



Georgia Department of Public Health

Tuberculosis Coding and Billing Tool

2014

Georgia Department of Public Health
Division of Health Protection
Office of Immunization and Infectious Disease
Tuberculosis Program

<http://dph.georgia.gov/tuberculosis-tb-prevention-and-control>

PREFACE

Historically, tuberculosis (TB) services in Georgia were provided free for the citizens of Georgia. In the case of active TB disease (cases/suspects), it was felt that patients should not be asked to pay for treatment they were told they had to take. As a result, there was a lack of emphasis on correct coding and revenue generation. Over time, as public health budgets decreased, patients who were not cases/suspects, contacts or converters were beginning to pay for screening services on a sliding fee scale or at a flat rate. This resulted in some codes being used for these services, but they were not standard across the state for the same service.

This tool was developed to assist the nurses at the local level describe the care they have always provided for out TB patients by breaking it down and coding each service. All services provided should be coded without regard to whether it is a billable service or not. We must deliver correct coding and medical billing practices. This tool is not intended to be a billing manual, but rather a way to guide how to translate the TB services provided into standard billing language. Please refer to the Public Health Billing Resource Manual, current version, for specific billing information.

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WHAT IS CODING

Medical coding is a process of classifying and assigning **codes** to specific services, diagnoses and procedures to be used on bills issued by **medical** providers. These codes, called Current Procedure Terminology or CPT codes, provide a uniform method of describing services provided to a patient. They are developed by the American Medical Association (AMA) and updated annually.

CPT codes are used in conjunction with International Classification of Diseases or ICD codes to explain the diagnosis and the procedure for a given patient. The use of both of these codes helps to ensure proper procedures and payment.

Using these codes even when a service is not billed enables public health leadership to see what services are being provided to patients, the time needed for nurses to provide those services and the cost associated with providing specific services. These things are used in Relative Value Units (RVUs) and Local Cost Reports. Reports such as these assist the leadership in determining the priorities of public health services and where to allocate diminishing funds.

HOW CODES ARE DETERMINED

Nurses use coding to provide audit proof documentation of the medical necessity of services provided to a patient. Documentation in the medical record must confirm that sufficient services were delivered to justify the codes used.

DOCUMENTATION BASICS

Medical records are legal documents. If a service is not documented, it was not done. Medical records must be legible. *Definition of legible = readable to anyone unfamiliar with the handwriting. If the documentation for a service is illegible, it was not done!*

REQUIRED CONTENTS

Date of service

Chief complaint/presenting problem

May be listed as a separate element or included as part of the history of present illness

History

Include:

- Relevant past and present diagnoses/comorbidities and risk factors - May be listed as separate elements or included as part of HPI
- Past medical/social/family history - If recorded previously, do not need to be re-recorded
- Review of systems

Exam

Include:

- Specific description of abnormal findings
- Specific description of relevant negative (normal) findings

Other data reviewed

Extent of data reviewed is important in determining complexity of decision-making:

- Lab, x-ray results
- Actual review of x-ray films, EKG, etc, should be noted as such
- Consultation reports
- Past medical records

Assessment

Including evidence of medical decision-making involved.

For new problems:

- Number of diagnostic possibilities considered (differential dx)
- Level of risk of complication/morbidity/mortality

For follow-ups:

- Progress/response to treatment
- Revision of diagnoses

Plan

- Number of therapeutic options considered
- Extent of counseling performed
- Specifics of treatment, including medications, procedures, other therapies
- Any consultations requested
- If not specifically documented, the rationale for tests and services ordered should be easily inferred

Author identification

- Legible name
- Signature

STEPS FOR DETERMINING CODES

There are three steps to determine proper codes. Step 1 is to document care provided. Step 2 is CPT coding of services provided. Step 3 is coding diagnoses and procedures with ICD codes. These three steps are outlined below.

Step 1

Utilizing HIPPA standards the nurse charts all procedures, testing, and care provided to a patient. This documentation should include the Key and Contributory Components as outlined in the following pages. Documentation and charting should be completed on paper or in computerized format as determined by each Public Health District, utilizing standard formats and approved abbreviations.

Step 2

An evaluation and management (E & M) code must be determined. These are the codes for every office visit/encounter a provider has with a patient and represents services rendered based on the amount of components performed during the office visit.

The different levels include the following. Only the first four will apply for nurses.

- Limited
- Problem focused
- Expanded problem focused
- Detailed
- Comprehensive

The evaluation and management code first depend upon whether the patient is new or established. If the patient is new, codes 99201 – 99204 will apply. If the patient is an established patient, codes 99211 – 99214 will be used.

The level of E&M services is defined by the extent of the three key components. The key components are history (H), physical examination (PE) and medical decision making complexity (MDC).

- History – what is the extent of the history taken? Is it oriented to a specific problem only? Is it a comprehensive history or somewhere in between?
- Physical Exam – what amount of physical exam is performed? How many systems examined? What level of detail for each system?
- Medical decision making complexity – How many diagnoses are considered? What amount of data is reviewed? What is the risk level for complications and/or death?

These three factors considered together determine the level of E&M service given. The setting or type of service then defines the specific code. The documentation in the medical record must confirm the level of detail needed to justify the code. To determine the level of CPT code, review the key components and contributory components. The contributory components are counseling/care coordination (CCC), the nature of the presenting problem and the average time.

Step 3

Once documentation is complete and the nurse codes the E&M code, **then** the nurse **verifies** all services provided are present and coded. These codes represent everything the nurse has done. For example, the nurse draws blood for a liver function test. The computer system should automatically add two codes that describe that action: “36415 = Collection of venous blood by venipuncture” and “99000 = handling and/or conveyance of a specimen for transfer from the office to a laboratory in addition to the code for a liver function test.

KEY COMPONENTS

1. HISTORY

The history includes four areas: chief complaint (CC), history of present illness (HPI), review of systems (ROS) and past family, social and medical history (PFSMH).

	CC	HPI	ROS	PFSMH
Problem focused	X	X		
Expanded problem focused	X	X	X	
Detailed	X	X	X	X

CHIEF COMPLAINT (CC)

Always include a concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the contact, usually stated in the client's own words

HISTORY OF PRESENT ILLNESS/COMPLAINT (HPI)

Elements include: location, quality, severity, duration, timing, context, modifying factors, and associated signs & symptoms.

A patient seeking a TB Screening needs to say why they need it now (work, school, exposure, etc). Document whether the patient needs the screening for employment purposes, entry into a program such as substance abuse or HIV clinic or if they were exposed to an active TB case or a named contact.

When eliciting the details about the nature of exposure for a contact, document all of the following:

- Location and environment of the exposure – Where did the exposure take place? Was it at school or work? If so, document the name of the workplace or school and describe the exact location of the exposure. Describe the environment.
- Amount of time spent with TB case – How much time is spent with the TB Case?
- Frequency of time spent with TB case – How often do the contact and the TB Case spend time together? Is it every day, once a week?
- Physical space between contact and TB case – What is the physical proximity of the contact and the TB Case? Six inches? 20 feet?

For example, “Ms. Smith and the TB Case share a 45 minute lunch break together in the ABC company break room. The break room is a 12 foot by 14 foot room with one table which seats 10 people. Ms. Smith states she sat at the same table with the TB case approximately 18 inches apart. They would eat lunch together at least 4 days a week.”

For an active TB suspect/case, describe current signs and symptoms thoroughly. Assist the patient in defining the date of the onset of symptoms. This is important in order to accurately determine the infectious period. Determine when the patient was around other people during the infectious period. Identify places and locations where exposure may have taken place.

For patients being monitored on treatment, it would include the treatment regimen, duration of treatment and number of doses completed. For active TB cases include whether they are in the initial phase or continuation phase of treatment.

Verify that the patient is on track to complete treatment within guidelines.

PERTINENT HISTORY/PROBLEM FOCUSED

The pertinent history is part of the HPI and will always include past TB history. It is very important to know if the patient has ever been diagnosed with active TB disease or TB infection before. Document dates of diagnosis or testing, location where the diagnosis or testing took place and what treatment was offered or completed. Document whether this patient was named as a contact to another TB case. Was he/she a contact to a known drug resistant case?

Also document date, and location of any BCG vaccination given to the patient.

For a person seeking a TST, you have to know the risk factors of the patient:

- HIV infection*
- Prolonged corticosteroid therapy
- Organ transplant
- TNF blockers
- Diabetes mellitus
- Silicosis
- End stage renal disease
- Gastrectomy
- Jejunioileal bypass
- Leukemia
- Lymphoma
- Cancer of the head or neck
- Less than 5 years of age

When monitoring patients on treatment, always update of any changes in medical history since the last visit. Has there been any alcohol or substance abuse? How is the patient complying to the prescribed regimen?

PAST FAMILY, SOCIAL AND MEDICAL HISTORY (PRSMH)

For persons starting treatment for active TB disease or TB infection, you need to complete form 3121R TB Services which have a complete medical history and social history. The family history would be very limited.

DEMOGRAPHICS

Certain demographic information is needed to help direct the focus of the contact investigation and the case management of the patient. Some of the demographic information is for reporting purposes to CDC.

SOCIAL HISTORY

A social history is helpful in determining any special needs that may need to be addressed in order to provide prompt and continuous treatment to completion. Substance use is a major cause of treatment interruption. Perform a Screening, Brief Intervention and Referral to Treatment (SBIRT) for Substance Use. The patient can be referred to the state social worker for an in-depth assessment and intervention if needed.

MEDICAL HISTORY

A thorough medical history is need to determine if there are any complicated acute or chronic medical conditions including (but not limited to): diabetes, renal insufficiency with estimated creatinine clearance less than 50 ml/min., end-stage renal disease on hemodialysis that will impact treatment. An alcohol and substance abuse assessment is needed. If HIV status is not documented, a test is indicated. Current prescriptions and over the counter medications need to be listed. Note any allergies and current immunization status.

REVIEW OF SYSTEMS (ROS)

All TB patients will have a review of systems. It will be very limited for TB screening including only constitutional, skin, and respiratory. For those patients starting or being monitored on treatment, it will be much more in-depth.

It is important for the patient to be able to describe a change from his/her "normal" baseline. The review of systems is primary to check for any adverse drug reactions. The patient education materials in the *Georgia TB Policy & Procedure Manual, 2014* can be used to aid in this monthly review.

CONSTITUTIONAL

Does the patient have any unexplained weight loss, fever, chills, weakness or fatigue, night sweats, and/or loss of appetite? How severe are they?

HEENT

Does the patient have any vision loss, blurred vision, double vision or trouble distinguishing colors? Does he/she wear glasses?

Does the patient have any hearing loss or ringing in the ears? Does he/she wear a hearing aid?

SKIN

What is the normal color of skin? Are there any rashes or itching? If so, what is the cause? Is there any bruising? Does the patient bruise easily?

CARDIOVASCULAR

Does the patient have any chest pain, chest pressure/chest discomfort, palpitations or edema?

RESPIRATORY

Is the patient experiencing any shortness of breath, cough or sputum? Is this something new or is this a chronic condition? Is the patient coughing up blood?

GASTROINTESTINAL

Does the patient have anorexia, heartburn, nausea, vomiting or diarrhea or abdominal pain? Does anything relieve it? Does anything precipitate it? What color are his/her stools? Is there any blood in the stool?

GENITOURINARY

What color is the patient's normal urine? Does he/she have bladder or kidney infections? Have they ever had a problem with kidney function?

NEUROLOGICAL

Does the patient have headaches? What kind and what relieves them? Does he/she have dizziness, syncope, paralysis, ataxia, numbness or tingling in the extremities? Is there any problem with memory or cognition?

MUSCULOSKELETAL

Does the patient have muscle and/or back pain? Does he/she have any arthritis, joint pain or stiffness? Is there any weakness in his/her limbs or any problem with gait and movement? Have they **experienced** signs of gout?

HEMATOLOGIC

Does the patient have anemia, bleeding or bruising? Are they on aspirin therapy?

LYMPHATICS

Has the patient ever had enlarged nodes or a history of splenectomy?

2. PHYSICAL EXAMINATION

All TB patients will have a physical examination. It can range from very limited to detailed.

A very limited physical examination is made for a person seeking a TB screening and follow-up to include the following:

- Observe characteristics of breathing; note any coughing or shortness of breath
- Observe overall skin texture
- Examine skin of arm for scarring, tattoos, veins, turgor
- Examine skin of arm for redness or bruising. Feel the arm for soft tissue swelling and induration. Measure only the induration.

A detailed nursing physical examination is indicated for patients starting on treatment for TB disease or TBI. This will establish how ill the person is as a baseline for documenting clinical improvement with treatment and/or provides a baseline to assess adverse drug reactions. Monthly monitoring would include the same physical examination to determine any changes from the baseline.

VITAL SIGNS

Temperature, Pulse, Respiration, blood pressure, height, current weight (compare to normal weight), BMI

EYES

Check color of sclerae. Check pupils for size and reaction to light. Perform a vision test for acuity and color discrimination.

SKIN

Observe the overall color of skin. Check trunk and back for bruising or rash. Check turgor and examine extremities for bruising.

GASTROINTESTINAL

Check abdomen for tenderness.

RESPIRATORY

Collect sputum specimens, if indicated. Observe presence/absence of cough and characteristics of cough.

MUSCULOSKELETAL

Observe the patient's movements and gait. Check for joint swelling or redness.

NEUROLOGICAL

Observe for dizziness, syncope, paralysis, ataxia when moving, or getting up and down. Check for any memory difficulty or change in cognition.

3. DECISION MAKING COMPLEXITY

Use all of the information obtained during the history, review of systems and physical examination to make your decision on how to handle this patient. Medical decision making complexity looks at the following.

- The number of diagnosis and/or the number of management options that must be considered
- Amount and/or complexity of data to review such as medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
- 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.

Decide if the complexity is straight forward, low, moderate or high complexity.

ARE THERE ANY SIGNS OR SYMPTOMS OF POSSIBLE ACTIVE TB?

- Does the patient need a complete evaluation for active TB?
- Does the patient need a referral for a physician, Chest x-ray, etc.?
- Does the patient need to be isolated?
- Does the patient need a mask?
- Do sputum specimens need to be collected?

WHAT METHOD OF EVALUATION IS BEST?

- Is a symptom screen letter appropriate?
- Is a TST or IGRA needed?
- Is there any contraindication to placing a TST, IGRA?
- Is the patient able to return to the clinic in 48-72 to have the TST read?
- Does the patient need a chest x-ray instead of/or addition to a TST, IGRA?

WHAT ARE THE RISK FACTORS OF THE PATIENT?

- Is this patient at high risk of progression to TB disease if infected?
- Based on the patient's history and risk factors, what is the cut off point for a TST?

WHAT IS THE PRIORITY OF THE PATIENT?

- What is the exposure history?
- Is this patient at high risk of progression to TB disease if infected?
- Does the patient need a chest x-ray along with a TST, IGRA?
- Will the patient need any follow-up after this test?
- Does this contact need to be placed on presumptive TB Infection treatment?

HIGH PRIORITY CONTACTS WITH A MEDICAL RISK

- Explain how the medical risk can lead to a progression to disease if the contact is infected
- Discuss window period and presumptive TB Infection treatment

TB SUSPECT/CASE

- Does the patient have a positive TST or IGRA?
- Does the patient have a positive AFB in sputum, bronchial brush, wash or lung tissue biopsy?
- Does the patient have an abnormal chest x-ray or CT imaging consistent with TB?
- Does the patient have symptoms compatible with TB?
- What is the infectious status of the patient?
- Has a diagnosis of pulmonary TB been confirmed?
- Do sputum specimens need to be collected?
- Have the symptoms of TB improved?
- What is the AFB smear status?
- What is the culture status?

- What is the isolation status of the patient?
- Is the patient able to produce sputum specimens?
- Is the patient maintaining desirable weight?

DRUG RESISTANCE

- Was the patient exposed to known drug resistant active case?
- Have drug susceptibility tests been ordered? Are there any results?

CONTRAINDICATIONS TO THE MEDICATIONS

- Is there any concurrent use of other medications that may cause interactions?
- Does the patient have any chronic liver disease?
- Does the patient have peripheral neuropathy?
- Does the patient have any known allergies to anti-tuberculosis drugs?
- Does the patient have any contraindications to isoniazid or rifampin?
- Is there any alcohol use or injection drug use?
- Are there any signs and symptoms of hepatotoxicity?
- Are there any symptoms of hepatitis?
- Are there any symptoms of neurotoxicity?
- Are there any adverse effects of the prescribed regimen?
- What were the results of the baseline labs?
- What were the previous monthly labs?

TESTS TO BE ORDERED

- Is the patient a man who has sex with other men?
- Has the patient been diagnosed with a sexually transmitted disease?
- Is the patient a sex contact or close household member of a person infected with hepatitis B or C?
- Was the person born in or born to parents who emigrated from countries where hepatitis B is common?
- Does a sputum specimen need to be collected?
- What blood tests need to be drawn?
- What are the results of previous lab work?
- Is follow-up for elevated glucose needed?

POTENTIAL FOR INTERRUPTION OF TREATMENT

- Is there any alcohol abuse or injection drug abuse?
- Does the patient use illicit drugs (injecting, inhaling, snorting, pill popping)?
- What was the result of the Screening, Brief Intervention and Referral to Treatment (SBIRT) for Substance Use?
- Are there language or cultural issues that need to be addressed?
- Are there social factors such as limited transportation, job security concerns or other factors that may become barriers to treatment?
- Does the patient need to be referred to the state social worker?

IS THIS A COMPLICATED CASE THAT NEEDS TO BE REFERRED TO THE CONTRACT PHYSICIAN

Are any of the following present that would need to be referred to the physician?

- Children from birth through 15 years
- Extrapulmonary TB
- Currently pregnant or breast-feeding
- Known history of infection or exposure to multiple drug resistant (MDR) *M. tuberculosis*, or any drug resistance on susceptibility testing
- Known HIV infection
- Other new and/or complicated acute or chronic medical conditions including (but not limited to): diabetes, renal insufficiency with estimated creatinine clearance less than 50 ml/min., end-stage renal disease on hemodialysis
- BMI greater than 30
- Known allergies to anti-tuberculosis drugs

TREATMENT OPTIONS

- What are the treatment regimen options?
- Are there any risks for the patient?
- What is the appropriate treatment regimen for this patient?
- Does the current regimen seem effective?
- Is the patient tolerating it well?
- Has the initial phase of treatment been completed within the time frame?
- Does the drug susceptibility indicate a change in medication is appropriate (such as dropping the ethambutol with pan sensitive results)?

TREATMENT ADHERENCE

- Is there any alcohol abuse or injection drug abuse?
- Does the patient use illicit drugs (injecting, inhaling, snorting, pill popping)?
- What was the result of the Screening, Brief Intervention and Referral to Treatment (SBIRT) for Substance Use?
- Are there language or cultural issues that need to be addressed?
- Are there social factors such as limited transportation, job security concerns or other factors that may become barriers to treatment?
- Does the patient need to be referred to the state social worker?
- Is the patient adherent to the prescribed regimen?
- Has anything changed since the last visit (pregnancy, etc)
- Has there been a lapse in treatment?
- What is the dose count this month? What is the dose count to date?
- Have the appropriate number of doses been completed within the established time period?

HAVE ANY COMPLICATIONS DEVELOPED

Are any of the following present that would need to be referred to the physician?

- Currently pregnant or breast-feeding
- Known HIV infection (especially new infection or positive HIV test results)

- Other new and/or complicated acute or chronic medical conditions including (but not limited to): diabetes, renal insufficiency with estimated creatinine clearance less than 50 ml/min., end-stage renal disease on hemodialysis
- BMI greater than 30
- Known or developed allergies to anti-tuberculosis drugs
- Treatment with once-weekly isoniazid and rifapentine during the continuation phase
- Decision to extend the continuation phase longer than four months (e.g., sputum culture collected 60 days (2 months) after treatment initiation is positive).

CONTRIBUTORY COMPONENTS

1. COUNSELINGCARE COORDINATION

Counseling is a discussion with a patient or the patient's family concerning one or more of the following issues:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of adherence to chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Risk reduction intervention can be for a total time of 15, 30 or 45 minutes. These times are reflected in the E&M code selected.

GENERAL EDUCATION

Regardless of the method of evaluation for the patient, basic information on TB and TB screening is indicated. Some things to cover may include the following:

- The difference between exposure, infection and disease
- Purpose of an evaluation and the methods (TST, IGRA, Chest X-Ray)
- Limitations of testing
- Discuss follow-up reading if a TST is placed. Discuss best way to remind patient, Obtain alternative contact information for the patient
- Explain the need for HIV status and the relationship between HIV and TB
- Discuss the patient's risk factors and why the test was chosen
- Explain how a medical risk can lead to a progression to disease if the patient is infected

- For a contact, discuss follow-up testing in 8 – 10 weeks. Emphasize the significance of the follow-up TST/IGRA. Discuss best way to remind patient, Obtain alternative contact information for the patient

TUBERCULIN SKIN TEST

- Do not rub, scratch or pick at injection site
- Do not cover injection site with a band-aid
- It is alright to get the injection site wet
- Set appointment for the patient to return in 48-72 hours to have the test read

RISK FACTORS OF THE PATIENT

Is this patient at high risk of progression to TB disease if infected?

Based on the patient's history and risk factors, what is the cut off point for a TST?

INTERPRETATION OF THE TST/IGRA RESULTS

Measurement of the induration

How the result interpreted

- Negative results
 - What a negative test means
- Positive results
 - What a positive result means
 - Advise not to have another TST done in future and to keep documentation about this test
 - Describe follow-up steps
 - Explain what TB infection (TBI) is and why it is important to treat
 - Explain the difference between TBI and active disease
 - Describe the signs & symptoms of TB and actions to take if they occur
 - Review any additional general TB education as needed for the individual patient.

Give the patient the results of the test. Document the date of the test, the results in mm and the name of the facility where the test was performed. Give a copy to the patient and explain that he/she needs to keep this documentation and show it the next time he/she needs a TB screening.

CHEST X-RAY

- For previous positive patients, explain why a TST is not indicated
- Explain the recommendations are not to have periodic chest x-rays unless they are experiencing symptoms. Show the value of the symptom screen form and complete for them.
- If a chest x-ray is indicated
 - Explain why a chest x-ray is needed
 - Set appointment for chest x-ray
 - Complete referral forms
 - Give instructions to patient as to where to go, what time and what will occur
 - Set appointment for follow-up to review the results of the chest x-ray

TREATMENT OPTIONS

- Discuss the appropriate treatment regimens
 - Active TB Disease
 - Initial phase with 4 drug therapy for 2 months
 - Continuation phase with 2 drug therapy for 4 months
 - DOT
 - Sputum sensitivities may alter drug regimen
 - TBI
 - Isoniazid for 9 months
 - Rifampin for 4 – 6 months
 - Isoniazid/Rifapentine weekly DOT for 12 weeks
- Dose counting combined with length of treatment to determine treatment completion

MEDICATIONS

- Review clients current prescription and over the counter use of medications and supplements to identify potential interactions
- Discuss the signs and symptoms of hepatotoxicity
- Discuss the symptoms of hepatitis
- Discuss the symptoms of neurotoxicity
- Have the patient verbalize when and how to contact the health department should adverse reaction appears
- Use the patient education portion of the current TB Policy and Procedure Manual

TREATMENT ADHERENCE

- Importance of completion of medication regime without missed days
- Assist client in planning to avoid interruptions in care

TB SUSPECT/CASE

- Explain the public health threat of TB and legal support for treatment
- Explain rationale for directly observed therapy (DOT).
- Demonstrate sputum specimen collection procedure at home and at clinic
- Explain infectious period and isolation
- Explain the consent for treatment, treatment plan, DOT agreement and medication information sheet to the patient. Answer any questions and assure he/she understands them before signing.
- Discuss the contact investigation plan
- Identify through talking with the patient, locations and people where exposure may have taken place. Gather information to locate and contact the high risk contacts first.
- Discuss confidentiality with the patient and prepare them for the possible deduction of their identity by co-workers / classmates / friends.
- Set up a time for the initial home visit and follow-up interview in 1-2 weeks

PATIENTS ON TREATMENT

- Develop a treatment plan with the patient.
- Continue the “12 Points of Tuberculosis (TB) Patient Education” and document on the “Patient Tuberculosis Education Record”
 - Transmission of Tuberculosis
 - Differences between TB infection (TBI) and active TB disease
 - Progression of TBI to active TB disease
 - Signs and symptoms of TB disease
 - Importance of HIV testing
 - Respiratory isolation and use of masks
 - Infectious period
 - Importance of chemotherapy as prescribed
 - Side effects and adverse medication reactions
 - Directly Observed Therapy
 - Importance of regular medical assessments
 - Importance of contact investigation
- Review the patient education portion in the current TB Policy and Procedure Manual to discuss expected side effects and adverse reactions to medications
- The rationale for using an alternative or back-up method of birth control (e.g., copper-bearing IUD such as ParaGard, condoms, diaphragm) is that when rifampin is prescribed, it reduces effectiveness (degree depending on method) of combined oral contraceptives, progestin-only oral contraceptives, levonorgestrel implants, Depo-Provera, patch and ring. Advise condom back- up.
- The client’s immunization status.
- If smoker or tobacco user, refer to a local cessation program and/or the Georgia Tobacco Quit Line, 1-877-270-STOP (7867).
- If alcohol/substance abuse known or suspected, educate, counsel and refer for appropriate treatment.
- Review sputum specimen collection procedure at home and at clinic
- Review infectious period and isolation
- Review method of birth control
- If alcohol/ substance abuse known or suspected, follow-up referral from last visit, discuss options and implications for TB treatment, refer for appropriate treatment.
- Discuss the contact investigation progress
- In talking with the patient, continue to identify locations and people where exposure may have taken place. Gather information to locate and contact the high risk contacts first.
- Discuss confidentiality with the patient and prepare them for the possible deduction of their identity by co-workers / classmates / friends.
- Review housing, transportation and other social issues with the patient.
- Offer incentive and enablers as appropriate

2. NATURE OF PRESENTING PROBLEM

The nature of the presenting problem is captured in the description of the chief complaint. It is the disease, condition, illness, injury, symptoms, sign, finding, complaint, or other reason for encounter. The medical necessity of services is based upon the nature of the presenting problem. A good question to ask is, "Was it necessary to perform and document all the work in the chart for the patient encounter given the nature of the patient's presenting problem and chief complaint?"

Minimal: A problem that might not require the presence of the physician, but service is provided under the physician's supervision.

Self-limited or minor: A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status or that has a good prognosis with management and compliance.

Low severity: A problem where there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.

Moderate severity: A problem where there is moderate risk of mortality without treatment, an uncertain prognosis or increased probability of prolonged functional impairment.

High severity: A problem where there is a moderate to high risk of mortality without treatment or high probability of severe, prolonged functional impairment.

3. AVERAGE TIME

When counseling and coordination of care account for more than 50% of the face-to-face patient encounter, then time becomes the key or controlling factor in selecting the level of service. The extent of counseling and/or coordination of care must be documented in the medical record. This may be done by inclusion of a notation such as the following, usually at the end of a note:

"The majority of this visit was counseling regarding X and coordination of care with Y, with a total face-to-face time of Z minutes." OR "Face to face time with patient X minutes, over 50% of which was devoted to counseling re: self-management of _____."

CLINICAL SERVICES

The following format is used to be consistent. This format can assist the nurse in charting and in determination of correct CPT evaluation and management codes.

HISTORY

- CHIEF COMPLAINT (CC) – included the nature of presenting problem
- HISTORY OF PRESENT COMPLAINT (HPI)
- PERTINENT HISTORY AND/OR PAST FAMILY, SOCIAL AND MEDICAL HISTORY (PRSMH)
- REVIEW OF SYSTEMS (ROS)

PHYSICAL EXAMINATION (PE)

DECISION MAKING COMPLEXITY (DMC)

COUNSELING / CARE COORDINATION / EDUCATION

TESTS AND PROCEDURES

EVALUATION AND MANAGEMENT (E&M) LEVEL

Examples of common TB services are given in this section. Refer back to the key components for detailed information. The E&M codes are at the discretion of the nurse performing the service and those given are only guidelines to assist the nurse in determining the correct code.

TUBERCULOSIS SCREENING

HISTORY

- Chief complaint – Patient presents to the health department for a TB screening
- Nature of presenting problem: Why does this patient want a TB screening today? If he/she is a contact? Document whether the patient needs the screening for employment purposes, entry into a program such as substance abuse or HIV clinic.
- HPI: Pertinent medical history/previous TB history
- Review of systems
 A limited review of systems is done to assess whether the patient has any signs and symptoms of active TB disease and whether there is any contraindication to performing a TST.
 - Constitutional
 - Skin
 - Respiratory

PHYSICAL EXAMINATION

- A very limited physical examination is made of the skin

DECISION MAKING

- Limited; Straightforward

COUNSELING/CARE COORDINATION

General education	Tuberculin skin test/IGRA	Chest x-ray
-------------------	---------------------------	-------------

TEST AND PROCEDURES

Administer a TST	HIV	Risk Reduction Interventions, including symptom screen (15 min.) (30 min.)
QFT	Screening for HIV	
T-Spot	Chest X-Ray	

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient
99201 - RN	99211 - LPN
99202 - RN	99212 - RN

TB SCREENING FOLLOW-UP (F/U), POSITIVE TST/IGRA

HISTORY

- Chief complaint – Patient presents to the health department for follow-up of TB screening.
- Nature of presenting problem: why a TST was done; patient’s risk of progression to disease
- HPI – Review risk factors for cut off point
- Review of systems – only to the extent to see if TB symptoms have appeared since last visit

PHYSICAL EXAMINATION

- A very limited physical examination is made to observe skin for redness and soft tissue swelling; feel for induration and measure if induration is found

DECISION MAKING

- Limited; Straightforward

COUNSELING/CARE COORDINATION

General education	Tuberculin skin test/IGRA	Chest x-ray
-------------------	---------------------------	-------------

TEST AND PROCEDURES

Chest X-Ray	Risk Reduction Interventions, including symptom screen (15 min.) (30 min.)
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EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient
99201 - RN	99211 – LPN; RN
99202 - RN	99212 - RN

TB SCREENING F/U, READ CHEST X-RAY

HISTORY

- Chief complaint – Patient presents to the health department for follow-up of a positive TB screening.
- Nature of presenting problem: Patient had a positive TST/IGRA; chest x-ray performed outside of the health department
- HPI – Review risk factors for cut off point; review details of current TB screening
- Review of systems – only to the extent to see if TB symptoms have appeared

PHYSICAL EXAMINATION

- A very limited physical examination is made to observe skin for redness and soft tissue swelling; feel for induration and measure if induration is found

DECISION MAKING

- Limited; Straightforward

COUNSELING/CARE COORDINATION

General education	Tuberculin skin test/IGRA	Chest x-ray
-------------------	---------------------------	-------------

TEST AND PROCEDURES

Refer chart and chest x-ray to contract physician

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient
99201 - RN	99211 – LPN; RN
99202 - RN	99212 - RN

TB SCREENING F/U, CHEST X-RAY RESULTS

HISTORY

- Chief complaint – Patient presents to the health department for follow-up of TB screening chest- x ray results
- Nature of presenting problem: Review of x-ray results, possible imitation of TBI meds or referral for abnormalities.
- HPI – Review risk factors for need of referral to PMD or contract physician
- Review of systems – only to the extent to see if TB symptoms have appeared since last visit

PHYSICAL EXAMINATION

- A very limited physical examination depending on completion of previous appointments.

DECISION MAKING

- Limited; Straightforward

COUNSELING/CARE COORDINATION

General education	Chest X-Ray	Difference of TBI and TB Disease
Treatment options & recommendations, if indicated		

TEST AND PROCEDURES

Risk Reduction Interventions, including symptom screen (15 min.) (30 min.)

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient
99201 - RN	99211 – LPN; RN
99202 - RN	99212 – RN
99203 – RN	99213 - RN

INITIAL TREATMENT FOR ACTIVE TB DISEASE

HISTORY

- Chief complaint – Patient presents to the health department for evaluation and treatment of suspected or confirmed active tuberculosis.
- Nature of presenting problem – how sick is the patient?
- HPI – Pertinent History/Past TB History
- Detailed Family, Social and Medical History
- Detailed Review of systems

Constitutional	Cardiovascular	Genitourinary	Hematologic
Heent	Respiratory	Neurological	Lymphatics
Skin	Gastrointestinal	Musculoskeletal	

PHYSICAL EXAMINATION

- Detailed physical examination

Vital Signs	Skin	Respiratory	Neurological
Eyes	Gastrointestinal	Musculoskeletal	

DECISION MAKING

- Low or Moderate complexity

COUNSELING/CARE COORDINATION

General Education	Risk Factors Of The Patient	Treatment Options
Medications	Treatment Adherence	Tb Suspect/Case
Tb Suspect/Case	Patients On Treatment	

TEST AND PROCEDURES

NAAT	AST	Hepatitis B Profile	Serum uric acid
HIV/ Screening for HIV	ALT	CBC with platelets	Pregnancy test
Sputum for AFB Smear, Culture & Sensitivity	Bilirubin	Glucose	TST
Risk Reduction Interventions (15, 30, 45 min.)	Alkaline Phosphatase	Serum Creatinine	Chest X-Ray
Screening, Brief Intervention and Referral to Treatment (SBIRT) for Substance Use? (15 – 30 min)	Vision acuity and color discrimination	Counseling for tobacco	Informed consent, sign legal forms
Order and dispense the appropriate medication			

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient
99203 – RN	99213 – RN
99204 – RN	99214 - RN

DRAFT

MONTHLY EVALUATION FOR ACTIVE TB DISEASE

HISTORY

- Chief complaint – Patient presents to the health department for monthly follow-up during treatment of suspected or confirmed active tuberculosis.
- Nature of presenting problem – how sick is the patient? What is the response to treatment? Any side effects?
- HPI – Pertinent History/Past TB History
- Detailed Review of systems

Constitutional	Cardiovascular	Genitourinary	Hematologic
Heent	Respiratory	Neurological	
Skin	Gastrointestinal	Musculoskeletal	

PHYSICAL EXAMINATION

- Detailed physical examination

Vital Signs	Skin	Respiratory	Neurological
Eyes	Gastrointestinal	Musculoskeletal	

DECISION MAKING

- Low or Moderate complexity

COUNSELING/CARE COORDINATION

General Education	Risk Factors Of The Patient	Treatment Options
Medications	Treatment Adherence	TB Suspect/Case
Tb Suspect/Case	Patients On Treatment	

TEST AND PROCEDURES

AST	ALT	Hepatitis B Profile	Serum uric acid
HIV/ Screening for HIV	Bilirubin	CBC with platelets	Pregnancy test
Sputum for AFB Smear, Culture & Sensitivity	Alkaline Phosphatase	Glucose	TST
Risk Reduction Interventions (15, 30, 45 min.)	Vision acuity and color discrimination	Serum Creatinine	Chest X-Ray
Screening, Brief Intervention and Referral to Treatment (SBIRT) for Substance Use? (15 – 30 min)	Order and dispense the appropriate medication	Counseling for tobacco	

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient
99203 – RN	99213 – RN
99204 – RN	99214 - RN

DRAFT

INITIAL TREATMENT FOR TBI

HISTORY

- Chief complaint – Patient presents to the health department for evaluation and treatment of tuberculosis infection
- Nature of presenting problem – what is the risk of the patient for progression to disease?
- HPI – Pertinent History/Past TB History
- Detailed Family, Social and Medical History
- Detailed Review of systems

Constitutional	Cardiovascular	Genitourinary	Hematologic
Heent	Respiratory	Neurological	Lymphatics
Skin	Gastrointestinal	Musculoskeletal	

PHYSICAL EXAMINATION

- Detailed physical examination

Vital Signs	Skin	Respiratory	Neurological
Eyes	Gastrointestinal	Musculoskeletal	

DECISION MAKING

- Low or Moderate complexity

COUNSELING/CARE COORDINATION

General Education	Risk Factors Of The Patient	Treatment Options
Medications	Treatment Adherence	Tb Suspect/Case
Tb Suspect/Case	Patients On Treatment	

TEST AND PROCEDURES

HIV/ Screening for HIV	Hepatitis B Profile	AST	Serum uric acid
Bilirubin	CBC with platelets	ALT	Pregnancy test
Alkaline Phosphatase	Serum Creatinine	Counseling for tobacco	Informed consent, sign legal forms
Risk Reduction Interventions (15, 30, 45 min.)	Screening, Brief Intervention and Referral to Treatment (SBIRT) for Substance Use (15 – 30 min)	Order and dispense the appropriate medication	

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient
99203 – RN	99213 – RN
99204 – RN	99214 - RN

DRAFT

MONTHLY EVALUATION FOR TBI

HISTORY

- Chief complaint – Patient presents to the health department for monthly evaluation for treatment of tuberculosis infection
- Nature of presenting problem – what is the risk of the patient for progression to disease? How is the patient tolerating the treatment regimen?
- HPI – Pertinent History/Past TB History
- Detailed Review of systems

Constitutional	Cardiovascular	Genitourinary	Hematologic
Heent	Respiratory	Neurological	Lymphatics
Skin	Gastrointestinal	Musculoskeletal	

PHYSICAL EXAMINATION

- Detailed physical examination

Vital Signs	Skin	Respiratory	Neurological
Eyes	Gastrointestinal	Musculoskeletal	

DECISION MAKING

- Straight forward, Low or Moderate complexity

COUNSELING/CARE COORDINATION

General Education	Risk Factors Of The Patient	Treatment Options
Medications	Treatment Adherence	Tb Suspect/Case
Tb Suspect/Case	Patients On Treatment	

TEST AND PROCEDURES

HIV/ Screening for HIV	Hepatitis B Profile	AST	Serum uric acid
Bilirubin	CBC with platelets	ALT	Pregnancy test
Alkaline Phosphatase	Serum Creatinine	Counseling for tobacco	
Risk Reduction Interventions (15, 30, 45 min.)	Screening, Brief Intervention and Referral to Treatment (SBIRT) for Substance Use (15 – 30 min)	Order and dispense the appropriate medication	

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient
	99212 - RN
99203 – RN	99213 – RN
99204 – RN	99214 - RN

DRAFT

DIRECTLY OBSERVED THERAPY (DOT) VISIT

HISTORY

- Chief complaint – Patient visit at home or in clinic for DOT
- Nature of presenting problem – assurance that medication is taken; prompt identification of any adverse reactions
- HPI –
- Detailed Review of systems

Constitutional	Cardiovascular	Genitourinary	Hematologic
Heent	Respiratory	Neurological	
Skin	Gastrointestinal	Musculoskeletal	

PHYSICAL EXAMINATION

- None

DECISION MAKING

- Straight forward

COUNSELING/CARE COORDINATION

General Education	Treatment Adherence	
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TEST AND PROCEDURES

- None

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient
	99211 – LPN; RN
	99212 - RN

CASE MANAGEMENT SERVICES

1. CONTACT INVESTIGATION

PRELIMINARY INTERVIEW WITH INDEX CASE

- Hospital, clinic or home visit for initial identification of exposure locations
- Assessment for risk of transmission based on patient characteristics
- Names and locating information for household contacts and close social contacts
- Time depends on tolerance of patient (30, 45 min., 1, 1.5, 2 hr.)

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

INITIAL HOME VISIT/THOROUGH INTERVIEW WITH CASE

- Home visit to assure adequacy of home isolation
- Thorough interview with patient about where exposure may have taken place during infectious period
- Identifying information about all exposed contacts
- Review of contact investigation process
- Counseling and education of patient and family
- Time (1, 1.5, 2, 2.5, 3 hr.)

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

FOLLOW-UP INTERVIEWS WITH INDEX CASE

- On-going interviews with patient to follow up on missed information, new information and progression of contact investigation
- Time (15, 30, 45, 60 min.)

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

FIELD VISITS FOR RISK ASSESSMENT FOR TRANSMISSION

- On-site visit to named exposure location to identify environmental factors and assess risk of transmission
- Preliminary data gathering for potential screening site, number of potential exposed contacts, estimated risk of those contacts and educational needs
- Time (15, 30, 45, 60 min., 1.5, 2, 2.5, 3 hrs.)

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

COORDINATION OF WORKPLACE/SCHOOL SCREENING

- On-site and/or telephone coordination of logistics of on-site screening
- Evaluation of logistics for flow of testing, confidentiality of contacts and minimal interruption of day
- Dates, times, locations, permissions, flyers and educational sessions set
- Time

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

EDUCATION AND COUNSELING OF EXPOSED INDIVIDUALS

- Group presentation about TB, risk of exposure, next steps and answering of questions
- Individual counseling after presentation of concerned contacts
- Distribution of materials about disease, upcoming testing, what to expect
- Time

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

2. COORDINATION OF CARE

DISCHARGE PLANNING WITH HOSPITAL

- Discussions with infection control nurse and discharge planner at hospital to ensure adequate place of discharge
- Coordination of aftercare for patient for transition from hospital care to outpatient care
- Time

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

CASE REVIEWS WITH OTHER MEDICAL STAFF

- Formal and information case conferences with other medical staff, contract physician, state office nurses, state office medical consultant and TB Program Manager
- Time

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

JOINT MEDICAL MANAGEMENT OF CASE

- Telephone conferences with private medical doctor to oversee care
- Collection and review of required reporting details to verify care
- Time

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

3. RETURN TO CARE

TELEPHONE CALLS

- Telephone calls to follow up on missed appointments
- Counseling and coordination of care to address barriers and develop strategies to keep patient in care until completion of treatment
- Time

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

LETTERS

- Letters to follow up on missed appointments
- Counseling and coordination of care to address barriers and develop strategies to keep patient in care until completion of treatment
- Time

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

FIELD VISITS

- Field/home visits to follow up on missed appointments
- Counseling and coordination of care to address barriers and develop strategies to keep patient in care until completion of treatment
- Time

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

LEGAL REMEDY

- Consultation with state office, District Medical Director, county attorney to escalate a patient's return to care
- Preparation of court papers, physician statements, health orders and court appearances
- Identification and preparation of confinement facility
- Preparation and transport of patient to confinement facility
- On-going follow-up for clinical management of care while confined
- Time

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

4. MONITORING CARE

TELEPHONE NURSE MONITORING PROCEDURE

- According to the current TB policy and procedure manual

HISTORY

- Chief complaint – Telephone call initiated by RN to monitor care of patient
- Nature of presenting problem – assurance that medication is taken; prompt identification of any adverse reactions
- HPI –
- Detailed Review of systems

Constitutional	Cardiovascular	Genitourinary	Hematologic
Heent	Respiratory	Neurological	
Skin	Gastrointestinal	Musculoskeletal	

PHYSICAL EXAMINATION

- None

DECISION MAKING

- Straight forward

COUNSELING/CARE COORDINATION

General Education	Treatment Adherence	
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TEST AND PROCEDURES

- None

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient
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HOME VISITS

HISTORY

- Chief complaint – home visit initiated by RN to monitor care of patient
- Nature of presenting problem – assurance that medication is taken; prompt identification of any adverse reactions
- HPI –
- Detailed Review of systems

Constitutional	Cardiovascular	Genitourinary	Hematologic
Heent	Respiratory	Neurological	
Skin	Gastrointestinal	Musculoskeletal	

PHYSICAL EXAMINATION

- None

DECISION MAKING

- Straight forward

COUNSELING/CARE COORDINATION

General Education	Treatment Adherence	
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TEST AND PROCEDURES

- None

EVALUATION AND MANAGEMENT (Recommended Codes)

New Patient	Established Patient

BILLING

Please refer to the Public Health Billing Resource Manual, current version, for specific billing information.

Medicaid and third party payers may be billed for all TB services but should not bill for TB medicines or the PPD solution which are purchased by the state at a discount from the federal 340B TB drug program and provided to all District TB programs. TB services can be charged according to the county sliding fee scale. All out of pocket payments for TB suspects, confirmed TB cases, converters, contacts to TB suspects or cases, and children under five years of age with TBI are to slide to zero dollars (\$-0-). For clients who fall outside these parameters (screening for employment, school, etc), if the client does not have the money on the day of service, the client can be billed for service.

It may be possible for contracts or MOUs to be executed with local facilities that frequently send employees or students to the health department for TB screening as a way to generate funds to cover these services.

Ideally, clients from high risk populations should not incur or only incur minimal charges from a county health department TB clinic because the benefit of providing TB services to them to prevent a future case far outweighs the cost of the service. An example would be a client who is enrolling in a substance abuse program and needs a TST or chest x-ray in order to be accepted to the program.

Kimberly Russell will help work on this section.

Requirements to be Reimbursed by a 3rd Party Payor:

- The patient is a member of Medicaid or other Insurance Company
 - We need to ask every person coming for services in HD what insurance they have and put it into the Clinical Information System (M & M or other) EVEN IF the service is not billable or that Insurance Company does not pay the HD!
 - People may have more than one Insurance
 - Some services will not be charged (TB Program funds cover): Still document what insurance the patient has!
- The service is provided by a Qualified Provider
 - Enrolled as a Medicaid Provider
 - County Health Department enrolled as an Entity (DSPS, Health Check)

- Service must be provided by Skilled Professional Medical Personnel (SPMP)
 - Individual Providers (N.P., Physicians Services)
- Or, there is a contract or agreement with an Insurance Company with an agreement that County Health Departments are In Network Providers for certain services.

IT SYSTEM (M&M, Aegis, Dekalb or Athens systems) must collect data in HIPAA-compliant format and be able to send it electronically in acceptable format (EDI = Electronic Data Interchange) All services must be identified with CPT Code (procedure codes) ICD-9 Code (Diagnosis) "Service Codes" may be used for Programmatic Reporting; not for billing.

- Some Districts have Centralized Billing
- Some Counties do their own billing
- Some Districts use a Clearinghouse

Your District Billing Supervisor is your new Best Friend.

- Each District Billing Supervisor is a member of the statewide Billing Advisory Work Group better known as "The BAWG"
- State Office contact: TB Program + Kimberly Russell (for now)

LAB QUICK REFERENCE SHEET

CLASS 3 - TB DISEASE

CLASS 4 - OLD TB DISEASE

CLASS 5 - TB SUSPECT

These patients are usually started on a 4 drug regimen of isoniazid, pyrazinamide, ethambutol and rifampin. When the **initial** 4 drug regimen is used, it is important to perform the following monthly lab assessments for the duration of the 4 drug treatment.

Isoniazid - monthly hepatic/liver function test

Pyrazinamide - monthly uric acid levels & creatinine

Ethambutol - monthly vision/color exam

Rifampin - monthly cbc with differential.

In addition to the above labs, a baseline serum glucose should be drawn. If the results are abnormal a Hgb A1C should be drawn at the next visit.

The hepatic/liver function test, the serum glucose and creatinine levels can be ordered as a comprehensive metabolic panel instead of ordering each individual lab in an effort to save money.

On all known diabetic patients, obtain a Hgb A1C with baseline labs.

The above labs are sent for processing to the lab provider for your county.

HIV testing should be done on all patients. TB patients *may* qualify for oraquick, if not, do venipuncture for HIV.

Hepatitis C ab should be drawn on all adults initially.

Hepatitis B profile should be drawn on all adults & anyone less than 18 yrs old who is foreign born.

The above three labs are sent for processing to the state lab.

During the initial phase of treatment assess the patient monthly for any signs or symptoms of gout or change in kidney function. If any signs or symptoms are present, continue to draw uric acid levels for gout and creatinine for kidney function. If the patient is asymptomatic for gout or kidney issues, then these labs do not have to be drawn every month.

During the continuation phase of treatment while the patient is on isoniazid & rifampin, monthly hepatic/liver function test and CBC with differential will be drawn monthly and **sent for processing to the lab provider for your county.**

CLASS 2 - TB INFECTION, NO DISEASE

If the patient is on isoniazid, monthly hepatic/liver function test is done.

If the patient is on rifampin, monthly hepatic/liver function test and CBC with differential is done.

The above labs are sent for processing to the lab provider for your county.

HIV testing should be done on all patients. TB patients *may* qualify for oraquick, if not, do venipuncture for HIV and send **for processing to the state lab.**

DRAFT

CPT Coding Guidelines for Office Visits

December 1998

Documentation in the clinical record must support the level of service as coded and billed.

The Key Components - History, Examination, and Medical Decision Making - must be considered in determining the appropriate code (level of service) to be assigned for a given visit.

History

type of patient new	type of history est.	details of History		
		HPI	ROS	other history
	99211		M.D. presence not required, minimal problem, typically 5 minute service	
99201	99212	problem focused	brief (1-3 elements)	
99202	99213	exp. prob. focused	brief (1-3 elements)	prob. pertinent (1 system)
99203	99214	detailed	ext. (≥4 elements)	extended (2-9 systems) pertinent (1 area)
99204		comprehensive	ext. (≥4 elements)	complete (≥10 systems) complete (≥ 2 areas)
99205	99215	comprehensive	ext. (≥4 elements)	complete (≥10 systems) complete (≥ 2 areas)

Examination

type of patient new	type of exam est.	details of Examination
99201	99212	limited - affected area or organ system
99202	99213	limited - affected area / organ system + other related / symptomatic areas
99203	99214	extended of affected area / organ system + related / symptomatic areas
99204		general multi-system exam or complete exam of single organ system
99205	99215	general multi-system exam or complete exam of single organ system

Medical Decision Making

type of patient new	type of decision making est.	details of Medical Decision Making		
		# of diagnoses / management options	amount/complexity of data	risk of complications / morbidity / mortality
	99211	may not require medical decision making		
99201		minimal	minimal	minimal
99202	99212	minimal	minimal	minimal
99203	99213	limited	limited	low
99204	99214	multiple	multiple	moderate
99205	99215	extensive	extensive	high

Note: for **new** patients, all **three** key components must meet or exceed the above requirements for a given level of service; for **established** patients, **two** of the three key components must meet or exceed the requirements.

Details of History		Details of Examination	
HPI elements (8): location quality severity duration timing context modifying factors assoc. signs/symptoms	ROS systems (14): symptoms (e.g. cough) eyes ears/nose/throat/mouth cardiovascular respiratory gastrointestinal genitourinary musculoskeletal integumentary neurologic psychiatric endocrine hematologic/lymphatic allergic/immunologic	body areas: head, including face neck chest, inc. breasts, axillae abdomen genitalia, groin, buttocks back, including spine each extremity	organ systems: constitutional (vital signs, general) eyes ears, nose, throat, mouth cardiovascular respiratory gastrointestinal genitourinary musculoskeletal integumentary neurologic psychiatric hematologic/lymphatic /immunologic

- **four additional factors** may be considered in determining the appropriate code (level of service) for a visit:
 1. **nature of the presenting problem** (minimal, self-limited/minor, low, moderate, or high severity)
 2. **coordination of care with other health care professionals** *
 3. **counseling** *
 4. **time** - see chart below for "typical" time spent face-to-face with patient/family for the various levels of service

	5 min.	10 min.	15 min.	20 min.	25 min.	30 min.	40 min.	45 min.	60 min.
new patient		99201		99202		99203		99204	99205
est. patient	99211	99212	99213		99214		99215		

* when counseling or coordination of care comprises more than 50% of the visit or service rendered, time is the key factor in determining the appropriate code and the total time spent should be clearly documented.

for more detail, please consult the AMA's annual Physician's Current Procedural Terminology, available from the AMA and other publishers

CPT CODES

ICD CODES

CROSS-REFERENCE WITH M&M CODES

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