Medical Compliance Services
Office of Billing Compliance
Coding, Billing & Documentation
2016

Department of Neurosurgery
Why Are We Here?

• To **EDUCATE** and **PROTECT** our providers and organization

• To provide you with every tool you need to maximize compliance and get paid what you deserve

• To update you on the latest CMS/OIG activities
Question to CMS: “...confused concerning the timeliness of my documentation in connection with the provider signature and submitting the claim to Medicare, and the timely filing rule. Can you provide more information?

• **Answer:** There are several provisions that may affect "timeliness" when talking about documentation.

  • A provider may not submit a claim to Medicare until the documentation is completed.
    • Until the practitioner completes the documentation for a service, **including signature**, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done.
  • The second is that practitioners are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record."
    • CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the service itself.
Global Surgery
Global Service: 1 Payment for Procedure

Major = Day before procedure thru 90 days after
Minor = Day of procedure (some until 10 days after)

Services Included In The Global Surgery Fee

• Preoperative visits, beginning with the day before a surgery for
  major procedures and the day of procedure for minor procedures.
  • If decision made for surgery within 24 hours of consultation or H&P
    then bill E/M with a modifier 57.

• Complications following procedure, which do not require additional
  trips to the operating room.

• Postoperative visits (follow up visits) during the postoperative period
  of the procedure that is related to recovery from the surgery.

• Postoperative pain management provided by the surgeon.
Services Not Included in the Global Surgery Fee

• Visits unrelated to the diagnosis for which the surgical procedure is performed. Treatment for the underlying condition or an added course of treatment which is not part of the normal recovery from surgery. Append modifier -24 to the E/M code.

• Treatment for postoperative complications that cause a return trip to the operating room, including ASCs and hospital outpatient departments. Append modifier -78 to the procedure code for the procedure provided in the operating room.

• Diagnostic tests and procedures, including diagnostic radiological procedures (no modifier required).

• Critical Care services (codes 99291 and 99292) unrelated to the surgery, or the critical care is above and beyond the specific anatomic injury or general surgical procedure performed Immunosuppressive therapy for organ transplants.
Modifiers

• Indicate that a separate service or procedure has been performed by the same physician on the same day (2 CPT codes submitted)

• **Medicare is monitoring these codes!**

• Recent report from CMS: 35% of claims using modifier -25 did not meet requirements, resulting in $538 million dollars in improper payments

You will be audited if you regularly use these codes! Ensure documentation supports the E/M and significant separate procedure.
Common Modifiers

**Modifier-24 (Surgery modifier):**

- Unrelated E/M service by the same physician during a post-op period
  - Example: surgeon managing immunosuppression in transplant pt.
  - Example: post-op TURP patient develops chest pain
  - Example: Critical Care services which are **UNRELATED** to the surgery where a seriously injured or burned patient is critically ill

**Modifier -57**

- Visit or consult on day of or day before a major surgery (90 days global period) when decision for surgery is made
| Modifier 22 | • Services performed are significantly greater than usually required", therefore its use should be exceptional. |
| Modifier 24 | • Separately Identifiable E/M by the Same Physician/Group during the global period. |
| Modifier 57 | • Significant, Separately Identifiable E/M by the Same Physician/Group on the Day of or within 24 hours of a major procedure. |
| Modifier 52 | • Surgeries for which services performed are significantly less than usually required may be billed with the "-52" modifier |
| Modifier 53 | • Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. Documentation describing the circumstances requiring the discontinuation of a procedure in the report is required. |
| Modifier 58 | • Staged or planned related surgical procedures done during the global period of the first procedure. Procedure may have been: Planned prospectively or at the time of the original procedure; More extensively than the original procedure; or for therapy following a diagnostic surgical procedure. A new post-operative period begins when the next procedure in the series is billed. |
**Modifier 62: Co-Surgery**

- Two surgeons (usually with different skills) with specialized skills act as co-surgeons. Both are primary surgeons, performing distinct parts of a single reportable procedure (same CPT code) performing the parts of the procedure simultaneously, e.g., heart transplant or bilateral knee replacements. (pays 125% of fee schedule)
- Co-surgery may be required because of the complexity of the procedure and/or the patient’s condition
- The additional surgeon is not working as an assistant, but is performing a distinct part of the procedure
- Each surgeon dictates his/her operative note describing his/her involvement in the procedure

**Modifier 66: Team Surgery**

- Team-Surgery Surgeries: Highly complex procedures (requiring the skilled services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of the modifier 66 to the basic procedure number used for reporting services. Reimbursement is determined "By Report". 
• In general, the services of assistants for surgeries furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service is non-payable.

• However, it is covered if such services are exceptional medical circumstances. **The TP must document in the operative note that a qualified resident was unavailable** for the procedure and **Documentation of qualifying circumstances must be included in the operating report.**

• Only one OP report is required and the primary attending physician must document in their OP report the specific participation of the assistant (Dr. XXX assisted me throughout the entire procedure...”)

• If the assistant is a physician append modifier 82 to their claim. If the assistant is a PA append an AS modifier to their claim
No Modifier Required If 2 Physicians Performing Unique Surgery CPT Codes on the Same Patient

• If surgeons of different specialties are each performing a different procedure (with specific CPT-4 codes), multiple surgery rules do not apply. If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services only.

• If some portions of the surgery care provided with unique CPT codes and others with co-surgery or assistant, then claim could include CPT codes both with and without modifiers.
Modifier 25 – Be ALERT

• Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.
  • The patient’s condition required a significant, separately identifiable E/M service, *above and beyond* the usual pre- and post-procedure care associated with the procedure or service performed.
  • The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, *different diagnoses are not required* for reporting of the E/M services on the same date.

• The service could be a minor procedure, diagnostic service, E/M visit with a preventive service or E/M with a Medicare Well Visit or Well-Woman service.

• It is *STRONGLY* recommended that 2 separate and distinct notes be included in the medical record to document the procedure and then the separate E/M service.

• Only a practitioner or coder should assign a modifier 25 to a Claim – Not a biller.
Modifier 25 – Be ALERT

• When Not to Use the Modifier 25
  • When billing for services performed during a postoperative period if related to the previous surgery
  • When there is only an E/M service performed during the office visit (no procedure done)
  • When on any E/M on the day a “Major” (90 day global) procedure is being performed
  • When a minimal procedure is performed on the same day unless the level of service can be supported as significant, separately identifiable. All procedures have “inherent” E/M service included.
  • When a patient came in for a scheduled procedure only
DOCUMENTATION REQUIREMENTS- OPERATIVE REPORT

Provide complete roadmap of what was done

Operative report – few components
- Where did you enter and exit?
- Where did you pass through?
- Technique and approach
- Open vs. closed, aspiration, percutaneous, etc.
- Screening vs. diagnostic vs. therapeutic
- Location/Site(s) –
- Right, left, bilateral, distal, proximal, depth, single/pleural,
- Severity/Risk
- Complex/simple......

DEBRIDEMENT TYPE CODES

Of extensive eczematous or infected skin
- % of body surface

With fractures/dislocations
- Skin and sub-Q
- Skin, sub-Q, muscle fascia, and muscle
- Skin, sub-Q, muscle fascia, muscle, and bone

“Regular” also by depth:
- Skin-partial thickness, Skin-full thickness
- Skin and sub-Q
- Skin, sub-Q, and muscle
- Skin, sub-Q, muscle, and bone
INTEGRAL SURGICAL SERVICES:

- Identification of anatomical landmarks
- Incision
- Evaluation of the surgical field
- Simple debridement of traumatized tissue
- Lysis of simple adhesions
- Isolation of structures such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring

(continued)

- Surgical cultures, Wound irrigation
- Insertion and removal of drains, suction devices, and pumps into same site
- Surgical closure and dressings
- Application, management, and removal of postoperative dressings including analgesic devices (preincisional TENS unit, institution of Patient Controlled Analgesia)
- Preoperative, intra-operative and postoperative documentation, including photographs, drawings, dictation, transcription as necessary to document the services provided
Some Procedures Have Certain Other Services

- Cleansing, shaving and prepping of skin
- Draping and positioning of patient
- Insertion of intravenous access
- Moderate sedation administration by the physician performing a procedure
- Local, topical or regional anesthesia administered by the physician performing the procedure

PROCEDURE(S): Many Questions

- Unbundled, inclusive mutually exclusive
- Co-surgeon vs. assistant surgeon
- Application of multiple guidelines
- Repeat, unrelated, staged?
  Site(s)
- Indications for surgery

REPAIR (Closure) Classifications

Simple, Intermediate, Complex

Instructions:
- Measure and record in cm
- Add lengths in same classification & anatomic sites grouped together
Billing Services When Working With Residents Fellows and Interns

All Types of Services Involving a resident with a TP Requires Appropriate Attestations In EHR or Paper Charts To Bill
Evaluation and Management (E/M)

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

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

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

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

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

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

**The documentation of the Teaching Physician must be patient specific.**
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
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.
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 personally performed the 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”
Overlapping Surgeries: CMS Requires

2 Overlapping Surgeries - CMS will pay for two overlapping surgeries, but the teaching surgeon must be present during the critical or key portions of both operations. Consequently, the critical or key portions may not take place at the same time.

✓ The teaching surgeon must **personally document** in the medical record that he/she was physically present during the critical or key portion(s) of both procedures.

✓ When a TP is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, **he or she must arrange for another qualified attending surgeon to immediately assist the resident in the other case should the need arise (this cannot be a resident or fellow.)**

➢ In the case of 3 concurrent surgical procedures, the role of the teaching surgeon in each of the cases is classified as a **supervisory service** to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule. It would not be a billable service if any of the three cases are Medicare.

**NOTE:** Under the new guidelines for Overlapping Surgeries, the surgeon must inform the patients prior to the performance of the procedure, and patient agree to the procedure, discuss with the patient what “critical portion of the operation” means and who might be performing some of the noncritical portions of the operation.
High-Risk Procedures & Diagnostic Services

**Angiography or Angiogram:** These procedures have two components: the Surgical Component and the Radiologic Component.

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

- **Example:** “I was present for the entire 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 images, films (and/or slides etc.) and agree with the resident’s findings and final report.”
Diagnostic Procedures

• **RADIOLOGY AND OTHER DIAGNOSTIC TESTS**

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

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

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

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

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

• It may merely be a brief phrase indicating if a test is "normal," "stable from a previous test" or "mild superior arcuate defect."
• 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.
Evaluation & Management (E/E)  
The 3 Key Documentation Elements

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

• The **Nature of the Presenting Problem** determines the level of documentation necessary for the service

• The level of care (**E/M service**) submitted must not exceed the level of care that is medically necessary

SO . . .

• Medical Decision-Making and Medical Necessity related to the Nature of the Presenting Problem determine the E/M level.

• The amount of history and exam should **not** generally alone determine the level.
Ignoring how medical decision-making affects E/M leveling can put you at risk.

- According to the Medicare Claims Processing Manual, chapter 12, section 30.6.1:
  
  - Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

  - That is, a provider should not perform or order work (or bill a higher level of service) if it’s not “necessary,” based on the nature of the presenting problem.
Medical Record Documentation

CMS:

“Each medical record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers”.
1. Number of Diagnoses or Treatment Options

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

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

2. Amount/Complexity of Data

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

3. Table of Risk

- Is the presenting problem self-limited?
- Are procedures required?
- Is there exacerbation of chronic illness?
- Is surgery or complicated management indicated?
- Are prescription medications being managed?
<table>
<thead>
<tr>
<th>MDM – Step 3: Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Min</strong></td>
</tr>
<tr>
<td>• One self-limited / minor problem</td>
</tr>
<tr>
<td>• Labs requiring venipuncture</td>
</tr>
<tr>
<td>• Rest Elastic bandages</td>
</tr>
<tr>
<td><strong>Low</strong></td>
</tr>
<tr>
<td>• 2 or more self-limited/minor problems</td>
</tr>
<tr>
<td>• Physiologic tests not under stress (PFT)</td>
</tr>
<tr>
<td>• OTC meds</td>
</tr>
<tr>
<td><strong>OP Level 3</strong></td>
</tr>
<tr>
<td>• 1 stable chronic illness (controlled HTN)</td>
</tr>
<tr>
<td>• Non-CV imaging studies</td>
</tr>
<tr>
<td>• Minor surgery w/no identified risk factors</td>
</tr>
<tr>
<td><strong>IP Sub 1</strong></td>
</tr>
<tr>
<td>• Acute uncomplicated illness / injury (simple sprain)</td>
</tr>
<tr>
<td>• Labs requiring arterial puncture</td>
</tr>
<tr>
<td>• PT, OT</td>
</tr>
<tr>
<td><strong>IP Initial 1</strong></td>
</tr>
<tr>
<td>• Gargles</td>
</tr>
<tr>
<td>• IV fluids w/out additives</td>
</tr>
<tr>
<td><strong>Mod</strong></td>
</tr>
<tr>
<td>• 1 &gt; chronic illness, mod. Exacerbation, progression or side effects of treatment</td>
</tr>
<tr>
<td>• Physiologic tests under stress (stress test)</td>
</tr>
<tr>
<td>• Prescription meds</td>
</tr>
<tr>
<td><strong>OP Level 4</strong></td>
</tr>
<tr>
<td>• 2 or more chronic illnesses</td>
</tr>
<tr>
<td>• Diagnostic endoscopies w/out risk factors</td>
</tr>
<tr>
<td>• Minor surgery w/identified risk factors</td>
</tr>
<tr>
<td><strong>IP Sub 2</strong></td>
</tr>
<tr>
<td>• Undiagnosed new problem w/uncertain prognosis</td>
</tr>
<tr>
<td>• Deep incisional biopsies</td>
</tr>
<tr>
<td>• Elective major surgery w/out risk factors</td>
</tr>
<tr>
<td><strong>IP Initial 2</strong></td>
</tr>
<tr>
<td>• Acute illness w/systemic symptoms (colitis)</td>
</tr>
<tr>
<td>• CV imaging w/contrast, no risk factors (angiogram, cardiac cath)</td>
</tr>
<tr>
<td>• Therapeutic nuclear medicine</td>
</tr>
<tr>
<td>• Acute complicated injury</td>
</tr>
<tr>
<td>• Obtain fluid from body cavity (lumbar puncture)</td>
</tr>
<tr>
<td>• IV fluids w/additives</td>
</tr>
<tr>
<td><strong>High</strong></td>
</tr>
<tr>
<td>• 1 &gt; chronic illness, severe exacerbation, progression or side effects of treatment</td>
</tr>
<tr>
<td>• CV imaging w/contrast, w/risk factors</td>
</tr>
<tr>
<td>• Elective major surgery w/risk factors</td>
</tr>
<tr>
<td><strong>OP Level 5</strong></td>
</tr>
<tr>
<td>• Acute or chronic illnesses that may pose threat to life or bodily function (acute MI)</td>
</tr>
<tr>
<td>• Cardiac electrophysiological tests</td>
</tr>
<tr>
<td>• Parenteral controlled substances</td>
</tr>
<tr>
<td><strong>IP Sub 3</strong></td>
</tr>
<tr>
<td>• Abrupt change in neurologic status (TIA, seizure)</td>
</tr>
<tr>
<td>• Diagnostic endoscopies w/risk factors</td>
</tr>
<tr>
<td>• Drug therapy monitoring for toxicity</td>
</tr>
<tr>
<td><strong>IP Initial 3</strong></td>
</tr>
<tr>
<td>• DNR</td>
</tr>
</tbody>
</table>
FOUR ELEMENTS of HISTORY

- Chief Complaint (CC:)
- History of Present Illness (HPI) location/quality/severity/duration/timing/context/modifying factors/associated symptoms
- Review of Systems (ROS)
- Past/Family/Social History (PFSHx)
1. **Chief Complaint**
   - Concise statement describing reason for encounter ("stomach pain,", "follow-up diabetes")
   - Can be included in HPI

   **IMPORTANT:**
   - The visit is not billable if Chief Complaint is not somewhere in the note
   - Must be “follow-up” of __________________________
History - HPI

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

**TWO TYPES:**

**BRIEF**
1-3 elements above or status of 1-2 diagnosis or conditions

**EXTENDED**
4 or > elements above or status of 3 or > diagnosis or conditions
History - ROS

4. REVIEW OF SYSTEMS

14 recognized:

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

THREE TYPES:  

- PROBLEM PERTINENT (1 SYSTEM)
- EXTENDED (2-9 SYSTEMS)
- COMPLETE (10 SYSTEMS)
3. **PAST, FAMILY, AND SOCIAL HISTORY**

- Patient’s previous illnesses, surgeries, and medications
- Family history of important illnesses and hereditary conditions
- Social history involving work, home issues, tobacco/alcohol/drug use, etc.

**TWO TYPES:**

**PERTINENT:** 1 area (P, F or S) generally related to HPI

**COMPLETE:** All 3 (P, F and S) for New patient and Initial Hospital or 2 of 3 areas (P, F or S) for established pt.
PEARLS FOR HISTORY DOCUMENTATION:

• Must have PAST/FAMILY/SOCIAL history for comprehensive history (ALL THREE)

• Don’t forget 10-system review!

• You cannot charge higher than a level 3 new or consult visit without COMPREHENSIVE HISTORY
Physical Examination

4 TYPES OF EXAMS

- Problem Focused (PF)
- Expanded Problem Focused (EPF)
- Detailed (D)
- Comprehensive (C)
Coding 1995: Physical Exam

**BODY AREAS (BA):**
- Head, including face
- Neck
- Chest, including breast and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

**CODING ORGAN SYSTEMS (OS):**
- Constitutional/General
- Eyes
- Ears/Nose/Mouth/Throat
- Respiratory
- Cardiac
- GI
- GU
- Musculoskeletal
- Skin
- Neuro
- Psychiatric
- Hematologic/Lymphatic
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
### Constitutional
Measurement of any three of the following vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight. (May be measured and recorded by ancillary staff)
General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

### Eyes
Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

### Cardiovascular
- Examination of carotid arteries (e.g., pulse amplitude, bruits)
- Auscultation of heart with notation of abnormal sounds and murmurs
- Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)

### Musculoskeletal
- Examination of gait and station

**Assessment of motor function including:**
- Muscle strength in upper and lower extremities
- Muscle tone in upper and lower extremities (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation, tardive dyskinesia)

### Extremities
- [See Musculoskeletal]

### Neurological
**Evaluation of higher integrative functions including:**
- Orientation to time, place and person
- Recent and remote memory
- Attention span and concentration
- Language (e.g., naming objects, repeating phrases, spontaneous speech)
- Fund of knowledge (e.g., awareness of current events, past history, vocabulary)

**Test the following cranial nerves:**
- 2nd cranial nerve (e.g., visual acuity, visual fields, fundi)
- 3rd, 4th & 6th cranial nerves (e.g., pupils, eye movements)
- 5th cranial nerve (e.g., facial sensation, corneal reflexes)
- 7th cranial nerve (e.g., facial symmetry, strength)
- 8th cranial nerve (e.g., hearing with tuning fork, whispered voice and/or finger rub)
- 9th cranial nerve (e.g., spontaneous or reflex palate movement)
- 11th cranial nerve (e.g., shoulder shrug strength)
- 12th cranial nerve (e.g., tongue protrusion)

- Examination of sensation (e.g., by touch, pin, vibration, proprioception)
- Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (e.g., Babinski)
- Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)
1995 and 1997 Exam Definitions

Problem Focused (PF): 99231, 99212 or 99201

- ‘95: Limited exam of the affected body area or organ system. (1 BA/OS)
- ‘97=Specialty and GMS: 1-5 elements identified by bullet.

Expanded Problem Focused (EPF): 99232, 99213 or 99202

- ‘95: Limited exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- ‘97=Specialty and GMS: At least 6 elements identified by bullet.

Detailed (D): 99233, 99221, 99214 or 99203

- ‘95: Extended exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- 97=Specialty: At least 12 elements identified by bullet (9 for eye and psyc)

Comprehensive (C): 99222, 99223, 99215 or 99204 and 99205

- ‘95: General multi-system exam (8 or more organ systems) or complete single organ system (a complete single organ system is undefined by CMS).
- ‘97=Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area.
Using Time to Code

• 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 for coding.
• It is typically used:
  • Significant exacerbation or change in the patient’s condition,
  • Non-compliance with the treatment/plan,
  • Counseling regarding previously performed procedures or tests to determine future treatment options, or
  • Behavior/school issues.

Required Documentation For Billing:

1. Total time of the encounter excluding separate procedure if billed
   • The entire time to prep, perform and communicate results of a billable procedure to a patient must be carved out of the E/M encounter time!
2. The amount of time dedicated CCC for that patient on that date of service. A template statement would not meet this requirement.
## Time-Based Billing for CCC

<table>
<thead>
<tr>
<th>Outpatient Counseling Time:</th>
<th>Inpatient Counseling Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 10 min</td>
<td>99221 30 min</td>
</tr>
<tr>
<td>99202 20 min</td>
<td>99222 50 min</td>
</tr>
<tr>
<td>99203 30 min</td>
<td>99223 70 min</td>
</tr>
<tr>
<td>99204 45 min</td>
<td>99231 15 min</td>
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<tr>
<td>99205 60 min</td>
<td>99232 25 min</td>
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<td>99241 15 min</td>
<td>99233 35 min</td>
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<td>99213 15 min</td>
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<td>99214 25 min</td>
<td></td>
</tr>
<tr>
<td>99215 40 min</td>
<td></td>
</tr>
</tbody>
</table>
Counseling/Coordination of Care CCC

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 was spent counseling the patient regarding ________ and addressing their multiple questions.

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

Documentation must reflect the specific issues discussed with patient present.
New Patients

Patient not seen by you or your billing group in the past three years (as outpatient or inpatient)
Hospital Inpatient Admission Orders

A Medicare patient is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner. If the order is not properly documented in the medical record, the hospital may not submit a claim for Part A payment.

Meeting the 2 midnight benchmark does not, in itself, render a patient an inpatient or serve to qualify them for payment under Part A. Rather, as provided in our regulations, a beneficiary is considered an inpatient (and Part A payment may only be made) if they are formally admitted as such pursuant to an order for inpatient admission by a physician or other required practitioner (Dentist, Podiatrist).

The order must be furnished by a physician or other practitioner (“ordering practitioner”) who is: (a) licensed by the state to admit inpatients to hospitals, (b) granted privileges by the hospital to admit inpatients to that specific facility, and (c) knowledgeable about the patient’s hospital course, medical plan of care, and current condition at the time of admission. The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision.

The ordering practitioner is not required to write the order but must sign the order reflecting that he or she has made the decision to admit the patient for inpatient services before the patient is discharged from the hospital or within 7 days of admission, whichever comes first.
Hospital Inpatient Admission Orders

• If certain non-physician practitioners and residents/fellows working within their residency program are authorized by the state in which the hospital is located to admit inpatients, and are allowed by hospital by-laws or policies to do the same, the ordering attending practitioner may allow these individuals to write inpatient admission orders on his or her behalf, but must counter-sign the order prior to patient’s discharge from the hospital.

• In countersigning the order, the ordering attending practitioner approves and accepts responsibility for the admission decision. This process may also be used for physicians (such as emergency department physicians) who do not have admitting privileges but are authorized by the hospital to issue temporary or “bridge” inpatient admission orders.
**TWO MIDNIGHT RULE DECISION TREE FOR MEDICARE PATIENTS**

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

- **NO**
  - Is the patient receiving an Inpatient only procedure? (Consult case management)
    - **NO**
      - Is the patient newly ventilated? (Excluding ventilation during surgery)
        - **NO**
          - Write an order for Outpatient OR Outpatient Observation Status
        - **YES**
          - Write an Inpatient Order along with expected length of stay
    - **YES**
      - Write an Inpatient Order

- **YES**
  - Write an order for Inpatient Status: Document that the patient meets the two midnight benchmark, the expected length of stay and the medical necessity for inpatient care.

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

* If a patient discharges early because of death, leaving AMA, transferring to another facility or an unforeseen recovery, then the patient should remain in patient with supportive documentation.
Inpatient E/M Coding

Inpatient Hospital

• Subsequent Hospital Care

  Three levels of service: 99231, 99232, 99233

  • 99231 - Stable, recovering, improving
    • Problem focused history or exam

  • 99232 - Not responding, minor complication
    • Expanded problem focused history or exam

  • 99233 - Very unstable, significant complications
    • Detailed history or exam

REMEMBER: What is medically necessary to document for that day?
Subsequent Hospital Visits
Inpatient Hospital

Medical Necessity should drive your documentation for each day’s visit:

What’s wrong with this audit?

Day 1: 99223
Day 2: 99233
Day 3: 99233
Day 4: 99233
Day 5: 99233
Day 6: 99239 (discharge to home)
Discharge Day Codes –
Teaching Physician Time Only!

• **CPT 99238**: TP’s management of patient’s D/C took < 30 minutes.

• **CPT 99239**: Differs from 99238 because it requires documentation of time > 30 minutes spent managing the patient (final exam, Rx management, POC after D/C).
  - The hospital discharge day management codes are to be used to report:
    - the total duration of time spent by a physician for final hospital discharge of a patient.
    - The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the physician on that date is not continuous,
    - Instructions for continuing care to all relevant caregivers, and
    - Preparation of discharge records, prescriptions and referral forms.

**EXAMPLE:** “I saw and evaluated the patient today and agree with resident note. Discharge instructions given to patient and Rx’s. To F/U in 5 days in clinic”

The hospital required discharge summary is not documentation of patient discharge management for billing a 99238 or 99239 unless there is a statement that indicates that the attending personally saw the patient and discussed discharge plans on the day the code was billed.
Hospital Discharge

IMPORTANT!

• Documentation should include:
  • final examination of patient
  • discharge instructions/follow-up
  • preparation of referrals/prescriptions
  • time spent

  • If less than 30 minutes: 99238
  • If more than 30 minutes: 99239 (TIME must be documented)
USING DIFFERENT LEVELS OF CARE

- 99223 * PATIENT ADMITTED
- 99233 * (PT. IS UNSTABLE)
- 99232 * (PT. HAS DEVELOPED MINOR COMPL.)
- 99231 * (PT. IS STABLE, RECOVERING, IMPROVING)
- 99238 * PATIENT DISCHARGED
Top Compliance Issues For Documenting in EMR
PAYORS ARE WATCHING EMR DOCUMENTATION

Once you sign your note, YOU ARE RESPONSIBLE FOR ITS CONTENT
Top Compliance Rules for EMR

Use “Copy Forward” with caution

- Each visit is unique

- **Cloned documentation** is very obvious to auditors

- If you bring a note forward it MUST reflect the activity for the CURRENT VISIT with appropriate editing

- **Strongly advise** NOT copying forward HPI, Exam, and complete Assessment/Plan
Top Compliance Rules for EMR

Don’t dump irrelevant information into your note

• (“the 10-page follow-up note”)

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

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

• Self-explanatory
Top Compliance Rules for EMR

Only Past/Family/Social History and Review of Systems may be used from a *medical student* or *nurse’s* note.

- Student or nurse may start the note
- Provider (resident or attending)
- must document HPI, Exam, and
- Assessment/Plan
Top Compliance Rules for EMR

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

• Cautious with ROS and Exam

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

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

• Demonstrates Medical Necessity

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

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

• Don’t say Today, Tomorrow, or Yesterday

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

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

• “Neuro status remains stable, will discontinue neuro checks” can be copied forward in error

• Better – “Neuro checks stopped on 2/24”

• “Added heparin on 4/26” – uses past tense and specific date for better accuracy
Copy / Paste Summary

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

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

• Make sure your note reflects the reality and accuracy of the service each day
Non-Physician Practitioners (NPP’s) or Physician Extenders

Who is a NPP?

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

• Collaborative agreement between the NPP and the group they are working with is required.
  • The agreement extends to all physicians in the group.
    • If the NPP is performing procedures it is recommended a physician confirm their competency with performance of the procedure.
• NPPs can bill independent under their own NPI # in all places-of-service and any service included in their State Scope of Practice.
  • Supervision is general (available by phone) when billing under their own NPI number.
  • Medicare and many private insurers credential NPPs to bill under their NPI.
  • Some insurers pay 85% of the fee schedule when billing under the NPP and others pay 100% of the fee schedule.
• Shared visit in the hospital or hospital based clinic (POS 19, 21, 22, 23)
Shared Visits

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

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

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

• Procedures, Consultations nor Critical Care Services **CANNOT** be billed shared
Shared Visits Between NPP and Physician

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

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

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

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

• The NPP MUST be an employee (or leased) to bill shared. 

**Documentation from a hospital employed NPP may not be utilized to bill a service under the physician.**
Shared Visits Between NPP and Physician

In order to bill under the physician name and NPI#, 

- Sufficient medical record documentation is the key to proper reimbursement. In all cases, documentation must substantiate the medical necessity of the shared/split visit; support the level of E/M code submitted, and the medical record should contain enough detail to allow a reviewer to:
  - identify both providers
  - link the physician notes to those of the NPP’s note
  - confirm that the physician and the NPP both saw the patient face-to-face
  - include legible/electronic signature(s)
  - include legible signatures from both providers (in case of paper records)

**Following examples that would adequately meet physician documentation requirements for a split/shared visit:**

- “I have personally performed a face to face diagnostic evaluation on this patient. My findings are as follows: ...Patient presents with abscess, onset 3 days ago. Has tried a warm compress; hot shower for relief. Exam shows right gluteal abscess 3cm warm tender and fluctuant. Incision and drainage not indicated, started on MRSA antibiotic coverage" **Signed by Attending Physician**

- “I have personally performed a face to face evaluation on this patient. I have reviewed and agree with the care plan. History and Exam by me shows: abdomen was tender to touch, no rebound. Labs /CT scan negative. IM Toradol given for pain. Pt discharged home.”
  **Signed by Attending Physician**

- “I have personally seen and evaluated Ms. X with (ARNP name). “My examination shows XYZ”. “Based on the findings, my plan is to schedule the patient for tumor ablation.”
  **Signed by Attending Physician**
Shared Visits Between NPP and Physician

Examples of physician documentation that would not adequately meet the shared/split visit requirements:

• "I have personally seen and examined the patient independently, reviewed the ARNPs/PAs history, exam and medical decision making and agree with the assessment and plan as written" signed by the physician.

• "Patient seen" signed by the physician

• "Seen and examined" signed by the physician

• "Seen and examined and agree with above (or agree with plan)" signed by the physician

• "As above" signed by the physician

• Documentation by the NPP stating "The patient was seen and examined by myself and Dr. X., who agrees with the plan" with a co-sign of the note by Dr. X.

• No comment at all by the physician or only a physician signature at the end of the note.

In the last three examples, the physician is only documenting that he/she agrees with the findings that the NPP has already documented. The documentation does not show that the physician had face-to-face contact with the patient or that he/she performed any of the history, exam or medical decision making elements. The guidelines require that there must be documentation of the face-to-face portion of the E/M encounter between the patient and the physician. The medical record should clearly identify the part(s) of the E/M service that were personally provided by the physician and those that were provided by the NPP.

Note: The physician must personally document his/her involvement in the patient’s care and cannot leave his/her documentation, of the visit, to the NPP.
Bill Independently and Not Shared

Billing Under The NPP NPI

• Does not require physician presence.
• Can evaluate and treat new conditions and new patients.
• Can perform all services under the state scope-of-practice.
• Can perform services within the approved collaborative agreement.
  • Recommend physician establish competency criteria and demonstration of performance of procedures within the collaborative agreement between the NPP and physician.
Current CMS Florida First Coast Audits

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

• Prepayment review for CPT® codes 99232 and 99233
  • Data indicates specialties internal medicine and cardiology are the primary contributors to the CERT error rate for subsequent hospital care services. The new audit will be based on a threshold of claims submitted for payment by cardiology and internal medicine specialties for 99232 and 99233. The audit will be implemented for claims processed on or after March 15, 2016.

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

• Prepayment review for CPT® codes 99204, 99205, 99215 and 99285 all specialties
• 99214 – Post-payment review
“Whoa—way too much information.”
• HIPAA, HITECH, Privacy & Security Health Insurance Portability and Accountability Act – HIPAA
  – Protect the privacy of a patient’s personal health information
  – Access information for business purposes only and only the records you need to complete your work.
  – Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  – PHI is protected even after a patient’s death!!!

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

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

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

If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:

- **Helenmarie Blake-Leger, Interim AVP Clinical Billing Compliance & HIPAA Privacy Officer**
  - **Phone:** (305) 243-6000
- **Iliana De La Cruz, Executive Director Office of Billing Compliance**
- **Gema Balbin-Rodriguez, Associate Director Office of Billing Compliance**
  - **Phone:** (305) 243-5842
  - **[Officeofbillingcompliance@med.miami.edu](mailto:Officeofbillingcompliance@med.miami.edu)**

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

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