Office of Billing Compliance
2014 Professional Coding, Billing and Documentation Program

Genetics

Prepared by:
Medical Compliance Services, Miller School of Medicine/University of Miami and Compliance Concepts, Inc.
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**What is a Compliance Program?**

**7 Elements of an Effective Compliance Program**

- A centralized process to promote honest, ethical behavior in the day-to-day operations of an organization, which will allow the organization to identify, correct, and prevent illegal conduct.

- It is a system of: FIND – FIX – PREVENT

The University of Miami implemented the Billing Compliance Plan on November 12, 1996. The components of the Compliance Plan are:

1. Policies and Procedures
2. Having a Compliance Officer and Compliance Committees
3. Effective Training and Education
4. Effective Lines of Communication (1-877-415-4357 or 305-243-5842)
5. Disciplinary Guidelines
6. Auditing and Monitoring
7. Detect Non-Compliance Issues and Develop Corrective Action Plans
The Government

• In order to address fraud and abuse in the Healthcare Field, the government has on-going reviews and investigations nationally to detect any actual or perceived waste and abuse.

• The Government does believe that the majority of Healthcare providers deliver quality care and submit accurate claims. However, the amount of money in the healthcare system, makes it a prime target for fraud and abuse.

Centers for Medicare and Medicaid Services (CMS) Estimates > $50 Billion In “Payment Errors” Annually in Healthcare

OIG reported that in FY 2013 that $5.8 billion was recovered from auditing providers
Health Care Laws

There are five important health care laws that have a significant impact on how we conduct business:

- False Claims Act
- Health Care Fraud Statute
- Anti-Kickback Statute
- Stark Law
- Sunshine Act
  - Requires manufacturers of drugs, medical devices and biologicals that participate in U.S. federal health care programs to report certain payments and items of value >$10 given to physicians and teaching hospitals.
What is a False Claim?

- A false claim is the knowing submission of a false or fraudulent claim for payment or approval or the use of a false record that is material to a false claim.

OR

- Reckless disregard of the truth or an attempt to remain ignorant of billing requirements are also considered violations of the False Claims Act.
How do you create a False Claim?

One method is to submit a claim form to the government.

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<td>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</td>
<td>E. DIAGNOSIS/POINTER</td>
<td>F. $ CHARGES</td>
<td>G. DAYS OR UNITS</td>
<td>H. SPN. ID</td>
<td>I. ID QUAL.</td>
<td>J. RENDERING PROVIDER ID. #</td>
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<td>CPT/HCPCS MODIFIER</td>
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</table>

This certification forms the basis for a false claim.

NUCC Instruction Manual available at: www.nucc.org
HOT TOPICS IN COMPLIANCE 2014

MEDICAL NECESSITY

Quality & Cost:
Emphasis on Pay-for-Performance
Practitioner reimbursement will likely be tied to outcomes soon.

Some experts say that the CMS penalties for not participating in the Physician Quality Reporting System (PQRS) signal that the pay-for-performance trend is not fading away and will likely be adopted by private payers.

“I think we’re slowly transitioning out of fee-for-service and into a system that rewards for quality while controlling cost,” says Miranda Franco, government affairs representative for the Medical Group Management Association. “The intent of CMS is to have physicians moving toward capturing quality data and improving metrics on [them].”
Audits are being conducted for all payer types based on the medical necessity of procedures and E/M levels. Procedure are often linked to diagnosis codes and the E/M audits are generally expressed in two ways in conjunction with the needs of the patient:

- Frequency of services (how often the patients are being seen) and,
- Intensity of service (level of CPT code billed).
Elements of Medical Necessity

- CMS’s determination of medical necessity is separate from its determination that the E/M service was rendered as billed.

- Complexity of documented co-morbidities that clearly influenced physician work.

- Physical scope encompassed by the problems (number of physical systems affected by the problems).
E/M Coding: Volume of Documentation versus Medical Necessity

• Word processing software, the electronic medical record, and formatted note systems facilitate the "carry over" and repetitive "fill in" of stored information.

• Even if a "complete" note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service.

• Information that has no pertinence to the patient's situation at that specific time cannot be counted.
Office of the Inspector General (OIG) Audit Focus

Annually OIG publishes its "targets" for the upcoming year. Included is:

- **Cutting and Pasting Documentation in the EMR**

  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 service provided on the DOS.
Medical Record Documentation Standards

Pre EMR:  “If it isn’t documented, it hasn’t been done.”
- Unknown

Post EMR:  “If it was documented, was it done and was it medically necessary to do.”
- Reviewers
EMR Documentation Pitfalls

On reviews, the following are targets to call into question EMR documentation is original and accurate:

- HPI and ROS don’t agree
- HPI and PE don’t agree
- CC is not addressed in the PE
- ROS and PFSH complete on every visit
- ROS all negative when patient coming for a CC
- Identical documentation across services (cloning)
- The lack of or Inappropriate Teaching Physician Attestations
Evaluation and Management E/M

Documentation and Coding

Inpatient, Outpatient and Consultations
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, that does not affect the designation of a new patient.
E/M Key Components

History (HX) - Subjective information
Examination (PE) - Objective information
Medical Decision Making (MDM) - Linked to medical necessity

The billable service is determined by the combination of these 3 key components with MDM often linked to medical necessity. For new patients all 3 components must be met or exceeded and established patient visits 2 of 3 are required to be met or exceeded. Often when downcoded for medical necessity it is determined that documented History and Exam exceeded what was necessary for the visit.
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) & History of Present Illness (HPI)
    - 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** 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 for New Patients in order to be counted towards the New Patient level of service billed.

- Focus upon present illness!

- **HPI drivers:**
  - Extent of PFSH, ROS and physical exam performed
  - Medical necessity for amount work performed and documented & Medical necessity for E & M assignment
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)

• 1 ROS documented = Pertinent

• 2-9 ROS documented = Extended

• 10 + = Complete (or documentation of pertinent positive and negative ROS and a notation “all others negative”. This would indicate all 14 ROS were performed and would be complete.)

Record positives and pertinent negatives. Never note the system(s) related to the presenting problem as "negative".
When using "negative" notation, always identify which systems were queried and found to be negative.
Review of Systems

- Constitutional
- Eyes
- Respiratory
- Ears, nose, mouth, throat
- Cardiovascular
- Musculoskeletal
- Gastrointestinal

- Genitourinary
- Psychiatric
- Integumentary
- Neurologic
- Allergy/Immunology
- Endocrine
- Hematologic/Lymphatic
- All Others Negative
Past, Family, and/or Social History

- **Past history**: the patient’s past experience with illnesses, surgeries, & treatments
- **Family history**: a review of medical events in the patient’s family, such as hereditary diseases, that may place a patient at risk
- **Social history**: age appropriate review of past and current activities

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"
Scoring E/M History

CHIEF COMPLAINT:

### HPI (history of present illness) elements: (Extended also includes status of 3 or > chronic conditions)

<table>
<thead>
<tr>
<th>Location</th>
<th>Severity</th>
<th>Timing</th>
<th>Modifying Factors</th>
<th>Brief (1-3)</th>
<th>Extended 4 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>□ Duration □ Context □ Associated signs and symptoms</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### ROS (Review of systems):

| □ Constitutional (wt loss, etc) | Ears, nose, mouth, throat | □ GI | □ Integumentary (skin, breast) | Endo | None | Pertinent to problem (1 system) | Extended (2-9 systems) | ** Complete |
| Eyes | Card/vasc | GU | Neuro | □ Hem/Lymph |
| Resp | □ MS | Psych | □ All/immuno | □ All others negative |

### PFSH (past medical, family, social history) areas:

Past history (the patient’s past experiences with illness, operations, injuries and treatments)

Family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk)

Social history (an age appropriate review of past and current activities)

* Complete PFSH:

**10 or more systems, or some systems with statement all others neg.**

2 hx areas: a) Estab pts. Office (outpt) care; domiciliary care; home care b) Emergency dept c) Subsequent nursing facility

3 hx areas: a) New pts. Office (outpt) care; domiciliary care; home care b) Consultations c) Initial hospital care d) Hospital observation e) Comprehensive nursing facility assessments

PROBLEM FOCUSED (PF)

EXP. PROB. FOCUSED (EPF)

DETAILED (D)

COMPREHENSIVE (C)
EXAMINATION

- 4 TYPES OF EXAMS
  - Problem focused (PF)
  - Expanded problem focused (EPF)
  - Detailed (D)
  - Comprehensive (C)
<table>
<thead>
<tr>
<th>BODY AREAS (BA):</th>
<th>CODING ORGAN SYSTEMS (OS):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, including face</td>
<td>Genitalia, groin, buttocks</td>
</tr>
<tr>
<td>Neck</td>
<td>Back, including spine</td>
</tr>
<tr>
<td>Chest, including breast and axillae</td>
<td>Each extremity</td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CODING ORGAN SYSTEMS (OS):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional/General</td>
</tr>
<tr>
<td>Eyes</td>
</tr>
<tr>
<td>Ears/Nose/Mouth/Throat</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Cardiac</td>
</tr>
<tr>
<td>GI</td>
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<tr>
<td>GU</td>
</tr>
<tr>
<td>Musculoskeletal</td>
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<tr>
<td>Skin</td>
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<tr>
<td>Neuro</td>
</tr>
<tr>
<td>Psychiatric</td>
</tr>
<tr>
<td>Hematologic/Lymphatic</td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td>Conjunctivae and lids; Pupils and irises (eg, reaction to light and accommodation, size and symmetry); Optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)</td>
</tr>
<tr>
<td>Ears, Nose, Mouth and Throat</td>
<td>External ears and nose (eg, overall appearance, scars, lesions, masses); Otoscopic external auditory canals and tympanic membranes; Hearing (eg, whispered voice, finger rub, tuning fork); Nasal mucosa, septum and turbinates; Lips, teeth and gums; Oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx</td>
</tr>
<tr>
<td>Neck</td>
<td>Neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus); Thyroid (eg, enlargement, tenderness, mass)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement); Percussion of chest (eg, dullness, flatness, hyperresonance); Palpation of chest (eg, tactile fremitus); Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Palpation of heart (eg, location, size, thrills); Auscultation of heart with notation of abnormal sounds and murmurs; Carotid arteries (eg, pulse amplitude, bruits); Abdominal aorta (eg, size, bruits); Femoral arteries (eg, pulse amplitude, bruits); Pedal pulses (eg, pulse amplitude); Extremities for edema and/or varicosities;</td>
</tr>
<tr>
<td>Chest/Breast</td>
<td>Breasts (eg, symmetry, nipple discharge); Palpation of breasts and axillae (eg, masses or lumps, tenderness)</td>
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<tr>
<td>Gastrointestinal (Abdomen)</td>
<td>Abdomen with notation of presence of masses or tenderness; Liver and spleen; Hernia (presence or absence); Anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses; Obtain stool sample for occult blood test (when indicated)</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>MALE: Scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass); Penis (exam of); Digital rectal prostate gland (eg, size, symmetry, nodularity, tenderness)</td>
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<td></td>
<td>FEMALE: Pelvic examination (with or without specimen collection for smears and cultures), including: External genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele); Urethra (eg, masses, tenderness, scarring); Bladder (eg, fullness, masses, tenderness); Cervix (eg, general appearance, lesions, discharge); Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support); Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity</td>
</tr>
<tr>
<td>Lymphatic</td>
<td>Palpation of lymph nodes in two or more areas: Neck; Axillae; Groin; Other</td>
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<tr>
<td>Musculoskeletal</td>
<td>Gait and station; Digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes); Joints, bones and muscles of one or more 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. Includes: Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions; Range of motion with notation of any pain, crepitation or contracture; Stability with notation of any dislocation (luxation), subluxation or laxity; Muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements</td>
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<tr>
<td>Skin</td>
<td>Skin and subcutaneous tissue (eg, rashes, lesions, ulcers); Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)</td>
</tr>
<tr>
<td>Neurologic</td>
<td>Test cranial nerves with notation of any deficits; Deep tendon reflexes with notation of pathological reflexes (eg, Babinski); Sensation (eg, by touch, pin, vibration, proprioception)</td>
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<tr>
<td>Psychiatric</td>
<td>Description of patient’s judgment and insight; Brief mental status including: Orientation to time, place and person, Recent and remote memory, Mood and affect (eg, depression, anxiety, agitation)</td>
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</table>
1995 and 1997 Exam Definitions

Problem Focused (PF)

- ‘95: a 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)

- ‘95: a 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)

- ‘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) GNS= At least 2 bullets from each of 6 areas or at least 12 in 2 or more areas.

Comprehensive (C)

- ‘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. GMS: At least 2 elements with bullet from each of 9 areas/systems.
Medical Decision Making

DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE!!

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 the number of management options.

**Step 2:**
- Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.

**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.

Note: The 2 most complex elements out of 3 will determine the overall level of MDM
### 3. MEDICAL DECISION MAKING

A) Number of Diagnosis or Treatment Options - identify each

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
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<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max=2</td>
<td>1</td>
<td>1 POINT: E- 2, NEW-1,2</td>
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<tr>
<td>Est. Problem (to examiner) stable, improved</td>
<td></td>
<td>1</td>
<td>2 POINTS: E-3, NEW-3</td>
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<tr>
<td>Est. Problem (to examiner) worsening</td>
<td></td>
<td>2</td>
<td>3 POINTS: E-4, NEW-4</td>
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<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max=1</td>
<td>3</td>
<td>4 POINTS: E-5, NEW-5</td>
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<tr>
<td>New prob. (To examiner); additional workup planned</td>
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<td>4</td>
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<tr>
<td>Total</td>
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</tbody>
</table>
**Amount and/or Complexity of Data Reviewed - total the points**

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
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<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**

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

2 POINTS:  
E-3, NEW-3  

3 POINTS:  
E-4, NEW-4  

4 POINTS:  
E-5. NEW-5
MDM Step 3: Table of Risk

- 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.
Risk Table

- Assess Patient Risk Based On:
  - Diagnoses
  - Diagnostics
  - Management Options

- 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
**Risk of Complications and/or Morbidity or Mortality**

Risk related to the *Presenting Problem* is based on the **risk anticipated between the current and next encounter**.

Risk related to *Diagnostic Procedures* or *Management Options* is based on the **risk anticipated during and immediately after procedure or txt.**

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled.

Enter the level of risk identified in Final Result for Complexity (table Below)

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>One self-limited or minor problem e.g., cold, insect bite</td>
<td>Laboratory tests requiring venipuncture</td>
<td>Rest</td>
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<td></td>
<td></td>
<td>Chest x-rays</td>
<td>Gargles</td>
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<td></td>
<td></td>
<td>EKG/EEG</td>
<td>Elastic bandages</td>
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<tr>
<td></td>
<td></td>
<td>Urinalysis</td>
<td>Superficial dressings</td>
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<tr>
<td></td>
<td></td>
<td>Ultrasound</td>
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<td></td>
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<td>KOH prep</td>
<td></td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Two or more self-limited or minor problems</td>
<td>Physiologic tests not under stress, e.g., pulmonary function tests</td>
<td>Over-the-counter drugs</td>
</tr>
<tr>
<td></td>
<td>One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes</td>
<td>Non-cardiovascular imaging studies with contrast, e.g., barium enema</td>
<td>Minor surgery with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>Superficial needle biopsies</td>
<td>Physical therapy</td>
</tr>
<tr>
<td></td>
<td>Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>Clinical laboratory tests requiring arterial puncture</td>
<td>Occupational therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Skin biopsies</td>
<td>IV Fluids without additives</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Physiologic tests not under stress, e.g., cardiac stress test, fetal contraction test</td>
<td>Minor surgery with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Two or more stable chronic illnesses</td>
<td>Diagnostic endoscopies with no identified risk factors</td>
<td>Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>Deep needle or incisional biopsy</td>
<td>Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath</td>
<td>Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>Cardiovascular imaging studies with contrast with identified risk factors</td>
<td>Elective major surgery (open, percutaneous or endoscopic with identified risk factors)</td>
</tr>
<tr>
<td></td>
<td>Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure</td>
<td>Cardiac electrophysiological tests</td>
<td>Emergency major surgery (open, percutaneous or endoscopic with identified risk factors)</td>
</tr>
<tr>
<td></td>
<td>An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss</td>
<td>Diagnostic endoscopies with identified risk factors</td>
<td>Parenteral controlled substances</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discography</td>
<td>Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid.

<table>
<thead>
<tr>
<th>Final Result for Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>B</strong></td>
</tr>
<tr>
<td><strong>C</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Type of decision making: STRAIGHT-FORWARD, LOW COMPLEX, MODERATE COMPLEX, HIGH COMPLEX
Using Time to Code

Time shall be considered for coding an E/M level when greater than 50% of total Teaching Physician visit time is Counseling /Coordinating Care –

Total time must be Face-to-face for OP and floor time / face-to-face for IP
What Is Counseling /Coordinating Care (CCC)?

A Discussion of:
- Diagnostic results, impressions, and/or recommended studies
- Prognosis
- Risks and benefits of management
- Instructions for treatment and/or follow-up
- Importance of compliance

Required Documentation:
- Total time of the encounter
- The amount of time dedicated to counseling / coordination of care
- The nature of counseling/coordination of care
Prolonged Services: To bill must be > than 30 minutes associated with E/M code time

- **OUTPATIENT:** 99354-99355 Prolonged practitioner service requiring face-to-face contact beyond the usual service.
  - 99354 is used to report a total duration of an additional 30-60 minutes on any given date.
  - 99355: add on code to 99354 to report each additional 15-30 minutes

- **INPATIENT:** 99356-99357 Prolonged physician service requiring unit/floor time beyond the usual service
  - 99356 is used to report a total duration of an additional 30-60 minutes on any given date.
  - 99357: add on code to 99356 to report each additional 15-30 minutes.

**REGULATIONS PER CMS:** The medical record must document by the practitioner to include the dated start and end times of the prolonged service.

A counseling visit when time will be the deciding factor, prolonged services can only be added to the highest level of E&M in the category.
The NP or PA MUST BE AN EMPLOYEE OF THE PRACTICE AND CANNOT BE A HOSPITAL EMPLOYEE TO UTILIZE ANY OF THEIR DOCUMENTATION FOR PHYSICIAN BILLING AS SHARED

- Shared visit with an NPP may be billed under the physician's name only if:
  - The physician provides a face-to-face portion of the visit and
  - The physician personally documents in the patient's record the portion of the E/M encounter with the patient they provided.

- If the physician does not personally perform or personally and contemporaneously document their face-to-face portion of the E/M encounter with the patient, then the E/M encounter may only be billed under the PA/ARNP's name and provider number.

- Procedures must be billed under the performing provider & not the supervisor. They cannot be “shared”
## Top Procedure Codes Billed

### Genetics

<table>
<thead>
<tr>
<th>Top 5 CPT Families by Units (Excl. E&amp;M)</th>
<th>% Tot</th>
<th>Top 5 E&amp;M by Units</th>
<th>% Tot</th>
</tr>
</thead>
<tbody>
<tr>
<td>MED NUTR THER, SUBSQ, INDIV, EA 15 MIN</td>
<td>28%</td>
<td>OFFICE/OUTPT VISIT, EST, LEVL V</td>
<td>29%</td>
</tr>
<tr>
<td>AMINO ACIDS, 6+ QUANT</td>
<td>9%</td>
<td>CONSULTATION, LEVEL IV</td>
<td>13%</td>
</tr>
<tr>
<td>ASSAY ORGANIC ACIDS QUALITATIVE</td>
<td>8%</td>
<td>CONSULTATION, LEVEL V</td>
<td>12%</td>
</tr>
<tr>
<td>INSITU HYBRIDIZATION, MANUAL</td>
<td>7%</td>
<td>OFFICE/OUTPT VISIT, EST, LEVL IV</td>
<td>10%</td>
</tr>
<tr>
<td>SUGARS SINGLE QUANTITATIVE, EACH SPECIMEN</td>
<td>7%</td>
<td>SUBSEQUENT HOSPITAL CARE, LEVL III</td>
<td>7%</td>
</tr>
<tr>
<td>All Other Codes</td>
<td>41%</td>
<td>All Other Codes</td>
<td>28%</td>
</tr>
<tr>
<td>Total</td>
<td>100.00%</td>
<td>Total</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
Medical Nutrition Therapy (MNT)

- **97802** Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- **97803** Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

**Overview of Medical Nutrition Therapy (MNT) Services**

- Medical nutrition therapy (MNT) includes nutritional diagnostic therapy and counseling services provided by registered dietitians (RDs) and state-licensed dietitians for the purpose of managing an acute or chronic condition or disease. As an essential component of any health system, MNT is designed to provide quality, safe care throughout the life cycle to help individuals optimize nutritional status and health.
Medical Nutrition Therapy (MNT)

- Under Medicare Part B, MNT coverage is available for qualifying beneficiaries with chronic kidney disease (stages 3-5), kidney transplant, diabetes, and gestational diabetes, when provided by a licensed RD or licensed nutrition professional. CMS defines a nutrition professional as "a dietitian or nutritionist licensed or certified in a state as of December 21, 2000...."

- Many other payers cover MNT services including but not limited to obesity, celiac disease, oncology, HIV/AIDS, and cardiovascular disease.

- MNT occurs over multiple patient visits. The typical MNT service includes an initial assessment and intervention followed by multiple reassessment and intervention visits. Follow up MNT visits are routinely provided for patients with disease states. Several payers, including Medicare, allow MNT to be provided via telehealth.
All diagnostic tests “must be ordered by the physician who is treating the beneficiary.” An “order” as a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. An order may include the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility
- A telephone call by the treating physician/practitioner or his/her office to the testing facility
- An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

Note: If the order is communicated via telephone, both the treating physician/practitioner or his/her office and the testing facility must document the telephone call in their respective copies of the beneficiary’s medical records. On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient’s medical record if it is available. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.
Diagnosis Coding & Medical Necessity

• Justification of medical services rendered to a patient - Diagnosis codes indicate the reason for the encounter
  • Document the most accurate diagnosis or signs /symptoms representing clinical conditions rendering treatment / services on a given DOS to the highest specificity
  • Physician claims require diagnosis codes and are often utilized on reviews to support medical necessity thru LCDs and NCDs, especially for radiology
• If the clinical findings of the test are inconclusive or negative – code Signs or Symptoms which prompted the encounter
• Do not choose diagnoses codes – if condition is described as “probable”, “possible” or “rule out”
• All requests for diagnostic testing must be documented in the reports and specify:
  • diagnosis (if confirmed) or signs or symptoms
Physicians submitting charges to the insurance carriers are “expected to know” that services will be considered “not medically necessary” if:

- There is a published policy outlining the coverage, or
- A given service was previously denied
  - due to diagnosis code listed on the claim
  - lack of appropriate modifiers
  - due to frequency limitation
Lab Services Diagnosis Coding

When choosing diagnosis codes for professional billing -

- Definitive diagnosis should be assigned to the highest degree of specificity, whenever possible
- If the findings are inconclusive – code the Signs and Symptoms which prompted the service
- Preventive services – screenings – document screening nature of the service

Diagnosis can not be assigned on basis of “rule out”, “possible” or “probable” history or findings
Guidelines for Teaching Physicians, Interns, Residents and Fellows

For Billing Services, All Types of Services Involving a Teaching Physician (TP) Requires Attestations In EHR or Paper Charts
Evaluation and Management (E/M)

**E/M IP or OP:** TP must personally document at least the following:
- That s/he performed the service or was physically present during the key or critical portions of the service when performed by the resident; AND
- The participation of the teaching physician in the management of the patient.

**Example:** ‘I saw and examined the patient and agree with the resident’s note...’

**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*
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
In the teaching setting the attending pathologist qualifies for reimbursement if:

- The teaching physician's signature is the only signature on the report *(Carrier will assume that the author/attending is indicating that he or she personally performed the interpretation).*

- If a resident prepares and signs the report, the teaching physician must indicate that he or she has personally reviewed the specimen and the resident's interpretation and either agrees with it or edits the findings. **Example:** “I personally reviewed the specimen and agree with the final report”.

In cases where the documentation shows simply a countersignature of the resident's interpretation by the teaching physician – no charges should be submitted by the attending physician.
Interpretation Reports

- **Elements of the report**
  - **Clinical Information must include**
    - Referring Physician
    - Patient Demographics
    - Clinical signs or symptoms or personal history of disease (reason the test was ordered)
  - **Body of the report should include**
    - Description of the specimen, procedure(s) including stain panel, add’l studies etc.
  - **Diagnosis**
    - If findings are negative – coding is based on signs or symptoms (indicated in clinical hx)
    - Diagnosis can not be assigned on basis of “rule out”, “possible” or “probable” history or findings
When to Use Modifiers

- **Bundled** – verb: to collect or gather up into a mass (Oxford Dictionary)
  
  A “bundled” service includes all of the steps necessary to complete a given procedure.

- **Unbundling** - occurs when 2 or more CPT codes are used to describe a service when a single, more comprehensive code exists that accurately describes the service performed.

**Fraud Alert**

Unbundling satisfies the OIG’s definition of a false or fraudulent claim.

Improper use of modifier –59 may result in “unbundling” of services.
Modifier 59 Definition

- Distinct procedural service Designates instances when *distinct* and *separate multiple services* are provided to a patient on a *single date of service*.

- *TIP* Strictly a billing modifier used to break the National Correct Coding Initiative (NCCI) edits.
  - Identifies procedures/services that are *not normally reported together*, but are *appropriate under the circumstances*.
  - Overrides the correct coding edit. Documentation must substantiate utilization.
Pathology and Modifier 59 Alert

- For all intent and purposes, Medicare has wrenched control over it from the AMA, so its primary use is to denote situations where a NCCI edit or a Medically Unlikely Edit (MUE) limit is appropriately bypassed due to the facts at hand.

- Medicare Part B contractors also want the 59 modifier used to declare that multiple units of the same CPT code being reported on the same day are all medically necessary.
Modifier – 91

If an ordering physician requests a laboratory test that requires that several of the same services (CPT code) be performed for the same beneficiary on the same day, **modifier -91 should be used** to indicate that multiple clinical diagnostic laboratory tests were done on the same day. (This modifier should not be used when multiple tests are described under a single code, e.g., glucose tolerance test.)

**Example:**

An arterial blood sample is drawn from a patient at three different intervals on the same day, and the blood testing is performed three times that same day CPT code 82803 – Gas, blood, any combination of pH, PCO2, PO2, CO2, HCO3 (including calculated O2 saturation)

Report the CPT code 82803 on the line item and code the modifier ‘-91’ after the CPT code. The information would appear as “82803-91” on the line item.
Modifier – 91

Frequency of Services

- Frequency of laboratory test is always a consideration. Carriers may request documentation when the frequency of an individual test appears to be not reasonable and necessary for a particular patient.

When modifier -91 should not be used?

- CPT manual indicates that modifier-91 should not be used in the following cases:
  - When tests are rerun to confirm initial results;
  - Multiple services were rendered due to testing problems with specimens or equipment;
  - Any other reason when a normal, one-time reportable result is all that is required
  - When there is a separate code indicating that series of test results were performed
2014 CPT Code Changes

Interprofessional consultations

- New codes to report interprofessional ("doctor-to-doctor") telephone/Internet consulting.
- Code 99446 is defined as an interprofessional telephone/Internet assessment and management service provided by a consultative physician, including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional, and involves 5 to 10 minutes of medical consultative discussion and review.
  - 99447: 11 to 20 minutes of medical consultative discussion and review
  - 99448: 21 to 30 minutes of medical consultative discussion and review
  - 99449: 31 minutes or more of medical consultative discussion and review
Interprofessional Consultations

- The services will typically be provided in complex and/or urgent situations where a timely face-to-face service with the consultant may not be possible. The written or verbal request, its rationale, and the conclusion for telephone/Internet advice by the treating/requesting physician or other qualified health care professional should be documented in the patient’s medical record.

- Medicare allowable $0.00
ICD-10 and Clinical Documentation

• Increased specificity of the ICD-10 codes requires more detailed clinical documentation to code some diagnoses to the highest level of specificity.

• Coding and documentation go hand in hand
  • ICD-10 based on complete and accurate documentation, even where it comes to right and left or episode of care.
  • ICD-10 should impact documentation as physicians are required to support medical necessity using appropriate diagnosis code—this is not an easy situation.

• Will not change the way a physician practices medicine
HIPAA
Final Reminders for All Staff, Residents, Fellows or Students

- 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.
Any Questions
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 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