New Patient

A new patient is one that has not been seen by the documenting clinician in the STD clinic or a member of their specialty in the same group practice in the past three years (thirty-six months)

ALL patients should be coded as "New" when billing is implemented.

Established Patient

An established patient is one who has received professional services from the clinician/qualified health care professional in the STD clinic or another clinician/ qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years

Ask yourself: Has this patient received clinical services from you or another clinician in the same CHD, within the past three years?

- If the answer is no, this is a new patient.
- If the answer is yes, this is an established patient.

Note: When you are coding the evaluation and management services you provide a patient, this distinction is an important one, as it enables you to receive reimbursement for the additional work new patient visits require.

Ask yourself: Has this patient received clinical services from you or another clinician in the same CHD, within the past three years?

If the answer is no, this is a new patient.

If the answer is yes, this is an established patient.

When to Code – 99211 Established Visits, Only

Basic guidelines

The following guidelines can help you decide whether a service qualifies for 99211:

- The patient must be established. According to CPT, an established patient is one who has received professional services from the physician or another physician of the same specialty in the same group practice within the past three years. Code 99211 cannot be reported for services provided to patients who are new to the physician.

- The provider-patient encounter must be face-to-face. For this reason, telephone calls with patients do not meet the requirements for reporting 99211.

- An E/M service must be provided. Generally, this means that the patient's history is reviewed, a limited physical assessment is performed or some degree of decision making occurs. If a clinical need cannot be substantiated, 99211 should not be reported. For example, 99211 would not be appropriate when a patient comes into the office just to pick up a routine prescription.

- Keep in mind that if another CPT code more accurately describes the service being provided, that code should be reported instead of 99211. For example, if a physician instructs a patient to come to the office to have blood drawn for routine labs, the nurse or lab technician should report CPT code 36415 (routine venipuncture) instead of 99211 since an E/M service was not required.

- The service must be separate from other services performed on the same day. Services that are considered part of another E/M service provided on the same day should not be reported with code 99211. For example, if a nurse provides instructions following a physician's minor procedure or takes a patient's vital signs prior to an encounter with the physician, 99211 should not be reported for these activities because they are considered part of the E/M service already being provided by the physician.

- No key components are required. Unlike other office visit E/M codes – such as 99212, which requires at least two of three key components (problem-focused history, problem-focused examination and straightforward medical decision making) – the documentation of a 99211 visit does not have any specific key-component requirements. Rather, the note just needs to include sufficient information to support the reason for the encounter and E/M service and any relevant history, physical assessment and plan of care. The date of service and the identity of the person providing the care should be noted along with any interaction with the supervising physician

Examples of services that may be billed using a 99211, assuming they are medically necessary

- Discussion (face-to-face) with patient following laboratory tests which indicate the need to adjust medications or repeat testing.
- PDPT

Examples of services generally not billable using 99211:

- For phone calls to patients
- Solely for the administering, dispensing or writing of prescriptions when no other E/M is necessary or performed
- For blood pressure checks when the information obtained does not lead to management of a condition or illness.
- When drawing blood for laboratory analysis or when performing other diagnostic tests, whether or not a claim for the venipuncture or other diagnostic study test is submitted separately
- Routinely when administering medications, whether or not an injection (or infusion) code is submitted on the claim separately.
- Telephone prescriptions (99211 requires face-to-face E/M service)

Telephone calls to inform of lab results (99211 requires face-to-face E/M service) 9 Prescription refills, even if provided face-to-face

New Patient Visits (3/3 History/Exam/Decision Making)

99201	99202	99203
•New patient focused visit; presenting problems are self-limiting and minor. •Problem focus history, exam with straightforward medical decision making •10 minutes •Example: •Asymptomatic •Results Pending •Screening/Testing only •Contacts with or without treatment	•New patient expanded visit; presenting problems are low or moderate •Expanded problem history, exam and low complexity decision making20 minutes •Example: •Symptomatic for one infection Ct, GC. TV, BV, etc.	•New patient detailed visit' presenting problems are of moderate severity. •Detailed history, examination, moderate complexity decision making •30 minutes •Example: •Co-Infection; Symptomatic for more than one infection or •Primary or Secondary Syphiis •Wart Treatment •PID, Epidymitis, Lower Abdominal Pain

Established Patient Visits (2/3 History/Exam/Decision Making)

99211 – PID or Epididymitis 3-day follow-up; Lab redraw, only, vomited medication, PDPT only; test results provided only. Typically 5 minutes.

99212	99213	99214
•Established patient focused visit; presenting problems are self-limiting and minor. •Problem focus history, exam with straightforward medical decision making •10 minutes •Example: •Asymptomatic •Results Pending •Screening/Testing only •Contacts with or without treatment	•Established patient expanded visit; presenting problems are low or moderate •Expanded problem history, exam and low complexity decision making •15 minutes •Example: •Symptomatic for one infection Ct, GC, TV, BV, etc.	•New patient detailed visit' presenting problems are of moderate severity. •Detailed history, examination, moderate complexity decision making •25 minutes •Example: •Co-infection; Symptomatic for more than one infection or •Primary or Secondary Syphiis •Wart Treatment •PID, Epidymitis, Lower Abdominal Pain

History Components

Both New and Established

Reason (s) for Visit, or Chief Complaint is REQUIRED FOR ALL VISITS. Reason(s) for Visit – not always the primary ICD-10. Concise statement in patient words

History of Present Illness of HPI: (MOST BE DONE BY PROVIDER)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

Note: The Electronic Health Record shows the following options. Complete all that apply.

- ✓ Status
- ✓ Pattern (Quality)
- ✓ Severity
- ✓ Duration
- ✓ Onset (Timing)
- ✓ Relieved by (Modifying factors)
- ✓ Associate Features (Associated Signs and Symptoms)
- ✓ Comments/Context

* Some examples of context would be wants STI screening, contact to chlamydia, unprotected intercourse, not using condoms – though relationship was monogamous, etc.

Staff may want to use the comment box to free text the HPI and/or document additional information pertaining to the 8 HPI elements that are not listed in the drop down boxes such as:

Patient complaining of *stabbing* (QUALITY) /*LLQ* (LOCATION) pain for *one day* (DURATION); *better when lying down* (MODIFYING FACTOR) ; *contact to GC* (CONTEXT) = **5 bulleted elements**

Patient complaining of white, lumpy (QUALITY) *vaginal* (LOCATION) discharge for *two days* (DURATION); *Heavier flow in the morning* (TIMING); *No change with Monistat* MODIFYING FACTORS) = **5 bulleted elements**

Pertinent Review of Systems and Exam Components – See Document Library, Communicable Disease, Attachments for Training, 10/03/2017

The Basics

- ICD-10 Codes – diagnosis – the "why"
- CPT Codes – service – the "what"
- Modifiers – exception – "the add'l info"

ICD-10 Code Look up

Always use the most specific code
• Cheat sheet for most common diagnoses
• Update it every year
• Not just for reimbursement

Screening/Preventive ICD-10 Z Code Examples
Screening: patient presents without problem

Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission:

- Screening for gonorrhea
- Screening for STIs

• Excludes:
- Screening for HIV (**Z11.4**)
- Screening for HPV (**Z11.51**)

Z11.8
Encounter for screening for other infectious and parasitic diseases

- Screening for chlamydia
- Screening for syphilis

Z71.XX
Persons encountering health services for other counseling and medical advice, not elsewhere classified

- **Z71.7** HIV counseling
- **Z71.89** Other specified counseling

What is a Screening "ENCOUNTER"?
• Lab test
• Radiology test
• Visual inspection
• Manual inspection

• Assessment
• Office visit

Status/Event ICD-10 Z Code Examples
Status change: patient is high-risk or "event"

Z20.2
Contact with and (suspected) exposure to venereal diseases

- Exposure to sexually transmissible disorder
- Exposure to disease that is predominantly sexually transmitted

- "The condom broke"
- "I don't use condoms all of the time"
- "I can't remember if we used one"

High-Risk Behavior Z Code Examples

Z72.51	Z72.52	Z72.53
High-risk **heterosexual** behavior	High-risk **homosexual** behavior	High-risk **bisexual** behavior

- Serial monogamist
- Unprotected intercourse – unless in a long-term single partner relationship
- Unprotected oral sex – unless in a long-term single partner relationship
- Unprotected anal sex – unless in a long-term single partner relationship
- Early age sexual activity before age 18
- Multiple partners
- High-risk partner
- Sex with partner who injects or has ever injected
- Exchange sex for money or drugs

STI Diagnosis or Symptom Related ICD-10 Code Examples - STI-Related ICD-10 Codes Non-Screening
Diagnostic: patient presents with a problem

- AIDS (only confirmed cases) B20
- Bacteremia R78.81
- Balanitis N48.1
- Candidiasis, oral thrush B37.0
- Candidiasis, esophageal B37.81
- Candidiasis, vulvovaginal B37.3
- Chlamydia, unspecified A74.9

- Chlamydial trachomatis A71.9
- Genital wart condyloma A63.0
- Gonococcal infection, cervix A54.03
- Gonorrhea, acute infection A54.00

STI-Related ICD-10 Codes Non-Screening

- Bacterial Vaginosis N76.0
- Cervicitis N72
- Pelvic inflammatory disease, unspecified N73.9
- Pelvic pain and/or perineal R10.2
- Trichomonas vulovaginits A59.01
- Trichomoniasis, NOS A59.9
- Vulvovaginitis, NOS N76.0
- Vaginitis/vulvitis-candida B37.3
- Molluscum contagiosum B08.1
- Viral warts, unspecified B07.9
- Ulceration of vulva N76.6
- Herpes, genital, NOS A60.9
- Herpetic Ulceration, vulva A60.04
- Herpes vulvovaginitis A60.04
- Herpes, penis A60.01
- Herpes, simplex, oral B00.2
- Herpes zoster, without complication B02.9
- HIV Infection (+), asymptomatic Z21
- *Syphilis – unspecified* A53.9
- *Syphilis – primary* A51.0
- *Syphilis – secondary* A51.49
- *Syphilis – neurosyphilis* A52.3
- *Syphilis – latent* A53.0

CPT Code(s) ICD	**10 Codes**
99214 – Office visit for STI and counseling	**1. N72** – Cervicitis **2. Z71.89** – Other specified counseling **3. Z11.18** – Screening for chlamydia

CPT Code(s) ICD (Modifier 25)	**10 Codes**
99213 – Office visit for irregular menses	**1. N92.6** – Irregular menses
99401 – 15 minutes preventive STI counseling	**2. Z71.89** – Other specified counseling **3. Z11.18** – Screening for chlamydia

SPECIAL CONSIDERATIONS:

Management for Presumptive Chlamydia and Gonorrhea:

Patients cannot be diagnosed for Chlamydia and gonorrhea without a reactive test result. When treating presumptively for Chlamydia and gonorrhea:

- Males should be coded as Urethritis
- Females should be coded as Cervicitis

Office Visits (99201-99215)

STIs

- Signs and symptoms
- Infection

Reported based on history, exam, and medical decision making (MDM)

New	Established
99201 – Problem focused with straightforward MDM	**99211** – Clinician not required
99202 – Expanded problem focused with straightforward MDM	**99212** – Problem focused with straightforward MDM
99203 – Detailed with low MDM	**99213** – Expanded problem focused with low MDM
99204 – Comprehensive with moderate MDM	**99214** – Detailed with moderate MDM

Office Visits (99201-99215)

- STIs
  - Signs and symptoms
  - Infection
- Reported based on time – more than 50% of the visit is counseling regarding a problem
- Documentation –"I spent 20/25 minutes today discussing…"

New	Established
99201 – 10 minutes	**99211** – 5 minutes
99202 – 20 minutes	**99212** – 10 minutes
99203 – 30 minutes	**99213** – 15 minutes
99204 – 45 minutes	**99214** – 25 minutes

Procedure CPT Examples

- Colposcopy: CPT 57420-57461
- Wart destruction:
  - Vulva: CPT 54050-54060
  - Penis: CPT 56501-56515
- Biopsy:
  - Vulva: CPT 56605
  - Penis: CPT 54100

Management for Genital Warts (Global Rule):
Repeat treatment every **10 days**, if necessary for up to 6 weeks. Code the initial visit as a new visit, and subsequent treatment visits as established with the E/M code 99211. No other services should be marked on the encounter form except the appropriate wart treatment, unless patient has a new complaint.