Office of Billing Compliance
2017 Coding, Billing and Documentation Program

Department of Interventional Radiology
# Top Billed Non-E/M Codes

<table>
<thead>
<tr>
<th>CODE</th>
<th>PROCEDURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>76937</td>
<td>PR US GUIDE, VASCULAR ACCESS</td>
</tr>
<tr>
<td>49083</td>
<td>PR ABDOM PARACENTESIS DX/THER W IMAGING GUIDANCE</td>
</tr>
<tr>
<td>76942</td>
<td>PR SONO GUIDE NEEDLE BIOPSY</td>
</tr>
<tr>
<td>10022</td>
<td>PR FINE NEEDLE ASP;W/IMAGING GUIDANCE</td>
</tr>
<tr>
<td>49424</td>
<td>PR CONTRAST INJ,ABSCESS/CYST VIA CATH TUBE</td>
</tr>
<tr>
<td>49440</td>
<td>PR INSERT GASTROSTOMY TUBE PERCUTANEOUS</td>
</tr>
<tr>
<td>76080</td>
<td>PR X-RAY FISTULA,ABSCESS,SINUS TRACT</td>
</tr>
<tr>
<td>77001</td>
<td>PR FLUOROGUIDE CNTRL VEN ACCESS,PLACE,REPLACE,REMOVE</td>
</tr>
<tr>
<td>99144</td>
<td>PR MOD CONS SED BY SAME PHYS, 5+ YRS, 1ST 30 MIN</td>
</tr>
<tr>
<td>20206</td>
<td>PR NEEDLE BIOPSY,MUSCLE</td>
</tr>
<tr>
<td>32555</td>
<td>PR THORACENTESIS NEEDLE/CATH PLEURA W/IMAGING</td>
</tr>
<tr>
<td>CODE</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>99213</td>
<td>PR OFFICE/OUTPT VISIT,EST,LEVL III</td>
</tr>
<tr>
<td>99203</td>
<td>PR OFFICE/OUTPT VISIT,NEW,LEVL III</td>
</tr>
<tr>
<td>99217</td>
<td>PR OBSERVATION CARE DISCHARGE</td>
</tr>
<tr>
<td>99214</td>
<td>PR OFFICE/OUTPT VISIT,EST,LEVL IV</td>
</tr>
<tr>
<td>99232</td>
<td>PR SUBSEQUENT HOSPITAL CARE,LEVL II</td>
</tr>
<tr>
<td>99231</td>
<td>PR SUBSEQUENT HOSPITAL CARE,LEVL I</td>
</tr>
<tr>
<td>99204</td>
<td>PR OFFICE/OUTPT VISIT,NEW,LEVL IV</td>
</tr>
<tr>
<td>99212</td>
<td>PR OFFICE/OUTPT VISIT,EST,LEVL II</td>
</tr>
<tr>
<td>99202</td>
<td>PR OFFICE/OUTPT VISIT,NEW,LEVL II</td>
</tr>
<tr>
<td>99221</td>
<td>PR INITIAL HOSPITAL CARE,LEVL I</td>
</tr>
<tr>
<td>99238</td>
<td>PR HOSPITAL DISCHARGE DAY,&lt;30 MIN</td>
</tr>
<tr>
<td>99233</td>
<td>PR SUBSEQUENT HOSPITAL CARE,LEVL III</td>
</tr>
<tr>
<td>99224</td>
<td>PR SUBSEQUENT OBSERVATION CARE,LEVEL I</td>
</tr>
</tbody>
</table>
# Bell Curves of National E/M Services for IR

## Interventional Radiology

### New Office Visits

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
<th>Count</th>
<th>Current Practice Dist. %</th>
<th>National Dist. %</th>
<th>Variance Practice vs. National</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>0</td>
<td>0.00%</td>
<td>4.68%</td>
<td>-4.68%</td>
</tr>
<tr>
<td>99202</td>
<td>12</td>
<td>3.79%</td>
<td>13.10%</td>
<td>-9.31%</td>
</tr>
<tr>
<td>99203</td>
<td>269</td>
<td>84.86%</td>
<td>41.05%</td>
<td>43.81%</td>
</tr>
<tr>
<td>99204</td>
<td>34</td>
<td>10.73%</td>
<td>30.99%</td>
<td>-20.27%</td>
</tr>
<tr>
<td>99205</td>
<td>2</td>
<td>0.63%</td>
<td>10.18%</td>
<td>-9.55%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>317</td>
<td><strong>100.00%</strong></td>
<td><strong>100.00%</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Established Office Visits

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
<th>Count</th>
<th>Current Practice Dist. %</th>
<th>National Dist. %</th>
<th>Variance Practice vs. National</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>1</td>
<td>0.18%</td>
<td>2.98%</td>
<td>-2.80%</td>
</tr>
<tr>
<td>99212</td>
<td>14</td>
<td>2.55%</td>
<td>16.03%</td>
<td>-13.47%</td>
</tr>
<tr>
<td>99213</td>
<td>439</td>
<td>80.11%</td>
<td>44.78%</td>
<td>35.33%</td>
</tr>
<tr>
<td>99214</td>
<td>92</td>
<td>16.79%</td>
<td>31.41%</td>
<td>-14.62%</td>
</tr>
<tr>
<td>99215</td>
<td>2</td>
<td>0.36%</td>
<td>4.80%</td>
<td>-4.44%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>548</td>
<td><strong>100.00%</strong></td>
<td><strong>100.00%</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Bell Curves of National E/M Services for IR

### Interventional Radiology

#### Initial Hospital Visits

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
<th>Count</th>
<th>Current Practice Dist. %</th>
<th>National Dist. %</th>
<th>Variance Practice vs. National</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>7</td>
<td>87.50%</td>
<td>29.95%</td>
<td>57.55%</td>
</tr>
<tr>
<td>99222</td>
<td>1</td>
<td>12.50%</td>
<td>40.18%</td>
<td>-27.68%</td>
</tr>
<tr>
<td>99223</td>
<td>0</td>
<td>0.00%</td>
<td>29.87%</td>
<td>-29.87%</td>
</tr>
<tr>
<td>Totals</td>
<td>8</td>
<td>100.00%</td>
<td>100.00%</td>
<td></td>
</tr>
</tbody>
</table>

#### Subsequent Hospital Visits

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
<th>Count</th>
<th>Current Practice Dist. %</th>
<th>National Dist. %</th>
<th>Variance Practice vs. National</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>40</td>
<td>30.30%</td>
<td>34.27%</td>
<td>-3.96%</td>
</tr>
<tr>
<td>99232</td>
<td>88</td>
<td>66.67%</td>
<td>34.54%</td>
<td>32.13%</td>
</tr>
<tr>
<td>99233</td>
<td>4</td>
<td>3.03%</td>
<td>31.19%</td>
<td>-28.16%</td>
</tr>
<tr>
<td>Totals</td>
<td>132</td>
<td>100.00%</td>
<td>100.00%</td>
<td></td>
</tr>
</tbody>
</table>
2017 Code Changes
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76706</td>
<td>Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)</td>
</tr>
<tr>
<td>77065</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral</td>
</tr>
<tr>
<td>77066</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral</td>
</tr>
<tr>
<td>77067</td>
<td>Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed</td>
</tr>
</tbody>
</table>
### CPT® 2017 Revised Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77002</td>
<td>Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) <em>(List separately in addition to code for primary procedure)</em></td>
</tr>
<tr>
<td>77003</td>
<td>Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) <em>(List separately in addition to code for primary procedure)</em></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>75791</td>
<td>Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological S&amp;I</td>
</tr>
<tr>
<td>75962</td>
<td>Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological S&amp;I</td>
</tr>
<tr>
<td>75964</td>
<td>Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological S&amp;I (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>75966</td>
<td>Transluminal balloon angioplasty, renal or other visceral artery, radiological S&amp;I</td>
</tr>
<tr>
<td>75968</td>
<td>Transluminal balloon angioplasty, each additional visceral artery, radiological S&amp;I (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>75978</td>
<td>Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological S&amp;I</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>77051</td>
<td>Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>77052</td>
<td>Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>36901</td>
<td>Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report</td>
</tr>
<tr>
<td>36902</td>
<td>Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty</td>
</tr>
<tr>
<td>36903</td>
<td>Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment</td>
</tr>
<tr>
<td>36904</td>
<td>Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)</td>
</tr>
<tr>
<td>36905</td>
<td>Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, ...including all imaging and radiological supervision and interpretation necessary to perform the angioplasty</td>
</tr>
</tbody>
</table>
## New Crosswalk Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>36906</td>
<td>Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit...with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit</td>
<td></td>
</tr>
<tr>
<td>37246</td>
<td>Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery</td>
<td></td>
</tr>
<tr>
<td>37247</td>
<td>Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)</td>
<td></td>
</tr>
<tr>
<td>37248</td>
<td>Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein</td>
<td></td>
</tr>
<tr>
<td>37249</td>
<td>Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)</td>
<td></td>
</tr>
</tbody>
</table>
New Moderate Sedation Codes
(Deleted Previous CPT codes for moderate sedation, 99143-99150)

As a result of the 2017 Physician Fee Schedule, moderate sedation will be separately billed and paid starting in 2017 using new CPT® codes.

Services for which moderate sedation was previously considered inherent will be accordingly reduced. While this creates greater accuracy and prevents double-payment in instances where a moderate sedation service is provided by a second provider, it creates new billing and workflow requirements.

Starting in 2017, Moderate Sedation CPT Codes 99151, 99152, 99153, 99155, 99156, 99157 should be used when administering moderate sedation with each procedure.

Moderate (also known as conscious) sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain cardiovascular function or a patent airway, and spontaneous ventilation is adequate.
Moderate Sedation Services Provided by the Same Physician

- **99151** Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than five years of age

- **99152** ; initial 15 minutes of intra-service time, patient age 5 years or older

- **+99153*** ; each additional 15 minutes of intra-service time (List separately in addition to code for primary service)

An independent trained observer is an individual who is qualified to monitor the patient during the procedure, who has no other duties (eg, assisting at surgery) during the procedure.
Moderate Sedation Provided by a Different Physician

- **99155**  Moderate sedation services provided by a physician or other qualified healthcare professional other than the physician or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient younger than 5 years of age.

- **99156**  Moderate sedation services provided by a physician or other qualified health-care professional other than the physician or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older.

- **+99157***  Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)
Moderate Sedation Notes

- Moderate sedation codes 99151, 99152, 99153, 99155, 99156, 99157 and G0500 are not used to report administration of medications for pain control, minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care (00100-01999).

- The new moderate sedation CPT codes – 99151-99157 published in CPT 2017 will be recognized by all payers.
Intraservice Time for Moderate Sedation

Not the same as intraservice time for the endoscopic procedure.

Intraservice time of moderate sedation is used to select the appropriate code(s) to report moderate sedation services:

• Begins with the administration of the sedating agent(s) (i.e., with the start of the first IV push of the sedating drug):
  • Ends when the procedure is completed, the patient is stable for recovery status, and the physician or other qualified health care professional providing the sedation ends personal continuous face-to-face time with the patient;
  • Includes ordering and/or administering the initial and subsequent doses of sedating agents;
  • Requires continuous face-to-face attendance of the physician or other qualified health care professional;
  • Requires monitoring patient response to the sedating agents, including:
    o Periodic assessment of the patient;
    o Further administration of agent(s) as needed to maintain sedation; and
    o Monitoring of oxygen saturation, heart rate, and blood pressure.
Preservice Work: The following preservice work components are not included when determining intra-service time for reporting:

- Assessment of the patient's past medical and surgical history;
- Review of the patient's previous experiences with anesthesia and/or sedation;
- Family history of sedation complications;
- Summary of the patient's present medication list;
- Drug allergy and intolerance history;
- Focused physical examination of the patient with emphasis on:
  - Mouth, jaw, oropharynx, neck and airway for Mallampati score assessment, chest and lungs;
  - Heart and circulation;
  - Vital signs, including heart rate, respiratory rate, blood pressure, and oxygenation with end tidal CO2 when indicated;
- Review of any pre-sedation diagnostic tests;
- Completion of a pre-sedation assessment form (with an American Society of Anesthesiologists [ASA] Physical Status classification);
- Patient informed consent;
- Immediate pre-sedation assessment prior to first sedating doses; and
- Initiation of IV access and fluids to maintain patency.
CPT Guidelines: Intraservice Work

- **Intraservice Work**: Intraservice time is used to determine the appropriate CPT code to report moderate sedation services.

- CPT indicates "**Intraservice time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.**" In other words, the clock starts when the drug is administered and ends when the physician leaves the patient's room.

- If the physician or other qualified health care professional who provides the sedation services also performs the procedure supported by sedation (99151, 99152, 99153), the physician or other qualified health care professional will supervise and direct an independent trained observer who will assist in monitoring the patient's level of consciousness and physiological status throughout the procedure.
CPT Guidelines: Postservice Work

**Postservice Work:** The postservice activities required for moderate sedation are included in the work described by each of these codes and are not reported separately. Once continuous face-to-face time with the patient has ended, additional face-to-face time with the patient is not added to the intraservice time, however, it is considered as part of the postservice work. The following postservice work components are not included, when determining intraservice time for reporting:

- Assessment of the patient's vital signs, level of consciousness, neurological, cardiovascular, and pulmonary stability in the post-sedation recovery period;
- Assessment of the patient's readiness for discharge following the procedure;
- Preparation of documentation regarding sedation service; and
- Communication with family/caregiver regarding sedation service.

Postservice work/times are not used to select the appropriate code.
Documentation Requirements

- Patient’s age
- History, physical and diagnostic test(s) reviews, as appropriate when performing sedation.
- **Duration of moderate sedation.** Intraservice time should be documented based on the specific number of minutes, as opposed to a range of time, to meet all payer requirements. If the physician does not document his/her intraservice time or if the time is less than 10 minutes, the service is not reportable.
- Who provided the sedation and procedure(s).
- Pre- and post-sedation assessment and/or monitoring.
- Additionally, when the clinician is performing both the sedation and procedure, the medical record should reflect the identity of the trained observer who was present, when appropriate.

It is also important that providers do not rely on the drug name to communicate whether moderate sedation was provided. Providers need to use the terms “moderate” or “conscious sedation,” in combination with “intraservice time,” to ensure the reader of the record understands moderate sedation was performed and the time recorded was intraservice. It is important to note here that deep sedation is not reportable for these codes.
## RVU Values

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Total RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>99151</td>
<td>Moderate Sedation, same physician performing the procedure, initial 15 minutes, &lt; 5 years (Requires independent trained observer)</td>
<td>0.67</td>
</tr>
<tr>
<td>99152</td>
<td>Moderate Sedation, same physician performing the procedure, initial 15 minutes, 5 years or older (Requires independent trained observer)</td>
<td>0.35</td>
</tr>
<tr>
<td>99153</td>
<td>Moderate Sedation, same physician performing the procedure, each additional 15 minutes (Requires independent trained observer)</td>
<td>0.31</td>
</tr>
<tr>
<td>99155</td>
<td>Moderate Sedation, other physician performing the procedure, initial 15 minutes, &lt; 5 years</td>
<td>2.63</td>
</tr>
<tr>
<td>99156</td>
<td>Moderate Sedation, other physician performing the procedure, initial 15 minutes, 5 years or older</td>
<td>2.15</td>
</tr>
<tr>
<td>99157</td>
<td>Moderate Sedation, other physician performing the procedure, each additional 15 minutes</td>
<td>1.63</td>
</tr>
</tbody>
</table>
## Time Requirements To Bill Moderate Sedation

<table>
<thead>
<tr>
<th>Total Intraservice Time for Moderate Sedation</th>
<th>Patient Age</th>
<th>Moderate Sedation performed by the same provider performing the procedure that Moderate Sedation is supporting – Code(s)</th>
<th>Moderate Sedation performed by different provider performing the procedure that Moderate Sedation is supporting – Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 Minutes</td>
<td>Any Age</td>
<td>Not Reported Separately</td>
<td>Not Reported Separately</td>
</tr>
<tr>
<td>10 – 22 Minutes</td>
<td>&lt; 5 Years</td>
<td>99151</td>
<td>99155</td>
</tr>
<tr>
<td>10 – 22 Minutes</td>
<td>5 Years or &gt;</td>
<td>99152</td>
<td>99156</td>
</tr>
<tr>
<td>23 – 37 Minutes</td>
<td>&lt; 5 Years</td>
<td>99151 + 99153 X 1</td>
<td>99155 + 99157 X 1</td>
</tr>
<tr>
<td>23 – 37 Minutes</td>
<td>5 Years or &gt;</td>
<td>99152 + 99153 X 1</td>
<td>99156 + 99157 X 1</td>
</tr>
<tr>
<td>38 – 52 Minutes</td>
<td>&lt; 5 Years</td>
<td>99151 + 99153 X 2</td>
<td>99155 + 99157 X 2</td>
</tr>
<tr>
<td>38 – 52 Minutes</td>
<td>5 Years or &gt;</td>
<td>99152 + 99153 X 2</td>
<td>99156 + 99157 X 2</td>
</tr>
</tbody>
</table>
Documentation When 2\textsuperscript{nd} Clinician

• As a result of the decreased threshold for the minimum time requirement and the RVU values the Centers for Medicare & Medicaid Services (CMS) assigned to the moderate sedation services, an increase in the volume reported is anticipated. Subsequently, with payments come heightened scrutiny regarding documentation, particularly when a second clinician is providing the sedation service. Given the substantial RVU variance when different providers are performing the sedation and related procedure, documentation must meet all requirements while simultaneously reflecting the medical necessity of having two clinicians involved.
Local Coverage Determinations (LCDs)
Creation and Purpose of LCD

• Local Coverage Determinations (LCDs) are created by the Medicare Administrative Contractor (MAC)
  • Local contractor level
  • Contractor Medical Directors responsibility
• May or may not be associated with a National Coverage Determination (NCD)
  • Assist in determining reasonable and necessary criteria
• LCDs cannot restrict or conflict with an NCDs
  • Or any CMS interpretive manuals
Locating LCDs

Search LCDs

Use First Coast Service Options' (First Coast) convenient lookup tool to quickly find information on current and draft LCDs, when they exist, for Medicare-covered procedure codes.

- Search for LCDs - search by procedure code, LCD id, keywords, or procedure code and diagnosis code.
- For help using the LCD and Procedure to Diagnosis lookup, view the how-to guides.

Search CMS Medicare Coverage Database

- List of Active, Future or Retired LCDs - search through CMS' indexed listings.
- Quick search of CMS' coverage database.
- Advanced search of CMS' coverage database - apply filters to find exactly what you need.
- Medicare Coverage Database Reports - view reports of National and Local Coverage data.
- List of NCDs - Alphabetical index of NCDs.
- CMS Medicare Coverage Center - provides an overview of Medical coverage.
- Medicare Coverage Database (NCD) quick reference guide - Use this guide for clarification on how to best search for LCD/NCD information.

Medical policy news

Additional development request (ADR) timeliness calculator

This calculator will assist you in determining when additional documentation requested by First Coast Service Options Inc. (First Coast) must be received.

Medical review

Find information pertaining to topics subject to medical review here.

More

Track Draft LCDs

Find the status of LCDs, view drafts, learn how to submit comments, and more using the resources listed below.

- Open Public Meeting Information
- View Draft LCDs
- Submit Comments
- Review Comment Summaries

Medical policy references and resources

- LCD Reconsideration Process - learn how to request LCD modifications.
- Medical Policy Resources - additional how-to guides regarding medical coverage information.
- Related CMS internet-only manuals - provides instructions, policies, and procedures related to Medicare coverage.
- Self-Administered Drugs - lists excluded self-administered injectable drugs incident to a physician's service.
- Clinical Trials - find information on clinical trials, including FAQs, extended coverage information request guidelines, and more.
- Online learning - Understanding NCDs and LCDs
- FAQs
- Medical coverage determination inquiries may be emailed, with supporting documentation, to MedicalPolicy@FGGO.com.
Local Coverage Determinations (LCDs) for First Coast Service Options, Inc.

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<th>Id</th>
<th>Title</th>
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<td>L33256</td>
<td>3D Interpretation and Reporting of Imaging Studies</td>
<td>10/01/15</td>
<td>10/01/16</td>
<td>N/A</td>
<td>09/28/16</td>
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<td>3D Interpretation and Reporting of Imaging Studies</td>
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</table>
On-going Inquiry By CMS

76376: 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; not requiring image post-processing on an independent workstation

76377: 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; requiring image post-processing on an independent workstation
• In freestanding and independent diagnostic testing facilities, Medicare expects the referring physician to generate an appropriate written request indicating the clinical need for the additional 3D imaging, that a copy of that request be maintained by the interpreting physician and the interpreting physician’s report addresses those specific clinical issues. In the event that a 3D interpretation is deemed urgently needed by the radiologist and the referring physician is not immediately available, the radiologist must document the time of the study, the specific need for the study, and a summary of the findings that were urgently transmitted to the practitioner named as the referring physician on the radiology report.

• CPT codes 76376 and 76377 may be considered medically unnecessary and denied if equivalent information obtained from the test has already been provided by another procedure (magnetic resonance imaging, ultrasound, angiography, etc.) or could be provided by a standard CT scan (two-dimensional) without reconstruction.

• Medicare expects that no more than 20 percent of the total Computerized Tomography (CT) and Magnetic Resonance (MR) imaging of any practice be submitted with 3-D rendering or interpretation, with or without image post-processing. However, for cancer evaluation applications, such as staging/monitoring for pulmonary metastases, this threshold may be often exceeded. Therefore, if data suggests providers are billing at higher rates for other indications for 3D rendering, then Medical Review may do pre or post pay reviews to validate the use and medical necessity of the test.

• All imaging studies will be subject to the American College of Radiology Guidelines for reporting.

• CPT code 76376 can be reported when 3D rendering is performed by a radiologist or a specially-trained technologist at the acquisition scanner. However, CPT code 76377 is reported when the 3D post-processing images are reconstructed on an independent workstation with concurrent physician supervision. In order to report 76377, the supervising physician must provide concurrent supervision.
In order to report the correct CPT code for the 3D analysis (76376 or 76377), it should be documented within the radiology report as to whether the 3D was performed on an independent workstation or on the acquisition scanner. Making an explicit statement within the radiology report will avoid ambiguity and aid the coder in accurately coding for the 3D reconstruction. Some practices may separately document this in the patient’s electronic medical record, but not actually in the report.

Imaging studies are complex with thousands of individual pictures. Beyond identifying a fracture in an emergency setting a discussion of treatment planning after the patient has left the department is common. 3D may be necessary to understand the anatomy for treatment planning. This discussion occurs after the acute event. Another vignette is an imaging study for stroke but later a seizure concern is identified subsequent to the emergency visit and 3D is applied to evaluate an anatomy of the hippocampus for a seizure focus.
ICD-10 Codes That Support Medical Necessity

Group 1 Paragraph: Note: All primary diagnosis codes must be related to the primary procedural code when rendered for the 3-D reconstruction. The use of these diagnosis codes implies the medical necessity of the 3-D rendering and interpretation, as outlined in this LCD, is documented in the medical record.

A written request for the study from the referring physician must also be in the medical record and made available upon request when performed in freestanding and independent diagnostic testing facilities.

The following lists include only those secondary diagnoses for which the identified CPT/HCPCS procedures are covered.

Note: If a covered secondary diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.
## Covered ICD-10 Codes for 76376 & 76377

### Group 1

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R90.82</td>
<td>White matter disease, unspecified</td>
</tr>
<tr>
<td>R91.8</td>
<td>Other nonspecific abnormal finding of lung field</td>
</tr>
<tr>
<td>R93.0</td>
<td>Abnormal findings on diagnostic imaging of skull and head, not elsewhere classified</td>
</tr>
<tr>
<td>R93.1</td>
<td>Abnormal findings on diagnostic imaging of heart and coronary circulation</td>
</tr>
<tr>
<td>R93.3</td>
<td>Abnormal findings on diagnostic imaging of other parts of digestive tract</td>
</tr>
<tr>
<td>R93.4</td>
<td>Abnormal findings on diagnostic imaging of urinary organs</td>
</tr>
<tr>
<td>R93.5</td>
<td>Abnormal findings on diagnostic imaging of other abdominal regions, including retroperitoneum</td>
</tr>
<tr>
<td>R93.6</td>
<td>Abnormal findings on diagnostic imaging of limbs</td>
</tr>
<tr>
<td>R93.7</td>
<td>Abnormal findings on diagnostic imaging of other parts of musculoskeletal system</td>
</tr>
<tr>
<td>R93.8</td>
<td>Abnormal findings on diagnostic imaging of other specified body structures</td>
</tr>
</tbody>
</table>
Covered ICD-10 Codes for 76376 & 76377:  
**Group 2:** Covered primary diagnosis for deep brain stem lead placement only.

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G20</td>
<td>Parkinson's disease</td>
</tr>
<tr>
<td>G21.4</td>
<td>Vascular parkinsonism</td>
</tr>
<tr>
<td>G24.1</td>
<td>Genetic torsion dystonia</td>
</tr>
<tr>
<td>G24.3</td>
<td>Spasmodic torticollis</td>
</tr>
<tr>
<td>G24.9</td>
<td>Dystonia, unspecified</td>
</tr>
<tr>
<td>G25.0</td>
<td>Essential tremor</td>
</tr>
<tr>
<td>G25.1</td>
<td>Drug-induced tremor</td>
</tr>
<tr>
<td>G25.2</td>
<td>Other specified forms of tremor</td>
</tr>
</tbody>
</table>
Documentation Requirements

• Documentation supporting the medical necessity should be legible, maintained in the patient’s medical record and made available to Medicare upon request.

• Use of one of the secondary diagnosis codes in this LCD implies medical necessity for 3-D rendering and interpretation.

• Documentation supporting medical necessity must be maintained in the medical record along with the written request for the study from the referring physician.

• 3D Reconstruction services are to be reported by a separate report or in a separate section of the base service report.

• A permanent archive of 3D studies of CTA studies is suggested by the ACR.
Tips for Coding Selective Catheters

The coding is extrapolated from practitioner documentation!

- First identify the point(s) of access where sheath has been placed (i.e., femoral, radial, jugular, brachial, etc.)
- Determine the approach (i.e., ipsilateral (same side) or contralateral (opposite sides)).
- Determine the point(s) of the highest level where the catheter was manipulated.
- The CPT code for selective catheterization supersedes CPT codes for non-selective catheterization.
- Never code for both selective and non-selective catheter placement from the same access and in the same vascular family.
- Code all imaging studies performed.
- Code for each vascular family separately.
- Code for each access separately.
- Code additional second or third order catheterizations within a family.
- Code for additional imaging studies within a family above the basic examination.
Additional 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.

---

**Coding Tips**
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.
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?
Choosing the Primary ICD-10 Code

Confirmed Diagnosis Based on Results of Test

- Report any confirmed diagnosis
- Signs and/or symptoms may be reported as additional diagnoses
- Signs/Symptoms

If the diagnostic test did not provide a diagnosis or was normal, the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.

- “On the rare occasion when the interpreting physician does not have diagnostic information as 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.” (Language removed in latest version of MCPM Chapter 23, Section 10.1.2)
Choosing the Primary ICD-10 Code

• **Uncertainty**: Considered by the ICD-10-CM Coding Guidelines as unconfirmed and should not be reported

Do not code the following diagnoses:

• Probable
• Suspected
• Questionable
• Rule out
• Working diagnosis
• Other similar terms indicating uncertainty.

Code to the highest degree of certainty (symptoms, signs, abnormal test results, or other reason for the visit)
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.
“Second Reads”


“Generally, carriers must pay for only one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. They pay for a second interpretation (which may be identified through the use of modifier “-77”) only under unusual circumstances (for which documentation is provided) such as a questionable finding for which the physician performing the initial interpretation believes another physician’s expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure.” -
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
CPT Code 76140: Consultation on X-ray examination made elsewhere, written report

You should **only report 76140 if a physician from another institution requests your physician's opinion on a radiograph and you send that physician your interpretation.** You should not report 76140 if a physician within your practice or hospital asks you to reread an x-ray that was primarily interpreted by another physician within the same practice. Instead, report 76140 when you interpret an imaging study that was primarily obtained and interpreted by a physician from a different practice and with a different provider number.

Medicare and some private payers assign "0" relative value units to 76140 and will not reimburse you for this service. If your commercial insurer allows payment for this service, ask for the coverage guidelines in writing before billing 76140 to avoid unnecessary denials. Your practice should establish a policy related to billing the patient for reinterpretations of outside films. If you intend to bill for this service, you should obtain an advance beneficiary notice for patients whose payers do not provide payment for 76140.
Referring/Treating Physician and Orders

• Orders must be specific to the diagnostic test requested.

• Diagnostic tests require documentation of the name of the referring/ordering provider.

  • Absent a valid ordering provider the claim will be denied.

  • Notations such as “Chest X-ray requested by Cardiology Service” are not acceptable – must be “person” specific
Treating Practitioner to Order all Tests

• Limited exceptions:
  • Allows additional testing to be done by the radiologist prior to or without contacting the treating physician/practitioner, when the radiologist determines that based on the result of an ordered diagnostic test, an additional diagnostic test should be performed. All of the following criteria must be met:
    • The diagnostic test ordered by the treating practitioner is performed;
    • Radiologist determines and documents that, because of the abnormal result of the diagnostic test performed, an additional diagnostic test is medically necessary;
    • A delay in additional diagnostic testing would have an adverse effect on the care of the patient;
    • The result of the test is communicated to and is used by the treating practitioner in the treatment of the patient; and
    • The radiologist documents in his/her report why additional testing was done.
The Interpreting Physician May:

- **Determine the test design, unless specified in the order.**
  - The interpreting physician may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).
  - An order for “MRI of orbit” without a specific contrast component would allow the interpreting physician to determine if contrast was medically appropriate for that specific patient without obtaining an updated order.

- **Modify, without notifying the treating physician/practitioner, an order with clear and obvious errors that would be apparent to a reasonable layperson,** such as the patient receiving the test (e.g., x-ray of wrong foot ordered).
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.
Radiological Reports

• Elements of the report
  • Clinical Information must include:
    • Referring/ordering Physician
    • Patient Demographics (unless readily available in the EMR)
    • Clinical signs or symptoms or personal history of disease
  • Body of the report should include
    • Description of the procedure including anatomical area, modality, and use of contrast.
    • Describes if and why additional testing was done.
  • Impression
    • Revises or confirms initial diagnosis
    • If findings are negative – coding is based on signs or symptoms

• All coding must be abstracted from the Body of the report and not from headers.
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
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: “Dr. TP (or I) was present for the entire (identify procedure).”

Diagnostic services with an interpretation: If documented by a resident to be billed by a TP requires that s/he personally document that s/he personally reviewed the images, tracing, slides etc. and the resident’s interpretation and either agrees with it or edits the findings.

- Example: “I personally reviewed the films (and/or slides etc.) and agree with the resident’s findings.”
Diagnostic Procedures

• **RADIOLOGY AND OTHER DIAGNOSTIC TESTS**

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

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

• **A countersignature by the Teaching Physician to the resident’s interpretation is not sufficient documentation.**
TP Guidelines for Procedures

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

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

**Major** – (>5 Minutes)

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

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

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

TP must be present during the entire viewing for payment.

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

Example: I was present for the entire viewing”.

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**Evaluation and Management (E/M)**

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

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

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

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

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

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

The documentation of the Teaching Physician must be patient specific.
Evaluation and Management (E/M)

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

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

*Medical Student documentation for billing only counts for ROS and PFSH. All other contributions by the medical student must be re-performed and documented by a resident or teaching physician.*
• 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.
Teaching Physician Services That Meet the Requirement for Presence During the Key Portion of the Service when working with a resident or fellow

Teaching Physician Services that are billed using this modifier are certifying that they have been present during the key portion of the service.
Inpatient and Outpatient Evaluation and Management E/M Documentation and Coding
Putting The Puzzle Together
The 3 Key Documentation Elements

- **History**
  - Focus on HPI

- **Medical Decision Making**

- **Physical Exam**
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) related to HPI,
  • Past Family, Social History (PFSH) related to HPI.
EXAMINATION

• 4 TYPES OF EXAMS

• Problem focused (PF)
• Expanded problem focused (EPF)
• Detailed (D)
• Comprehensive (C)
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
PHYSICAL EXAM: General Multi-System Examination (BA/OS) Elements of Examination

**BA** Head, including the face
**BA** Neck: neck (masses, symmetry, etc); thyroid
**BA** Chest (Breasts): inspection breast; palpation breast/axillae
**BA** Abdomen
**BA** Genitalia, groin, buttocks
**BA** Back, including spine
**BA** Left upper extremity  **BA** Right upper extremity  **BA** Left lower extremity  **BA** Right lower extremity

**OS** Constitutional: vitals (sit/stand BP; sup BP; temp; pulse rate; resp; ht; wt)  **or** General appearance
**OS** Eyes: conjunctivae/lids; pupils/irises; optic discs
**OS** Ears, Nose, Mouth/Throat: exam ears/ nose; exam auditory canal/tympanic membrane; hearing assessment; Exam nasal mucosa/septum/turbinates; exam lips/teeth/gums; exam oropharynx/palates
**OS** Respiratory: respiratory effort; percussion of chest; palpation of chest; auscultation of lungs
**OS** Cardiovascular: palpation heart; auscultation; Exam of: carotid; femoral arteries; abd aorta; pedal pulses; Exam extremities for edema/varicosities
**OS** Gastrointestinal: exam of abd; exam liver/spleen; hernia +/-; exam anus, perineum, rectum; stool specimen if appropriate
**OS** Genitourinary:  **Male**: exam of scrotum; exam of penis; DRE of prostate;
**Female**: exam ext genitalia, vagina, urethra, bladder, cervix, uterus, adnexa/parametria
**OS** Musculoskeletal: gait/station; inspect digits/nails; inspect/ROM/stability/strength of head/neck, spine/rib/pelvis (Rt upper, Lt upper, Rt lower, Lt lower extremities can be OS also)
**OS** Skin: inspect skin/subcutaneous tissue; palpation skin/subcutaneous tissue
**OS** Neurologic: test cranial nerves; deep tendon reflexes, sensations
**OS** Psychiatric: judgment/ insight; orientation to person/place/time; recent/remote memory; mood & affect
**OS** Hematological/lymphatic palpation of nodes neck, axillae, groin, other
Medical Decision Making

DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE!! Include all diagnosis that impact the 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
### Number of Diagnoses or Treatment Options

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

Multiply the number in column B & C and put the product in column D.

Enter a total for column D.

Bring total to line A in Final Result for Complexity (table below).

### Risk of Complications and/or Morbidity or Mortality

**Level of Risk**

- **Minimal**
  - One self-limited or minor problem, e.g., cold, insect bite, thea cornita

- **Low**
  - Two or more self-limited or minor problems
  - One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cutaneous, BPH
  - Acute uncontrolled illness or injury, e.g., cystitis, allergic rhinitis, simple sore

- **Moderate**
  - One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment
  - Two or more stable chronic illnesses
  - Un DIAGNOSIS with uncertain prognosis, e.g., lump in breast
  - Acute illness with systemic symptoms, e.g., pancreatitis, peptic ulcer, burns, acute MI
  - Acute complication, e.g., head injury with brief loss of consciousness

- **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 body function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe uncontrolled arthritis, psychiatric illness with potential to self or other, periodic, acute renal failure
  - An acute change in neurologic status, e.g., seizure, TIA, weakness or sensory loss

### Diagnostic Procedure(s) Ordered

- Laboratory tests requiring venipuncture
- Chest x-rays
- EKG/EEG
- Ultrasound
- Ultrasound, e.g., echo
- KUB prep
- Physiologic tests under stress, e.g., cardiac stress test, coronary catherization
- Diagnostic endoscopists with or without risk factors
- Deep needle or surgical biopsy
- Cardiovascular imaging with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization
- Ultrasound, thoracentesis, ultrasound, chest x-rays
- Cardiac angiography, cardiac catheterization
- Diagnostic endoscopists with identified risk factors
- Discography

### Management Options Selected

- Rest
- Gargles
- Elastic bandages
- Sterile dressings
- Over-the-counter drugs
- Minor surgery with no identified risk factors
- Physical therapy
- Occupational therapy
- Therapeutic nuclear medicine
- IV fluids without additives
- Minor surgery with identified risk factors
- Major surgery (open, percutaneous or endoscopic) with identified risk factors
- Major surgery (open, percutaneous or endoscopic)
- Percutaneous catheterization
- Drug therapy requiring intensive monitoring for toxicity
- Decision not to resuscitate or to de-escalate care because of poor prognosis

### Amount and/or Complexity of Data Reviewed

<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 CT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CT</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 or discussion of care 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**

Bring total to line C in Final Result for Complexity (table below).
Q&A From First Coast

• How to determine further work-up under number of diagnoses

• Q. In medical-decision making, how does one determine further work-up under “number of diagnoses”?

• A. A key element of the medical-decision making category includes management decisions made by the physician to determine a diagnosis and treatment. Evidence of further work-up within documentation would include: indicating a problem is worsening/probable and/or listing possible management options, advice sought, referrals or consultations, and the initiation of or change in treatment.
Using Time to Code an E/M

Time shall be considered for coding an E/M in lieu of H-E-MDM when > 50% of the total billable practitioner visit time is counseling/coordination of care (CCC.)

Time is only Face-to-face for OP setting

• Coding based on time is generally the exception & is typically used for:
  • Exacerbation or change in the patient’s condition or new diagnosis,
  • Non-compliance with the treatment/plan,
  • Counseling regarding previously performed procedures or tests to determine future treatment options

Issues that may not lend themselves to typical E/M encounter. Examples:

• Behavior/school issues, ADHA
• Non-compliance with medications or treatments
• Introduction of new medications or treatments
Using Time to Code an E/M

Required Documentation For Billing:

1. Total time of the encounter excluding separate procedure if billed
2. The amount of time dedicated CCC for that patient on that date of service.
3. A template statement would not meet the documentation requirements.
4. The documentation MUST be individualized for each patient visit!
5. Check boxes for time and check boxes for CCC are NOT acceptable for coding an E/M service based on time.
Proper Language used in documentation of time:

- “I spent ____ minutes with the patient and family and over 50% was in counseling about her diagnosis, treatment options including _______ and ______.”
- “I spent ____ minutes with the patient and family more than half of the time was spent discussing the risks and benefits of treatment with……(list risks and benefits and specific treatment)”
- “This entire ______ minute visit I spent counseling the patient regarding ________ and addressing their multiple questions.

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

Documentation must reflect the specific issues discussed with patient present.

Document the specific topics that were discussed during the counseling (i.e. diagnosis, prognosis, treatment options, medical management and side effects, etc).
# Time-Based Billing for CCC

## Outpatient Counseling Time:
- 99201 10 min
- 99202 20 min
- 99203 30 min
- 99204 45 min
- 99205 60 min
- 99241 15 min
- 99242 30 min
- 99243 40 min
- 99244 60 min
- 99245 80 min
- 99211 5 min
- 99212 10 min
- 99213 15 min
- 99214 25 min
- 99215 40 min

## Inpatient Counseling Time:
- 99221 30 min
- 99222 50 min
- 99223 70 min
- 99231 15 min
- 99232 25 min
- 99233 35 min
- 99251 20 min
- 99252 40 min
- 99253 55 min
- 99254 80 min
- 99255 110 min
Observation Services

- The CMS Claims Processing Manual indicates that for a physician to bill the initial observation care codes, there must be a medical observation record for the patient which contains dated and timed physician’s admitting orders to observation status.

- The observation record should reflect the care the patient receives while in observation, nursing notes, and progress notes prepared by the physician while the patient was in observation status. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.
Documentation Requirements:

• If the patient requires to be admitted to observation, the physician must clearly document in the order “place patient into observation status”.

• The physician must also document the medical reasons why the patient requires to be admitted to observation on the physician’s orders. The order must be signed and dated by the attending physician.

• The physician’s order to admit the patient to observation must have the time the patient was admitted to observation and the time the patient is discharged from observation.
Observation Services

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

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

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

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

At 24 hours, the physician should evaluate patient’s condition to decide if the patient needs to remain in observation for an additional 24 hours.
INITIAL OBSERVATION CARE SERVICES
99218, 99219, 99220

The codes to use when an observation stay spans more than one calendar date include:

99218-Initial observation care for problems of low severity. Documentation requires a detailed or comprehensive history, a detailed or comprehensive exam, and straightforward or low complexity MDM.
99219-Initial observation care for problems of moderate severity. Documentation requires a comprehensive history, a comprehensive exam, and moderate complexity MDM.
99220-Initial observation care for problems of high severity. Documentation requires a comprehensive history, a comprehensive exam, and high complexity MDM.

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>HISTORY</th>
<th>EXAMINATION</th>
<th>MEDICAL DECISION-MAKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>99218</td>
<td>Detailed or Comprehensive</td>
<td>Detailed or Comprehensive</td>
<td>Straightforward or Low Complexity</td>
</tr>
<tr>
<td>99219</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>99220</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
SUBSEQUENT OBSERVATION SERVICES

• All levels of **Subsequent Observation Care** (99224-99226) include reviewing the medical record and reviewing the results of diagnostic tests and changes in the patient’s status (i.e., changes in the history, physical condition and response to management) since the last assessment by the physician.

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

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

• Outpatient observation time begins **when the patient is physically placed in the observation bed. Outpatient observation time ends at the time it’s documented in the physician’s discharge orders.**
SUBSEQUENT OBSERVATION CARE SERVICES, CONTINUED

Two out of the three components must be documented. Time spent must be documented.

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>HISTORY</th>
<th>EXAMINATION</th>
<th>MEDICAL DECISION-MAKING</th>
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</thead>
<tbody>
<tr>
<td>99224</td>
<td>Detailed or Comprehensive</td>
<td>Detailed or Comprehensive</td>
<td>Straightforward or Low Complexity 15 Min.</td>
</tr>
<tr>
<td>99225</td>
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<td>Moderate Complexity 25 Min.</td>
</tr>
<tr>
<td>99226</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High Complexity 35 Min.</td>
</tr>
</tbody>
</table>
Observation care discharge includes services on the date of observation discharge (can only be used on a calendar day other than the initial day of observation). These services include a final exam, discussion of the observation stay, follow-up instructions, and documentation.
The codes for same day observation admit and discharge include:

- **99234**-Observation or inpatient hospital care for problems of low severity. Documentation requires a detailed or comprehensive history, a detailed or comprehensive exam, and straightforward or low complexity MDM.

- **99235**-Observation or inpatient hospital care for problems of moderate severity. Documentation requires a comprehensive history, a comprehensive exam, and moderate complexity MDM.

- **99236**-Observation or inpatient hospital care for problems of high severity. Documentation requires a comprehensive history, a comprehensive exam, and high complexity MDM.
## OBSERVATION CARE SERVICES
Admission and Discharge on the Same Calendar Date

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>HISTORY</th>
<th>EXAMINATION</th>
<th>MEDICAL DECISION-MAKING</th>
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</thead>
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</tr>
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<td>99235</td>
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<td>Comprehensive</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>99236</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
Hospital observation services should be coded and billed according to the time spent in observation status as follows:

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

- Coverage of outpatient observation services are restricted to situations where a patient exhibits an uncommon or unusual reaction or complication after a surgical procedure is performed such as:
  - The inability to urinate (requiring catheterization)
  - The inability to keep solids or liquids down (requiring continued intravenous feeding)
  - The inability to control pain (requiring intramuscular or intravenous analgesics)
  - The inability to move the lower extremities and safely ambulate after spinal anesthesia (requiring continued bed rest and sensation assessment and monitoring)
  - Unexpected surgical bleeding (requiring frequent dressing changes, and/or dressing reinforcement)
  - Unstable vital signs (requiring continued monitoring and/or drug intervention)
  - and the patient’s condition requires monitoring or treatment beyond the treatment customarily provided in the immediate postoperative period. OUTPATIENT OBSERVATION SERVICES SHOULD BE ORDERED AT THAT TIME. The order should never be performed and signed by the attending physician prior to the surgical procedure.
  - “Four (4) to six (6) hours” is used as a guideline for a normal recovery period. Observation would be appropriate when the recovery of the patient exceeds the normal recovery period.”
Observation Care Services

Below there is a list of issues to consider when billing for observation services:

Only the physician who admits the patient to observation status and is responsible for his/her stay in observation may bill using observation codes.

All other physicians who see the patient in observation must bill E/M outpatient service codes or outpatient consultation codes, as appropriate.

The initial observation care code is the initial day of care. This is determined by calendar date, not 24-hour period. Therefore, any time spent in observation until midnight of the first day is considered as one day. If patient is evaluated after midnight or any time on the day following the initial evaluation a subsequent observation care code is to be used.

A patient should not stay in an observation longer than 48 hours. A decision should be made by the attending physician to either admit or discharge the patient home.

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

At 48 hours, the physician should re-evaluate patient’s condition and decide if patient needs to be admitted to the hospital or discharged home.
Q: How should we bill for a patient admitted to observation status by a resident on day 1 at 9:00 p.m. but not seen by an attending until day 2 at 8:00 a.m.? (The patient is ready for discharge on day 2 as well.) The attending saw the patient only that one calendar date.

Should the attending bill the second day as a same-day admit and discharge (99234-99236)? Or as initial observation care (99218-99220) on that second day and an observation discharge (99217)?

A: You must base your claim on the attending physician’s date of service, so you can’t bill for the first day when only the resident saw the patient. Use the observation admit and discharge same-day codes (99234-99236) and bill day 2 as the only date of service.
Q: How should I code services rendered to a patient admitted to observation status on one date, then admitted as an inpatient for two additional days?

A: Bill an initial observation care code, 99218-99220, on the first date, when the patient is in observation status. Any evaluation and management services in another setting, such as the office or an emergency department, that are related to the admission to observation status cannot be billed separately, as they are considered part of the initial observation care service.

• Bill an initial inpatient hospital care code, 99221-99223, on the second date, on which you admit the patient to the hospital inpatient setting. You cannot report the observation care discharge service code, 99217, in conjunction with a hospital admission. All related evaluation and management services are part of the initial hospital care service, regardless of the setting.

• Bill a hospital discharge service code, 99238-99239, for the third date.
Q: What about admission and discharge from observation to home on the same date?

A: Bill a CPT “Observation or Inpatient Care Services (Including Admission and Discharge Services)” code, **99234-99236**. These codes are to be used for a same-date admission and discharge in the observation status or inpatient setting.

- For billing Medicare patients a minimum of 8 hours in “observation status” is required.

Q: What if I admit a patient to observation status and then send him or her home the next day?

A: If the patient is admitted to observation status on one calendar date and discharged on the next date, bill an initial observation care code, **99218-99220**, for the first date of service and the observation care discharge service code, **99217**, for the second.
Q: Does Medicare require a minimum number of hours on observation status before a physician can bill 99234-99236?

A: Yes. A patient must be in observation status at least eight hours for a physician to bill a same-date admission and discharge code. Medicare rules differ from the instructions in the CPT code book for this scenario and, thus, are more likely to differ from private-payer billing rules. For Medicare:

- If the patient is admitted to observation status and is then discharged home on the same date of the observation stay that lasted at least eight hours (but fewer than 24 hours, since it must be on the same date), bill a code from the 99234-99236 range.

- If the patient is discharged home after fewer than eight hours in observation status, bill only an initial observation care code, 99218-99220.

- The Medicare eight-hour minimum rule for observation status pertains to same-date admission and discharge only. If, as happens rarely, a Medicare patient is admitted to observation status and is discharged in fewer than eight hours on a different date, bill an initial observation care code, 99218-99220, for the first date of service and the observation care discharge service code, 99217, on the second date.
Completing the Puzzle
# Evaluation & Management Coding Card

## Initial Inpatient and Observation Codes

<table>
<thead>
<tr>
<th>Codes</th>
<th>99221 / 99218</th>
<th>99222 / 99219</th>
<th>99223 / 99220</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CC</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
</tr>
<tr>
<td>HPI</td>
<td>4+</td>
<td>4+</td>
<td>4+</td>
</tr>
<tr>
<td>ROS</td>
<td>2-9</td>
<td>10+</td>
<td>10+</td>
</tr>
<tr>
<td>PFSH</td>
<td>1-2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Exam</td>
<td>D</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>MDM</td>
<td>SF or Low</td>
<td>Mod</td>
<td>High</td>
</tr>
<tr>
<td>Time</td>
<td>IP 30 min</td>
<td>IP 50 min</td>
<td>IP 70 min</td>
</tr>
</tbody>
</table>

All 3 components must be met

## Subsequent Hospital and Observation Codes

<table>
<thead>
<tr>
<th>Codes</th>
<th>99231 / 99224</th>
<th>99232 / 99225</th>
<th>99233 / 99226</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CC</td>
<td>Always</td>
<td>Always</td>
<td>Always</td>
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<tr>
<td>HPI</td>
<td>1-3</td>
<td>1-3</td>
<td>4+</td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>1</td>
<td>2-9</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Exam</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
</tr>
<tr>
<td>MDM</td>
<td>SF or Low</td>
<td>Mod</td>
<td>High</td>
</tr>
<tr>
<td>Time</td>
<td>15 min</td>
<td>25 min</td>
<td>35 min</td>
</tr>
</tbody>
</table>

2 of the 3 components must be met
Evaluation & Management Coding

According to CMS, the medical necessity of the E/M level billed is the overarching criteria in addition to the requirements for the history, exam, and medical decision making.

### OP New Patient or IP/OP Consult - ALL 3 components must be met

<table>
<thead>
<tr>
<th>Codes</th>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>LEVEL 4</th>
<th>LEVEL 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC</td>
<td>Always</td>
<td>Always</td>
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<td>Always</td>
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<tr>
<td>HPI</td>
<td>1-3</td>
<td>1-3</td>
<td>4+</td>
<td>4+</td>
<td>4+</td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>1</td>
<td>2-9</td>
<td>10+</td>
<td>10+</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>1-2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Exam</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>MDM</td>
<td>SF</td>
<td>SF</td>
<td>Low</td>
<td>Mod</td>
<td>High</td>
</tr>
</tbody>
</table>

**N = NEW PATIENT  O = OUTPT CONSULTS  I = INPT CONSULTS**

### Established Patient Office Visit - 2 of 3 components must be met

<table>
<thead>
<tr>
<th>Codes</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
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</thead>
<tbody>
<tr>
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<td>Always</td>
<td>Always</td>
</tr>
<tr>
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<td>Always</td>
<td>1-3</td>
<td>4+</td>
</tr>
<tr>
<td>ROS</td>
<td>Not Required</td>
<td>None</td>
<td>1</td>
<td>2-9</td>
<td>10+</td>
</tr>
<tr>
<td>PFSH</td>
<td>Nurse Visit</td>
<td>None</td>
<td>None</td>
<td>1</td>
<td>2-3</td>
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<tr>
<td>Exam</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>MDM</td>
<td>SF</td>
<td>Low</td>
<td>Mod</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>5 min</td>
<td>10 min</td>
<td>15 min</td>
<td>25 min</td>
<td>40 min</td>
</tr>
</tbody>
</table>
Prolonged Non Face-to-Face Time

99358: Prolonged evaluation and management service before and/or after direct patient care; first hour

99359: each additional 30 minutes with a maximum of 2 units

• Report this service if the provider spends time in either preparation or evaluation of the outcome of treatment before or after the face-to-face encounter with a patient.

Clinical Responsibility: For these service, the provider puts extra effort and time into the treatment of the patient. For example, the provider evaluates the patient’s previous records in cases where the patient opted to change his provider and the new provider performs extra work to understand and plan the treatment of the patient. The provider can also invest extra time to review the reports and progress after the patient has undergone treatment.

Codes 99358 and 99359 are used when a prolonged service is provided that is neither face-to-face time in the office or outpatient setting, nor additional unit/floor time in the hospital or nursing facility setting during the same session of an evaluation and management service and is beyond the usual physician or other qualified health care professional service time.

<table>
<thead>
<tr>
<th>Code Status</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Fees</td>
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<tr>
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<td>Local</td>
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<tr>
<td>99358</td>
<td>$113.41</td>
</tr>
<tr>
<td>99359</td>
<td>$54.55</td>
</tr>
</tbody>
</table>
Prolonged Non Face-to-Face Time

This prolonged service may be reported on a different date than the primary service to which it is related. For example, extensive record review may relate to a previous evaluation and management service performed earlier and commences upon receipt of past records. However, it must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.

Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous.

- Code 99358 is used to report the first hour of prolonged service (cannot bill if <30 minutes of time) on a given date regardless of the place of service. It should be used only once per date.
- Code 99359 is used to report each additional 30 minutes beyond the first hour regardless of the place of service. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date.
  - Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

REGULATIONS PER CMS: The medical record must be documented by the practitioner to include the dated start and end times of any prolonged service.
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](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:

- **Helenmarie Blake-Leger, Interim AVP of Compliance & Chief Privacy Officer**
  - Phone: (305) 243-6000
  - Iliana De La Cruz, RMC, Executive Director, Professional Billing Compliance
  - Gema Balbin-Rodriguez, Director, Professional Billing Compliance
    - Phone: (305) 243-5842
    - Email: Officeofbillingcompliance@med.Miami.edu

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

- Office of billing Compliance website: www.obc.med.miami.edu