a certain measure must, therefore, report with complete accuracy. Because this would allow no room for error without losing the entire incentive payment, CMS recommends that providers report on more than 80 percent of their patient population for each measure, whenever possible, even up to 100 percent.

Claims-based: (January 1 start date)

- Successfully report on a minimum of 30 consecutive patients in the group between January 1 - December 31 (Medicare patients only)
- or -
- Successfully report on a minimum of 80 percent of patients in the group with a minimum 30 patients between January 1 - December 31 (Medicare patients only)



Claims-based: (July 1 start date)

- Successfully report on a minimum of 80 percent of patients in the group with a minimum 15 patients between July 1 - December 31 (Medicare patients only)

NOTE: The following option is still available for mid-year start: Successfully report on a minimum of 30 consecutive patients in the group whose visits took place at any time in the calendar year (Medicare patients only).

Exclusions

Exclusion modifiers may be appended to a CPT® II code (on a claim) OR within a registry to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. These modifiers serve as denominator exclusions for the purpose of measuring performance. Some measures do not provide for performance exclusions.

Reasons for appending a performance measure exclusion modifier fall into one of four categories:

1P exclusion modifier due to medical reasons

Examples include: not indicated (absence of organ/limb, already received/performed); contraindicated (patient allergic history, potential adverse drug interaction)

2P exclusion modifier due to patient reasons

Examples include: patient declined; economic, social, or religious reasons

3P exclusion modifier due to system reasons

Examples include: resources to perform the services not available; insurance or coverage/payer-related limitations; other reasons attributable to health care delivery system

8P reporting modifier - action not performed, reason not otherwise specified



Chapter Ten

Sample Letters

The ACR has written many letters over the years to aid practices with insurance appeals and denials. The letters can be located on the ACR website at www.rheumatology.org/practice.

List of sample letters include:

- Medical necessity for infliximab
- Modifier- 25 denial
- MRI letter
- Frequent documentation requests
- Frequent medical records request
- Denial of biologics
- E/M level 4 letter
- Lab Panels
- Infusion denials
- VFA
- Peer-review for rituximab
- Infliximab used for AS
- Restriction of performing DEXA
- Anti-CCP
- Bundling drugs in with procedure
- Denial of ibandronate
- Allowable for infliximab after failed treatment
- Denial of TB test

Sample Forms

Over the years our members have used forms for their practice that aid them in performing their day-to-day duties in their office. Some of our members have been gracious enough to share forms for your use. The forms are available online at www.rheumatology.org/practice.

Sample Advance Notice to Beneficiary (General and Laboratory Use)

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**NOTE:** If Medicare doesn't pay for (D) _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) _____ below.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS:**Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the (D) _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the (D) _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the (D) _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:

(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08)

Form Approved OMB No. 0938-0566



Appendix B

Medicare Part B Carriers

ALABAMA

Cahaba Government Benefits Administrators (GBA)

PO Box 13384
Birmingham, AL 35205-3384
Phone: 205-220-1214
Fax: 205-220-1218
www.cahabagba.com

ALASKA

Noridian Administrative Services, LLC

7525 NE Ambassador Place, Ste B
Portland, OR 97220
Phone: 503-944-8810
Fax: 503-944-8814
www.noridianmedicare.com

ARIZONA

Noridian Administrative Services, LLC

8920 N 23rd Ave, Ste #1
Phoenix, AZ 85021
Phone: 602-749-2506
Fax: 602-749-2550
www.noridianmedicare.com

ARKANSAS

Pinnacle Business Solutions, Inc.

515 West Pershing Blvd
North Little Rock, AR 72114
Phone: 501-210-0703
Fax: 501-210-0756
www.pinnaclemedicare.com

CALIFORNIA

Palmetto GBA

PO Box 1476 Medical Review Part B
Augusta, GA 30903-1476
Phone: 310-476-5760
Fax: 803-462-3918
www.palmettogba.com

COLORADO

Trailblazer Health Enterprises, Inc.

8330 LBJ Freeway, Exec Center III
Dallas, TX 75243-1213
Phone: 469-372-6074
Fax: 469-372-2649
www.trailblazerhealth.com

CONNECTICUT

National Government Services, Inc.

P.O. Box 4767
Syracuse, NY 13221-4767
Phone: 914-801-3567
Fax: 914-801-3600
www.ngsmedicare.com

DELAWARE

Highmark Medicare Services

120 Fifth Avenue, Ste P5101
Pittsburgh, PA 15222-3099
Phone: 412-544-1931
Fax: 412-544-1971
www.highmarkmedicareservices.com



DISTRICT OF COLUMBIA

Highmark Medicare Services
120 Fifth Avenue, Ste P5101
Pittsburgh, PA 15222-3099
Phone: 412-544-1931
Fax: 412-544-1971
www.highmarkmedicareservices.com

FLORIDA

First Coast Service Options, Inc.
532 Riverside Avenue 20T
Jacksonville, FL 32202
Phone: 904-791-8211
Fax: 904-361-0327
www.medicare.fcso.com

GEORGIA

Cahaba Government Benefits Administrators (GBA)
P.O. Box 13384
Birmingham, AL 35205-3384
Phone: 205-220-1214
Fax: 205-220-1218
www.cahabagba.com

HAWAII

Palmetto GBA
PO Box 1476 Medical Review Part B
Augusta, GA 30903-1476
Phone: 310-476-5760
Fax: 803-462-3918
www.palmettogba.com

IDAHO

CIGNA Government Services
Two Vantage Way RTG 576
Nashville, TN 37228
Phone: 615-782-4565
Fax: 615-782-4480
www.cignagovernmentservices.com

ILLINOIS

Wisconsin Physician Services Corp
111 East Wacker Drive, Ste. 950
Chicago, IL 60601
Phone: 312-228-6254
Fax: 312-228-6280
www.wpsic.com

INDIANA

National Government Services
8115 Knue Road, INA102-AF10
Indianapolis, IN 46250
Phone: 317-841-4607
Fax: 317-841-4600
www.ngsmedicare.com

IOWA

Wisconsin Physician Services
111 East Wacker Drive, Ste. 950
Chicago, IL 60601
Phone: 312-228-6254
Fax: 312-228-6280
www.wpsic.com

**KANSAS**

Wisconsin Physician Services

111 East Wacker Drive, Ste. 950

Chicago, IL 60601

Phone: 312-228-6254

Fax: 312-228-6280

www.wpsic.com

KENTUCKY

National Government Services, Inc

8115 Knue Road, INA102-AF10

Indianapolis, IN 46250

Phone: 317-841-4607

Fax: 317-841-4600

www.ngsmedicare.com

LOUISIANA

Pinnacle Business Solutions, Inc.

515 West Pershing Blvd

North Little Rock, AR 72114

Phone: 501-210-0703

Fax: 501-210-0756

www.pinnaclemedicare.com

MAINE

National Heritage Insurance Company

75 Sgt. William B. Terry Drive

Hingham, MA 02043

Phone: 781-741-3122

Fax: 781-741-3211

www.medicarenhic.com

MARYLAND

Highmark Medicare Services

120 Fifth Avenue, Ste P5101

Pittsburgh, PA 15222-3099

Phone: 412-544-1931

Fax: 412-544-1971

www.highmarkmedicareservices.com

MASSACHUSETTS

National Heritage Insurance Company

75 Sgt. William B. Terry Drive

Hingham, MA 02043

Phone: 781-741-3122

Fax: 781-741-3211

www.medicarenhic.com

MICHIGAN

Wisconsin Physician Services

111 East Wacker Drive, Ste 950

Chicago, IL 60601

Phone: 312-228-6254

Fax: 312-228-6280

www.wpsic.com

MINNESOTA

Wisconsin Physician Services

111 East Wacker Drive, Ste 950

Chicago, IL 60601

Phone: 312-228-6254

Fax: 312-228-6280

www.wpsic.com



MISSISSIPPI

Cahaba Government Benefits Administrators (GBA)

PO Box 13384
Birmingham, AL 35205-3384
Phone: 205-220-1214
Fax: 205-220-1218
www.cahabagba.com

MISSOURI

Wisconsin Physician Services

111 East Wacker Drive, Ste. 950
Chicago, IL 60601
Phone: 312-228-6254
Fax: 312-228-6280
www.wpsic.com

MONTANA

Noridian Administrative Services, LLC

8920 N 23rd Ave, Ste #1
Phoenix, AZ 85021
Phone: 602-749-2506
Fax: 602-749-2550
www.noridianmedicare.com

NEBRASKA

Wisconsin Physician Services

111 East Wacker Drive, Ste. 950
Chicago, IL 60601
Phone: 312-228-6254
Fax: 312-228-6280
www.wpsic.com

NEVADA

Palmetto GBA

PO Box 1476 Medical Review Part B
Augusta, GA 30903-1476
Phone: 310-476-5760
Fax: 803-462-3918
www.palmettogba.com

NEW HAMPSHIRE

Highmark Medicare Services

120 Fifth Avenue, Ste. P5101
Pittsburgh, PA 15222-3099
Phone: 412-544-1931
Fax: 412-544-1971
www.highmarkmedicareservices.com

NEW JERSEY

National Government Services

120 Fifth Avenue, Ste. P5101
Pittsburgh, PA 15222-3099
Phone: 412-544-1931
Fax: 412-544-1971
www.highmarkmedicareservices.com

NEW MEXICO

TrailBlazer Health Enterprises, LLC

8330 LBJ Freeway, Exec Center III
Dallas, TX 75243-1213
Phone: 469-372-6074
Fax: 469-372-2649
www.trailblazerhealth.com

**NEW YORK**

National Government Services, Inc.
P.O. Box 4767
Syracuse, NY 13221-4767
Phone: 914-801-3567
Fax: 914-801-3600
www.ngsmedicare.com

NORTH CAROLINA

CIGNA Government Services
4135 Mendenhall Oaks Parkway
High Point, NC 27256
Phone: 336-821-4511
Fax: 336-821-4591
www.cignagovernmentservices.com

NORTH DAKOTA

Noridian Administrative Services, LLC
8920 N 23rd Ave, Ste. #1
Phoenix, AZ 85021
Phone: 602-749-2506
Fax: 602-749-2550
www.noridianmedicare.com

OHIO

Palmetto GBA
4249 Easton Way, Ste. 400
Columbus, OH 43219
Phone: 614-473-6424
Fax: 614-473-6204
www.palmettogba.com

OKLAHOMA

Trailblazer Health Enterprises, LLC
8330 LBJ Freeway, Exec Center III
Dallas, TX 75243-1213
Phone: 469-372-6074
Fax: 469-372-2649
www.trailblazerhealth.com

OREGON

Noridian Administrative Services, LLC
7525 NE Ambassador Place, Ste. B
Portland, OR 97220
Phone: 503-944-8810
Fax: 503-944-8814
www.noridianmedicare.com

PENNSYLVANIA

Highmark Medicare Services
120 Fifth Avenue, Ste. P5101
Pittsburgh, PA 15222-3099
Phone: 412-544-1931
Fax: 412-544-1971
www.highmarkmedicareservices.com

PUERTO RICO

First Coast Service Options, Inc.
532 Riverside Avenue 20T
Jacksonville, FL 32202
Phone: 904-791-8211
Fax: 904-361-0327
www.medicare.fcso.com



RHODE ISLAND

National Heritage Insurance Company

75 Sgt. William B. Terry Drive
Hingham, MA 02043
Phone: 781-741-3122
Fax: 781-741-3211
www.medicarenhic.com

SOUTH CAROLINA

Palmetto GBA
P.O. Box 100190, AG-300
Columbia, SC 29202-3190
Phone: 803-763-5059
Fax: 803-935-0199
www.palmettogba.com

SOUTH DAKOTA

Noridian Administrative Services, LLC
8920 N 23rd Ave, Ste. #1
Phoenix, AZ 85021
Phone: 602-749-2506
Fax: 602-749-2550
www.noridianmedicare.com

TENNESSEE

Cahaba Government Benefits Administrators (GBA)
P.O. Box 13384
Birmingham, AL 35205-3384
Phone: 205-220-1214
Fax: 205-220-1218
www.cahabagba.com

TEXAS

Trailblazer Health Enterprises, Inc.
8330 LBJ Freeway, Exec Center III
Dallas, TX 75243-1213
Phone: 469-372-6074
Fax: 469-372-2649
www.trailblazerhealth.com

UTAH

Noridian Administrative Services, LLC
8920 N 23rd Ave, Ste. #1
Phoenix, AZ 85021
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Fax: 602-749-2550
www.noridianmedicare.com

VERMONT

National Heritage Insurance Company
75 Sgt. William B. Terry Drive
Hingham, MA 02043
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Fax: 781-741-3211
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VIRGIN ISLANDS

First Coast Service Options, Inc.
532 Riverside Avenue 20T
Jacksonville, FL 32202
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WASHINGTON

Noridian Administrative Services, LLC
7525 NE Ambassador Place, Ste. B
Portland, OR 97220
Phone: 503-944-8810
Fax: 503-944-8814
www.noridianmedicare.com

WEST VIRGINIA

Palmetto GBA
4249 Easter Way
Columbus, OH 43219
www.palmettogba.com

WISCONSIN

Wisconsin Physician Services
111 East Wacker Drive, Ste. 950
Chicago, IL 60601
Phone: 312-228-6254
Fax: 312-228-6280
www.wpsic.com

WYOMING

Noridian Administrative Services, LLC
8920 N 23rd Ave, Ste. #1
Phoenix, AZ 85021
Phone: 602-749-2506
Fax: 602-749-2550
www.noridianmedicare.com



Appendix C

Centers for Medicare and Medicaid Services Regional Offices

If you have difficulties with the Medicare carrier which seems unresolvable through direct communication with the carrier and/or through interaction between the Committee on Rheumatologic Care or a medical society liaison, you may want to report your concerns to the appropriate regional office of the Centers for Medicare and Medicaid Services. The addresses of the 10 CMS regional offices across the country are listed below.

Region I – Boston

(Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont)

Associate Regional Administrator
CMS
Program Operations
John F. Kennedy Federal Building
Room 2325
Boston, MA 02203
617-565-1282

Region II – New York

(New Jersey, New York, Puerto Rico, US Virgin Islands)

Association Regional Administrator
CMS
Program Operations
Jacob K. Javits Federal Building
26 Federal Plaza, 38th Floor
New York, NY 10278
212-616-2519

Region III – Philadelphia

(Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia)

Associate Regional Administrator
CMS
Public Ledger Building, Suite 216
150 S. Independence Mall West
Philadelphia, PA 19106
215-861-4097

**Region IV – Atlanta**

(Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, Tennessee)

Associate Regional Administrator

CMS

Program Operations

Atlanta Federal Center

61 Forsyth Street, SW, Suite 4T20

Atlanta, GA 30303

404-562-7379

Region V – Chicago

(Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)

Associate Regional Administrator

CMS

Program Operations

233 North Michigan Avenue, Suite 600

Chicago, IL 60601

312-886-3642

Region VI – Dallas

(Arkansas, Louisiana, New Mexico, Oklahoma, Texas)

Associate Regional Administrator

CMS

Program Operations

1301 Young Street, Suite 714

Dallas, TX 75202

214-767-6444

Region VII – Kansas City

(Iowa, Kansas, Missouri, Nebraska)

Associate Regional Administrator

CMS

Program Operations

Richard Bolling Federal Building

601 East 12th Street, Room 235

Kansas City, MO 64106

816-426-6538



Region VIII – Denver

(Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming)

Associate Regional Administrator

CMS

Federal Office Building

Colorado State Bank Building

1600 Broadway, Suite 700

Denver, CO 80202

303-844-6538

Region IX – San Francisco

(American Samoa, Arizona, California, Guam, Hawaii, Nevada, Common Wealth of the Northern Mariana Islands)

Associate Regional Administrator

CMS

Program Operations

75 Hawthorne Street, Suite 408

San Francisco, CA 94105

415-744-3501

Region X – Seattle

(Alaska, Idaho, Oregon, Washington)

Associate Regional Administrator

CMS

Program Operations

2201 Sixth Avenue, MS-40

Seattle, WA 98121

206-615-2315