Why Are We Here?

• To EDUCATE and PROTECT our providers and organization
• To provide you with every tool you need to maximize compliance and get paid what you deserve
• To update you on the latest CMS/OIG activities
Question to CMS: “...confused concerning the timeliness of my documentation in connection with the provider signature and submitting the claim to Medicare, and the timely filing rule. Can you provide more information?

• **Answer:** There are several provisions that may affect "timeliness" when talking about documentation.
  • A provider may not submit a claim to Medicare until the documentation is completed.
  • Until the practitioner completes the documentation for a service, **including signature**, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done.
  • The second is that practitioners are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record."
    • CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the service itself.
Anesthesia CoP Documentation Requirements

Anesthesia - Specific Documentation Recommendations:

- **Pre-Anesthesia evaluation**
  - CMS requirements include that a pre-anesthesia evaluation must be performed within 48 hours of the induction of anesthesia by an anesthesia practitioner.

- **Intra – Operative Record**
  - Attendance during procedure – Presence induction, emergence, key portions and any separate billed procedures (lines etc.)

- **Post-Anesthesia Care Unit Evaluation**
  - CMS requirements include that a post-anesthesia evaluation must be performed within 48 hours after the conclusion of anesthesia by an "individual qualified to administer anesthesia".
Pre-Anesthesia Evaluation: 48 Hours Prior

- Interview and examine the patient to discuss medical history and assess aspects of physical condition that might affect perioperative risk
  - Adverse reaction to previous anesthesia
  - Patient’s desire regarding blood/blood product transfusions
- Review of medical record
- Obtain and review tests and consults necessary for anesthesia
- **Determine the anesthesia plan**, counsel patient accordingly to obtain informed consent
- Determine appropriate prescription of preoperative medications
- If evaluation was performed >48 hours from service, then update must be documented. Include a notation (handwritten or pre-printed) on the anesthesia record that the patient was evaluated immediately prior to induction with a signature by the attending anesthesiologist attesting to the statement.
- Co-signed Pre-Anesthesia Evaluation does not support that the TP agrees with the anesthesia plan
Intra-Operative Anesthesia Record

• The anesthesia record (time-based record of events) should indicate:

  • Patient’s vital signs including temperature, oxygenation, ventilation and circulation
  • Type of anesthesia administered (e.g., MAC, general, etc.)
  • Amount of all drugs and agents used including times given
  • Unusual events occurring during the anesthesia monitoring period
  • Total time
  • Provision of indicated post anesthesia care
Post - Anesthesia Record: Within 48 Hours

• As indicated:
  • Evaluation on admission and discharge from post anesthesia;
  • Time based record of vitals signs and level of consciousness;
  • Drugs provided to the patient including the dosage and time;
  • Any unusual post anesthesia events or complications;
  • Post anesthesia visits and follow-up;
  • Initiation of any pain management services such as patient controlled anesthesia.

An individual qualified to administer anesthesia must perform a post anesthesia evaluation. This is a CoP and not the same as the 7th Step of Medical Direction for attending physician billing.
§482.52 Condition of Participation: Anesthesia Services

The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:

* Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
* Cardiovascular function, including pulse rate and blood pressure;
* Mental status;
* Temperature;
* Pain;
* Nausea and vomiting; and
* Postoperative hydration.
Completion of Anesthesia Record

• Times
• Change of Personnel
• Medical Direction Documentation
• Teaching Physician Documentation
Changes of Personnel

- Changes in anesthesia personnel during the course of an anesthetic occur as part of our practice model
  - Attending anesthesiologist
  - Resident
  - Nurse anesthetist

- Clearly document
  - Name of person assuming care
  - Time care was transferred

- When calculating primary and secondary concurrency it is imperative that time is accurately recorded. It is necessary to record and compare both the primary physician and the relieving physician (2* concurrency) when determining personally performed and medical direction for billing and modifiers.
Time – ASA & CPT

Anesthesia time starts when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance; that is, when the patient may be safely placed under post-anesthesia supervision.
Time Is NOT

• Time spent talking to the patient about their anesthetic
• Time spent performing and documenting the pre-anesthesia visit
• Time spent setting up a room, drawing up drugs, setting up monitoring equipment, checking out the anesthesia machine
Discontinuous Time

• “In counting anesthesia time, the anesthesia practitioner can add blocks of anesthesia time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.” 42 CFR§414.46

• Document activities

• Report by modifying start or end time appropriately
Time Documentation

- Carefully document all times to the nearest minute
- Do NOT round to the nearest 5 minutes

REMEMBER TO RECORD THE END TIME

- Failure to record end time is one of the major stumbling blocks that prevents timely billing

Record it – **ON THE SPOT**
How are You Paid for Anesthesia Services?

Formula for Anesthesia Services Billing & Reimbursement

\[(\text{Base Units} + \text{Time Units} \times 15) \times \text{Conversion Factor}\]

= Billed Amount or Reimbursement Amount

*Time Units = Duration of case in minutes / 15 minutes
Base units are determined by the procedure code.
Conversion Factor is a dollar amount determined by the anesthesia group to bill and by the carrier/carrier contract to determine reimbursement.
Additional benefits are not provided for the following services, as they are considered included in the base anesthesia unit values:

- preoperative consultation/discussion of anesthesia plan and additional tests if needed to assess the anesthetic risk, including preoperative evaluation done in the staging area
- preoperative medication and/or medication orders
- administration of suitable anesthetic agents for the regional/anatomical site of surgery and any “preparation” of the patient
- intubation and/or placement of intravenous lines and appropriate monitoring (e.g., blood pressure, EKG, temperature, capnography, mass spectrometry, oximetry) to evaluate the vital functions of the patient, including blood pressure, pulse, tidal volume, and temperature
- initiation of mechanical ventilation during the anesthetic period
Billing Modifiers Affecting Payments

• **Modifiers Used By Anesthesiologists**
  • **AA:** Anesthesia services performed personally by anesthesiologist
  • **AD:** Medical supervision by a physician (anesthesiologist); more than four concurrent anesthesia procedures or medical direction not met
  • **QK:** Medical direction of two, three or four concurrent anesthesia procedures
  • **QY:** Anesthesiologist medically directs one CRNA

• **Modifiers Used By CRNAs**
  • **QX:** CRNA service with medical direction by a physician
  • **QZ:** CRNA service without medical direction by a physician
Physical Status Modifier: added to each reported anesthesia code to indicate the patient's condition at the time anesthesia was administered

P1  Normal, healthy patient.

P2  Patient with mild systemic disease; e.g. anemia, chronic asthma, chronic bronchitis, diabetes mellitus, essential hypertension, heart disease that only slightly limits physical activity, obesity.

P3  Patient with severe systemic disease; e.g. angina pectoris, chronic pulmonary disease that limits activity, history of prior myocardial infarction, heart disease that limits activity, poorly controlled essential hypertension, morbid obesity, diabetes mellitus, type I with vascular complications.

P4  Patient with severe systemic disease that is a constant threat to life; e.g. advanced pulmonary/renal/hepatic dysfunction, congestive heart failure, persistent angina pectoris, unstable/rest angina.

P5  Moribund patient who is not expected to survive without the operation.

P6  Declared brain-dead patient whose organs are being removed for donor purposes.
Personally Performed (AA) Anesthesia Service

• The attending anesthesiologist is involved with one case personally or one or two anesthesia cases with an intern or resident or the teaching physician is continuously involved in a single case involving a student nurse anesthetist.

• The physician and the CRNA (or) AA are both involved in one anesthesia case and the services of each are found to be medically necessary. In these instances, documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers.
  • The physician would report using modifier AA, and the CRNA would use modifier QZ

• Payment for services that are “personally performed” are made at 100% of the fee schedule amount.

• TP involved with a resident in a single anesthesia case, two concurrent resident cases, or in a single resident case that is concurrent to another case paid under the medical direction rules (with a CRNA)
• ACGME rules prohibit an anesthesiologist from supervising or medically directing more than two concurrent cases if the anesthesiologist is involved in the training of a resident.
Services "medically directed" are paid at 50% of the fee. MEDICAL DIRECTION STEPS MUST BE DOCUMENTED BY THE TP

Medical Direction Criteria: The “7 Steps”

“Medical direction” of two, three or four concurrent cases with CRNA’s and/or residents is billable when the anesthesiologist meets seven criteria:

1. Performs a pre-anesthesia examination and evaluation
2. Prescribes the anesthesia plan
3. Personally participates in the most demanding aspects of the anesthesia plan including, if applicable, induction and emergence
Medical Direction (cont.)

4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual
5. Monitors the course of anesthesia administration at frequent intervals
6. Remains physically present and available for immediate diagnosis and treatment of emergencies
7. Provides indicated post-anesthesia care. This MUST be documented by the attending physician and is required for billing (minimum example: Patient safe/ready for transfer to PACU.)

Co-signed orders would not be acceptable documentation to support the physicians meeting the provision of indicated post anesthesia care 7th step requirement.

Documentation/Attestation Required By Anesthesiologist For Billing
Medical Direction (cont.)

**Add New Attestation**

- Present for Induction
- Present for Emergence
- Present for Critical Points
- Present for MAC
- Postoperative Care - ICU
- Postoperative Care - PACU
- Postoperative Care - PARU
- Postoperative Care - Phase II
- Present for Line Placement
- Present for TEE Exam
- Present for Position
- Anesthesia Pre-op

**Documentation/Attestation Required By Anesthesiologist For Billing**
Medical Direction Things You CAN Do

• Emergency of short duration
• Epidural/caudal for labor patient
• Periodic monitoring of OB patient
• Receive patients for next surgery
• Check on/discharge from PACU
• Coordinate scheduling
• Short breaks to use the bathroom etc. or quick snack
Medical Direction Things You CAN Do

Question to CMS: Do you agree that the medically directing anesthesiologist may perform duties such as placement of lines and epidurals in the holding areas consistent with this policy?

Yes, we agree that such duties are reasonable, consistent with sound medical practice, and would not cause the medically directing anesthesiologist to be in violation of CMS's rules for medical direction. As long as the medically directing anesthesiologist "remains physically present and available for immediate diagnosis and treatment of emergencies“. We would agree that the following procedures would be an illustrative but not exclusive list of allowed interventions:

- Placement of a Swanz-Ganz catheter, central line, or arterial line
- Placement of an epidural catheter for post-operative analgesia or in preparation for subsequent surgery (for a "to follow case")
- Placement of other peripheral nerve blocks prior to subsequent surgery, to include brachial plexus blocks, ankle blocks, femoral nerve blocks, etc.

The series of questions and answers were published in November 1999 by a Medicare carrier in response to 18 questions submitted by the Georgia Society of Anesthesiologists. The responses were the result of negotiations between those parties as well as the ASA and CMS (then HCFA).
Medical Direction Things You CAN’T Do

• Personally provide an anesthetic except labor epidural
  • Can’t do an ECT
• Go down the hall and see a patient in the pain clinic
• Go outside the immediate area to deliver a lecture
• Go out to extended lunch and leave area
Definition of Immediately Available When Medically Directing

Committee of Origin: Economics : Approved by the ASA House of Delegates on October 17, 2012)

• A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to return to re-establish direct contact with the patient to meet medical needs and address any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the same group or department.

• Differences in the design and size of various facilities and demands of the particular surgical procedures make it impossible to define a specific time or distance for physical proximity.
Working With CRNA

Anesthesia by a CRNA with Medical Direction:

• For physician billing, the 7 rules of medical direction must be met and the physician must be immediately available for each case. The CRNA would bill for time and units with a QX modifier and the physician would bill for the same codes with a QK modifier. Procedure would be separately billable by the TP if they were present for the entire or key and critical portions of the procedure performed by a resident or fellow and document their presence. If the CRNA performed the procedure, the procedure should be billed under the CRNA.
• An anesthesiologist is considered “immediately available” when needed by a CRNA or AA under the anesthesiologist’s supervision only if he/she is physically located within the same area as the CRNA, e.g., in the same operative/procedural suite, or in the same labor and delivery unit, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed.
Working With Student CRNA’s

Anesthesiologist and Student CRNAs:

An anesthesiologist can work with no more than two SRNAs who are not providing services with a CRNA and bill services. As medical direction (QK modifier) for their service with no SRNA billing.

Teaching CRNAs and Student CRNAs: Medicare Claims Processing Manual
-- Section 140.5

• A teaching CRNA (not under the medical direction of a physician) can be paid under Medicare Part B when continuously present and supervising a single case or two concurrent cases with student nurse anesthetists. The CRNA should report the service using the usual “QZ” modifier which designates that he or she is not medically directed by an anesthesiologist. If the CRNA is being medically directed than they can supervise a SRNA in their case and bill with the QY and the anesthesiologist with the QK modifier for 50% each of the fee schedule.
Canceled Anesthesia

• If case canceled prior to induction, bill for pre-op assessment with 99231-99233, as supported by documentation standards.

• If case is canceled after induction, bill applicable surgical anesthesia code with base units + time with -53 modifier.
Qualifying Circumstances

- Many anesthesia services are performed under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions and/or unusual risk factors.

These are add-on codes and should not be reported alone! Some payers have pay an additional fee for these codes.
Qualifying Circumstances (Cont.)

+ **99100** Patient is of extreme age, under 1 year or over 70

+ **99116** Complicated by utilization of total body hypothermia

+ **99135** Complicated by utilization of controlled hypotension

+ **99140** Complicated by emergency conditions
  
  • Must specify condition
Obstetric Procedures

• Anesthesia services consist of the administration of an anesthetic agent to produce either a partial or complete loss of sensation. In obstetrics, anesthetic agents are most often administered via injections or continuous infusion into the subarachnoid, subdural, or epidural spaces of the spine, in order to produce circumscribed areas of loss of sensation. This type of anesthesia is often referred to as neuraxial analgesia.

• A frequently used anesthesia technique used in labor and delivery is continuous epidural analgesia. Customarily, an epidural catheter is placed during the first stage of labor. Pain is controlled during labor and childbirth by the continuous bathing of the lumbar nerve roots within the epidural space using an anesthetic agent administered through the indwelling catheter. Usually, the catheter remains in place through the delivery and may remain in place to achieve pain control after delivery.

• Clear documentation of any visits/evaluations/encounters with the patient by the anesthesiologist or anesthetist during labor or delivery must be noted in the medical record and must be available if requested. This includes, but is not limited to, documentation of catheter placement(s), administration of medications, visits to assess effectiveness of analgesia, attendance at delivery, and post-partum follow-up care. All OB anesthesia services must be submitted using units and time.
Neuraxial analgesia/anesthesia for planned vaginal delivery (See ASA guide for appropriate reporting code 01967):

1. Report up to 60 minutes of time for epidural catheter insertion and removal and delivery.
   - Note: These 60 minutes may be used at the discretion of the anesthesiologist. If either the insertion/removal of the epidural catheter and/or the delivery, individually or combined, exceeds the 60 minute threshold, additional time may be reported provided the medical record documentation supports the need for additional time.

2. Report 15 minutes of time for each hour patient is in labor. A notation must be made in the medical record, signed by the anesthesiologist or CRNA, which confirms that they visited the laboring patient during each hour of labor (a short progress note is acceptable for this notation).

3. Report actual time, in minutes, for time spent with the patient for the management of complications or adverse events, provided that actual care time is fully documented in the medical record.

• **NOTE:** this code is used for all vaginal deliveries and associated labor, and the labor portion of deliveries that are accomplished by Cesarean section.
Billing Guidelines for Code 01967

Neuraxial Labor Analgesia Reimbursement Calculations

Report total minutes and start and stop times.

- Consistent with a method described in the ASA RVG® reimbursement for neuraxial labor analgesia (CPT code 01967) is based on Base Unit Value plus Time Units subject to a cap of 435 minutes. Modifying Units for physical status modifiers and qualifying circumstance codes will be considered in addition to the Base Unit Value for labor or delivery anesthesia services in accordance with the Standard Anesthesia Formula.

•
Obstetric Anesthesia: Labor Epidural
Coding for labor epidurals is a lot like dealing with the obstetrics patients themselves - - no two cases are exactly alike, which leads to several coding challenges.

Tip 1: Divide Your Labor Codes by Delivery Type
• Your first step in coding a delivery is checking whether the anesthetist administered a continuous or non-continuous epidural. Report non-continuous (or spinal) anesthesia based on whether the patient had a vaginal or cesarean delivery:
  • 01960 -- *Anesthesia for vaginal delivery only* (5 base units plus time)
  • 01961 -- *Anesthesia for cesarean delivery only* (7 base units plus time)

Though 01960 and 01961 apply in some cases, most deliveries include a continuous epidural instead.

The primary code for delivery with continuous epidural is 01967 (*Neuraxial labor analgesia/anesthesia for planned vaginal delivery [this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor]*).
Add-on Codes

• You can expand your delivery coding with two labor anesthesia add-on codes. The codes in question are:
  
  • +01968 - Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (list separately in addition to code for primary procedure performed)
  
  • +01969 - Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)

**Remember:** You cannot report 01968 or 01969 alone because they are add-on codes. Instead, report either of these codes as appropriate in conjunction with 01967. Primary code 01967 is 5 base units; add 3 additional units for 01968 or 5 more units for 01969, then report the total time represented by both codes.

The code you attribute the total time to (all time with code 01967 or split between 01967 and the appropriate add-on code) will vary by payer.

Medicare requires for the obstetrical add-on codes, that the anesthesia time be separately reported with each of the primary and the add-on codes based on the amount of time appropriately associated with either code. Both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes are recognized.
Start, Stop and Total Anesthesia Time

CPT-4 Code 01967 Billing Requirements: (neuraxial labor analgesia/anesthesia for planned vaginal delivery [includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor]), all claims of 20 units or more require that an anesthesia report be attached.

Claims for 19 units or less for code 01967 do not require detailed documentation on the claim form or an attachment

“Time in Attendance” With the Patient

If billing for obstetrical regional anesthesia (CPT-4 code 01967), in addition to the documentation requirements noted above, providers also must document “time in attendance” on the anesthesia report. Only time in attendance with the patient may be billed.

“Time in attendance” is time when the anesthesiologist or CRNA monitors the patient receiving neuraxial labor analgesia, and the anesthesiologist or CRNA is readily and immediately available in the labor or delivery suite. If the actual time in attendance is less than the total quantity billed (in either the Service Units or Days or Units box), the claim will be reimbursed for the time in attendance with the patient.

If two or more patients receive neuraxial analgesia concurrently, no more than four total time units per hour may be billed and must be apportioned among the claims, including claims to other insurance carriers.
Tip 2: Verify Add-Ons Versus Surgical CPT

Most payers prefer the anesthesia labor codes, which simplifies your job. Some carriers still require surgical CPT Codes for labor epidurals, however, instead of the anesthesia codes.

These include:

• 62311 -- *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)*

• 62319 -- *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, [...]*
Good News for Labor Epidural Supervision


• CMS has removed language specifically exempting labor epidurals from the physician supervision requirements.

• Hospitals are now required to “establish policies and procedures, based on nationally recognized guidelines, that address whether specific clinical situations involved anesthesia versus analgesia,” as well as, “the minimum qualifications and supervision requirements for each category of practitioner who is permitted to provide analgesia services.”

• Note: analgesia via epidurals/spinals for Labor & Delivery is permitted to be administered by CRNAs without MD supervision.

• However, for a physician to personally bill for the epidural, he or she must be present for the placement of the catheter.
Supervision

• The administration of medication via an epidural or spinal route for the purpose of analgesia, during labor and delivery, is not considered anesthesia and therefore is not subject to the anesthesia supervision requirements at 42 CFR 482.52(a).

• However, if the obstetrician or other qualified physician attending to the patient determines that an operative delivery (i.e., C-section) of the infant is necessary, it is likely that the subsequent administration of medication is for anesthesia, as defined, and the anesthesia supervision requirements at 42 CFR 482.52(a) would apply.
Points Not To Forget From Anesthesia Reviews

• Physician must document involvement in preanesthesia evaluation and documentation within 48 hours of administration and the post anesthesia evaluation within 48 hours.

• Physician must sign presence statement for line placements which are separately billable. Each line placement or procedure (e.g., A-line, CVP, TEE) must have a specific attestation statement for present for entire procedure or key/critical (if over 5 minutes) for each procedure to bill.

• There have been issues identified with patients leaving prior to post-anesthesia evaluation. Every effort should be made to obtain prior to patient leaving if a shorter OP procedure.

• **Start time of anesthesia must include enough documentation to support continual presence by a practitioner at the start.**
Anesthesia OIG Cases

- Vanderbilt University: Whistleblower case by 3 former VUMC anesthesiologists alleging:
  - Surgery schedules showed surgeons were booking simultaneous cases in different parts of the hospital and "scheduling and staffing policies force surgeons to routinely overbook their schedules and rely on residents to perform the critical portions."
  - Anesthesia billing issues with supervision
    - Vanderbilt routinely — "nearly 100 percent of the time," according to the filing — submits false claims for so-called "medically directed" anesthesia despite not meeting the stringent federally mandated criteria.
Anesthesia Billing Categories

There are distinctions between the various billing categories of anesthesia services and are essential because they impact payment. Table 1 illustrates the significant differences that can occur depending on how you perform and bill an anesthesia claim.

<table>
<thead>
<tr>
<th>Billing Category</th>
<th>Physician Allowed Amount</th>
<th>CRNA/AA Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>M.D. Personally Performed</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td>Teaching</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Direction</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Medical Supervision</td>
<td>3 base units + 1 time unit (if present at induction)</td>
<td>50%</td>
</tr>
<tr>
<td>CRNA Performed w/o Supervision</td>
<td>N/A</td>
<td>100%</td>
</tr>
</tbody>
</table>
Minor Procedure With an E/M
Modifier 25 – Be ALERT

• Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.
  • The patient’s condition required a significant, separately identifiable E/M service, *above and beyond* the usual pre- and post-procedure care associated with the procedure or service performed
  • The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, *different diagnoses are not required* for reporting of the E/M services on the same date.

• The service could be a minor procedure, diagnostic service, E/M visit with a preventive service or E/M with a Medicare Well Visit or Well-Woman service.

• It is *STRONGLY* recommended that 2 separate and distinct notes be included in the medical record to document the procedure and then the separate E/M service

• Only a practitioner or coder should assign a modifier 25 to a Claim – Not a biller.
Modifier 25 – Be ALERT

• When Not to Use the Modifier 25
  • When billing for services performed during a postoperative period if related to the previous surgery
  • When there is only an E/M service performed during the office visit (no procedure done)
  • When on any E/M on the day a “Major” (90 day global) procedure is being performed
  • When a minimal procedure is performed on the same day unless the level of service can be supported as significant, separately identifiable. All procedures have “inherent” E/M service included.
  • When a patient came in for a scheduled procedure only
Injections

• Injection Therapy
  • Injection therapy is intended to be a means to an end. The goal is to provide the patient with enough pain relief to bridge from inactivity to physical therapy, where orthopedic problems can be better treated with special exercises. For years, physicians have used cortisone injections, steroid injections, trigger point injections and nerve blocks to relieve pain caused by osteoarthritis, rheumatoid arthritis, sports injury and more.
Injection Codes (000 Global Days):

- **20600**: Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance
  - **20604**: with ultrasound guidance, with permanent recording and reporting

- **20605**: Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
  - **20606**: with ultrasound guidance, with permanent recording and reporting

- **20610**: Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
  - **20611**: with ultrasound guidance, with permanent recording and reporting

Please note if the patient brought their own medication or if office supplied the med.
• Modifier 25 is used by the provider to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a **significant, separately identifiable** E/M service above and beyond the other service provided or **beyond the usual preoperative and postoperative care associated with the procedure that was performed**.

• Modifier 25 is designed to allow payment for the E/M service in addition to the procedure or service in these situations.

• Reporting an E/M service with modifier 25 is appropriate in the following situations:
  • The patient requires evaluation “above and beyond” what is typically expected as part of the evaluation prior to the procedure.
  • The patient’s condition has changed or worsened and the patient needs to be re-evaluated.
  • The patient presents with a new, separate problem than what prompted the procedure.
Sample Improper Use of Modifier 25 # 3 Example Scenario Coding & Rationale

• An established patient returns to the orthopedic physician with escalating right knee pain 6 months post a series of Hyaluronan injections. After evaluating the knee and the patient’s medical suitability for the procedure (meds, vitals, etc.), the physician determines a second series of hyaluronan injections is needed and performs the first of three intra-articular injections. 20610 It would not be appropriate to bill the E/M visit, because the focus of the visit is related to the knee pain, which precipitated the injection procedure. The evaluation of the knee problem and the patient’s medical suitability for the procedure is included in the injection procedure reimbursement
Billing Services When Working With Residents Fellows and Interns

All Types of Services Involving a resident with a TP Requires Appropriate Attestations in EHR or Paper Charts To Bill
Evaluation and Management (E/M)

E/M IP or OP: TP must personally document by a personally selected macro in the EMR or handwritten at least the following:

- That s/he was present and performed key portions of the service in the presence of or at a separate time from the resident; AND
- The participation of the teaching physician in the management of the patient.

• Initial Visit: “I saw and evaluated the patient. I reviewed the resident’s note and agree, except that the picture is more consistent with an upper respiratory infection not pneumonia. Will begin treatment with.........”

• Initial or Follow-up Visit: “I saw and evaluated the patient. Discussed with resident and agree with resident’s findings and plan as documented in the resident’s note.”

• Follow-up Visit: “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s finding and plans as written.”

• Follow-up Visit: “I saw and evaluated the patient. Agree with resident’s note, but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

The documentation of the Teaching Physician must be patient specific.
Unacceptable TP Documentation

• Assessed and Agree
• Reviewed and Agree
• Co-signed Note
• Patient seen and examined and I agree with the note
• As documented by resident, I agree with the history, exam and assessment/plan
Evaluation and Management (E/M)

**Time Based E/M Services:** The TP must be present and document for the period of time for which the claim is made. Examples:

- Critical Care Hospital Discharge (>30 minutes) or
- E/M codes where more than 50% of the TP time spent counseling or coordinating care

*Medical Student documentation for billing only counts for ROS and PFSH. All other contributions by the medical student must be re-performed and documented by a resident or teaching physician.*
TP Guidelines for Procedures

**Minor** – (< 5 Minutes): For payment, a minor procedure billed by a TP requires that s/he is physically present during the entire procedure.

Example: ‘I personally performed the procedure’
Example: ‘I was present for the entire procedure.’

**Major** – (>5 Minutes)

• SINGLE Procedure / Surgery — When the teaching surgeon is present or performs the procedure for a single non-overlapping case involving a resident, he/she or the resident can document the TP’s physical presence and participation in the surgery.

Example: “I was present for the entire procedure (or key and critical portions & description of the key and critical portions of the procedure and immediately available).”

**Endoscopy Procedures** (excluding Endoscopic Surgery):

TP must be present during the entire viewing for payment.

• The viewing begins with the insertion and ends with the removal.
• Viewing of the entire procedure through a monitor in another room does not meet the presence requirement.

Example: “I was present for the entire viewing”
• The Teaching Anesthesiologist must report the “GC” modifier with the Teaching claim along with the appropriate payment modifier for Medicare patients, only.
Anesthesia

Anesthesia - For the operating room portion of the case the teaching anesthesiologist must be present and document presence for:

- Induction, critical events, and emergence (if applicable) and available throughout.
  - If not be present for “emergence” of patients going directly to ICU, document it.
- Signature is required for the teaching physician providing each portion
- Minor procedures (line placements etc.) must be separately attested to for billing.
  - If needed, add addendums to the record to clarify if needed.
- Additional documentation of specific times attending was present during the course of an anesthetic adds strength to the attestation.
• TEACHING PHYSICIANS WHO SEEK REIMBURSEMENT FOR OVERSIGHT OF PATIENT CARE BY A RESIDENT MUST PERSONALLY SUPERVISE ALL SERVICES PERFORMED BY THE RESIDENT.

• PERSONAL SUPERVISION PURSUANT TO RULE 59G-1.010(276), F.C.A, MEANS THAT THE SERVICES ARE FURNISHED WHILE THE SUPERVISING PRACTITIONER IS IN THE BUILDING AND THAT THE SUPERVISING PRACTITIONER SIGNS AND DATES THE MEDICAL RECORDS (CHART) WITHIN 24 HOURS OF THE PROVISION OF THE SERVICE.
Critical Care: Medical Review Guidelines

- **Clinical Criterion** – A high probability of sudden, clinically significant or life threatening deterioration of the patient's condition which requires a high level of physician preparedness to intervene urgently.

- **Treatment Criterion** – Life or organ supporting interventions that require frequent assessment and manipulation by the physician.
  - Withdrawal of or failure to initiate these interventions would result in sudden, clinically significant / life-threatening deterioration in the patient’s condition.

- Time spent teaching or by residents may not be used in CC time and NPP time cannot be added to physician time.

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the requirements.
## CC Codes 99291 and 99292

<table>
<thead>
<tr>
<th>Time</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30 min</td>
<td>Appropriate E/ M code</td>
</tr>
<tr>
<td>30-74 min</td>
<td>99291 x 1</td>
</tr>
<tr>
<td>75-104 min</td>
<td>99291 x 1 and 99292 x 1</td>
</tr>
<tr>
<td>105-134 min</td>
<td>99291 x 1 and 99292 x 2</td>
</tr>
<tr>
<td>135-164 min</td>
<td>99291 x 1 and 99292 x 3</td>
</tr>
</tbody>
</table>
Critical Care Documentation & Criteria

MM5993 Related Change Request Number: 5993

• The TP documentation must include:
  • Time the teaching physician spent providing critical care (resident time and
time teaching residents does not count toward the 30 minute minimum);
  • That the patient was critically ill during the time the TP saw the patient (met
clinical criterion of a high probability of sudden, clinically significant or life
threatening deterioration of the patient's condition);
  • What made the patient critically ill; and
  • The nature of the treatment and management provided by the TP (treatment
criterion of Life or organ supporting interventions that require frequent
assessment and manipulation by the physician.)

• Combination of the TP's documentation and the resident’s may support CC
provided that all requirements for CC services are met. The TP documentation
may tie into the resident's documentation. The TP may refer to the resident’s
documentation for specific patient history, physical findings and medical
assessment as long as additional TP documentation is included to support their
CC time.
CC TP & Resident Documentation

• CMS examples of acceptable TP documentation for critical care involving Resident.
  • "Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition providing fluids, pressor drugs and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."
Evaluation & Management (E/E)
The 3 Key Documentation Elements

- Medical Decision Making
- Physical Exam
- History
  Focus on HPI
• The **Nature of the Presenting Problem** determines the level of documentation necessary for the service.

• The level of care (**E/M service**) submitted must not exceed the level of care that is medically necessary.

**SO . . .**

• Medical Decision-Making and Medical Necessity related to the Nature of the Presenting Problem determine the E/M level.

• The amount of history and exam should **not** generally alone determine the level.
Ignoring how medical decision-making affects E/M leveling can put you at risk.

• According to the Medicare Claims Processing Manual, chapter 12, section 30.6.1:

  • Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

  • That is, a provider should not perform or order work (or bill a higher level of service) if it’s not “necessary,” based on the nature of the presenting problem.
Medical Decision-Making

1. Number of Diagnoses or Treatment Options

- One or two stable problems? = **LOWER**
- No further workup required? = **COMPLEXITY**
- Improved from last visit? = **COMPLEXITY**

- Multiple active problems? = **HIGHER**
- New problem with additional workup? = **HIGHER**
- Are problems worse? = **HIGHER**
2. Amount/Complexity of Data

- Were lab/x-ray ordered or reviewed?
- Were other more detailed studies ordered? (Echo, PFTs, BMD, EMG/NCV, etc.)
- Did you review old records?
- Did you view images yourself?
- Discuss the patient with consultant?
Medical Decision-Making

3. Table of Risk

- Is the presenting problem self-limited?
- Are procedures required?
- Is there exacerbation of chronic illness?
- Is surgery or complicated management indicated?
- Are prescription medications being managed?
## MDM – Step 3: Risk

<table>
<thead>
<tr>
<th></th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Min</strong></td>
<td>• One self-limited / minor problem</td>
<td>• Labs requiring venipuncture</td>
<td>• Rest   Elastic bandages Gargles Superficial dressings</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>• 2 or more self-limited/minor problems</td>
<td>• Physiologic tests not under stress (PFT)</td>
<td>• OTC meds  Minor surgery w/no identified risk factors PT, OT IV fluids w/out additives</td>
</tr>
<tr>
<td><strong>OP Level 3</strong></td>
<td>• 1 stable chronic illness (controlled HTN)</td>
<td>• Non-CV imaging studies Superficial needle biopsies</td>
<td>• Prescription meds  Minor surgery w/identified risk factors</td>
</tr>
<tr>
<td><strong>IP Sub 1</strong></td>
<td>• Acute uncomplicated illness / injury (simple sprain)</td>
<td>• Labs requiring arterial puncture Skin biopsies</td>
<td>• Elective major surgery w/out risk factors  Therapeutic nuclear medicine IV fluids w/additives Closed treatment, FX / dislocation w/out manipulation</td>
</tr>
<tr>
<td><strong>IP Initial 1</strong></td>
<td></td>
<td></td>
<td>• Parenteral controlled substances  Drug therapy monitoring for toxicity DNR</td>
</tr>
<tr>
<td><strong>Mod</strong></td>
<td>• 1 &gt; chronic illness, mod. Exacerbation, progression or side effects of treatment</td>
<td>• Physiologic tests under stress (stress test)</td>
<td>• Elective major surgery w/risk factors Emergency surgery</td>
</tr>
<tr>
<td><strong>IP Initial 2</strong></td>
<td>• 2 or more chronic illnesses</td>
<td>• Diagnostic endoscopies w/out risk factors</td>
<td>• Parenteral controlled substances  Drug therapy monitoring for toxicity DNR</td>
</tr>
<tr>
<td><strong>OP Level 4</strong></td>
<td>• Undiagnosed new problem w/uncertain prognosis</td>
<td>• Deep incisional biopsies</td>
<td>• Elective major surgery w/risk factors Emergency surgery</td>
</tr>
<tr>
<td><strong>IP Sub 2</strong></td>
<td>• Acute illness w/systemic symptoms (colitis)</td>
<td>• CV imaging w/contrast, no risk factors (arteriogram, cardiac cath)</td>
<td>• Parenteral controlled substances  Drug therapy monitoring for toxicity DNR</td>
</tr>
<tr>
<td><strong>IP Initial 2</strong></td>
<td>• Acute complicated injury</td>
<td>• Obtain fluid from body cavity (lumbar puncture)</td>
<td>• Elective major surgery w/risk factors Emergency surgery</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>• 1 &gt; chronic illness, severe exacerbation, progression or side effects of treatment</td>
<td>• CV imaging w/contrast, w/risk factors</td>
<td>• Parenteral controlled substances  Drug therapy monitoring for toxicity DNR</td>
</tr>
<tr>
<td><strong>OP Level 5</strong></td>
<td>• Acute or chronic illnesses that may pose threat to life or bodily function (acute MI)</td>
<td>• Cardiac electrophysiological tests</td>
<td>• Parenteral controlled substances  Drug therapy monitoring for toxicity DNR</td>
</tr>
<tr>
<td><strong>IP Sub 3</strong></td>
<td>• Abrupt change in neurologic status (TIA, seizure)</td>
<td>• Diagnostic endoscopies w/risk factors</td>
<td>• Parenteral controlled substances  Drug therapy monitoring for toxicity DNR</td>
</tr>
<tr>
<td><strong>IP Initial 3</strong></td>
<td></td>
<td></td>
<td>• Parenteral controlled substances  Drug therapy monitoring for toxicity DNR</td>
</tr>
</tbody>
</table>
FOUR ELEMENTS of HISTORY

• Chief Complaint (CC:)
• History of Present Illness (HPI)
• Review of Systems (ROS)
• Past/Family/Social History (PFSHx)
History

1. **Chief Complaint**
   - Concise statement describing reason for encounter
     - “back pain”
     - “follow-up for numbness”
   - Can be included in HPI

   **IMPORTANT:**
   - The visit is not billable if Chief Complaint is not somewhere in the note
   - Must be “follow-up” of ____________________________
History - HPI

2. The HPI is a chronological description of the patient’s illness or condition. The elements to define the HPI are:
   • Location: Right lower extremity, at the base of the neck, center of lower back
   • Quality: Bright red, sharp stabbing, dull
   • Severity: Worsening, improving, resolving
   • Duration: Since last visit, for the past two months, lasting two hours
   • Timing: Seldom, first thing in the morning, recurrent
   • Context: When walking, fell down the stairs, patient was in an MVA
   • Modifying Factors: Took Tylenol, applied cold compress: with relief/without relief
   • Associated Signs and Symptoms: With nausea and vomiting, hot and flushed, red and itching

TWO TYPES:
BRIEF 1-3 elements above or status of 1-2 diagnosis or conditions
EXTENDED 4 or > elements above or status of 3 or > diagnosis or conditions
3. REVIEW OF SYSTEMS

14 recognized:

- Constitutional
- Psych
- Eyes
- Respiratory
- ENT
- GI
- CV
- GU
- Skin
- MSK
- Neuro
- Endocrine
- Heme/Lymph
- Allergy/Immunology

THREE TYPES:  
- PROBLEM PERTINENT (1 SYSTEM)
- EXTENDED (2-9 SYSTEMS)
- COMPLETE (10 SYSTEMS)
4. **PAST, FAMILY, AND SOCIAL HISTORY**
- Patient’s previous illnesses, surgeries, and medications
- Family history of important illnesses and hereditary conditions
- Social history involving work, home issues, tobacco/alcohol/drug use, military service, etc.

**TWO TYPES:**
- **PERTINENT:** 1 area (P, F or S) generally related to HPI
- **COMPLETE:** All 3 (P, F and S) for New patient & Initial Hospital or 2 of 3 areas (P, F or S) for established pt.
4 TYPES OF EXAMS

- Problem Focused (PF)
- Expanded Problem Focused (EPF)
- Detailed (D)
- Comprehensive (C)
## Coding 1995: Physical Exam

### BODY AREAS (BA):
- Head, including face
- Neck
- Chest, including breast and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

### CODING ORGAN SYSTEMS (OS):
- Constitutional/General
- Eyes
- Ears/Nose/Mouth/Throat
- Respiratory
- Cardiac
- GI
- GU
- Musculoskeletal
- Skin
- Neuro
- Psychiatric
- Hematologic/Lymphatic
1997 Sub-Specialty Physical Exam

- Cardiovascular
- Musculoskeletal
- Ears, Nose, Mouth and Throat
- Neurological
- Eyes
- Skin

- Psychiatric
- Genitourinary (Female) (Male)
- Respiratory
- Hematologic / Lymphatic / Immunologic
- General Multi-system Exam
Constitutional

- Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)

- General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)

Cardiovascular

- Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)

Lymphatic

- Palpation of lymph nodes in neck, axillae, groin and/or other location

Musculoskeletal

- Examination of gait and station
- Examination of joint(s), bone(s) and muscle(s)/tendon(s) of four of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:
  - Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
  - Assessment of range of motion with notation of any pain (eg, straight leg raising), crepitation or contracture
  - Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
  - Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

- NOTE: For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.

Skin

- Inspection and/or palpation of skin and subcutaneous tissue (eg, scars, rashes, lesions, cafe-au-lait spots, ulcers) in four of the following six areas: 1) head and neck; 2) trunk; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity.

- NOTE: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.
1995 and 1997 Exam Definitions

Problem Focused (PF): 99231, 99212 or 99201
- ’95: Limited exam of the affected body area or organ system. (1 BA/OS)
- ’97=Specialty and GMS: 1-5 elements identified by bullet.

Expanded Problem Focused (EPF): 99232, 99213 or 99202
- ’95: Limited exam of affected BA/OS & other symptomatic/related OS.(2-7 BA/OS)
- ’97=Specialty and GMS: At least 6 elements identified by bullet.

Detailed (D): 99233, 99221, 99214 or 99203
- ’95: Extended exam of affected BA/OS and other symptomatic/related OS.(2-7 BA/OS)
- 97=Specialty: At least 12 elements identified by bullet (9 for eye and psyc)

Comprehensive (C): 99222, 99223, 99215 or 99204 and 99205
- ’95: General multi-system exam (8 or more organ systems) or complete single organ system (a complete single organ system is undefined by CMS).
- ’97=Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area.
Using Time to Code

• Time shall be considered for coding an E/M in lieu of H-E-MDM when > 50% of the total billable practitioner visit time is counseling/coordination of care (CCC.)
  • **Time is only Face-to-face for OP setting**
• Coding based on time is generally the exception for coding.
• It is typically used:
  • Significant exacerbation or change in the patient’s condition,
  • Non-compliance with the treatment/plan,
  • Counseling regarding previously performed procedures or tests to determine future treatment options, or
  • Behavior/school issues.

Required Documentation For Billing:

1. Total time of the encounter excluding separate procedure if billed
   • The entire time to prep, perform and communicate results of a billable procedure to a patient must be carved out of the E/M encounter time!
2. The amount of time dedicated CCC for that patient on that date of service. A template statement would not meet this requirement.
# Time-Based Billing for CCC

## Outpatient Counseling Time:

<table>
<thead>
<tr>
<th>Code</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
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<tr>
<td>99202</td>
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<td>99203</td>
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<td>99214</td>
<td>25 min</td>
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<tr>
<td>99215</td>
<td>40 min</td>
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</tbody>
</table>

## Inpatient Counseling Time:

<table>
<thead>
<tr>
<th>Code</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
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<td>50 min</td>
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<td>99254</td>
<td>80 min</td>
</tr>
<tr>
<td>99255</td>
<td>110 min</td>
</tr>
</tbody>
</table>
Counseling/Coordination of Care CCC

Proper Language used in documentation of time:

• “I spent ____ minutes with the patient and family and over 50% was in counseling about her diagnosis, treatment options including _______ and ______.”

• “I spent ____ minutes with the patient and family more than half of the time was spent discussing the risks and benefits of treatment with……(list risks and benefits and specific treatment)”

• “This entire ______ minute visit was spent counseling the patient regarding ________ and addressing their multiple questions.

Total time spent and the time spent on counseling and/or coordination of care must be documented in the medical record.

Documentation must reflect the specific issues discussed with patient present.
New Patients

Patient not seen by you or your billing group in the past three years (as outpatient or inpatient)
Inpatient E/M Coding

Inpatient Hospital

• Subsequent Hospital Care

Three levels of service: 99231, 99232, 99233

• **99231** - Stable, recovering, improving
  • **Problem focused** history or exam

• **99232** - Not responding, minor complication
  • **Expanded problem focused** history or exam

• **99233** - Very unstable, significant complications
  • **Detailed** history or exam

**REMEMBER:** What is medically necessary to document for that day?
Subsequent Hospital Visits

Inpatient Hospital

Medical Necessity should drive your documentation for each day’s visit:

What’s wrong with this audit?

Day 1: 99223
Day 2: 99233
Day 3: 99233
Day 4: 99233
Day 5: 99233
Day 6: 99239 (discharge to home)
Important!

Hospital Discharge

Documentation should include:

- final examination of patient
- discharge instructions/follow-up
- preparation of referrals/prescriptions
- time spent

- If less than 30 minutes: 99238
- If more than 30 minutes: 99239 (TIME must be documented)
Top Compliance Issues For Documenting in EMR
Documentation in EMR

PAYORS ARE WATCHING EMR DOCUMENTATION

Once you sign your note, YOU ARE RESPONSIBLE FOR ITS CONTENT
Top Compliance Rules for EMR

Use “Copy Forward” with caution

- Each visit is unique

- **Cloned documentation** is very obvious to auditors

- If you bring a note forward it MUST reflect the activity for the CURRENT VISIT with appropriate editing

- **Strongly advise** NOT copying forward HPI, Exam, and complete Assessment/Plan
Top Compliance Rules for EMR

Don’t dump irrelevant information into your note

• (“the 10-page follow-up note”)

• Be judicious with “Auto populate”
• Consider Smart Templates instead
• Marking “Reviewed” for PFSHx or labs is OK from Compliance standpoint (as long as you did it!)
Top Compliance Rules for EMR

Never copy ANYTHING from one patient’s record into another patient’s note

• Self-explanatory
Top Compliance Rules for EMR

Only Past/Family/Social History and Review of Systems may be used from a *medical student* or *nurse’s* note

- Student or nurse may start the note
- Provider (resident or attending)
- must document HPI, Exam, and
- Assessment/Plan
Top Compliance Rules for EMR

Be careful with pre-populated “No” or “Negative” templates

• Cautious with ROS and Exam

• Macros, Check-boxes, or Free Text are safer and more individualized
Top Compliance Rules for EMR

Link diagnosis to each test ordered (*lab*, *imaging*, *cardiographics*, *referral*)

- Demonstrates Medical Necessity
- Know your covered diagnoses for your common labs
Copy/Paste Philosophy:

Your note should reflect the reality of the visit for that day
Use Specific Dates

• Don’t say Today, Tomorrow, or Yesterday

• Write specific dates, i.e., “ID Consult recommends ceftriaxone through 9/3”, instead of “six more days”, which could be carried forward inaccurately

• “Heparin stopped 6/20 due to bleeding” will always be better than “Heparin stopped yesterday”, which can be carried forward in error
Use Past Tense

• “Neuro status remains stable, will discontinue neuro checks” can be copied forward in error

• Better – “Neuro checks stopped on 2/24”

• “Added heparin on 4/26” – uses past tense and specific date for better accuracy
Copy / Paste Summary

• Copy/Paste can be a valuable tool for efficiency when used correctly

• There are major Compliance risks when used inappropriately, including potential fraud and abuse allegations, denial of hospital days, and adverse patient outcomes

• Make sure your note reflects the reality and accuracy of the service each day
Current CMS Florida First Coast Audits

• Prepayment review for CPT® code 99291:
  • In response to continued Comprehensive Error Rate Testing (CERT) errors and risk of improper payments a prepayment threshold edit for CPT® code 99291 claims submitted on or after March 15, 2016, that will apply to all providers.

• Prepayment review for CPT® codes 99232 and 99233
  • Data indicates specialties internal medicine and cardiology are the primary contributors to the CERT error rate for subsequent hospital care services. The new audit will be based on a threshold of claims submitted for payment by cardiology and internal medicine specialties for 99232 and 99233. The audit will be implemented for claims processed on or after March 15, 2016.

• Prepayment review for CPT® codes 99222 and 99223
  • First Coast conducted a data analysis for codes 99222 and 99223 (initial hospital care). Implementing a prepayment review audit for CPT 99222 by all specialties; and CPT 99223 billed cardiology specialty. The audit will be implemented for claims processed on or after April 7, 2016.

• Prepayment review for CPT® codes 99204, 99205, 99215 and 99285 all specialties

• 99214 – Post-payment review
HIPAA, HITECH, PRIVACY AND SECURITY

• HIPAA, HITECH, Privacy & Security Health Insurance Portability and Accountability Act – HIPAA
  – Protect the privacy of a patient’s personal health information
  – Access information for business purposes only and only the records you need to complete your work.
  – Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  – PHI is protected even after a patient’s death!!!

• Never share your password with anyone and no one use someone else’s password for any reason, ever –even if instructed to do so.

✓ If asked to share a password, report immediately.
✓ If you haven’t completed the HIPAA Privacy & Security Awareness on-line CBL module, please do so as soon as possible by going to:

http://www.miami.edu/index.php/professional_development_training_office/learning/ulearn/
HIPAA, HITECH, Privacy & Security

Several breaches were discovered at the University of Miami, one of which has resulted in a class action suit. As a result, “Fair Warning” was implemented.

What is Fair Warning?

- **Fair Warning** is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.
- **Fair Warning** protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.
- **Fair Warning** is an initiative intended to reduce the cost and complexity of HIPAA auditing.

UHealth has policies and procedures that serve to protect patient information (PHI) in oral, written, and electronic form. These are available on the Office of HIPAA Privacy & Security website:

http://www.med.miami.edu/hipaa
“Whoa—way too much information.”
Available Resources at University of Miami, UHealth and the Miller School of Medicine

- If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  - **Helenmarie Blake-Leger, Interim AVP of Clinical Billing Compliance & HIPAA Privacy Officer** @ 305-243-6000
  - **Iliana De La Cruz, RMC, Director Office of Billing Compliance**
  - **Gema Balbin-Rodriguez, Associate Director Office of Billing Compliance**
    - Phone: (305) 243-5842
    - Email: Officeofbillingcompliance@med.Miami.edu

Also available is The University’s fraud and compliance hotline via the web at [www.canewatch.ethicspoint.com](http://www.canewatch.ethicspoint.com) or toll-free at 877-415-4357 (24 hours a day, seven days a week). Your inquiry or report may remain anonymous.

- Office of billing Compliance website: [www.obc.med.miami.edu](http://www.obc.med.miami.edu)