Department of General Medicine

Office of Billing Compliance
2015 Coding, Billing and Documentation Program
Documentation in the EHR - EMR
Volume of Documentation vs Medical Necessity

Annually OIG publishes its "targets" for the upcoming year. Included is EHR Focus and for practitioners could include:

Pre-populated Templates and Cutting/Pasting Documentation containing inaccurate or incomplete or not provided information in the medical record

- **REMEMBER:** More volume is not always better in the medical record, especially in the EMR with potential for cutting/pasting, copy forward, pre-defined templates and pre-defined E/M fields. Ensure the billed code is reflective of the actual service provided on the DOS only.
General Principles of Documentation

• All documentation must be legible to all readers. Illegible documents are considered not medically necessary if it is useless to provide a continuum of care to a patient by all providers. Documentation is for the all individuals not just the author of the note.

• Per the Centers for Medicare and Medicaid services (CMS) 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 date of service.
  • 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, and this includes a signature.

• An addendum to a note should be dated and timed the day the information is added to the medical record and only contain information the practitioner has direct knowledge is true and accurate.
General Principals of Documentation

• All documentation must be legible to all readers.

• Complete and timely
  • Including signature

• Addendum: Dated and timed day added
  • Practitioner has direct knowledge is true and accurate.
2015 Code Changes
New & Revised Codes

• New
  • 90630  Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
  • 90651  Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use

• Revised
  • 90654  Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use
  • 90721  Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP/Hib), for intramuscular use
  • 90723  Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use
  • 90734  Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivalent, for intramuscular use

• Vaccines/Toxoids (90630, 90651, 90654, 90721, 90723, 90734 ) identify the vaccine product only. To report the administration of a vaccine/toxoid, the vaccine/toxoid product code must be used in addition to an immunization administration code(s) 90460, 90461, 90471, 90472, 90473, 90474.
Advance Care Planning (ACP)

Two new codes have been created for advance care planning, including completion of advance directive. Although this service is frequently provided by oncology physicians, it must be completely documented in the medical record in order to report the following codes:

• 99497: Advance care planning (ACP), including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.

• 99498: each additional 30 minutes and should be listed separately and in addition to 99497.

CMS will not pay separately for this service in calendar year (CY) 2015, but it will consider separate payment in subsequent years.
ACP (Advanced Care Planning)

• An advance directive is a document that appoints an agent and/or records the wishes of a patient pertaining to his or her medical treatment at a future time should he or she lack decisional capacity at that time.

• To report the code(s), the patient need not be present as the discussion can also be between a physician or qualified healthcare professional and a family member or surrogate. Because the purpose of the visit is the discussion, no active management of the problem(s) is undertaken during this time period.

• Completion of relevant legal forms is also not required at the time of the discussion. It is important to note that this service is limited to advance care planning.

• As stated in the guidelines, certain E/M services performed on the same day may be reported separately.
Chronic Care Management (CCM)

99490: Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

AMA CPT Symposium: CMS clarify CCM billing:

• For the new monthly chronic care management (CCM) services, practices should bill the claim on “the last day of the calendar month for which the CCM service is billed,” according to a senior CMS official.
  • For example, if services began in January, practices would bill 99490 with the date of service of Jan. 31 to earn the about $40 payment.
**CCM**

1. **CCM has no face-to-face visit requirement.** “We would in general assume that if a patient has two chronic conditions that the physician would want to see them, but it’s not part of this service,” said Kathy Bryant, CMS director of the division of practitioner services.

2. **Outside providers can bill CCM services.** Asked whether providers could “contract out” CCM services to an outside agency or provider, Bryant replied, “it is an incident-to service and incident-to rules allow contracted providers, as long as the regulation is followed.”

3. **CCM is not a capitated payment.** It’s “not a per-beneficiary, per-month payment,” Bryant warns. “We do not believe that in a fee-for-service system we have the capability to pay this way. You must provide 20 minutes of services during a calendar month to bill this code.”
Along those same lines, you can’t automatically charge for a CCM service for the care of a patient just because he has two chronic illnesses, warned David Ellington, M.D., of the AMA’s CPT Editorial Panel. The CCM patient is “not someone with two very stable illnesses,” he explained. Instead, the patient’s “chronic conditions place the patient at significant risk of death, acute exacerbation, decompensation or functional decline,” he added.

4. Keep time records. CMS doesn’t have a specific policy for how you should document your time when providing CCM services. “If it were up to me, I would keep actual time records,” Bryant said. According to CPT, if you record fewer than 20 minutes of CCM services per month, you can’t bill for the service. The usual CPT time conventions — which allow you to round up to a code’s required time when more than half the time is reached — do not apply for 99490, he says.
CCM

• **5. Inform the beneficiary when you start care.** A Medicare patient may not see you in February, but she will have to pay a coinsurance in February for your CCM services, Bryant explains. To bill for CCM, you must inform the beneficiary so she will understand what’s going on, she adds.

• **6. Watch Medicare, CPT for place-of-service rules.** As far as Medicare is concerned, CCM is a non-face-to-face service and has no requirement for place of service, Bryant said. However, CPT is a little stricter. The CPT manual specifies that a CCM patient is at home in a domiciliary, rest home or assisted living facility, Ellington pointed out. CCM was not meant to be a service performed for hospital inpatients, he said.
Reminder: Transitional Care Management (TCM)

Identify Qualifying Patients – Services are applicable to any division who is managing the comprehensive responsibility for a patient’s care

- CPT® codes 99495 and 99496 represent the oversight, management, and/or coordination of services for all medical conditions, psychosocial needs, and activities of daily living support by providing first contact with the patient and continuous access by the provider for 30 days post-discharge.

Documentation must include:

- Timing of the initial post-discharge communication with the patient or caregivers
- Date of the face-to-face visit
- Care/Coordination provided
- Complexity of the MDM
- Medication reconciliation and management no later than date of the first face-to-face visit is included in TCM service.
**Basic requirements/rules per CMS**

<table>
<thead>
<tr>
<th>Post-discharge TCM codes</th>
<th>Type of MDM</th>
<th>Communicate within 2 business days* of discharge</th>
<th>Face-to-face visit within 7 days</th>
<th>Payable once in 8 to 14 days per patient</th>
<th>Additional E/M service reportable</th>
<th>Billable during post-op period of 010 and 090 procedures</th>
<th>Patient may be new or established</th>
</tr>
</thead>
<tbody>
<tr>
<td>99495</td>
<td>Moderate</td>
<td>Yes **</td>
<td>No***</td>
<td>Yes</td>
<td>Yes^^^</td>
<td>No</td>
<td>√√√</td>
</tr>
<tr>
<td>99496</td>
<td>High</td>
<td>Yes **</td>
<td>Yes***</td>
<td>No</td>
<td>Yes^^^</td>
<td>No</td>
<td>√√√</td>
</tr>
</tbody>
</table>

* Business days are counted as Monday through Friday, except holidays without respect to normal business hours.

**After two or more documented unsuccessful attempts at communication are made within a timely fashion, per CMS, keep trying until patient is reached.

***Per CMS, the face-to-face visit required for TCM services cannot be furnished by same provider on same day as the discharge management service.

^^^Once per/individual/group regardless of subsequent admit/discharge at 30 days post-discharge or after per CMS.

- After the first required face-to-face visit.

√√√ Patient may be new to the practice. Provider may opt to bill new patient visit instead of TCM service code.
Teaching Physicians (TP) Guidelines

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.
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.*
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
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 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.
Diagnostic Procedures

• **RADIOLOGY AND OTHER DIAGNOSTIC TESTS**

• **General Rule:** The Teaching Physician may bill for the interpretation of diagnostic Radiology and other diagnostic tests if the interpretation is performed or reviewed by the Teaching Physician with modifier 26 in the hospital setting.

• **Teaching Physician Documentation Requirements:**
  - Teaching Physician prepares and documents the interpretation report.
  - OR
  - Resident prepares and documents the interpretation report.
  - The Teaching Physician must document/dictate: “I personally reviewed the film/recording/specimen/images and the resident’s findings and agree with the final report”.

• A countersignature by the Teaching Physician to the resident’s interpretation is not sufficient documentation.
Orders” Are Required For Any Diagnostic Procedure With a TC / 26 Modifier

• The CPT descriptions of documentation requirements for many ophthalmic diagnostic tests include the phrase, ".

• . . with interpretation and report." Once the appropriate individual has performed the test, you must document your interpretation of the results somewhere in the medical records. This doesn't have to be anything elaborate.

• It may merely be a brief phrase indicating if a test is "normal," "stable from a previous test" or "mild superior arcuate defect."
Orders” Are Required For Any Diagnostic Procedure With a TC / 26 Modifier

• All services billed for interpretation must include an order (even as a notation in the encounter note for the DOS) and distinct report for in order to bill.

• For Medicare, the Interpretation and Report needs the Three C’s to be addressed:
  • Clinical Findings,
  • Comparative Data, when appropriate; and
  • Clinical Management

• There must be a written report that becomes part of the patient’s medical record and this should be as complete as possible.
Primary Care Exception (PCE)

In order to function under PCE, certain requirements must be met and approval must be granted. Qualifying residency programs may include family practice, general internal medicine, geriatric medicine, pediatrics and obstetrics/gynecology.

In general, PCE allows the medical resident to see patients without the physical presence of a teaching physician for lower level E/M services (levels 3 and below) and certain preventive services.

The teaching physician (TP) has the primary medical responsibility for patients cared for by the medical residents under PCE and is responsible for reviewing the care provided by the medical resident during or immediately after each visit.

If the TP personally sees and evaluates the patient, regular teaching rules apply and the TP can bill above level 3 visits.
PCE

TP can work with 4 residents and 3 of the 4 must have > 6months experience.
The TP cannot be managing any other staff while providing PCE services (including NP’s and PA’s).
For payment, a PCE service billed by a teaching physician requires that s/he personally document the extent of his/her participation in the review and direction of the services furnished to each patient.

Example: ‘While the patient was in clinic (or immediately after the resident saw the patient), I reviewed the patient’s medical history, the resident’s findings on physical examination, the patient’s diagnosis and treatment plan with the resident and agree with the information documented.’
EXAMPLES OF TEACHING PHYSICIANS DOCUMENTATION UNDER THE PRIMARY CARE EXCEPTION:

• Case discussed with Dr. Resident at the time of the visit. Patient presents a diagnosis of  
…………………….and treatment with…………………….Agree or (revise) with diagnosis of…………………..and plan of 
care …………………………….

• Or:

• Patient case reviewed and discussed with resident at the time of visit. Given a history of ............... Exam 
and assessment show....................... .(state test findings of significance). I agree (revise) plan of care 
as..........................................

• Phrases such as, “Discussed and agree with resident’s assessment and plan” are NOT adequate, since 
this language does not show when the review occurred and what patient specific information was 
reviewed with resident.

GE MODIFIER

• The GE Modifier must be used to bill Medicare for any service involving residents 
under the Teaching Physician Primary Care Exception Rule.
Modifier GC
CMS Manual Part 3 - Claims Process - Transmittal 1723

- Teaching Physician Services That Meet the Requirement for Presence During the Key Portion of the Service when working with a resident or fellow

- Teaching Physician Services that are billed using this modifier are certifying that they have been present during the key portion of the service.
Inpatient, Outpatient and Consultations

Evaluation and Management E/M

Documentation and Coding
What is the definition of "new patient" for billing E/M services?

• “New patient" is a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.

• An interpretation of a diagnostic test, reading an x-ray or EKG etc., (billed with a -26 modifier ) in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.
E/M Key Components

• **History (H)** - Subjective information
• **Examination (E)** - Objective information
• **Medical Decision Making (MDM)** – The assessment, plan and patient risk

The billable service is determined by the combination of these 3 key components.

• All 3 Key Components are required to be documented for all E/M services.
• For coding the E/M level
  • New OP and initial IP require all 3 components to be **met or exceeded** and
  • Established OP and subsequent IP require 2 of 3 key components to be **met or exceeded and one must be MDM**.

*When downcoded for “medical necessity” on audit, it is often determined that documented H and E exceeded what was deemed “necessary” for the visit (MDM).*
Elements of an E/M History

The extent of information gathered for history is dependent upon clinical judgment and nature of the presenting problem.

Documentation of the patient’s history includes some or all of the following elements:

• Chief Complaint (CC) and History of Present Illness (HPI) are required to be documented for every patient for every visit

WHY IS THE PATIENT BEING SEEN TODAY

• Review of Systems (ROS)

• Past Family, Social History (PFSH)
History of Present Illness (HPI)
A KEY to Support Medical Necessity to in addition to MDM

• HPI is chronological description of the development of the patient’s present illness or reason for the encounter from the first sign and/or symptom or from the previous encounter to the present or the status of chronic conditions being treated at this visit.
  • The HPI must be performed and documented by the billing provider in order to be counted towards the level of service billed.

  Focus upon present illness or reason for the visit!

• HPI drivers:
  • Extent of PFSH, ROS and physical exam performed

• NEVER DOCUMENT PATIENT HERE FOR FOLLOW-UP WITHOUT ADDITIONAL DETAILS OF REASON FOR FOLLOW-UP. This would not qualify as a CC or HPI.
HPI

• Status of chronic conditions being managed at visit
  • Just listing the chronic conditions is a medical history
  • Their status must be addressed for HPI coding

OR

• Documentation of the HPI applicable elements relative to the diagnosis or signs/symptoms being managed at visit
  • Location
  • Quality
  • Severity
  • Duration
  • Timing
  • Context
  • Modifying factors
  • Associated signs and symptoms
Review of Systems (ROS)

- Constitutional
- Eyes
- Respiratory
- Ears, nose, mouth, throat
- Cardiovascular
- Musculoskeletal
- Gastrointestinal
- Genitourinary
- Psychiatric
- Integumentary
- Neurologic
- Allergy/Immunology
- Endocrine
- Hematologic/Lymphatic

ROS is an inventory of specific body systems in the process of taking a history from the patient. The ROS is designed to bring out clinical symptoms which the patient may have overlooked or forgotten. In theory, the ROS may illuminate the diagnosis by eliciting information which the patient may not perceive as being important enough to mention to the physician relative to the reason for the visit.
Past, Family, and/or Social History (PFSH)

- **Past history:** The patient’s past medical experience with illnesses, surgeries, & treatments. May also include review of current medications, allergies, age appropriate immunization status

- **Family history:** May include a review of medical events in the patient’s family, such as hereditary diseases, that may place a patient at risk or Specific diseases related to problems identified in the Chief Compliant, HPI, or ROS

- **Social history:** May include age appropriate review of past and current activities, marital status and/or living arrangements, use of drugs, alcohol or tobacco and education.

Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services. **Don't use the term "non-contributory" for coding a level of E/M**
Examination

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
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 and 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.
Medical Decision Making (MDM)

Document everything that affects your service today!!

Exchange of clinically reasonable and necessary information and the use of this information in the clinical management of the patient

Step 1:
- Number of possible diagnosis and/or management options affecting today's visit. List each separate in A/P and address every diagnosis or management option from visit. Is the diagnosis and/or management options:
  - “New” self-limiting: After the course of prescribed treatment is it anticipated that the diagnosis will no longer be exist (e.g. otitis, poison ivy, ...)
  - New diagnosis with follow-up or no follow-up (diagnosis will remain next visit)
  - Established diagnosis that stable, worse, new,

Step 2:
- Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
  - Labs, radiology, scans, EKGs etc. reviewed or ordered
  - Review and summarization of old medical records or request old records
  - Independent visualization of image, tracing or specimen itself (not simply review of report)

Step 3:
- The risk of significant complications, morbidity, and/or mortality with the patient’s problem(s), diagnostic procedure(s), and/or possible management options.
  - # of chronic conditions and are the stable or exacerbated (mild or severe)
  - Rx’s ordered or renewed. Any Rx toxic with frequent monitoring?
  - Procedures ordered and patient risk for procedure

Note: The 2 most complex elements out of 3 will determine the overall level of MDM
# MDM Step 1: # Dx & Tx Options

## Number of Diagnosis or Treatment Options – Identify Each That Effects Patient Care For The DOS

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max=2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner) stable, improved</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner) worsening</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max=1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New prob. (To examiner); additional workup planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Total** 41
### MDM Step 2: Amt. & Complexity of Data

**Amount and/or Complexity of Data Reviewed – Total the points**

<table>
<thead>
<tr>
<th>REVIEWED DATA</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report).</td>
<td>2</td>
</tr>
</tbody>
</table>

**Total** 42

1 POINT: 
- E-2, NEW-1,2
- IP Level 1

2 POINTS: 
- E-3, NEW-3
- IP Level 1

3 POINTS: 
- E-4, NEW-4
- IP Level 2

4 POINTS: 
- E-5, NEW-5
- IP –Level 3
MDM Step 3: Risk Table for Complication

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

**DG:** Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

Risk is assessed based on the risk to the patient between present visit and the NEXT time the patient will be seen by billing provider or risk for planned intervention.
<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| **Min Risk** | • One self-limited / minor problem | • Labs requiring venipuncture  
• CXR  
• EKG/ECG  
• UA | • Rest  
• Elastic bandages  
• Gargles  
• Superficial dressings |
| E-2, New –1  
or 2, IP -1 |  |  |  |
| **Low Risk** | • 2 or more self-limited/minor problems  
• 1 stable chronic illness (controlled HTN)  
• Acute uncomplicated illness / injury (simple sprain) | • Physiologic tests not under stress (PFT)  
• Non-CV imaging studies (barium enema)  
• Superficial needle biopsies  
• Labs requiring arterial puncture  
• Skin biopsies | • OTC meds  
• Minor surgery w/no identified risk factors  
• PT, OT  
• IV fluids w/out additives |
| E-3, NEW-3  
IP - 1 |  |  |  |
| **Mod Risk** | • 1 > chronic illness, mod. Exacerbation, progression or side effects of treatment  
• 2 or more chronic illnesses  
• Undiagnosed new problem w/uncertain prognosis  
• Acute illness w/systemic symptoms (colitis)  
• Acute complicated injury | • Physiologic tests under stress (stress test)  
• Diagnostic endoscopies w/out risk factors  
• Deep incisional biopsies  
• CV imaging w/contrast, no risk factors (arteriogram, cardiac cath)  
• Obtain fluid from body cavity (lumbar puncture) | • Prescription meds  
• Minor surgery w/identified risk factors  
• Elective major surgery w/out risk factors  
• Therapeutic nuclear medicine  
• IV fluids w/additives  
• Closed treatment, FX / dislocation w/out manipulation |
| E-4, NEW-4  
IP-2 |  |  |  |
| **High Risk** | • 1 > chronic illness, severe exacerbation, progression or side effects of treatment  
• Acute or chronic illnesses that may pose threat to life or bodily function (acute MI)  
• Abrupt change in neurologic status (TIA, seizure) | • CV imaging w/contrast, w/risk factors  
• Cardiac electrophysiological tests  
• Diagnostic endoscopies w/risk factors | • Elective major surgery w/risk factors  
• Emergency surgery  
• Parenteral controlled substances  
• Drug therapy monitoring for toxicity  
• DNR |
Using Time to Code Counseling /Coordinating Care (CCC)

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 CCC. Time is only Face-to-face for OP setting.

Coding based on time is generally the exception for coding. It is typically used when there is a significant exacerbation or change in the patient’s condition, non-compliance with the treatment/plan or counseling regarding previously performed procedures or tests to determine future treatment options.

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 to counseling / coordination of care
3. The specific nature of counseling/coordination of care for that patient on that date of service. A template statement would not meet this requirement.
Counseling /Coordinating Care (CCC)?

Documentation must reflect the specific issues discussed with patient present.

Proper Language used in documentation of time:

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

• “I spent ____ minutes with the patient 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.
Routine Physical Exam: Preventive

• Periodic comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, coded as new or established patient; infant to 65 years & older.
Preventive Services

When a practitioner sees an asymptomatic patient for a head-to-toe routine physical, the correct procedure code to report is 99381-99395 (periodic preventive medicine evaluation and management) or EPSDT.

The extent and focus of the services will largely depend on the age of the patient.

If an abnormality/ies is encountered or a pre-existing problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is **significant enough to require additional work to perform the key components of a problem-oriented E/M service**, then the appropriate Office/Outpatient code **99201-99215** should also be reported. Modifier **25** should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.
Preventive Services

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.

The "comprehensive" nature of the Preventive Medicine Services codes 99381-99397 reflects an age and gender appropriate history/exam and is not synonymous with the "comprehensive" examination required in Evaluation and Management codes 99201-99350.

Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination.
Effective February 5, 2015, Medicare began covering lung cancer screening counseling and a shared decision making visit, for patients meeting the criteria below, annual screening for lung cancer with low dose computed tomography (LDCT).

- Age 55 – 77 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Current smoker or one who has quit smoking within the last 15 years; and
- Receives a written order for LDCT lung cancer screening that meets the following criteria:
  
  For the initial LDCT lung cancer screening service: a patient must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision making visit, provided by a physician or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist).
Lung Cancer Screening Counseling and Annual Screening for Lung Cancer with Low Dose Computed Tomography

A lung cancer screening counseling and shared decision making visit includes the following elements and must be documented in the patient’s medical record:

• Determination of patient’s eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
• Shared decision making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
• Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment;
• Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and
• If appropriate, a written order for lung cancer screening with LDCT.
Lung Cancer Screening Counseling and Annual Screening for Lung Cancer with Low Dose Computed Tomography

*For subsequent LDCT lung cancer screenings*: the patient must receive a written order for LDCT lung cancer screening. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the criteria for a counseling and shared decision making visit.

Written orders for both initial and subsequent LDCT lung cancer screenings must contain the following information, which must also be documented in the patient’s medical record:

- Beneficiary date of birth;
- Actual pack - year smoking history (number);
- Current smoking status, and for former smokers, the number of years since quitting smoking;
- Statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and
- National Provider Identifier (NPI) of the ordering physician/practitioner.
Other Medicare Preventive Services

- Alcohol Misuse Screening and Counseling
- Bone Mass Measurements
- Cardiovascular Disease Screening Tests
- Colorectal Cancer Screening
- Counseling to Prevent Tobacco Use (for Asymptomatic Patients)
- Depression Screening
- Diabetes Screening
- Diabetes Self-Management Training (DSMT)
- Glaucoma Screening
- Hepatitis C Virus (HCV) Screening
- Human Immunodeficiency Virus (HIV) Screening
- Influenza, Pneumococcal, and Hepatitis B Vaccinations and their Administration
- IPPE
- Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD), also known as a CVD risk reduction visit
- IBT for Obesity
- Medical Nutrition Therapy (MNT)
- Prostate Cancer Screening
- Screening for Sexually Transmitted Infections (STIs) Screening And High Intensity Behavioral Counseling (HIBC) to Prevent STIs
- Screening Mammography
- Screening Pap Tests
- Screening Pelvic Examination (includes a clinical breast examination)
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)
# Annual Wellness Visit

Initial AWV Components: Applies for the First Time a Beneficiary Receives an AWV

**Acquire Beneficiary Information**

<table>
<thead>
<tr>
<th>Acquire Beneficiary Information</th>
<th>Required Elements</th>
</tr>
</thead>
</table>
| **Administer HRA**              | - Collects self-reported information from the beneficiary;  
                                  - You or the beneficiary can complete the HRA before or during the AWV encounter;  
                                  - Accounts for the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs and is appropriately tailored to their needs;  
                                  - Takes no more than 20 minutes to complete; and  
                                  - At a minimum, addresses the following topics:  
                                    - Demographic data;  
                                    - Self-assessment of health status;  
                                    - Psychosocial risks;  
                                    - Behavioral risks;  
                                    - Activities of Daily Living (ADLs), including, but not limited to: dressing, bathing, and walking; and  
                                    - Instrumental ADLs, including, but not limited to: shopping, housekeeping, managing own medications, and handling finances. |
| **Establish a list of current providers and suppliers** | Include current providers and suppliers regularly involved in providing medical care to the beneficiary. |
| **Establish the beneficiary’s medical/family history** | At a minimum, collect and document the following:  
  - Medical events in the beneficiary’s parents, siblings, and children, including diseases that may be hereditary or place the beneficiary at increased risk;  
  - Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments; and  
  - Use of, or exposure to, medications and supplements, including calcium and vitamins. |
| **Review the beneficiary’s potential risk factors for depression, including current or past experiences with depression or other mood disorders** | Use any appropriate screening instrument for beneficiaries without a current diagnosis of depression, which you may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations. |
| **Review the beneficiary’s functional ability and level of safety** | Use direct observation of the beneficiary, or select appropriate screening questions or a screening questionnaire, from various available screening questions or standardized questionnaires recognized by national professional medical organizations to assess, at a minimum, the following topics:  
  - Ability to successfully perform ADLs;  
  - Fall risk;  
  - Hearing impairment; and  
  - Home safety. |
# Annual Wellness Visit

<table>
<thead>
<tr>
<th>Begin Assessment</th>
<th>Required Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Assess</td>
<td>Obtain the following measurements:</td>
</tr>
<tr>
<td></td>
<td>- Height, weight, body mass index (or waist circumference, if appropriate), and</td>
</tr>
<tr>
<td></td>
<td>blood pressure; and</td>
</tr>
<tr>
<td></td>
<td>- Other routine measurements as deemed appropriate based on medical and family</td>
</tr>
<tr>
<td></td>
<td>history.</td>
</tr>
</tbody>
</table>

| □ Detect any cognitive impairment the beneficiary may have | Assess the beneficiary’s cognitive function by direct observation, with due       |
|                                                          |   consideration of information obtained via beneficiary reports and concerns      |
|                                                          |   raised by family members, friends, caretakers, or others.                      |

### Counsel Beneficiary

<table>
<thead>
<tr>
<th>Establish a written screening schedule for the beneficiary, such as a checklist for the next 5 to 10 years, as appropriate</th>
<th>Base written screening schedule on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>- Age-appropriate preventive services Medicare covers;</td>
</tr>
<tr>
<td></td>
<td>- Recommendations from the United States Preventive Services Task Force (USPSTF)</td>
</tr>
<tr>
<td></td>
<td>and the Advisory Committee on Immunization Practices (ACIP);</td>
</tr>
<tr>
<td></td>
<td>- The beneficiary’s HRA, health status, and screening history.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Establish a list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or underway for the beneficiary</th>
<th>Include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>- Any mental health conditions or any risk factors or conditions identified</td>
</tr>
<tr>
<td></td>
<td>through an IPPE, and</td>
</tr>
<tr>
<td></td>
<td>- A list of treatment options and their associated risks and benefits.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Furnish personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs</th>
<th>Includes referrals to programs aimed at:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>- Community-based lifestyle interventions to reduce health risks and promote</td>
</tr>
<tr>
<td></td>
<td>self-management and wellness;</td>
</tr>
<tr>
<td></td>
<td>- Fall prevention;</td>
</tr>
<tr>
<td></td>
<td>- Nutrition;</td>
</tr>
<tr>
<td></td>
<td>- Physical activity;</td>
</tr>
<tr>
<td></td>
<td>- Tobacco-use cessation; and</td>
</tr>
<tr>
<td></td>
<td>- Weight loss.</td>
</tr>
</tbody>
</table>
Subsequent Annual Wellness Visit

Subsequent AWV Components: Applies for all Subsequent AWVs After a Beneficiary’s First AWV

Acquire Update of Beneficiary History

<table>
<thead>
<tr>
<th>Acquire Update of Beneficiary Information</th>
<th>Required Elements</th>
</tr>
</thead>
</table>
| □ Update HRA                             | ▪ Collects self-reported information from the beneficiary;  
  ▪ You or the beneficiary can complete the update of HRA before or during the AWV encounter;  
  ▪ Takes no more than 20 minutes to complete, and  
  ▪ At a minimum, addresses the following topics:  
    ▪ Demographic data;  
    ▪ Self-assessment of health status;  
    ▪ Psychosocial risks;  
    ▪ Behavioral risks;  
    ▪ ADLs, including, but not limited to: dressing, bathing, and walking, and  
    ▪ Instrumental ADLs, including, but not limited to: shopping, housekeeping, managing own medications, and handling finances. |
| □ Update the list of current providers and suppliers | Include current providers and suppliers regularly involved in providing medical care to the beneficiary. |
| □ Update the beneficiary’s medical/family history | At a minimum, update and document the following:  
  ▪ Medical events in the beneficiary’s parents, siblings, and children, including diseases that may be hereditary or place the beneficiary at increased risk;  
  ▪ Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments; and  
  ▪ Use of, or exposure to, medications and supplements, including calcium and vitamins. |

Begin Assessment

<table>
<thead>
<tr>
<th>Begin Assessment</th>
<th>Required Elements</th>
</tr>
</thead>
</table>
| □ Assess         | Obtain the following measurements:  
  ▪ Weight (or waist circumference, if appropriate) and blood pressure; and  
  ▪ Other routine measurements as deemed appropriate based on medical and family history. |
| □ Detect any cognitive impairment that the beneficiary may have | Assess the beneficiary’s cognitive function by direct observation, with due consideration of information obtained via beneficiary reports and concerns raised by family members, friends, caretakers, or others. |
## Subsequent Annual Wellness Visit

<table>
<thead>
<tr>
<th>Counsel Beneficiary</th>
<th>Required Elements</th>
</tr>
</thead>
</table>
| □ Update the written screening schedule for the beneficiary | Base written screening schedule on:  
  - Age-appropriate preventive services Medicare covers;  
  - Recommendations from the USPSTF and the ACIP; and  
  - The beneficiary’s health status and screening history. |
| □ Update the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway for the beneficiary | Include any such risk factors or conditions identified. |
| □ Furnish personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs | Includes referrals to programs aimed at:  
  - Community-based lifestyle interventions to reduce health risks and promote self-management and wellness;  
  - Fall prevention;  
  - Nutrition;  
  - Physical activity;  
  - Tobacco-use cessation; and  
  - Weight loss. |
Annual Wellness Visit

- **G0438** Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit
- **G0439** Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit

No Specific Diagnosis Required for Billing

- Medicare Part B covers AWV if performed by a:
  - Physician (a doctor of medicine or osteopathy);
  - Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist); or
  - Medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals who are working under the direct supervision of a physician (doctor of medicine or osteopathy) (In the Office Setting, Place of Service 11).
Modifiers: Provider Documentation MUST Support the Use of All Modifiers

A billing code modifier allows you to indicate that a procedure or service has been altered by some specific circumstance but has not changed in its definition.

Documentation in the operative report must support the use of any modifier.
Minor Procedure With an E/M
Modifier 25: Minor Procedure with E/M

- If a procedure has a global period of XXX, 000 or 010 days, it is defined as a minor surgical procedure. Scopes, sutures etc.
- In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure.
- The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service.
- However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25.
- If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure in and of itself.

Only a practitioner or coder should designate a modifier 25 to an E/M service (not a biller) based exclusively on the documentation.
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.
Critical Care
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.

- **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.
• For time based codes, the physician must document the total amount of time spent on any calendar day providing critical care services to a patient. This time may be noncontiguous.

• Absent exceptional circumstances, generally requiring the skills of different specialty providers, critical care billed by one provider cannot overlap in time with critical care provided by another provider. The time must be spent on the unit. It may include direct bedside care or time spent discussing the case with consultants or reviewing pertinent laboratory or imaging data.
## Time Based 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>
Time-Based Critical Care

• One can also include time spent getting essential information from family members, but should not include minutes just updating the family on the patient’s progress. Such conversations can be via telephone, but must be made from the unit in which the patient is cared for. A summary of such interactions should be entered into the medical record to support the total amount of time in critical care.

• **99291**: Critical care, evaluation and management (E/M) of the critically ill or critically injured patient; first 30-74 min

• 99292: each additional 30

  99291 should be reported by a provider or subspecialty group only once in a calendar day. Critical care time < 30 min in a single day should be reported using the E/M codes **99221-99233**
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.
Procedures Bundled Into Critical Care

- Introduction of needle or intracatheter, vein (36000)
- Venipuncture, age 3 years or older, necessitating physician’s skill (36410)
- Collection of venous blood by venipuncture (36591)
- Collection of blood specimen from a completely implantable venous access device (36591)
- Arterial puncture, withdrawal of blood for diagnosis (36600)
- Nasogastric or orogastric tube placement, requiring physician’s skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report) (43752)
- Radiologic examination, chest; single view, stereo, or two view (71010, 71015, 71020)
- Gastric intubation and aspiration or lavage for treatment (91105)
Procedures Bundled Into Critical Care

• Temporary transcutaneous pacing (92953)
• Indicator dilution studies with dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (93561 and 93562)
• Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day, subsequent day, nursing facility (94002, 94003, 94004)
• Continuous positive airway pressure ventilation (CPAP), initiation and management (94662)
• Continuous negative pressure ventilation, initiation and management (94662)
• Noninvasive ear or pulse oximetry for oxygen saturation, single, multiple, or continuous (94760, 94761, 94762)
• Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data) (99090)
Procedures Not Bundled Into Time-Based Critical Care Codes

- These procedures should be reported separately with a 25 modifier appended to the critical care service. The time needed to complete any of these services cannot be counted as critical care time. Separate documentation is needed. Examples include:
  - Intubation, endotracheal, emergency procedure (31500)
  - Tracheostomy, planned (31600)
  - Bronchoscopy, rigid or flexible (31622)
  - Thoracentesis, with insertion of tube (32421, 32422)
  - Insertion of tunneled pleural catheter with cuff (32550)
  - Cardiopulmonary resuscitation (92950)
In-Patient Hospital Care
USING DIFFERENT LEVELS OF CARE

99223 *
PATIENT
ADMITTED

99233 *
(PAT. IS
UNSTABLE)

99232 *
(PAT. HAS
DEVELOPED
MINOR COMPL.)

99231 *
(PAT. IS
STABLE,
RECOVERING,
IMPROVING)

99238 *
PATIENT
DISCHARGED
Present on Admission (POA) & Hospital-Acquired Conditions (HAC)

• POA is defined as being present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter (including emergency department, observation, or outpatient surgery) are considered POA;

• Under the Hospital-Acquired Conditions—Present on Admission (HAC-POA) program, accurate coding of hospital-acquired conditions (HACs) and present on admission (POA) conditions is critical for correct payment.

• The importance of consistent, complete documentation in the medical record from any and all Physicians/Practitioners involved in the care and treatment of the patient is used to determine whether a condition is POA;

• It is crucial that physicians/practitioners document all conditions that are present on admission;

• The Hospital must include the POA indicator on all claims that involve Medicare inpatient admissions. The hospital is subject to a law or regulation that mandates the collection of POA indicator information.
Admission to Hospital - Two-Midnight Rule

• If the physician expects a patient’s stay to cross at least 2 midnights, and is receiving medically necessary hospital care, the stay is generally appropriate for inpatient admission.

• Must have a clear inpatient order written and signed before discharge. Physician or practitioner must be:
  • –Licensed by the state to admit patients to hospitals
  • –Granted privileges by the facility to admit
  • –Knowledgeable about the patients hospital course, medical care, and current condition at the time of admission

• Must have documentation to support certification
• Anticipated length of stay
• Discharge planning
TWO MIDNIGHT RULE DECISION TREE FOR MEDICARE PATIENTS

Does the physician expect the patient to require more than two midnights of hospital care that cannot be performed at a lower level of care? This includes care provided in the emergency room and/or if the patient is transferred to the hospital.

NO

Is the patient receiving an Inpatient only procedure? (Consult case management)

NO

Is the patient newly ventilated? (Excluding ventilation during surgery)

NO

Write an order for Outpatient OR Outpatient Observation Status

YES

Write an Inpatient Order

YES

Write an Inpatient Order along with expected length of stay

* If the physician writes an inpatient order and then after one day of treatment the patient can receive care at a lower level, change the status to observation with a condition code (44) through case management.

* If a patient discharges early because of death, leaving AMA, transferring to another facility or an unforeseen recovery, then the patient should remain in patient with supportive documentation.
Admission to Hospital - Two-Midnight Rule

Exceptions to the Rule

• Inpatient only procedures
• Newly initiated acute mechanical ventilation
• Not occurring, as would be anticipated, with a procedure
• Unforeseen Circumstances such circumstances must be documented:
  – Death
  – Transfer to another hospital
  – AMA
  – Unexpected clinical improvement
  – Election of hospice care
Two-Midnight Rule vs Observation Care

An observation status patient may be admitted to an inpatient status at any time for medically necessary continued care, but the patient can never be retroactively changed from observation to inpatient (replacing the observation as if it never occurred).

Physician orders to "admit to inpatient" or "place patient in outpatient observation" should be clearly written. Be aware that an order for "admit to observation" can be confused with an inpatient admit. Likewise, an order for "admit to short stay" may be interpreted as admit to observation by some individuals and admit to inpatient by others.
Observation Care Services

Billing Guidelines

• **Procedure Codes**: 99218, 99219, 99220, 99224-99226 and 99234-99236

• Outpatient observation services require monitoring by a physician and other ancillary staff, which are reasonable and necessary to evaluate the patient’s condition. These services are only considered medically necessary when performed under a specific order of a physician.

• Outpatient observation services are not to be used for the convenience of the hospital, its physicians, patients, patients’ families, or while waiting placement to another facility.

• Outpatient observation services, generally, do not exceed 24 hours. Some patients may require a second day of observation up to a maximum of 48 hours.

• At 24 hours, the physician should evaluate patient’s condition to decide if the patient needs to remain in observation for an additional 24 hours.
OBSERVATION CARE SERVICES

- Hospital observation services should be coded and billed according to the time spent in observation status as follows:

<table>
<thead>
<tr>
<th>Time Spent</th>
<th>8 Hours or Less</th>
<th>&gt; 8 Hours &lt; 24 Hours</th>
<th>24 Hours or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Observation Care</td>
<td>99218-99220</td>
<td>99234-99236</td>
<td>99218-99220</td>
</tr>
<tr>
<td>Observation or Inpatient Care</td>
<td>(Initial Observation Care)</td>
<td>(Observation or Inpatient Care)</td>
<td>(Initial Observation Care)</td>
</tr>
<tr>
<td>99224-99226 Subsequent Day different calendar day</td>
<td>99224-99226 Subsequent Day different calendar day</td>
<td>99224-99226 Subsequent Day different calendar day</td>
<td></td>
</tr>
<tr>
<td>Same Calendar Date</td>
<td>Same Calendar Date</td>
<td>Same Calendar Date</td>
<td>Same Calendar Date</td>
</tr>
<tr>
<td>Admission paid</td>
<td>Admission and Discharge Included</td>
<td>Admission paid</td>
<td>Admission paid</td>
</tr>
<tr>
<td>Discharge not paid separately</td>
<td>Discharge not paid separately</td>
<td>Discharge not paid separately</td>
<td>Discharge paid separately</td>
</tr>
<tr>
<td>Different Calendar Date</td>
<td>Different Calendar Date</td>
<td>Different Calendar Date</td>
<td>Different Calendar Date</td>
</tr>
<tr>
<td>Admission and Discharge (99217) paid separately</td>
<td>Use codes 99218-99220</td>
<td>Admission and Discharge paid separately</td>
<td>Admission and Discharge paid separately</td>
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<td>Discharge (99217) paid separately</td>
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<td>Discharge (99217) paid separately</td>
<td>Discharge paid separately</td>
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Observation Care Services

• Subsequent Observation Care Codes are **TIME-BASED CODES** and time spent at bedside and on Hospital floor unit must be documented by the physician.

• At 48 hours, the physician should re-evaluate patient’s condition and decide if patient needs to be admitted to the hospital or discharged home.

• Outpatient observation time begins **when the patient is physically placed in the observation bed. Outpatient observation time ends at the time it’s documented in the physician’s discharge orders.**
Non-Physician Practitioners (NPP’s) or Physician Extenders

Who is a NPP?

Physician Assistant (PA)
Nurse Practitioner (NP)
NPP Agreements & Billing Options

- Collaborative agreement between the NPP and the group they are working with is required.
  - The agreement extends to all physicians in the group.
    - If the NPP is performing procedures it is recommended a physician confirm their competency with performance of the procedure.
- NPPs can bill independent under their own NPI # in all places-of-service and any service included in their State Scope of Practice.
  - Supervision is general (available by phone) when billing under their own NPI number.
  - Medicare and many private insurers credential NPPs to bill under their NPI.
  - Some insurers pay 85% of the fee schedule when billing under the NPP and others pay 100% of the fee schedule.
- Incident-to in the office (POS 11)
- Shared visit in the hospital or hospital based clinic (POS 21, 22, 23)
Shared Visits

• The shared/split service is usually reported using the physician's NPI.

• When an E/M service is a shared encounter between a physician and a NPP, the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient and can be billed under the physician.

• If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the non-physician's NPI.

• Procedures **CANNOT** be billed shared
Shared Visits Between NPP and Physician

Shared visits may be billed under the physician's name if and only if:

1. The physician provides a medically necessary face-to-face portion of the E/M encounter (even if it is later in the same day as the PA/ARNP's portion); and

2. The physician personally documents in the patient's record the details of their face-to-face portion of the E/M encounter with the patient.

• If the physician does not personally perform and personally and contemporaneously document their face-to-face portion of the E/M encounter with the patient, then the E/M encounter cannot be billed under the physician's name and must be billed under the NPP.

• The NPP MUST be an employee (or leased) to bill shared. Documentation from a hospital employed NPP may not be utilized to bill a service under the physician.
Bill Independently and Not Shared

Billing Under The NPP NPI

- Does not require physician presence.
- Can evaluate and treat new conditions and new patients.
- Can perform all services under the state scope-of-practice.
- Can perform services within the approved collaborative agreement.
  - Recommend physician establish competency criteria and demonstration of performance of procedures within the collaborative agreement between the NPP and physician.
“INCIDENT TO”

• “Incident to” services must be an integral part of the patient’s treatment course
• Provided under the physician’s direct personal supervision (Physician must be present in the office suite and be immediately available to provide assistance and direction throughout the time the services are being performed)
• Commonly rendered without charge (included in physician’s professional services)
• Commonly furnished in a physician’s office (not in a hospital setting)
• Auxiliary Personnel must be directly employed by the physician, physician group or entity that employs the physician or may be a leased employee
“INCIDENT TO”

Established Patient Visits: “Incident to” Billing Requirements

• Incident-to services are those services commonly furnished in a physician’s office that are “incident to” the professional services of a physician.
• Physician must personally perform an initial service for each new condition, make an initial diagnosis, and establish a treatment plan.
• Physician must personally perform subsequent services at a frequency that reflects his/her active participation in and management of the course of the treatment for each medical condition.
• Services must be performed under a physician’s direct personal supervision: (Present in the office suite and immediately available to provide assistance and direction throughout the time the ancillary staff, ARNP, PA is performing the “incident to” services.)
Scribed Notes

- Record entries made by a "scribe" should be made upon the direction of the physician. A scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently or obtain any information independently except to ROS and PFSH. They cannot obtain the HPI, any portion of the PE or MDM.
- The scribe must note "written by xxxx, acting as scribe for Dr. yyy." Then, Dr. yyy indicating that the note accurately reflects work and decisions made by him/her and then authenticate with signature.
- It is inappropriate for an employee of the physician to round at one time and make entries in the record, and then for the physician to see the patient at a later time and note "agree with above...".
- AAMC does not support someone “dictating” as a scribe by an NPP, as scribing is over the shoulder immediate documenter with no services personally performed by the scribe. In this case, the physician should be dictating their own visit. Scribes can do EMRs under their own password.
Scribed Notes

- Individuals can only create a scribe note in an EHR if they have their own password/access to the EHR for the scribe role. Documents scribed in the EHR must clearly identify the scribe’s identity and authorship of the document in both the document and the audit trail.

- Scribes are required to notify the provider of any alerts in the EPIC System. Alerts must be addressed by the provider.

- Providers and scribes are required to document in compliance with all federal, state, and local laws, as well as with internal policy.

- Failure to comply with this policy may result in corrective and/or disciplinary action by the hospital and/or department under the University of Miami Medical Group disciplinary policies applicable.

- Verbal orders may neither be given to nor by scribes. Scribes may pend orders for providers based upon provider instructions.

- The following attestation must be entered by the scribe:
  - “Scribed for [Name of provider] for a visit with [patient name] by [Name of scribe] [date and time of entry].

- The following attestation should be entered by provider when closing the encounter:
  - “I was present during the time with [patient name] was recorded. I have reviewed and verified the accuracy of the information which was performed by me.” [Name of provider][Date and time of entry].
ICD-10
Looks like a go!
Diagnosis Coding
International Classification of Disease (ICD-10)

- ICD-10 is scheduled to replace ICD-9 coding system on October 1, 2015.
- ICD-10 was developed because ICD-9, first published in 1977, was outdated and did not allow for additional specificity required for enhanced documentation, reimbursement and quality reporting.
- ICD-10 CM will have 68,000 diagnosis codes and ICD-10 PCS will contain 76,000 procedure codes.
- This significant expansion in the number of diagnosis and procedure codes will result in major improvements including but not limited to:
  - Greater specificity including **laterality, severity of illness**
  - Significant improvement in coding for primary care encounters, external causes of injury, mental disorders, neoplasms, diabetes, injuries and preventative medicine.
  - Allow better capture of socio-economic conditions, family relationships, and lifestyle
  - Will better reflect current medical terminology and devices
  - Provide detailed descriptions of body parts
  - Provide detailed descriptions of methodology and approaches for procedures
UHealth/UMMG
2015 PQRS
Patient Safety and Quality Office
CMS Quality Improvement Programs

- Meaningful Use (MU)
- Physician Quality Reporting System (PQRS)
- Value Based Payment Modifier (VBPM)
<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>POTENTIAL MEDICARE PAYMENT REDUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful Use</td>
<td>1%</td>
</tr>
<tr>
<td>PQRS</td>
<td>1.5%</td>
</tr>
<tr>
<td>VBPM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4%</td>
</tr>
<tr>
<td>TOTAL PENALTIES</td>
<td>2.5%</td>
</tr>
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</table>
## 2015 PQRS Eligible Providers

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Practitioners</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>Physician Assistant</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>DO</td>
<td>Nurse Practitioner</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Doctor of Podiatric</td>
<td>Clinical Nurse Specialist*</td>
<td>Qualified Speech-Language Therapist</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
<td>CRNA</td>
<td></td>
</tr>
<tr>
<td>DDS</td>
<td>Certified Nurse Midwife</td>
<td></td>
</tr>
<tr>
<td>DMD</td>
<td>Clinical Social Worker</td>
<td></td>
</tr>
<tr>
<td>Doctor of Chiropractic</td>
<td>Clinical Psychologist</td>
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<tr>
<td></td>
<td>Registered Dietician</td>
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<tr>
<td></td>
<td>Nutrition Professional</td>
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</tr>
<tr>
<td></td>
<td>Audiologists</td>
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</tr>
</tbody>
</table>
PQRS

Reporting Requirements:
✓ Reporting Period = Full CY
✓ Report 9 Measures from 3 National Quality Strategy Domains

Reporting Options:
 Claims, EHR, Registry
 Individual or GPRO

<table>
<thead>
<tr>
<th>NATIONAL STRATEGY DOMAINS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication &amp; Care Coordination</td>
</tr>
</tbody>
</table>
Physician Impact

Workflow and documentation changes

TO DO:
✓ Study Measure Specifications
✓ Ensure documentation meets measure requirements
✓ Bill PQRS quality code when required in MCSL/UChart
✓ Document chronic conditions/secondary diagnoses
✓ Use UChart Smart Phrases
✓ Ensure medical support staff completes required documentation
Clinical Trials
Requirements for Billing Routine Costs for Clinical Trials

Effective for claims with dates of service on or after January 1, 2014 it is mandatory to report a clinical trial number on claims for items/services provided in clinical trials/studies/registries, or under CED.

Professional

• For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) (do not use CT on the electronic claim, e.g., 12345678) when a clinical trial claim includes:
  • ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
  • Modifier Q0 (investigational clinical service provided in a clinical research study that is in an approved clinical research study) and/or
  • Modifier Q1 (routine clinical service performed in a clinical research study that is in an approved clinical research study), as appropriate (outpatient claims only).

Hospital

• For hospital claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:
  • Condition code 30;
  • ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
  • Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Items or services covered and paid by the sponsor may not be billed to the patient or patient’s insurance, this is double billing.
The principal investigator (PI) is responsible for assuring that all required approvals are obtained prior to the initiation of the clinical trial. For any clinical study involving an IDE, the PI must obtain approval for the IDE clinical trial from the Medicare Administrative Contractor (MAC) for Part A / Hospital.

Additionally, for clinical studies involving an IDE, the PI is responsible for communicating about the trial and the IDE to the Medicare Part B (physician) MAC.

Once approval has been received by the MAC, the following needs to take place:

• The Study must be entered in the Velos System within 48 hours.
• The PI is responsible for ensuring that the IDE or the no charge device is properly set up in the facility charge master to allow accurate and compliant charging for that device before any billing will occur.
Inpatient Billing for Items and Services in Category B IDE Studies

• Payment for the device may not exceed the Medicare-approved amount for a comparable device that has been already FDA-approved.

Routine Care Items and Services

• Hospital providers shall submit claims for the routine care items and services in Category B IDE studies approved by CMS (or its designated entity) and listed on the CMS Coverage Website, by billing according to the clinical trial billing instructions found in §69.6 of this chapter [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf), and as described under subsection D ("General Billing Requirements").
Investigational Device Exemption (IDE)

Category B Device. On a 0624 revenue code line, institutional providers must bill the following for Category B IDE devices for which they incur a cost:

• Category B IDE device HCPCS code, if applicable
• Appropriate HCPCS modifier
• Category B IDE number
• Charges for the device billed as covered charges

• If the Category B IDE device is provided at no cost, outpatient prospective payment system (OPPS) providers must report a token charge in the covered charge field along with the applicable HCPCS modifier (i.e., modifier – FB) appended to the procedure code that reports the service to furnish the device, in instances when claims processing edits require that certain devices be billed with their associated procedures. For more information on billing ‘no cost items’ under the OPPS, refer to chapter 4, §§20.6.9 and 61.3.1 of this manual.
WHEN THE TRIAL ENDS OR REACHES FULL ENROLLMENT?

When the trial ends, whether due to reaching full enrollment or for any other reason, the PI must work with their department resource and/or the relevant Revenue Integrity Office(s) to inactivate the item in the charge master so that it may no longer be used.

If the device is approved by the FDA and is no longer considered investigational or a Humanitarian Device Exemption (HDE) and will continue to be used at UHealth, the PI must work with their department resource and/or the relevant Revenue Integrity Office(s) to inactivate the investigational device in the charge master and to ensure that a new charge code is built for the approved device. At this point, ongoing maintenance responsibility would transfer to the relevant Revenue Integrity Office(s).
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 AND SECURITY

• 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
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:
  - Gemma Romillo, Assistant Vice President of Clinical Billing Compliance and HIPAA Privacy; or
  - Iliana De La Cruz, RMC, Director Office of Billing Compliance
    - **Phone:** (305) 243-5842
    - **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).

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