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

Department of OB/GYN
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.
Code Changes
1. Report Ovarian Sclerotherapy With a New Code

   • **49185**, Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed.

   • Sclerotherapy, a treatment used for years to treat varicose veins and hemorrhoids, also works as an alternative treatment for endometriomas instead of open or laparoscopic surgical removal. Endometriomas, those cystic masses of endometrial tissue forming outside the uterus, can be removed from an ovary using sclerotherapy with injection of a chemical agent like 95 percent ethanol or methotrexate. When injected into the endometrial cyst, the sclerosing agent destroys the cyst wall and prevents its regrowth.

   • Note that **49185** is not limited to Ob-gyn use—it can also be used to report chemical sclerotherapy of any cystic lesion, including lymphoceles and seromas. Before CPT® 2016 added this new code, providers reported sclerotherapy procedures using an unlisted procedure code.
2. Two New MRI Codes for Fetal Imaging
   • **74712**, Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation
   • **+74713** ...each additional gestation (List separately in addition to code for primary procedure)
   • Starting in 2016, you’ll be able to use **74712** and **+74713** to report fetal MRI. Before these codes were introduced, you had to report fetal MRI with an unlisted procedure code or with a pelvic MRI code. Providers use fetal MRI when abnormalities seen on ultrasound are not clearly definable and more information is needed to make decisions about therapy, delivery, or prognosis. For example, providers might order a fetal MRI in cases of maternal obesity, oligohydramnios, or advanced gestational age.

3. Check Out Changes to Screening Mammography
   • **77057**, Screening mammography, bilateral (2-view study of each breast)
   • The word “film” in the older version of this code has been changed to “study,” because the number of films taken has no effect on the use of the code.
4. New OB Lab Panel Code That Includes HIV Testing

- **80081**, *Obstetric panel (includes HIV testing)* ...

This new code differs from the existing 80055 (*Obstetric panel*) in that it adds HIV antigen tests to the set of tests that 80055 covers. This means that in 2016, you’ll report 80081 when you need to code for an obstetric panel that includes HIV testing along with a complete blood count (CBC), white blood cell (WBC) count with differential, hepatitis B surface antigen, rubella antibody, syphilis test, antibody screen, and blood typing.

5. New Genetic Marker Test Code

- **81432**, *Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 14 genes, including ATM, BRCA1, BRCA2, BRIP1, CDH1, MLH1, MSH2, MSH6, NBN, PALB2, PTEN, RAD51C, STK11, and TP53*

The AMA added this code to CPT® 2016’s section for Genomic Sequencing Procedures and Other Molecular Multianalyte Assays. Use it for full genomic sequence analysis for at least 14 genes, including the ones listed in the official description. If the lab performs some but not all of these gene-sequencing analyses, don’t use this code; instead, you’ll report an appropriate code for an individual test, such as the appropriate code in the range 81211-81217 for BRCA1 and BRCA2.
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.
Major Surgery Modifiers

• **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 less than usually 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 78** - Return to OR for related procedure during the post-op period including postoperative complications.

• **Modifier 79** - Procedure or service during a post-operative period unrelated to the original procedure.
Co-Surgery

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.
Assistant Surgeon and Assistant at Surgery

Modifier 82: Physician Assistant Surgeon in a Teaching Hospital

Modifier AS: PA or NP Assistant at Surgery in a Teaching Hospital

• 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 or CRNP 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.
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
Minor Procedure With an E/M
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.
Modified 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
Delivery, Antepartum and Postpartum Care
Billing Ultrasounds

• One ultrasound (procedure code 76801 or 76805) is reimbursed per pregnancy regardless of pregnancy risk factors.
  • Modifier 22 cannot be used with procedure code 76801 or 76805.

• Complex pregnancy conditions may require a detailed fetal anatomic examination. Florida Medicaid will reimburse one ultrasound (procedure code 76811) to provider specialties 47 (radiology) and 65 (maternal/fetal).
  • This procedure is limited to one procedure per pregnancy and must include a detailed anatomic evaluation of fetal brain and ventricles, face, heart with outflow tracts, chest anatomy, abdominal organ specific anatomy, and limbs. As clinically indicated, a detailed evaluation of the umbilical cord, placenta and other fetal anatomy must be documented and maintained in the medical record.

• For multiple gestations, an additional procedure code, 76812, must be included to identify the additional gestation with a detailed fetal anatomic examination.
  • Documentation must include the same components as procedure code 76811, and maintained in the medical records.
Billing Ultrasounds

• Follow-up ultrasounds (procedure code 76815 or 76816) are reimbursed for recipients who have a diagnosis listed on the Diagnosis Code List for Additional Ultrasounds for Pregnant Women (Appendix C).
  • A maximum of three follow-up ultrasounds may be reimbursed with a diagnosis code on Appendix C with no documentation of medical necessity.
• If more than three follow-up ultrasounds are required, the additional ultrasound(s) must be billed with a modifier 22.
  • A report must be submitted with the claim that documents the medical necessity, its findings, and a plan of care. Only the diagnosis or diagnoses justifying the reason or reasons for the follow-up ultrasound should be included on the claim. Supporting documentation must be included for each diagnosis listed on the claim. Without all components of this documentation the claim will be denied.
• Abbreviated ultrasounds (procedure code 76815) are reimbursed for fetal position, fetal heart beat, placenta location or qualitative amniotic fluid volume when clinically indicated.
• Follow-up ultrasounds (procedure code 76816) are reimbursed when findings including fetal measurements for assessment of fetal size, and interval growth or re-evaluation of one or more anatomic abnormalities are documented in the report.

For more information on billing ultrasounds you may refer to the Florida Medicaid Practitioner Coverage and Limitations Handbook Chapter 2 Pages 63-72.
Vaginal Delivery

59400 - Routine obstetric care including antepartum care, vaginal delivery (w/or w/o episiotomy, and/or forceps) and postpartum care

59409 - Vaginal delivery only (with or without episiotomy and/or forceps)

59410 - Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care

59614 - Vaginal delivery only, after previous C-Section delivery (with or without episiotomy and/or forceps; including postpartum

59610 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps and postpartum care, after previous C-Section
Delivery, Antepartum and Postpartum Care

Florida Medicaid classifications of C-Section delivery Codes

**Cesarean Delivery**

- **59510** - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- **59514** - Cesarean delivery only
- **59515** - Cesarean delivery only; including postpartum care
- **59618** - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care. Following an attempted vaginal delivery after previous C-Section delivery
- **59525** - C-Section delivery with removal of uterus (Hysterectomy)
- **59620** - C-Section delivery only, *(following attempted vaginal delivery)* after previous C-Section delivery
- **59622** - C-Section delivery *(following attempted vaginal delivery)* after previous C-Section delivery; including postpartum care
Delivery, Antepartum and Postpartum Care

The following services are included in the OB global package:

• The initial obstetrics visit. This includes patient history, examination, recording of weight, vital signs and counseling and/or advise provided regarding the pregnancy.
• Monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits to delivery to monitor ongoing progress of the pregnancy. This includes weight and vital sign monitoring, assessment of fetal heart tones and routine chemical urinalysis.
• Routine fetal monitoring during labor.
• The ordering and administration by the attending physician of medication during labor (i.e., Pitocin).
• Hospital admission and discharge services (labor & delivery). Hospital admission with 24 hours of the delivery is considered part of the OB package and can not be billed separately.
Normal Spontaneous Vaginal Delivery

- Management of uncomplicated labor including fetal monitoring
- Placement of internal fetal and/or uterine monitors
- Vaginal delivery with or without forceps or vacuum extraction
- Delivery of placenta, any method
- Episiotomy and repair/suturing of lacerations
- Administration of intravenous oxytocin
Cesarean Delivery

• Management of uncomplicated labor including fetal monitoring
• Preoperative counseling including rationale for cesarean delivery
• Incision into uterus with delivery of fetus, placenta and fetal membranes
• Placement of internal fetal and/or uterine monitors
• Administration of intravenous oxytocin.
## Regional Perinatal Intensive Care Center (RPICC) Obstetrical Services Fee Schedule

Note: ICD-9 Effective 01/01/15 to 09/30/15  ICD-10 Effective 10/01/15 to 12/31/15

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Billing for Sterilizations for Medicaid

• Sterilizations are reimbursable using the appropriate CPT code, TG modifier, and diagnosis code.

• The waiting period between obtaining the written consent and the sterilization procedure must be at least 30 days but no more than 180 days.

• In cases of a premature delivery, the consent must have been completed and signed at least 30 days prior to the expected date of delivery and 72 hours prior to sterilization.

• Abbreviations and signature stamps are not acceptable on these forms.

• The physician who performed the sterilization must sign and date the Consent for Sterilization form on or after the date the sterilization procedure was performed.

• Providers must specify Essure® method of sterilization on the consent form, if appropriate, and submit the form with the claim.
Hysterectomy Acknowledgement Form

- Hysterectomies are reimbursable using the appropriate CPT code, TG modifier, and diagnosis code.

- Federal regulations require that a recipient or her representative be informed verbally and in writing prior to a hysterectomy that the operation will make her permanently incapable of reproducing. Federal regulations further require that the recipient or her representative sign a written acknowledgment of receipt of this information.

- The provider must have either obtained a Hysterectomy Acknowledgment Form, or a consent form that includes the same information as the Hysterectomy Acknowledgment Form in order to be reimbursed by Medicaid. If the provider does not obtain the Form or a consent form that contains the same information, Medicaid cannot reimburse for the service.

- An Exception to Hysterectomy Acknowledgment Form is required if the patient;
  - was sterile before hysterectomy was performed; or
  - required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior completion of the Hysterectomy Acknowledgment Form was not possible

The appropriate AHCA form, incorporated by reference in Rule 59G-1.045, F.A.C.:

State of Florida Exception to Hysterectomy Acknowledgment Requirement, ETA-5001, June 2016
State of Florida Hysterectomy Acknowledgment Form, HAF-5000, June 2016

- Providers must submit the applicable form with the claim.
Contraception Counseling ICD-10 Codes

• Z30.0: Encounter for general counseling and advice on contraception
• Z30.01: ENCOUNTER FOR INITIAL PRESCRIPTION OF CONTRACEPTIVES
• Z30.011: Contraceptive pills, initial prescription
• Z30.012: Emergency contraception, prescription
• Z30.013: Injectable contraceptive, initial prescription
• Z30.014: Intrauterine contraceptive device, initial prescription
• Z30.018: Other contraceptives, initial prescription
• Z30.019: Contraceptives unspecified, initial prescription
• Z30.02: COUNSELING AND INSTRUCTION IN NATURAL FAMILY PLANNING TO AVOID PREGNANCY
• Z30.09: ENCOUNTER FOR OTHER GENERAL COUNSELING AND ADVICE ON CONTRACEPTION
Genetic Counseling: CPT 96040

- **96040**: Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family
  - The trained genetic counselor meets with an individual, couple, or family to investigate family genetic history and assess the risks associated with genetic defects in offspring. This code covers 30 minutes of face-to-face counseling, review of medical data, or data collection (interviews).

- **Issue**: Medicare and many insurers do not pay for Genetic Counseling as a professional fee when provided by a genetic counselor. Genetic Counselors are not issued a license in the State of Florida.

- In the AMA CPT Code book the following instruction is listed.
  - *Genetic counseling and education provided to an individual by a physician or other qualified health care professional (ARNP) may report an evaluation and management services code.*
Preventive Well Woman 99381-99395

The extent and focus of the services will largely depend on the age of the patient. Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination.

The "comprehensive" nature of the Preventive Medicine Services codes 99381-99397 reflects an age and gender appropriate history/exam and is not synonymous with the "comprehensive" examination required in Evaluation and Management codes 99201-99350.

If an abnormality/ies is encountered or a pre-existing problem is addressed in the process of performing preventive services, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate code could also be reported with Modifier 25.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine service and which does not require significant additional work and the performance of the key components of a problem-oriented E/M service should not be reported.
Medicare Well Woman

Medicare will reimburse for G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and Q0091 (Pap Smear) if it has been 2 years for women at normal risk. Annually if the patient meets the criteria for high-risk or women of childbearing age with abnormal Pap test within past 3 years.

High risk factors for cervical and vaginal cancer are any one of the following:

- Early onset of sexual activity (under 16 years of age);
- Multiple sexual partners (five or more in a lifetime);
- History of sexually transmitted disease (including human immunodeficiency virus {HIV} );
- Fewer than three negative Pap smears within the previous 7 years;
- Prenatal exposure to diethylstilbestrol – Exposed daughters of women who took DES during pregnancy.

• High Risk: Z77.22, Z77.9, Z91.89, Z72.89, Z72.51, Z72.52, and Z72.53
• Low Risk: Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89

Source: Noridian Medicare Services/Medicare Preventive Services
Screening Breast & Pelvic Exam: G0101

• Documentation MUST include at least 7 of the following 11 elements:
  1. Inspection and palpation of breasts
  2. Digital rectal exam including sphincter tone, presence of hemorrhoids, masses

• Pelvic exam (with or without specimen collection for smears and cultures) including:
  3. External genitalia (e.g., general appearance, hair distribution, lesions)
  4. Urethral meatus (e.g., size, location, lesions, prolapse)
  5. Urethra (e.g., masses, tenderness, scarring)
  6. Bladder (e.g., fullness, masses, tenderness)
  7. Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
  8. Cervix (e.g., general appearance, lesions, discharge)
  9. Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
 10. Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)
 11. Anus and perineum
Screening for PAP Tests

Medicare will reimburse for Q0091 (screening pap smear; obtaining, preparing and conveyance to lab)

Every 2 years for women at normal risk.

Annually if the patient is at high risk of developing cervical or vaginal cancer or women of childbearing age with abnormal Pap test within past 3 years.

ICD-10 Coding

- High risk – Z77.21, Z77.22, Z77.9, Z91.89, Z92.89, Z72.51, Z72.52, and Z72.53
- Low risk – Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89

Source: Medicare Preventive Services
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
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 due to her high risk pregnancy, maternal/fetal symptoms, I will order a fetal biophysical profile with NST, today, 3/6.”

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.
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
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.’
Example: ‘I personally performed the 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 & immediately available).”

**Deliveries** (Delivery-only codes (59409, 59514, or 59612, 59620) - TP must be present during key portions of each stage of delivery.
- Admission to the hospital (admission H&P)
- Uncomplicated labor and infant delivery
- Delivery of Placenta
*Note:

Below is the verbiage to be used to start the auto text for the provider’s attestation.

**Vaginal Deliveries:**
I was present for delivery, or
I was immediately available for delivery.

**C-Section Deliveries:**
I was present during key portions of delivery.
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.

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

**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 ultrasound (or films and/or slides etc.) and agree with the resident’s findings and final report.”
• 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 the GC modifier are certifying that they have been present during the key portion of the service.

Medicare Payor ONLY
Top Compliance Issues For Documenting in EMR
PAYORS ARE WATCHING EMR DOCUMENTATION

Once you sign your note, YOU ARE RESPONSIBLE FOR ITS CONTENT
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
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
“I hear there’s a new ICD-10 code for carpal tunnel syndrome caused by clicking too many times in an EMR system.”
Inpatient and Outpatient

Evaluation and Management E/M Documentation and Coding
Evaluation & Management (E/E)
The 3 Key Documentation Elements

- History: Focus on HPI
- Medical Decision Making
- Physical Exam
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”.
Medical Decision-Making

1. Number of Diagnoses or Treatment Options

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

Multiple active problems?
New problem with additional workup? = HIGHER COMPLEXITY
Are problems worse?
2. Amount/Complexity of Data

- Were lab/x-ray ordered or reviewed?
- Were other more detailed studies ordered? (Echo, U/S, Fetal Biophysical Profile, NSTs, Doppler, 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>Level</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>• One self-limited / minor problem</td>
<td>• Labs requiring venipuncture</td>
<td>• Rest&lt;br&gt;• Elastic bandages&lt;br&gt;• Gargles&lt;br&gt;• Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>• 2 or more self-limited/minor problems&lt;br&gt;• 1 stable chronic illness (controlled HTN)&lt;br&gt;• Acute uncomplicated illness / injury (simple sprain)</td>
<td>• Physiologic tests not under stress (PFT)&lt;br&gt;• Non-CV imaging studies&lt;br&gt;Superficial needle biopsies&lt;br&gt;• Labs requiring arterial puncture&lt;br&gt;• Skin biopsies</td>
<td>• OTC meds&lt;br&gt;• Minor surgery w/no identified risk factors&lt;br&gt;• PT, OT&lt;br&gt;• IV fluids w/out additives</td>
</tr>
<tr>
<td>OP Level 3&lt;br&gt;IP Sub 1&lt;br&gt;IP Initial 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mod</td>
<td>• 1 &gt; chronic illness, mod. Exacerbation, progression or side effects of treatment&lt;br&gt;• 2 or more chronic illnesses&lt;br&gt;• Undiagnosed new problem w/uncertain prognosis&lt;br&gt;• Acute illness w/systemic symptoms (colitis)&lt;br&gt;• Acute complicated injury</td>
<td>• Physiologic tests under stress (stress test)&lt;br&gt;• Diagnostic endoscopies w/out risk factors&lt;br&gt;• Deep incisional biopsies&lt;br&gt;• CV imaging w/contrast, no risk factors (arteriogram, cardiac cath)&lt;br&gt;• Obtain fluid from body cavity (lumbar puncture)</td>
<td>• Prescription meds&lt;br&gt;• Minor surgery w/identified risk factors&lt;br&gt;• Elective major surgery w/out risk factors&lt;br&gt;• Therapeutic nuclear medicine&lt;br&gt;• IV fluids w/additives&lt;br&gt;• Closed treatment, FX / dislocation w/out manipulation</td>
</tr>
<tr>
<td>OP Level 4&lt;br&gt;IP Sub 2&lt;br&gt;IP Initial 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>• 1 &gt; chronic illness, severe exacerbation, progression or side effects of treatment</td>
<td>• CV imaging w/contrast, w/risk factors&lt;br&gt;• Cardiac electrophysiological tests&lt;br&gt;• Diagnostic endoscopies w/risk factors</td>
<td>• Elective major surgery w/risk factors&lt;br&gt;• Emergency surgery</td>
</tr>
</tbody>
</table>
| OP Level 5<br>IP Sub 3<br>IP Initial 3 | • Acute or chronic illnesses that may pose threat to life or bodily function (acute MI)<br>• Abrupt change in neurologic status (TIA, seizure) | • CV imaging w/contrast, w/risk factors<br>• Cardiac electrophysiological tests<br>• Diagnostic endoscopies w/risk factors | • Parenteral controlled substances<br>• Drug therapy monitoring for toxicity<br>• DNR }
Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid.

<table>
<thead>
<tr>
<th></th>
<th>Number diagnoses or treatment options</th>
<th>≤ 1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>≥ 4 Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Highest Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>B</td>
<td>Amount and complexity of data</td>
<td>≤ 1 Minimal or low</td>
<td>2 Limited</td>
<td>3 Multiple</td>
<td>≥ 4 Extensive</td>
</tr>
</tbody>
</table>

Type of decision making

- STRAIGHT-FORWARD
- LOW COMPLEX.
- MODERATE COMPLEX.
- HIGH COMPLEX.
Four Elements of History

• Chief Complaint (CC:)
• History of Present Illness (HPI)
• Review of Systems (ROS)
• Past/Family/Social History (PFSHx)
History

1. **Chief Complaint**
   - Concise statement describing reason for encounter
     - “back pain”
     - “follow-up for numbness”
   - Can be included in HPI

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

• **Location:** Right lower extremity, 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
3. 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)
4. **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, military service, etc.

**TWO TYPES:**

- **PERTINENT:** 1 area (P, F or S) generally related to HPI
- **COMPLETE:** All 3 (P, F and S) for New patient & Initial Hospital or 2 of 3 areas (P, F or S) for established pt.
PEARLS FOR HISTORY DOCUMENTATION FOR NEW PATIENTS:

- 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
### GU Examination for Female

#### Constitutional
- Measurement of any three of the following seven 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)

#### Neck
- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of thyroid (e.g., enlargement, tenderness, mass)

#### Respiratory
- Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

#### Cardiovascular
- 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)

#### Gastrointestinal (Abdomen)
- Examination of abdomen with notation of presence of masses or tenderness
- Examination for presence or absence of hernia
- Examination of liver and spleen
- Obtain stool sample for occult blood test when indicated

#### Genitourinary

**FEMALE:**
- Includes at least seven of the following eleven elements identified by bullets:
  - Inspection and palpation of breasts (e.g., masses or lumps, tenderness, symmetry, nipple discharge)
  - Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses
  - Pelvic examination (with or without specimen collection for smears and cultures) including:
    - External genitalia (e.g., general appearance, hair distribution, lesions)
    - Urethral meatus (e.g., size, location, lesions, prolapse)
    - Urethra (e.g., masses, tenderness, scarring)
    - Bladder (e.g., fullness, masses, tenderness)
  - Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
  - Cervix (e.g., general appearance, lesions, discharge)
  - Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
  - Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)
  - Anus and perineum
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 & 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 psyche)

**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>
</tr>
<tr>
<td>99205   60 min</td>
<td>99232   25 min</td>
</tr>
<tr>
<td>99241   15 min</td>
<td>99233   35 min</td>
</tr>
<tr>
<td>99242   30 min</td>
<td>99251   20 min</td>
</tr>
<tr>
<td>99243   40 min</td>
<td>99252   40 min</td>
</tr>
<tr>
<td>99244   60 min</td>
<td>99253   55 min</td>
</tr>
<tr>
<td>99245   80 min</td>
<td>99254   80 min</td>
</tr>
<tr>
<td>99211   5 min</td>
<td>99255   110 min</td>
</tr>
<tr>
<td>99212   10 min</td>
<td></td>
</tr>
<tr>
<td>99213   15 min</td>
<td></td>
</tr>
<tr>
<td>99214   25 min</td>
<td></td>
</tr>
<tr>
<td>99215   40 min</td>
<td></td>
</tr>
</tbody>
</table>
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.
Prolonged Services: 2016 UPDATE:

• **99354-99355**  Prolonged practitioner E/M or *psychotherapy service(s)* (beyond the typical service time of the primary E/M or psychotherapy service) in the office or other outpatient setting requiring *direct patient contact* beyond the usual service; first hour (List separately in addition to code for office or other outpatient E/M *(99201-99215, 99241-99245, 99324-99337, 99341-99350)* or *psychotherapy service 90837*) – Billed by physicians, ARNPs or PAs
  
  • To bill practitioner prolonged codes must be > than 30 minutes associated with E/M

• **99415**: Prolonged clinical staff service (the service beyond the typical service time) during an E/M service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient E/M service)
  
  • To bill clinical staff Prolonged codes, time starts at >45 minutes

• **99416**: Prolonged clinical staff service (the service beyond the typical service time) during an E/M service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)
  
  • Do bill 99416 with 99415
  
  • Do not bill 99415 or 99416 with 99354-99355

**NOTE:** Document what you did and how long you did it. If you are billing additional procedures, document the time and note that they are excluded from the prolonged service so double-dipping is not questioned. OUTPATIENT ONLY.

**REGULATIONS PER CMS:** The medical record must document by the practitioner to include the dated start and end times of the prolonged service.
Prolonged Services: 2016 UPDATE:

Under the ‘incident to’ provision, clinical staff may provide the new prolonged services CPT codes, 99415 and 99416. Office Place of service (11)

• “Clinical staff” A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service; but who does not individually bill that professional service.

• Clinical staff are medical assistants, licensed practical nurse, etc.

• Other policies may also affect who may bill specific services according to state laws

• Inclusion or exclusion (in the AMA-CPT codebook) does not imply any health insurance coverage or reimbursement policy.

• Must check with individual healthcare plans for coverage allowances.
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**

1. **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.**
   - **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.
   - **NO**
     - Is the patient receiving an Inpatient only procedure? (Consult case management)
       - **YES**
         - Write an Inpatient Order
       - **NO**
         - Is the patient newly ventilated? (Excluding ventilation during surgery)
           - **YES**
             - Write an Inpatient Order along with expected length of stay
           - **NO**
             - Write an order for Outpatient OR Outpatient Observation Status

* 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?
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”

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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)
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)
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
Non-Physician Practitioners (NPP’s) or Physician Extenders

Who is a NPP?

Physician Assistant (PA)
Nurse Practitioner (NP)
Clinical Nurse Specialist (CNS)
Optometrist
PT, OT, SLP
Nurse Midwives
Clinical Psychologists
Clinical Social Workers
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.
• Shared visit can take place in the hospital or hospital based clinic (POS 19, 21, 22, 23) Off-campus Outpatient Hospital, Inpatient Hospital, Outpatient/Observation Hospital and Emergency Room.
  • 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.
• Incident-to in the office (POS 11) ONLY
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.

3. An Attestation alone, by the Attending Physician, is not acceptable as Physician Documentation. The Teaching Physician Rule does not apply to NPPs (Nurse Practitioners or PAs).

• 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 a shared visit. Documentation from a hospital employed NPP may not be utilized to bill a service under the physician unless it’s only the ROS and PMFS Hx.
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  
  - include legible signatures from both providers  
  - confirm that the physician and the NPP both saw the patient face-to-face  
  - include legible/electronic signature

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 treating 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 treating 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 treating 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.
“INCIDENT TO”

- “Incident to” services must be an integral part of the patient’s treatment course.
- Physician must personally perform an initial service and for any new condition, make an initial diagnosis, and establish a treatment plan.
- Physician must personally perform subsequent services at a frequency that reflects his/her active participation in and management of the course of the treatment for each medical condition.
- Provided under the physician’s direct personal supervision (Physician must be present in the office suite and be immediately available to provide assistance and direction throughout the time the services are being performed by the practitioner)
- Commonly rendered without charge (included in physician’s professional services)
- Commonly furnished in a physician’s office POS 11 (not in a hospital setting)
- Auxiliary Personnel must be directly employed by the physician, physician group or clinical department that employs the physician or may be a leased employee.
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**
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)
CASE SAMPLES
“Whoa—way too much information.”
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 Office of Billing Compliance
  • Gema Balbin-Rodriguez, Associate Director Office of 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