Health Care Telemedicine WV Perinatal

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Disclaimer

- The information contained herein is correct as of the time of preparation and the resources available. Most resources used are developed by the AMA, Medicaid, Medicare and other coding resources. The preparer hopes that the information included in this document provides an adequate edification on telehealth CPT, HCPCS and ICD9 – CM coding, in addition to billing and reimbursement information.

Definitions -- Medicaid

- **Telemedicine** – use of medical information exchanged from one site to another via electronic communications to improve a patient's health.
- **Electronic communication** – the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distance site.
- **Distant or Hub Site** – site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.
- **Originating or Spoke Site** – the location of the Medicaid patient at the time the service being furnished via a telecommunications system occurs.
- **Telehealth** – use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

Additional Telehealth Services for 2011

- Office or Other Outpatient Services
- Subsequent Hospital Care Services (with limitation of one telehealth visit every 3 days)
- Subsequent nursing facility care services (not including the Federally-mandated periodic visits under 483.40(c) and with the limitation of one telehealth visit every 30 days)
- Professional Consultations
- Psychiatric diagnostic interview examination
- Neurobehavioral status exam

Additional Telehealth Services for 2011 Reg 410.78

- Individual psychotherapy
- Pharmacologic management
- ESRD related services included in the capitation amount (KDE)
- Individual and group medical nutrition therapy (MNT) services
- Individual and group kidney disease education services
- Individual and group diabetes self management (DSMT) training services

RBRVS Reimbursement Formula

- The formula for 2011 physician fee schedule payment amount is as follows:

2011 Non-Facility Pricing Amount =

- [(Work RVU * Work GPCI) +
- (Transitioned Non-Facility PE RVU * PE GPCI) +
- (MP RVU * MP GPCI)] * Conversion Factor (CF)

2011 Facility Pricing Amount =

- [(Work RVU * Work GPCI) +
- (Transitioned Facility PE RVU * PE GPCI) +
- (MP RVU * MP GPCI)] * Conversion Factor

Reimbursement – Medicaid – Office and OP Visits

Code	Description	2011 Allowance Non-Facility	2011 Allowance Facility
99201	New patient (Level 1)	28.29	17.87
99202	New patient (Level 2)	48.89	34.25
99203	New patient (Level 3)	71.48	52.61
99204	New patient (Level 4)	110.94	89.35
99205	New patient (Level 5)	137.99	114.66
99211	Established patient (Level 1)	13.15	6.20
99212	Established patient (Level 2)	28.29	17.62
99213	Established patient (Level 3)	47.40	34.49
99214	Established patient (Level 4)	70.98	53.11
99215	Established patient (Level 5)	95.80	75.20

Reimbursement – Medicaid – Office, Outpatient & Inpatient Consultations

Code	Description	Non-facility	Facility
99241	Office/OP Consultation (Level 1)	32.01	22.33
99242	Office/OP Consultation (Level 2)	61.05	47.65
99243	Office/OP Consultation (Level 3)	83.64	66.51
99244	Office/OP Consultation (Level 4)	123.60	104.98
99245	Office/OP Consultation (Level 5)	151.40	130.55
99251	IP Consultation (Level 1)	33.01	33.01
99252	IP Consultation (Level 2)	51.37	51.37
99253	IP Consultation (Level 3)	77.93	77.93
99254	IP Consultation (Level 4)	112.43	112.43
99255	IP Consultation (Level 5)	136.01	136.01

Reimbursement – Medicaid – Inpatient/Subsequent Visits

Code	Description	Allowance
99221	Inpatient visit (Level 1)	68.75
99222	Inpatient visit (Level 2)	93.32
99223	Inpatient visit (Level 3)	137.00
99231	Subsequent visit (Level 1)	26.80
99232	Subsequent visit (Level 2)	48.64
99233	Subsequent visit (Level 3)	69.99

Reimbursement – Medicaid – Vaginal Delivery

Code	Description	Allowance Non-Facility	Allowance Facility
59400	Global vaginal delivery	1,381.23	1,381.23
59409	Vaginal delivery only	845.50	845.50
59410	Vaginal delivery including postpartum care	1,071.14	1,071.14
59412	External cephalic version, w/ or w/o tocolysis	107.65	107.65
59414	Delivery of placenta	97.69	97.69
59425	Antepartum care only; 4-6 visits	469.68	368.92
59426	Antepartum care only; 7 visits	838.60	651.27
59430	Postpartum care only	174.31	145.19

Reimbursement -- Medicaid

Code	Description	Allowance Non-facility	Allowance Facility
97804	Medical Nutrition Therapy – MNT group	9.43	9.43
96153	Health and Behavior intervention – HABI --group	2.97	2.73
96154	Health and Behavior intervention – HABI -- family	13.15	12.90

Reimbursement – Medicaid – HCPCS Codes

Code	Description	2011 Allowance
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	37.97
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes	12.65
G0420	Face to face educational services related to the care of chronic kidney disease; individual, per session, per one hour	0.00
G0421	Face to face educational services related to the care of chronic kidney disease; group, per session, per one hour	0.00
Q3014	Telehealth originating site facility fee	$24.10
T1014	Telehealth transmission, per minute, professional services bill separately	0.00

Reimbursement Obstetric Ultrasounds

CPT Code	Description	Medicaid Allowance
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation	Comp = 88.85 TC= 54.60 26=33.75
+76802	Each additional gestation (List separately in addition to code for primary procedure)	Comp =48.15 TC= 19.35 26= 28.29
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal or maternal evaluation, after first trimester(>14 weeks 0 days), transabdominal approach; single or first gestation	Comp = 101.51 TC= 67.26 26= 33.75
+76810	Each additional gestation (List separately in addition to code for primary procedure)	Comp = 67.01 TC= 33.25 26= 33.50

Reimbursement Obstetric Ultrasounds

CPT Code	Description	Medicaid Allowance
76811	Ultrasound, pregnant uterus, real time image documentation, fetal and maternal evaluation plus detailed fecal anatomic examination, transabdominal approach; single or first gestation	Comp =132.04 TC= 67.01 26= 65.02
+76812	Each additional gestation (List separately in addition to code for primary procedure)	Comp =140.23 TC=78.92 26=61.30
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation	Comp =86.87 TC=46.41 26=40.45
+76814	Each additional gestation (List separately in addition to code for primary procedure)	Comp =55.84 TC=21.84 26=33.75

Reimbursement Obstetric Ultrasounds

CPT Code	Description	Medicaid Allowance
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume): 1 or more fetuses	Comp = 62.05 TC=40.20 26=21.59
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus	Comp =79.92 TC=50.38 26=29.03

Reimbursement Obstetric Ultrasounds

CPT Code	Description	Medicaid Allowance
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	Comp =70.48 TC=44.42 26=25.56
76818	Fetal biophysical profile; with non-stress testing	Comp =83.64 TC=47.40 26=35.98
76819	Fetal biophysical profile; without non-stress testing	Comp =63.04 TC=36.23 26=26.55
76820	Doppler velocimetry, fetal; umbilical artery	Comp =31.76 TC=14.89 26=16.87
76821	Doppler velocimetry, fetal; middle cerebral artery	Comp =66.51 TC=41.94 26=24.07

Reimbursement Obstetric Ultrasounds

CPT Code	Description	Medicaid Allowance
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;	Comp =147.92 TC=90.84 26=56.83
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study	Comp =85.38 TC=56.83 26=28.29
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete	Comp =45.17 TC=25.81 26=19.35
76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study	Comp =33.50 TC=14.39 26=18.86

Non-Obstetric Ultrasounds

CPT Code	Description	Medicaid Allowance
76830	Ultrasound, transvaginal	Comp =84.88 TC=61.05 26=23.57
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed	Comp =85.13 TC=60.31 26=24.57
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	Comp =84.63 TC=60.80 26=23.57
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	Comp =68.75 TC=54.85 26=13.40

Modifiers

- GQ – Via asynchronous telecommunications system
- GT – Via interactive audio and video telecommunication systems

ICD9-CM

- ICD9 = International Classification of Diseases 9th Revision, Clinical Modification
- All claims must have an ICD9 code
- Guidelines – general or chapter specific
- Code to highest level of specificity

Secondary Diabetes Mellitus

ICD9-CM Code	Description
249	Secondary Diabetes Mellitus
249.0 (5th digit req)	Secondary diabetes mellitus without mention of complication
249.2 (5th digit req)	Secondary diabetes mellitus with ketoacidosis
249.4 (5th digit req)	Secondary diabetes mellitus with renal manifestations
249.5 (5th digit req)	Secondary diabetes mellitus with ophthalmic manifestations
249.8 (5th digit req)	Secondary diabetes mellitus with other specified manifestations

Diabetes Mellitus

ICD9-CM Code	Description
250	Diabetes Mellitus
250.0 (5th Digit req)	Diabetes mellitus without mention of complication
250.1 (5th Digit req)	Diabetes mellitus with ketoacidosis
250.4 (5th digit req)	Diabetes with renal manifestations
250.5 (5th digit req)	Diabetes with ophthalmic manifestations

Gestational Diabetes

ICD9 CM Code	Description
648	Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth or the puerperium
648.0	Diabetes mellitus
648.8	Abnormal glucose tolerance
V58.67	Long-term (current) use of insulin

ICD-10 CM Effective 10-1-2013

- Training/Review of Records
- Electronic Transaction 5010 1-1-2012
- Volume of Codes today versus tomorrow
- Codes are alpha-numeric
- Up to seven positions
- Mapping

Version Comparison

ICD-9 CM

Code
V58.67
648.81

ICD-10

Code	Description
Z79.4	Long term (current) use of insulin
O24.419	Gestational diabetes mellitus in pregnancy, unspecified controlled
O24.429	Gestational diabetes mellitus, in childbirth, unspecified control

Version Comparison

ICD 9

Code
648.81 continued
648.00

ICD 10

Code	Description
O99.810	Abnormal glucose complicating pregnancy
O99.814	Abnormal glucose complicating pregnancy
O24.319	Unspecified pre-existing diabetes mellitus in pregnancy, unspecified trimester

Version Comparison

ICD9

Code
250.50

ICD10

Code	Description
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema

Version Comparison

ICD 9

Code
250.50 continued

ICD 10

Code	Description
E11.36	Type 2 diabetes mellitus with diabetic cataract
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication

Documentation

- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
- The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Documentation

- Principles of documentation are applicable to all types of medical and surgical services in all settings
  - The medical record should be complete and legible.
  - The documentation for each patient encounter should include:
    - Reason for the encounter and relevant history,
    - Physical examination findings
    - Prior diagnostic test results
    - Assessment, clinical impression, or diagnosis
    - Plan for care
    - Date and legible identity of the observer

Documentation

- Comorbidities/underlying diseases or other factors that increase the complexity of medical decision-making by increasing the risk of complications, morbidity, and/or mortality are documented.
- If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure, eg, laparoscopy, are documented.
- If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure is documented.
- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis are documented or implied.

Documentation

- Steps involved in accurate documentation and operative report coding include
  - Detailed dictation by the physician
  - A complete operative report prepared by the medical transcriptionist and correct interpretation by the coder
  - Reporting what was actually done, avoiding codes based on reimbursement value
  - Recognizing that coding is not only a reimbursement tool used by payers, but also a documentation tool that is part of the patient's medical history
  - A written account of the history, diagnosis, and procedures performed

Top Coding & Documentation Errors

- The service is upcoded one level
  - Documentation in the chart does not support the level of services
- The service is downcoded
  - Documentation in the chart supports a higher level of service
- CC or reason for the visit is missing from the note
- Assessment is not always clearly documented
  - Coders cannot use rule out, probable, or suspected conditions for a diagnosis
  - When diagnosis is unknown or unclear, document signs and symptoms

Top Coding & Documentation Errors

- Documentation is not initialed or signed
- Tests ordered are not always listed in the documentation but are billed on the encounter form/superbill
  - When tests are ordered document in the plan
- Documentation of medication is not always clear
- Diagnosis is not always referenced correctly
- Documentation is missing
- Dictation is lost

Top Coding & Documentation Errors

- Superbill/encounter form and/or charge (fee) ticket are not available
- Documentation was not completed, so there is no record that an action was taken
- Superbill/encounter form is incomplete or incorrect
- Documentation is hard to read
  - The auditor will disallow the visit when he or she cannot read the documentation

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