Diagnosis Coding
International Classification of Disease (ICD-10)

• ICD-10 compliance –
  • Relying on the information that comes across with each order to dictate the clinical information section of reports.
    • Is that sufficient?
  • Using report templates that pull this information directly from the order.
    • For example, the text might read “Special instructions: r/o pulmonary embolism” along with the actual ICD-10 code.
  • What is the best approach?
## Radiology Tip Sheet for ICD-10

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Document site:</th>
<th>Document type of intraluminal device:</th>
<th>Document approach:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angioplasty (Non-Coronary)</td>
<td>- Head and neck&lt;br&gt;- Innominate&lt;br&gt;- Intracranial&lt;br&gt;- Lower extremity&lt;br&gt;- Upper extremity&lt;br&gt;- Pulmonary&lt;br&gt;- Subclavian artery&lt;br&gt;- Veins&lt;br&gt;- Visceral(trunk)&lt;br&gt;- Other upper arterial</td>
<td>- Non-Drug Eluting&lt;br&gt;- Drug Eluting</td>
<td>• Open&lt;br&gt;• Percutaneous&lt;br&gt;• Percutaneous Endoscopic</td>
</tr>
<tr>
<td>C.A.T Scan</td>
<td>Document site of scan</td>
<td>Document type of contrast, if used:</td>
<td></td>
</tr>
<tr>
<td>Central Venous Catheter Placement</td>
<td>Document site of catheter insertion: &lt;br&gt;- Atrium&lt;br&gt;- Inferior vena cava&lt;br&gt;- Innominate vein&lt;br&gt;- Subclavian vein&lt;br&gt;- Superior vena cava</td>
<td>Document substance, if administered: &lt;br&gt;- Antibiotics&lt;br&gt;- Antineoplastic&lt;br&gt;- Dialysis&lt;br&gt;- Nutritional substance&lt;br&gt;- Other</td>
<td>• Open&lt;br&gt;• Percutaneous&lt;br&gt;• Percutaneous endoscopic&lt;br&gt;• Guidance</td>
</tr>
<tr>
<td>MRI</td>
<td>Document site of MRI</td>
<td>Document type of contrast, if used:</td>
<td></td>
</tr>
<tr>
<td>Thoracentesis</td>
<td></td>
<td>Document laterality:</td>
<td>Document device, if used:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Left&lt;br&gt;• Right</td>
<td>• With drainage device&lt;br&gt;• Without drainage device</td>
</tr>
</tbody>
</table>
2016 Code Changes
Molecular Code Changes

Total 2016 CPT Code changes for Radiology

<table>
<thead>
<tr>
<th>Radiology Specification</th>
<th>New</th>
<th>Deleted</th>
<th>Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Radiology</td>
<td>14</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>31</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Nervous System</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Category III Codes</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
2016 Code Changes

Medicare is bundling two or more codes that are frequently billed together into a single new code to describe the entire procedure. This process usually assigns a lower total value to the single procedure code than the multiple combined codes carried. On the positive side, there are now new codes to describe previously unlisted procedures, which will result in more reliable and appropriate reimbursement for those procedures.
Radiology Updates

- Nuclear Medicine subsection changes include two added and one revised code.
- Interventional Radiology was impacted most by new codes for urinary imaging and percutaneous drainage procedures, as well as biliary tract imaging and percutaneous drainage procedures.
  - As seen in previous years, these new codes now include imaging guidance and/or radiological supervision and interpretation.
- Additional instructional notes were added throughout the radiology section regarding guidance procedures now bundled into new surgical codes. The code specifics will appear later in this document.
Update NUCLEAR & IR Codes

• NUCLEAR MEDICINE
  • New codes have been added to describe gastric emptying with small bowel and colon transit studies.

• INTERVENTIONAL RADIOLOGY
  • Changes include multiple deleted and new codes for urinary and biliary imaging and percutaneous drainage procedures which now include all imaging and RS&I. Previously reported as unlisted CPT codes, new codes were added to describe soft tissue marker placement and percutaneous image-guided sclerotherapy fluid collection. Mechanical thrombectomy codes have been revised and new intracranial therapy codes have been added that describe revascularization of cerebral vessels and prolonged intracranial infusion therapy.
Changes to the Diagnostic Radiology Section include deleted codes and new codes for spine, hip/pelvis, and extremity exams. New MRI codes were added for fetal evaluation. Several codes were revised to replace the term “films” with the term “images”. Urinary and biliary imaging radiological supervision and interpretation (RS&I) codes were deleted. Several parenthetical notes were added throughout the section to reflect changes in other procedures (e.g., new surgical procedures now bundling imaging).
## 2016 Code Changes

### Percutaneous Biliary Procedures

New bundled codes replace 9 codes that were previously used in combination with S&I codes. All of the new codes include any diagnostic imaging or imaging guidance, as well.

<table>
<thead>
<tr>
<th>Description</th>
<th>Old Code(s)</th>
<th>New Code</th>
<th>Fee</th>
<th>Description</th>
<th>Old Code(s)</th>
<th>New Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection for Cholangiogram, existing Access</td>
<td>47500</td>
<td>47531</td>
<td>$109.56</td>
<td>Exchange of biliary drainage catheter (change drain)</td>
<td>47525</td>
<td>47536</td>
<td>$168.46</td>
</tr>
<tr>
<td></td>
<td>74320</td>
<td></td>
<td></td>
<td></td>
<td>75984</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placement of biliary drainage catheter, internal-external (insert drain)</td>
<td>47511</td>
<td>47534</td>
<td>$475.24</td>
<td></td>
<td>47505</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>75982</td>
<td></td>
<td></td>
<td></td>
<td>74320</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(injection)</td>
<td>47500</td>
<td></td>
<td></td>
<td></td>
<td>74305</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>75982</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conversion of external biliary drainage catheter to internal-external</td>
<td>47511</td>
<td>47535</td>
<td>$275.70</td>
<td></td>
<td>47505</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(insert drain)</td>
<td>75982</td>
<td></td>
<td></td>
<td></td>
<td>74305</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(injection)</td>
<td>74320</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2016 Code Changes

Five (5) New codes below describe procedures that are currently billed using endoscopic or unlisted procedure codes.

<table>
<thead>
<tr>
<th>Description</th>
<th>New Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal of biliary drainage catheter, requiring fluoroscopic guidance</td>
<td>47537</td>
<td>$117.25</td>
</tr>
<tr>
<td>(e.g., with concurrent internal biliary stents)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placement of stent(s) into bile duct, each stent, existing access</td>
<td>47538</td>
<td>$375.67</td>
</tr>
<tr>
<td>New access, without placement of separate biliary drainage catheter</td>
<td>47539</td>
<td>$508.07</td>
</tr>
<tr>
<td>New access, with placement of separate biliary drainage catheter</td>
<td>47540</td>
<td>$606.29</td>
</tr>
<tr>
<td>Placement of access through a biliary tree and into a small bowel</td>
<td>47541</td>
<td>$327.28</td>
</tr>
</tbody>
</table>
2016 Code Changes

Genitourinary System/Renal Pelvis Catheterization

Four (4) new codes for renal pelvis catheter procedures will bundle the S&I and imaging guidance with the surgical procedure and will include the diagnostic nephrostogram and/or ureterogram.

In addition, a new code 50430 for injection for antegrade nephrostogram and/or ureterogram, complete diag. procedure including imaging guidance, (e.g., ultrasound & fluoroscopy) S&I and interpretation, new access. And 50431, for existing access.

<table>
<thead>
<tr>
<th>Description</th>
<th>Old Code(s)</th>
<th>New Code</th>
<th>Fee</th>
<th>Description</th>
<th>Old Code(s)</th>
<th>New Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement of nephrostomy catheter, percutaneous</td>
<td>50392</td>
<td>50432</td>
<td>$250.99</td>
<td>Exchange nephrostomy catheter, percutaneous</td>
<td>50398</td>
<td>50435</td>
<td>$114.93</td>
</tr>
<tr>
<td></td>
<td>74475</td>
<td></td>
<td></td>
<td></td>
<td>75984</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placement of nephroureteral catheter, percutaneous, new access</td>
<td>50393</td>
<td>50433</td>
<td>$310.07</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>74480</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convert nephrostomy catheter to nephroureteral catheter, percutaneous,</td>
<td>50393</td>
<td>50434</td>
<td>$237.82</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>via pre-existing nephrostomy tract</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>74480</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The new codes below describe procedures for ureteral stenting, embolization and dilation. These include diagnostic imaging (such as nephrostogram) and all imaging guidance, supervision and interpretation.

<table>
<thead>
<tr>
<th>Description</th>
<th>New Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement of ureteral stent, pre-existing nephrectomy tract</td>
<td>50693</td>
<td>$248.45</td>
</tr>
<tr>
<td>New access, without separate nephrostomy catheter</td>
<td>50694</td>
<td>$321.61</td>
</tr>
<tr>
<td>New access, with separate nephrostomy catheter</td>
<td>50695</td>
<td>$407.93</td>
</tr>
<tr>
<td>Ureteral embolization or occlusion (used in addition to code for primary procedure)</td>
<td>50705</td>
<td>$235.75</td>
</tr>
<tr>
<td>Balloon dilation ureteral stricture (used in addition to code for primary procedure)</td>
<td>50706</td>
<td>$215.12</td>
</tr>
</tbody>
</table>
New codes for intracranial thrombectomy and infusion therapy. These include catheter placement, supervision and interpretation, as well as diagnostic angiography and all imaging guidance.

<table>
<thead>
<tr>
<th>Description</th>
<th>New Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis</td>
<td>61645</td>
<td>$976.37</td>
</tr>
<tr>
<td>Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis; initial vascular territory</td>
<td>61650</td>
<td>$639.98</td>
</tr>
<tr>
<td>Each additional vascular territory (add to 61650)</td>
<td>61651</td>
<td>$271.86</td>
</tr>
</tbody>
</table>
Tips for Catheter Placement

1) Code to the highest order selective cath placement within each vascular family
2) Code the selective cath placement only if both nonselective & selective placements are performed from one access point
3) Code each separate access site
4) All vessels imaged with documentation of findings in the report can be assigned the S&I codes more than once, even if they were not individually selected & if the code does not have the code narrative “selective” exceptions
5) Aorta takes precedence over other nonselective codes
6) Code each vascular family separately, using modifiers to distinguish the different vessels
7) Code to where the tip of the cath is, not to the tip of the wire
8) Do not code for injecting small amounts of contrast to localize a vessel for subsequent selection
Documentation of Device Position

• The final position of all devices inserted permanently or long-term with imaging guidance (eg, stents, endovascular grafts, central venous catheters, inferior vena cava filters, embolic agents, drainage catheters) should be documented with imaging.

• Benefits of documenting device position should be weighed against ionizing radiation risks of x-ray documentation (eg, in pregnancy).
ARCHIVING OF IMAGES

• General Principles
• All pertinent imaging data should be saved in permanently retrievable digital or hard-copy format. Examples of pertinent imaging data include:
  • The relevant anatomy that will affect patient management, device position, complications, and transient adverse events (such as emboli) that might have been successfully treated during a given procedure.
  • If ultrasound guidance is used to gain entry into a blood vessel, it is optional to save a sonographic image of this blood vessel.
The Final Report IR Required:

1. To transmit procedural information to all members of health care community who may participate in subsequent care of the patient;
2. For legal purposes;
3. For reimbursement.

Specific information included in this report depends on the procedure. Recommend elements:

1. Procedure;
2. Date;
3. Operator(s);
4. Indication;
   - This information should include access site (and all attempted access sites), guidance modalities, catheters/guide wires/needles, vessels or organs catheterized, technique, and hemostasis.
   - Each major vessel catheterized for imaging or intervention should be noted specifically. If informed consent was obtained, this should be stated;
6. Complications;
7. Results/findings;
8. Conclusion;
9. Plan, if appropriate.
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
Face-to-Face Visits and Consultations

**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.
**Face-to-Face Visits and Consultations**

**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
Procedures

Minor – (< 5 Minutes & 0 -10 Day Global): 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— 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 (or key and critical portions & description of the key and critical portions of the procedure) and immediately available.”

Endoscopy Procedures (excluding Endoscopic Surgery):

TP must be present during the entire viewing for payment.

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

Example: “I was present for the entire viewing”.

**High-Risk Procedures & Diagnostic Services**

**Complex or high-risk procedures:** Requires personal (in person) supervision of its performance by a TP and is billable only when the TP is present with the resident for the entire procedure. These procedures typically include cardiac and other interventional services.

- *Example:* “I was present for the entire (identify procedure).”
• **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.**
The CPT descriptions of documentation requirements for many 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."
Medical Necessity For Procedures

- **What is Medical Necessity?**
  - It is a concept of justification of medical services rendered to a patient
  - services deemed “not medically necessary” – ARE NOT reimbursable

- **How does Insurance Carrier know if services were Medically Necessary?**
  - ICD-10-CM diagnosis codes indicate the reason for the visit
    - Providers should choose only the diagnosis representing clinical conditions they are treating the patient for on a given date of service
    - Use most accurate dx code
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
Modifiers
Consultation on Previous Interpretation

• 77  Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional: It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service.
Modifier 76 Fact Sheet

Repeat Procedure by the Same Physician; use when it is necessary to report repeat procedures performed on the same day.

• **Appropriate Usage**
  • On procedure codes that cannot be quantity billed
  • Report each service on a separate line, using a quantity of one and append 76 to the subsequent procedures
  • The same physician performs the services

• **Inappropriate Usage**
  • Repeat services due to equipment or other technical failure
  • For services repeated for quality control purposes

• **Additional Information**
  • Medicare considers two physicians, in the same group with the same specialty performing services on the same day as the same physician
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.
# IR Global 000, 010 Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22510010</td>
<td>Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic</td>
</tr>
<tr>
<td>32557000</td>
<td>Pleural drainage, percutaneous, with insertion of indwelling catheter</td>
</tr>
<tr>
<td>37193010</td>
<td>Removal intravascular vena cava filter</td>
</tr>
<tr>
<td>50395000</td>
<td>Introduction of guide to establish nephrostomy tract, percutaneous</td>
</tr>
<tr>
<td>36558010</td>
<td>Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older</td>
</tr>
</tbody>
</table>
Some Commercial Guidelines

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

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

• Reporting an E/M service with modifier 25 is appropriate in the following situations:
  • The patient requires evaluation “above and beyond” what is typically expected as part of the evaluation prior to the procedure.
  • The patient’s condition has changed or worsened and the patient needs to be re-evaluated.
  • The patient presents with a new, separate problem than what prompted the procedure.
Modifier 59: Distinct Procedural Service

- Designates instances when *distinct and separate multiple services* are provided to a patient on a single date of service and should be paid separately.

- Modifier-59 is defined for use in a wide variety of circumstances to identify:
  - Different encounters Different anatomic sites (Different services (Most commonly used and frequently incorrect)).
Conditional Orders

- CMS has approved the use of conditional orders as long as they are limited to a specific patient.
  - Example: a patient-specific order reads: “Diagnostic mammogram of right breast with ultrasound, as indicated,” the radiologist may add the ultrasound to characterize the mass.

- A standing order for all patients of a given treating physician/practitioner (e.g., “if gallbladder ultrasound for Dr. Smith is negative, do UGI”) is not acceptable. The conditional order process can be replicated across diagnostic testing modalities (i.e., CT; MRI; Ultrasound; etc) with the understanding that such conditional orders MUST BE patient-specific.
Physician Supervision Of Diagnostic Tests

• Levels of Supervision when a technician is utilized:
  • **Personal** – Physician in the room
    • e.g. myelography, cisternography, dacryocystography
  • **Direct** – Physician in the suite (available)
    • administration of contrast media
  • **General** – Physician provides overall supervision
    • films

Supervision requirements apply to charges for global or technical component – It does not apply if Radiologist bills for interpretation and report only.
What Services Can Be in One Report

Combined services into one report is not restricted

• Each service included in the report must include all report components to be identified for review (essentially 2 diagnostic studies – interpretations in one report:
  • Clinical Information related to the specific area reviewed
  • Body of the report should include each anatomical area, modality, and use of contrast
  • Impression for each area reviewed

• Typically see combined reports included from one ordering practitioner.

• HOWEVER! When multiple are performed on the same day, a modifier has to be attached to the individual charge. An issue can arise with report accession numbers for billing in some organizations.
Inpatient and Outpatient

Evaluation and Management E/M
Documentation and Coding
Current CMS Florida First Coast Audits

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

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

• Prepayment review for CPT® codes 99204 and 99205 (New Patient Visit) and 99215 (established patient visit) all specialties

• 99214 – Post-payment review all specialties

• Claims billed with Modifier 24 must be submitted supportive documentation
The 3 Key Documentation Elements

- Physical Exam
- History
  Focus on HPI
- Medical Decision Making
Medical Decision-Making

1. Number of Diagnoses or Treatment Options

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

Multiple active problems?
New problem with additional workup? = HIGHER COMPLEXITY
Are problems worse? = HIGHER COMPLEXITY
Medical Decision-Making

2. Amount/Complexity of Data

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

3. Table of Risk

- Is the presenting problem self-limited?
- Are procedures required?
- Is there exacerbation of chronic illness?
- Is surgery or complicated management indicated?
- Are prescription medications being managed?
FOUR ELEMENTS of HISTORY

- Chief Complaint (CC:)
- History of Present Illness (HPI)
  location/quality/severity/duration/timing/context/modifying factors/associated symptoms
- Review of Systems (ROS)
- Past/Family/Social History (PFSHx)
History

1. **Chief Complaint**
   - Concise statement describing reason for encounter
   - Can be included in HPI

   **IMPORTANT:**
   - The visit is not billable if Chief Complaint is not somewhere in the note
   - Must be “follow-up” of ____________________________
2. The HPI is a chronological description of the patient’s illness or condition. The elements to define the HPI are:

- **Location**: Right lower quadrant, at the base of the neck, center of lower back
- **Quality**: Bright red, sharp stabbing, dull
- **Severity**: Worsening, improving, resolving
- **Duration**: Since last visit, for the past two months, lasting two hours
- **Timing**: Seldom, first thing in the morning, recurrent
- **Context**: When walking, fell down the stairs, patient was in an MVA
- **Modifying Factors**: Took Tylenol, applied cold compress: with relief/without relief
- **Associated Signs and Symptoms**: With nausea and vomiting, hot and flushed, red and itching

TWO TYPES:

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

14 recognized:

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

THREE TYPES:

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

**TWO TYPES:**

- **PERTINENT:** 1 area (P, F or S) generally related to HPI
- **COMPLETE:** All 3 (P, F and S) for New patient and Initial Hospital
  or 2 of 3 areas (P, F or S) for established pt.
Physical 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
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.
# Time-Based Billing for CCC

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<th>Outpatient Counseling Time:</th>
<th>Inpatient Counseling Time:</th>
</tr>
</thead>
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<tr>
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<td>99221 30 min</td>
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<tr>
<td>99202 20 min</td>
<td>99222 50 min</td>
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<tr>
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<td>99215 40 min</td>
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</tbody>
</table>
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.
• TEACHING PHYSICIANS WHO SEEK REIMBURSEMENT FOR OVERSIGHT OF PATIENT CARE BY A RESIDENT MUST PERSONALLY SUPERVISE ALL SERVICES PERFORMED BY THE RESIDENT.

• PERSONAL SUPERVISION PURSUANT TO RULE 59G-1.010(276), F.C.A, MEANS THAT THE SERVICES ARE FURNISHED WHILE THE SUPERVISING PRACTITIONER IS IN THE BUILDING AND THAT THE SUPERVISING PRACTITIONER SIGNS AND DATES THE MEDICAL RECORDS (CHART) WITHIN 24 HOURS OF THE PROVISION OF THE SERVICE.
Top Compliance Issues For Documenting in EMR
Once you sign your note, you are responsible for its content.
Top Compliance Rules for EMR

Don’t dump irrelevant information into your note

• (“the 10-page follow-up note”)

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

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

• Self-explanatory
Top Compliance Rules for EMR

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

- Cautious with ROS and Exam

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

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

• Demonstrates Medical Necessity

• Know your covered diagnoses for your common labs
Copy/Paste Philosophy:

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

• Don’t say Today, Tomorrow, or Yesterday

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

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

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

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

• Make sure your note reflects the reality and accuracy of the service each day
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. yyyy." Then, Dr. yyyy 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 scriber. 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 the encounter was recorded with [patient name]. I have reviewed and verified the accuracy of the information which was performed by me.” [Name of provider][Date and time of entry].
"Whoa—way too much information."
HIPAA, HITECH, PRIVACY AND SECURITY

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

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

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

  http://www.miami.edu/index.php/professional_development_training_office/learning/ulearn/
• HIPAA, HITECH, Privacy & Security
• Several breaches were discovered at the University of Miami, one of which has resulted in a class action suit. As a result, “Fair Warning” was implemented.
• What is Fair Warning?
  • Fair Warning is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.
  • Fair Warning protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.
  • Fair Warning is an initiative intended to reduce the cost and complexity of HIPAA auditing.
• UHealth has policies and procedures that serve to protect patient information (PHI) in oral, written, and electronic form. These are available on the Office of HIPAA Privacy & Security website: http://www.med.miami.edu/hipaa
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 Officer; 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 (24hours a day, seven days a week).
• Office of billing Compliance website: www.obc.med.miami.edu