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

Interventional Radiology

Prepared by:
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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.

<table>
<thead>
<tr>
<th>A. DATE(S) OF SERVICE</th>
<th>B. PLACE OF SERVICE</th>
<th>C. EMG</th>
<th>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th>
<th>E. DIAGNOSIS/POINTER</th>
<th>F. $ CHARGES</th>
<th>G. DAYS OR UNITS</th>
<th>H. EMR FAMILY PLAN</th>
<th>I. ID QUAL</th>
<th>J. RENDERING PROVIDER ID. #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>NPI</td>
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<td>NPI</td>
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<td>NPI</td>
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<td>NPI</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>NPI</td>
</tr>
</tbody>
</table>

This certification forms the basis for a false claim.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: ___________________________ DATE: ___________________

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)
One final note on the False Claims Act

- “Qui tam” or "whistle blower" provisions allow private persons to sue those who defraud the Government.

- Merely informing the Government about the False Claims Act violation is not enough.

- An individual who files a False Claims Act suit receives an award only if, and after, the Government recovers money from the defendant as a result of the lawsuit.
HOT TOPICS IN COMPLIANCE 2014
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-9-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

Example:
- patient with thoracic spondylosis– ICD-9 code 721.41
- patient with lumbar region spondylosis – ICD-9 code 721.42
Elements of Medical Necessity For E/M

- 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).
What Are We Seeing Out There?

• Audits are being conducted for all payer types based on the medical necessity of E/M levels. The audits are generally expressed in two ways:

  • Frequency of services (how often the patient is seen) and,

  • Intensity of service (CPT level).
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.
**What We Found:** CMS and its contractors had adopted few program integrity practices specific to EHRs

**What We Recommend:** Although EHR technology may make it easier to perpetrate fraud, CMS and its contractors have not adjusted their practices for identifying and investigating fraud in EHRs.

**Recommendations**
- First, CMS should provide guidance to its contractors on detecting fraud
- Second, CMS should direct its contractors to use providers’ audit logs.
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
Quality & Cost: Emphasis on Pay-for-Performance PQRS & Meaningful Use

- 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 will 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].”
Evaluation and Management E/M

Documentation and Coding

Inpatient, Outpatient and Consultations
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)
    - WHY IS THE PATIENT BEING SEEN TODAY
  - History of Present Illness (HPI),
  - 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.
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"
<table>
<thead>
<tr>
<th>Location</th>
<th>Severity</th>
<th>Timing</th>
<th>Modifying Factors</th>
<th>Brief</th>
<th>Extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Duration</td>
<td>Context</td>
<td>Associated signs and symptoms</td>
<td>(1-3 elements)</td>
<td>4 or more</td>
</tr>
</tbody>
</table>

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

**ROS (Review of systems):**
- Constitutional (wt loss, etc)
- Ears, nose, mouth, throat
- GI
- Integumentary (skin, breast)
- Endo

**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 negative**
  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**

**EXP. PROB. FOCUSED**

**DETAILED**

**COMPREHENSIVE**
EXAMINATION

- 4 TYPES OF EXAMS
  - Problem focused (PF)
  - Expanded problem focused (EPF)
  - Detailed (D)
  - Comprehensive (C)
Coding 1995: Physical Exam Definitions

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
- 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
- **Eyes**
  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)

- **Ears, Nose, Mouth and Throat**
  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

- **Neck**
  Neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus); Thyroid (eg, enlargement, tenderness, mass)

- **Respiratory**
  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)

- **Cardiovascular**
  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

- **Chest/Breast**
  Breasts (eg, symmetry, nipple discharge); Palpation of breasts and axillae (eg, masses or lumps, tenderness)

- **Gastrointestinal (Abdomen)**
  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)

- **Genitourinary**
  **MALE:**
  Scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass); Penis (exam of); Digital rectal prostate gland (eg, size, symmetry, nodularity, tenderness)
  **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)

- **Lymphatic**
  Palpation of lymph nodes in **two or more** areas: Neck; Axillae; Groin; Other

- **Musculoskeletal**
  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

- **Skin**
  Skin and subcutaneous tissue (eg, rashes, lesions, ulcers); Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)

- **Neurologic**
  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)

- **Psychiatric**
  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)
# 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>
</tr>
</thead>
<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>
</tr>
<tr>
<td>Est. Problem (to examiner) stable, improved</td>
<td></td>
<td>1</td>
<td>2 POINTS: E-3, NEW-3</td>
</tr>
<tr>
<td>Est. Problem (to examiner) worsening</td>
<td></td>
<td>2</td>
<td>3 POINTS: E-4, NEW-4</td>
</tr>
<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>
</tr>
<tr>
<td>New prob. (To examiner); additional workup planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### DOCUMENTATION AUDIT TOOL

#### B
**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**

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 text.

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>
</table>
| Minimal       | • One self-limited or minor problem e.g., cold, insect bite | • Laboratory tests requiring venipuncture  
• Chest x-rays  
• EKG/EEG  
• Urinalysis  
• Ultrasound  
• KOH prep | • Rest  
• Gargles  
• Elastic bandages  
• Superficial dressings |
| Low           | • Two or more self-limited or minor problems  
• One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes  
• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain | • Physiologic tests not under stress, e.g., pulmonary function tests  
• Non-cardiovascular imaging studies with contrast, e.g., barium enema  
• Superficial needle biopsies  
• Clinical laboratory tests requiring arterial puncture  
• Skin biopsies | • Over-the-counter drugs  
• Minor surgery with no identified risk factors  
• Physical therapy  
• Occupational therapy  
• IV fluids without additives |
| Moderate      | • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment  
• Two or more stable chronic illnesses  
• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast  
• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis  
• Acute complicated injury, e.g., head injury with brief loss of consciousness | • Physiologic tests not under stress, e.g., cardiac stress test, fetal contraction test  
• Diagnostic endoscopies with no identified risk factors  
• Deep needle or incisional biopsy  
• Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath  
• Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis | • Minor surgery with identified risk factors  
• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors  
• Prescription drug management  
• Therapeutic nuclear medicine  
• IV fluids with additives  
• Closed treatment of fracture or dislocation without manipulation |
| High          | • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
• 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  
• An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss | • Cardiovascular imaging studies with contrast with identified risk factors  
• Cardiac electrophysiological tests  
• Diagnostic endoscopies with identified risk factors  
• Discography | • Elective major surgery (open, percutaneous or endoscopic with identified risk factors)  
• Emergency major surgery (open, percutaneous or endoscopic with identified risk factors)  
• Parenteral controlled substances  
• Drug therapy requiring intensive monitoring for toxicity  
• Decision not to resuscitate or to de-escalate care because of poor prognosis |
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 2\textsuperscript{nd} circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid.

| **Final Result for Complexity** |
|-------------------|-----------------|-----------------|-----------------|-----------------|
| **A** | Number diagnoses or treatment options | \( \leq 1 \) Minimal | 2 Limited | 3 Multiple | \( \geq 4 \) Extensive |
| **B** | Highest Risk | Minimal | Low | Moderate | High |
| **C** | Amount and complexity of data | \( \leq 1 \) Minimal or low | 2 Limited | 3 Multiple | \( \geq 4 \) Extensive |
| 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 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., 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.

- In 2012, the AMA CPT instructions for billing new patient visits include physicians in the same specialty and subspecialty. However, for Medicare E/M services the same specialty is determined by the physician's or practitioner's primary specialty enrollment in Medicare.
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
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
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 or Dr. (teaching physician) 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 (or Dr. TP) was present for the entire (or key and critical portions) of the procedure and immediately available.”

*Medical Student documentation for billing only counts for ROS and PFSH*
Other Complex or High-Risk Procedures

- For complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicate that the procedure requires personal (in person) supervision of its performance by a physician, the physician services associated with the procedure are billable only when the teaching physician is present with the resident.

Example:
“Dr. TP (or I) was present for the entire (identify procedure).”

The teaching physician or resident must document the TP’s physical presence and participation in the procedure. The TP or resident should identify the specific procedure. These procedures typically include high-risk interventional codes.
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
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”
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
# Top Procedure Codes Billed in 2013

<table>
<thead>
<tr>
<th>Top 5 Procedure</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>76942</td>
<td>SONO GUIDE NEEDLE BIOPSY</td>
<td>11%</td>
</tr>
<tr>
<td>77001</td>
<td>FLUOROGUIDE CNTRL VEN ACCESS,PLACE, REPLACE,REMOVE</td>
<td>7%</td>
</tr>
<tr>
<td>49083</td>
<td>ABDOM PARACENTESIS DX/THER W IMAGING GUIDANCE</td>
<td>5%</td>
</tr>
<tr>
<td>76937</td>
<td>US GUIDE, VASCULAR ACCESS</td>
<td>5%</td>
</tr>
<tr>
<td>77012</td>
<td>PR CT GUIDANCE NEEDLE PLACEMENT</td>
<td>4%</td>
</tr>
<tr>
<td>All other PR Codes</td>
<td></td>
<td>31%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top 5 E&amp;M</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td>OFFICE/OUTPT VISIT</td>
<td>27%</td>
</tr>
<tr>
<td>99213</td>
<td>PR OFFICE/OUTPT VISIT,</td>
<td>20%</td>
</tr>
<tr>
<td>99212</td>
<td>PR OFFICE/OUTPT VISIT,EST,LEVL II</td>
<td>20%</td>
</tr>
<tr>
<td>99203</td>
<td>PR OFFICE/OUTPT VISIT,NEW,LEVL III</td>
<td>18%</td>
</tr>
<tr>
<td>99202</td>
<td>PR OFFICE/OUTPT VISIT,NEW,LEVL II</td>
<td>5%</td>
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<tr>
<td>All other E/M Codes</td>
<td></td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100.0%</td>
</tr>
</tbody>
</table>
2014 CPT Code Changes Review

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

- Medicare Does Not Pay This Service
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
2014 CPT Code Changes

- **VASCULAR STENTING**
  - New codes were developed that bundle the surgical and radiologic portions of stent procedures into a single code.
  - There are two new pairs of codes, one for arterial stents and one for venous stents. These codes are reported per vessel treated rather than per stent placed.
  - For dialysis access treatment coding purposes, the definition of “vessel” is different than the anatomical definition and should be reviewed in the CPT manual to ensure correct reporting. Each pair of stent codes has a parent code used to report the first vessel treated, with an add-on code for reporting additional stented vessels during the same procedure.
2014 CPT Code Changes

- **VASCULAR STENTING**
  - The arterial stent codes apply to any artery that does not have an anatomy-specific CPT code (carotid, iliac and infrainguinal, intracranial, coronary, and vertebral arteries have specific stent placement codes).
  - Any ballooning performed to treat the stented vessel (before, during, or after stent placement) is included in the work of the stent codes and is not separately reported. Selective catheterization of the vessel(s) is not included in the work described by the stent codes and is separately reported. In addition, ultrasound guidance for vessel puncture and intravascular ultrasound are not included in the work of these codes.
  - Covered stents placed to treat aneurysms (eg, popliteal aneurysms), pseudoaneurysms, or extravasations are coded with these new stent codes (with the exception of aortic and iliac aneurysms, which are reported with codes specific for endovascular repair of aneurysms in those anatomic sites). Stents placed to create latticework for facilitating coil embolization are reported with embolization codes and should not be reported with the new stent codes.
2014 CPT Code Changes

- **VASCULAR STENTING Coding**
  - 37236: Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery
    - +37237: each additional artery
  - 37238: Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein
    - +37239: each additional vein
  - **Erratum**: These codes (37236-37239) would be used to report placement of covered stents for aneurysms, except for vessels where there are codes specific for the vessel being treated. There is an existing CPT code for placement of a popliteal stent (37226), and this code would be used to report treatment of a popliteal aneurysm with a covered stent rather than one of the new, generic arterial stent codes.
2014 CPT Code Changes

- **EMBOLIZATION**
  - Four new codes were created to describe nonneurologic embolization procedures. These codes bundle the surgical and radiological portions of the work of embolization into single codes. Four categories of embolization were identified as separate types of work:
    - General venous
    - General arterial
    - Arterial treatment of tumors
    - Arterial/venous/lymphatic hemorrhage or extravasation
2014 CPT Code Changes

- **EMBOLIZATION**

- These codes do not include the work of selective catheterization of the vessel(s) embolized, diagnostic angiography if performed, ultrasound guidance for vessel access, or the work of handling and dosing chemotherapy or radiotherapy. Those services may be separately reported when performed. The existing codes 37204 (previous embolization code) and 37210 (specific code for uterine fibroid embolization) were deleted from CPT and can no longer be used. The radiologic supervision and interpretation codes 75894 (embolization) and 75898 (follow-up angiography during embolization) were not deleted but should not be reported with the new embolization codes because those portions of work are included in the new bundled embolization codes.
2014 CPT Code Changes

- **EMBOLIZATION: Coding**
- 37241: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)
  - 37242: arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)
  - 37243: for tumors, organ ischemia, or infarction
  - 37244: for arterial or venous hemorrhage or lymphatic extravasation
2014 CPT Code Changes

- **FEVAR**
  - A set of eight new codes will be available to report fenestrated endograft repair of the abdominal and visceral aorta (FEVAR). Four codes describe the placement of a fenestrated device to treat the visceral aorta only, and four codes describe placement of a fenestrated device that extends across the visceral aorta and into the infrarenal aorta and/or iliac(s). Unlike the existing codes for EVAR, these new codes bundle additional components of the work of the procedure into a single code. Selective catheterization of the aorta and visceral arteries, stenting of any visceral vessels, and the radiologic supervision and interpretation are all included in the work of the FEVAR codes (and not separately reported as they are with the other abdominal and thoracic EVAR codes). As with the other EVAR codes, any angioplasty and/or stenting performed within the target treatment zone of the endograft is included in the work described by the FEVAR codes.
2014 CPT Code Changes

- **FEVAR**
  - Because the current technology requires extensive measurement and planning services that are performed several weeks prior to the implant procedure, this portion of the work is not included in the FEVAR codes, which is also different than the other codes describing endovascular repair of abdominal and thoracic aortic aneurysms. It is anticipated that a separate code to report this work will be developed for 2015. Placement of a proximal extension or cuff is not reported separately with the FEVAR codes, but distal extensions or cuffs may be separately reported.
2014 CPT Code Changes

- **FEVAR: Coding**
  - 34841: Endovascular repair of the visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac, or renal artery)
  - 34842: including two visceral artery endoprostheses (superior mesenteric, celiac, and/or renal artery[s])
  - 34843: including three visceral artery endoprostheses (superior mesenteric, celiac, and/or renal artery[s])
  - 34844: including four or more visceral artery endoprostheses (superior mesenteric, celiac, and/or renal artery[s])
  - 34845: Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and a concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac, or renal artery)
  - 34846: including two visceral artery endoprostheses (superior mesenteric, celiac, and/or renal artery[s])
  - 34847: including three visceral artery endoprostheses (superior mesenteric, celiac, and/or renal artery[s])
  - 34848: including four or more visceral artery endoprostheses (superior mesenteric, celiac, and/or renal artery[s])
2014 CPT Code Changes

- **INTRATHORACIC COMMON CAROTID/ INNOMINATE STENT PLACEMENT**
  - Code 37217 was created to report the placement of an intrathoracic common carotid or innominate artery stent from an open, retrograde exposure. This code includes the work of the open exposure, selective catheter placement, all angioplasty performed, stent placement, and all imaging guidance.
2014 CPT Code Changes

- **PERCUTANEOUS ABSCESS/FLUID COLLECTION DRAINAGE**
  - Four new codes are being introduced to describe percutaneous drainage of fluid collections. These codes bundle the surgical procedure with all imaging guidance used for the procedure into single codes. The imaging guidance may be fluoroscopy, ultrasound, computed tomography, magnetic resonance imaging, or any combination of those modalities. These codes replace the former set of codes that included organ-specific descriptors and are designed to apply to drainage procedures for all types of fluid collections rather than specifically for abscesses. Moderate sedation is included in these codes.
2014 CPT Code Changes

- PERCUTANEOUS ABSCESS/FLUID COLLECTION DRAINAGE
  - Coding
    - 10030: Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck); percutaneous
    - 49405: Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous
    - 49406: Peritoneal or retroperitoneal, percutaneous
    - 49407: Peritoneal or retroperitoneal, transvaginal, or transrectal
BREAST BIOPSY AND BREAST LOCALIZATION

There are six new codes describing breast biopsy and placement of localization device(s) performed with imaging guidance (19081–19086) and eight new codes describing placement of breast localization device(s) performed with imaging guidance (19281–19284). These codes are specific to the type of imaging guidance performed (mammographic, stereotactic, ultrasonic, or magnetic resonance imaging).
2014 CPT Code Changes

**BREAST BIOPSY AND BREAST LOCALIZATION: Coding**

- **19081**: Biopsy of the breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance
  - +19082: each additional lesion, including stereotactic guidance
- **19083**: Biopsy of the breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance
  - +19084: each additional lesion, including ultrasound guidance
- **19085**: Biopsy of the breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance
  - +19086: each additional lesion, including magnetic resonance guidance
- **19281**: Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance
  - +19282: each additional lesion, including mammographic guidance
- **19283**: Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance
  - +19284: each additional lesion, including stereotactic guidance
- **19285**: Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance
  - +19286: each additional lesion, including ultrasound guidance
- **19287**: Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance
  - +19288: each additional lesion, including magnetic resonance guidance.
HIPAA and 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 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 (24 hours a day, seven days a week).
- Office of billing Compliance website: [www.obc.miami.edu](http://www.obc.miami.edu)