Office of Billing Compliance
2015 Coding, Billing and Documentation Program

Department of Optometry
2015 Code Changes
New Code: 92145

Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report

- Replaced the Category III CPT code, 0181T, introduced July 1, 2007

Q Why measure corneal hysteresis?
- A Measuring the biomechanical properties of the cornea enables ophthalmologists, optometrists, and researchers to quantify various corneal conditions. Hysteresis is a measurement that characterizes response to application and removal of force (load/unload). Low corneal hysteresis (CH) demonstrates that the cornea is less capable of absorbing (damping) the energy of an air pulse. Clinical studies suggest that a low CH measurement may indicate ocular abnormalities or eyes at risk for disease.

Q What are the indications for CH testing?
- A The device FDA 510(k) states that the indications for use are for the measurement of intraocular pressure and the corneal biomechanical response. The most common clinical application of the CH measurement is the diagnosis and monitoring of glaucoma. Additionally, the CH measurement provides information which may be useful in identification of corneal pathology or pre-refractive surgery risk assessment.

Q What is the average Medicare reimbursement for this test?
- A CPT 92145 is defined as “unilateral or bilateral” so reimbursement is usually for both eyes. The first quarter 2015 national Medicare Physician Fee Schedule allowable for 92145 is $15.73. This includes $6.79 for the technical component and $8.94 for the professional component (i.e., interpretation). Other payers set their own rates, which may differ significantly from the Medicare published fee schedule.
New Code: 92145

• Q Will Medicare and other third-party payers cover CH testing?
  • A Sometimes. In the absence of a published policy, coverage is determined on a case-by-case basis at the discretion of the payer. Some payers have published policies that declare CH is “experimental and investigational” and consequently not covered.

• Q May beneficiaries be held financially responsible for payment if Medicare denies the claim?
  • A Yes. Before testing, ask the patient to agree to be financially responsible if reimbursement is not forthcoming. Obtain the patient’s signature on an ABN for Medicare patients or on another suitable waiver form for other payers.

• Q What documentation is required in the medical record for CH testing?
  • A In addition to the results of the test, the medical record should contain:
    • Patient’s name and date of test
    • Order for the test with medical rationale
    • Reliability of the test
    • Test findings (i.e., printout)
    • Assessment, diagnosis
    • Comparison with prior tests (if available)
    • Impact on treatment, prognosis
    • Physician’s signature
New Code: 92145

• Q How frequently may CH testing be repeated?
  • A There are no published limitations for repeated testing. In general, this and all diagnostic tests are reimbursed when medically indicated. Clear documentation of the reason for testing is always required. Too-frequent testing can garner unwanted attention from Medicare and other third party payers.

• Q Must the physician be in the office while CH testing is being performed?
  • A Under Medicare program standards, this test requires only general supervision. General supervision means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure.

• Q Is CH testing bundled with other services?
  • A Yes. According to Medicare’s National Correct Coding Initiative (NCCI), 92145 is bundled with provocative tests for glaucoma (92140), as are the glaucoma screening codes G0117 and G0118. In addition, the E/M service 99211 is bundled with this test.
HOT TOPICS IN COMPLIANCE 2015

Documentation in the EHR - EMR
Volume of Documentation vs Medical Necessity

Annually OIG publishes its "targets" for the upcoming year. Included is EHR Focus and for practitioners could include:

- Pre-populated Templates and Cutting/Pasting: Documentation containing inaccurate or incomplete or not provided information in the medical record

- **REMEMBER:** More volume is not always better in the medical record, especially in the EMR with potential for cutting/pasting, copy forward, pre-defined templates and pre-defined E/M fields. Ensure the billed code is reflective of the actual service provided on the DOS only.
General Principles of Documentation

- All documentation must be legible to all readers. Illegible documents are considered not medically necessary if it is useless to provide a continuum of care to a patient by all providers. Documentation is for all individuals, not just the author of the note.

- Per the Centers for Medicare and Medicaid services (CMS), 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 date of service.
  - 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, and this includes a signature.

- An addendum to a note should be dated and timed the day the information is added to the medical record and only contain information the practitioner has direct knowledge is true and accurate.
Visit Coding Decision

Optometrists can select either the “eye codes” or E/M visit codes for their services.

• Choosing Correct Codes
  • Most Optometrists prefer using the Eye Codes, believing they are easier to use and more audit-proof. That is not necessarily so. If you use only eye codes, not only are you punishing yourself financially, but you also may be found to be upcoding or downcoding under audit. For example, the intermediate eye code for established patients (CPT code 92012) is not always suitable for coding frequent follow-ups such as follow-up examination for corneal abrasion. (The correct code for healing corneal abrasion often usually is E/M code 99212).
  • The Center for Medicare and Medicaid Services (CMS) wants you to code correctly — to neither upcode nor downcode.
  • Typically eye codes are billed in the OP setting for visits related to “routine” eye follow-ups or complaints.
  • E/M codes are usually billed for specific eye injury, complaint or IP services.
Ophthalmology Codes

• S0620 Routine ophthalmological examination including refraction; new patient (not a Medicare Code)
• S0621 Routine ophthalmological examination including refraction; established patient (not a Medicare Code)
• 92002 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
• 92004 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
• 92012 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
• 92014 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
S Code Documentation

• So620-1 are defined ‘routine ophthalmological examination, includes refraction. These are HCPCS codes, not CPT, and as a result, most continue use the 99xxx or 92xxx visit codes, combined with 92015, refraction, to report their eye care visits.

• The word 'routine' in the definition indicates that the visit had no medical reason/chief complaint/presenting problem. Doctors who choose to use the S codes would use them whenever there was no medical reason for the visit, whether the patient has insurance to cover the visit or not. This is further complicated because most of the vision plans that cover the 'non medical visits' don't accept the use of the S code.

• An advantage in the S codes is that offices can establish fees for their 99xxx and 92xxx office visits as if they are always used for medical cases, reserving the S codes; in most cases with a lower fee; for the visits without a medical reason.
General Ophthalmologic Services: New 92002-04 & Established 92012-14

13 elements of an ophthalmologic exam including:

- Test visual acuity (does not include determination of refractive error)
- Ocular mobility (required for comprehensive level)
- Intraocular pressure
- Retina (vitreous, macula, periphery, and vessels)
- Optic disc
- Gross visual fields (required for comprehensive level)

- Eyelids and adnexa (required for intermediate level)
- Pupils
- Iris
- Conjunctiva
- Cornea
- Anterior chamber
- Lens
Comprehensive Examination 92004-92014

- Includes 9 or more elements and:
  - History, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination.
  - It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry.
  - A new patient always includes initiation of diagnostic and treatment programs.
  - An established patient always includes initiation or continuation of diagnostic and treatment programs.
Includes 3 -8 elements and-

- Intermediate history
- General medical observations
- External ocular and adnexal examination
- If less than 3 elements are provided, then the service must be billed with an E/M code.
Intermediate and Comprehensive

Ophthalmological services constitute integrated services in which medical decision making cannot be separated from the examining techniques used. Ophthalmological codes are appropriate for services to new or established patients when the level of service includes several basic routine optometric/ophthalmologic examination techniques, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, tonometry, and basic sensorimotor examination, that are integrated with and cannot be separated from the diagnostic evaluation.

Diagnosis Codes that Support Medical Necessity

• In addition to the general documentation requirements and the specified number of elements necessary to report a particular level of service, the "reasonable and necessary" requirements for billing Medicare must also be met. Therefore, certain diagnosis codes may not justify the "reasonable and necessary" criteria for reporting a particular level of service.
Routine Eye Examinations

• Medicare does not cover routine eye examinations or refractions 92015

• For “statutory exclusions” (services never covered by Medicare) Advanced Beneficiary Notice (ABN) is not necessary

HOWEVER

• For patients with secondary insurance that may cover these services, a claim can be submitted to Medicare to obtain a formal “denial” of reimbursement
  • Explain Medicare coverage policy to the patient
  • Explain that patient has the choice of having the service
  • Indicate how much the patient will be financially responsible for
  • Append appropriate modifier (GY) if you need to obtain a denial from Medicare to process secondary insurance claim
Contact Lenses

• Proper coding for contact lens exams?
  • Patient comes in for routine eye exam and CL fit, code 92004/14 and 92310. If a refraction was done also bill 92015.
    • 92310 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia

• First follow-up exam after the contact lenses are dispensed is included in the 92310, as its definition includes "medical supervision of adaptation".

• Patient presents for a routine eye exam, doesn't want CL's at that visit, but decides a month down the road they now want CL's.
  • Code 92310 for the fitting and supervision of adaptation.
    • If medically necessary for a specific patient a limited examination to be sure no eye changes have occurred.
Optometry Technician vs Optometry Student

For billing purposes, a billing practitioner can utilize the below services only, when performed by a technician or student, if referenced in their note:

- **Optometry Technician can perform and document:**
  - Visual acuity
  - Intraocular pressure (IOP)
  - Confrontation visual field exam

- **Optometry Student can perform and document:**
  - ROS and PFSH in an E/M service
Inpatient, Outpatient and Consultations

Evaluation and Management E/M

Documentation and Coding
What is the definition of "new patient" for billing E/M services?

• “New patient" is a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.

• An interpretation of a diagnostic test, reading an x-ray or EKG etc., (billed with a -26 modifier ) in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.
E/M Key Components

• **History (H)** - Subjective information
• **Examination (E)** - Objective information
• **Medical Decision Making (MDM)** – The assessment, plan and patient risk

The billable service is determined by the combination of these 3 key components.
• All 3 Key Components are required to be documented for all E/M services.
• For coding the E/M level
  • New OP and initial IP require all 3 components to be **met or exceeded** and
  • Established OP and subsequent IP require 2 of 3 key components to be **met or exceeded**.

*When downcoded for “medical necessity” on audit, it is often determined that documented H and E exceeded what was deemed “necessary” for the visit (MDM).*
Elements of an E/M History

The extent of information gathered for history is dependent upon clinical judgment and nature of the presenting problem.

Documentation of the patient’s history includes some or all of the following elements:

• Chief Complaint (CC) and History of Present Illness (HPI) are required to be documented for every patient for every visit

WHY IS THE PATIENT BEING SEEN TODAY

• Review of Systems (ROS)

• Past Family, Social History (PFSH)
History of Present Illness (HPI)
A KEY to Support Medical Necessity to in addition to MDM

• HPI is chronological description of the development of the patient’s present illness or reason for the encounter from the first sign and/or symptom or from the previous encounter to the present or the status of chronic conditions being treated at this visit.
  • The HPI must be performed and documented by the billing provider in order to be counted towards the level of service billed.

Focus upon present illness or reason for the visit!

• HPI drivers:
  • Extent of PFSH, ROS and physical exam performed

• NEVER DOCUMENT PATIENT HERE FOR FOLLOW-UP WITHOUT ADDITIONAL DETAILS OF REASON FOR FOLLOW-UP. This would not qualify as a CC or HPI.
HPI

• Status of chronic conditions being managed at visit
  • Just listing the chronic conditions is a medical history
  • Their status must be addressed for HPI coding

OR

• Documentation of the HPI applicable elements relative to the diagnosis or signs/symptoms being managed at visit
  • Location
  • Quality
  • Severity
  • Duration
  • Timing
  • Context
  • Modifying factors
  • Associated signs and symptoms
Review of Systems (ROS)

- Constitutional
- Eyes
- Respiratory
- Ears, nose, mouth, throat
- Cardiovascular
- Musculoskeletal
- Gastrointestinal
- Genitourinary
- Psychiatric
- Integumentary
- Neurologic
- Allergy/Immunology
- Endocrine
- Hematologic/Lymphatic

ROS is an inventory of specific body systems in the process of taking a history from the patient. The ROS is designed to bring out clinical symptoms which the patient may have overlooked or forgotten. In theory, the ROS may illuminate the diagnosis by eliciting information which the patient may not perceive as being important enough to mention to the physician relative to the reason for the visit.
**ROS**

**Tip:** There are no specific rules about how much to ask the patient about each system. This is left up to the discretion of the individual practitioner.

**Tip:** It is not necessary that the physician personally perform the ROS. It is acceptable to have staff record the *ROS* or the patient fill out an *ROS* questionnaire. However, the physician MUST review the information and comment on pertinent findings in the body of the note. In addition the physician should initial the *ROS* questionnaire and maintain the form in the chart as a permanent part of the medical record and note review of the form in the note.

**Tip:** You DO NOT need to re-record a ROS if there is an earlier version available on the chart. It is acceptable to review the old ROS and note any changes. The practitioner must note the date and location of the previous ROS and comment on any changes in the body of the current note.

**Tip:** The ROS may be recorded separately or may be documented within the HPI.
Past, Family, and/or Social History (PFSH)

• **Past history:** The patient’s past medical experience with illnesses, surgeries, & treatments. May also include review of current medications, allergies, age appropriate immunization status.

• **Family history:** May include a review of medical events in the patient’s family, such as hereditary diseases, that may place a patient at risk or Specific diseases related to problems identified in the Chief Compliant, HPI, or ROS.

• **Social history:** May include age appropriate review of past and current activities, marital status and/or living arrangements, use of drugs, alcohol or tobacco and education.

Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services. **Don't use the term "non-contributory” for coding a level of E/M**
Past, Family, and/or Social History (PFSH)

- **Tip:** Some follow-up encounters DO NOT require a review of the PFSH including 99212, 99213 and subsequent hospital visits. 99214 requires only 1 element to be reviewed and recorded.

- **Tip:** You DO NOT need to re-record a PFSH if there is an earlier version available on the chart. It is acceptable to review the old PFSH and note any changes. You must note the date and location of the previous PFSH and comment on any changes in the information since the original PFSH was recorded.

- **Tip:** Staff can record and document the PFSH or the patient can fill out a PFSH questionnaire. However, the physician MUST state that he or she reviewed the information and comment on pertinent findings in the body of the note. In addition the physician should initial the PFSH questionnaire and maintain the form in the chart as a permanent part of the medical record.

- **Tip:** It only requires ONE element from EACH component of PFSH to qualify for a complete PFSH. There is no need to overload the documentation with superfluous information which may not be clinically relevant.

- **Tip:** The PFSH may be recorded separately or may be. documented within the HPI.
Examination

4 TYPES OF EXAMS

- Problem Focused (PF)
- Expanded Problem Focused (EPF)
- Detailed (D)
- Comprehensive (C)
### Eyes

- Test visual acuity (Does not include determination of refractive error)
  - Gross visual field testing by confrontation
  - Test ocular motility including primary gaze alignment
  - Inspection of bulbar and palpebral conjunctivae
- Examination of ocular adnexae including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes
- Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology
- Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film
- Slit lamp examination of the anterior chambers including depth, cells, and flare
- Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus

### Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)

**Ophthalmoscopic examination through dilated pupils (unless contraindicated)** of:

- Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer
- Posterior segments including retina and vessels (eg, exudates and hemorrhages)

### Neurological/Psychiatric

**Brief assessment of mental status including:**

- Orientation to time, place and person
- Mood and affect (eg, depression, anxiety, agitation)
1997 Eye Physical Exam Definitions

Problem Focused (PF)

- ‘97=Specialty and GMS: 1-5 elements identified by bullet.

Expanded Problem Focused (EPF)

- ‘97=Specialty and GMS: At least 6 elements identified by bullet.

Detailed (D)

- 97=Specialty: At least 12 elements identified by bullet (9 for eye and psyc) GNS= At least 2 bullets from each of 6 areas or at least 12 in 2 or more areas.

Comprehensive (C)

- ‘97=Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area.
Medical Decision Making (MDM)

DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE TODAY!!

Exchange of clinically reasonable and necessary information and the use of this information in the clinical management of the patient

**Step 1:**
- Number of possible diagnosis and/or management options affecting today's visit. List each separately in A/P and address every diagnosis or management option from visit. Is the diagnosis and/or management options:
  - "New" self-limiting: After the course of prescribed treatment is it anticipated that the diagnosis will no longer be exist (e.g. otitis, poison ivy, ...)
  - New diagnosis with follow-up or no follow-up (diagnosis will remain next visit)
  - Established diagnosis that stable, worse, new,

**Step 2:**
- Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
  - Labs, radiology, scans, EKGs etc. reviewed or ordered
  - Review and summarization of old medical records or request old records
  - Independent visualization of image, tracing or specimen itself (not simply review of report)

**Step 3:**
- The risk of significant complications, morbidity, and/or mortality with the patient's problem(s), diagnostic procedure(s), and/or possible management options.
  - # of chronic conditions and are the stable or exacerbated (mild or severe)
  - Rx's ordered or renewed. Any Rx toxic with frequent monitoring?
  - Procedures ordered and patient risk for procedure

Note: The 2 most complex elements out of 3 will determine the overall level of MDM
## MDM Step 1: # Dx & Tx Options

**Number of Diagnosis or Treatment Options – Identify Each That Effects Patient Care For The DOS**

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max=2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner) stable, improved</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner) worsening</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max=1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New prob. (To examiner); additional workup planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### MDM Step 2: Amt. & Complexity of Data

#### Amount and/or Complexity of Data Reviewed – Total the points

<table>
<thead>
<tr>
<th>REVIEWED DATA</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
</tbody>
</table>

Total: 34

1 POINT: E- 2, NEW-1,2 IP Level 1

2 POINTS: E-3, NEW-3 IP Level 1

3 POINTS: E-4, NEW-4 IP Level 2

4 POINTS: E-5, NEW-5 IP –Level 3
MDM Step 3: Risk Table for Complication

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

**DG:** Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

Risk is assessed based on the risk to the patient between present visit and the NEXT time the patient will be seen by billing provider or risk for planned intervention.
<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Min</strong></td>
<td>• One self-limited / minor problem (subconjunctival Hemorrhage)</td>
<td>• Tonometry • PAM • Contrast sensitivity • Schmir’s test • Topical diagnostic agent (rose bengal) • Ultrasound • Color Vision • Visual field • Lab tests requiring venipuncture • EKG • Chest X-ray</td>
<td>• Rest • Elastic bandages • Gargles • Superficial dressings</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>• 2 or more self-limited/minor problems • 1 stable chronic illness (controlled glaucoma) • Acute uncomplicated illness / injury (simple sprain)</td>
<td>• Gonioscopy • Ophthalmodynamometry • Conjunctival culture • Oral FA • Provocative glaucoma test • MRI/MRA</td>
<td>• OTC meds • Minor surgery w/no identified risk factors • Occlusion • Pressure Patch • IV fluids w/out additives</td>
</tr>
<tr>
<td><strong>Mod</strong></td>
<td>• 1 &gt; chronic illness, mod. Exacerbation, progression or side effects of treatment • 2 or more chronic illnesses • Undiagnosed new problem w/uncertain prognosis (red eye) • Acute illness w/systemic symptoms (facial palsy with corneal exposure) • Acute complicated injury</td>
<td>• Corneal Culture • Retrobulbar injection • Deep needle biopsy or incisional biopsy • Physiological stress tests</td>
<td>• Prescription meds • Minor surgery w/identified risk factors • Elective major surgery w/out risk factors • Therapeutic nuclear medicine • IV fluids w/additives</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>• 1 &gt; chronic illness, severe exacerbation, progression or side effects of treatment • Acute or chronic illnesses that may pose threat to life or bodily function (trauma, endophthalmitis, retinoblastoma, malignancies, angle closure) • Abrupt change in neurologic status (TIA, seizure)</td>
<td>• Vitreous tap • Anterior Chamber tap • Fine needle biopsy – orbital, ocular</td>
<td>• Elective major surgery w/risk factors • Emergency surgery • Parenteral controlled substances • Drug therapy monitoring for toxicity • DNR</td>
</tr>
</tbody>
</table>
Using Time to Code Counseling /Coordinating Care (CCC)

Time shall be considered for coding an E/M in lieu of H-E-MDM when > 50% of the total billable practitioner visit time is CCC. Time is only Face-to-face for OP setting.

Coding based on time is generally the exception for coding. It is typically used when there is a significant exacerbation or change in the patient’s condition, non-compliance with the treatment/plan or counseling regarding previously performed procedures or tests to determine future treatment options.

Required Documentation For Billing:
1. Total time of the encounter excluding separate procedure if billed
   • The entire time to prep, perform and communicate results of a billable procedure to a patient must be carved out of the E/M encounter time!
2. The amount of time dedicated to counseling / coordination of care
3. The specific nature of counseling/coordination of care for that patient on that date of service. A template statement would not meet this requirement.
Counseling /Coordinating Care (CCC)?

Documentation must reflect the specific issues discussed with patient present.

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

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

- Record entries made by a "scribe" should be made upon the direction of the physician. A scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently or obtain any information independently except to ROS and PFSH. They cannot obtain the HPI, any portion of the PE or MDM.

- The scribe must note "written by xxxxx, acting as scribe for Dr. yyyy." Then, Dr. yyyy indicating that the note accurately reflects work and decisions made by him/her and then authenticate with signature.

- It is inappropriate for an employee of the physician to round at one time and make entries in the record, and then for the physician to see the patient at a later time and note "agree with above...".

- AAMC does not support someone “dictating” as a scribe by an NPP, as scribing is over the shoulder immediate documenter with no services personally performed by the scriber. In this case, the physician should be dictating their own visit. Scribes can do EMRs under their own password.
Scribed Notes

• Individuals can only create a scribe note in an EHR if they have their own password/access to the EHR for the scribe role. Documents scribed in the EHR must clearly identify the scribe’s identity and authorship of the document in both the document and the audit trail.

• Scribes are required to notify the provider of any alerts in the EPIC System. Alerts must be addressed by the provider.

• Providers and scribes are required to document in compliance with all federal, state, and local laws, as well as with internal policy.

• Failure to comply with this policy may result in corrective and/or disciplinary action by the hospital and/or department under the University of Miami Medical Group disciplinary policies applicable.

• Verbal orders may neither be given to nor by scribes. Scribes may pend orders for providers based upon provider instructions.

• The following attestation must be entered by the scribe:
  • “Scribed for [Name of provider] for a visit with [patient name] by [Name of scribe] [date and time of entry].

• The following attestation should be entered by provider when closing the encounter:
  • “I was present during the time with [patient name] was recorded. I have reviewed and verified the accuracy of the information which was performed by me.” [Name of provider][Date and time of entry].
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 a corneal tear. 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. This is consistent with Nodular episcleritis will start with FML® suspension q.i.d and f/up in 4 days. .”

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:

- E/M codes where more than 50% of the TP time spent counseling or coordinating care

*Medical Student/Optometry Student documentation for billing only counts for ROS and PFSH. All other contributions by the medical/optometry student must be re-performed and documented by a resident or teaching optometrist.*
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.

**If > 5 Minutes**

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

An Optometrist Can Be The Ordering & Treating Physician

• The CPT descriptions of documentation requirements for many ophthalmic 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."
Orders” Are Required For Any Diagnostic Procedure With a TC / 26 Modifier

• All services billed for interpretation must include an order (even as a notation in the encounter note for the DOS) and distinct report for in order to bill.

• For Medicare, the Interpretation and Report needs the Three C’s to be addressed:
  • Clinical Findings,
  • Comparative Data, when appropriate; and
  • Clinical Management

• There must be a written report that becomes part of the patient’s medical record and this should be as complete as possible.
Modifers: Provider Documentation **MUST Support the Use of All Modifiers**

A billing code *modifier* allows you to indicate that a procedure or service has been altered by some specific circumstance but has not changed in its definition.

**Modifiers allow to:**

- Increase reimbursement
- Facilitate correct coding
- Indicate specific circumstances
- Prevent denial of services
- Provide additional information

**Documentation in the operative report must support the use of any modifier**
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.
Modifier 25: 000 or 010 Global Days

• If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. A global XXX it is typically a diagnostic procedure.

• In general E/M services on the same date of service as the minor surgical procedure are included in the payment for the procedure.

• The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service.

• However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25.

• As of 2014 if a minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure in and of itself.
ICD-10

Looks like a go!
Diagnosis Coding
International Classification of Disease (ICD-10)

- ICD-10 is scheduled to replace ICD-9 coding system on October 1, 2015.
- ICD-10 was developed because ICD-9, first published in 1977, was outdated and did not allow for additional specificity required for enhanced documentation, reimbursement and quality reporting.
- ICD-10 CM will have 68,000 diagnosis codes and ICD-10 PCS will contain 76,000 procedure codes.
- This significant expansion in the number of diagnosis and procedure codes will result in major improvements including but not limited to:
  - Greater specificity including laterality, severity of illness
  - Significant improvement in coding for primary care encounters, external causes of injury, mental disorders, neoplasms, diabetes, injuries and preventative medicine.
  - Allow better capture of socio-economic conditions, family relationships, and lifestyle
  - Will better reflect current medical terminology and devices
  - Provide detailed descriptions of body parts
  - Provide detailed descriptions of methodology and approaches for procedures
Clinical Trials
Effective for claims with dates of service on or after January 1, 2014 it is mandatory to report a clinical trial number on claims for items/services provided in clinical trials/studies/registries, or under CED.

**Professional**

- For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) *(do not use CT on the electronic claim, e.g., 12345678)* when a clinical trial claim includes:
  - ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
  - Modifier Q0 (investigational clinical service provided in a clinical research study that is in an approved clinical research study) and/or
  - Modifier Q1 (routine clinical service performed in a clinical research study that is in an approved clinical research study), as appropriate (outpatient claims only).

**Hospital**

- For hospital claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:
  - Condition code 30;
  - ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
  - Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

*Items or services covered and paid by the sponsor may not be billed to the patient or patient’s insurance, this is double billing.*
WHO IS RESPONSIBLE FOR OBTAINING APPROVAL FROM THE MAC(S) FOR AN INVESTIGATIONAL DEVICE EXEMPTION (IDE) CLINICAL TRIAL?

The principal investigator (PI) is responsible for assuring that all required approvals are obtained prior to the initiation of the clinical trial. For any clinical study involving an IDE, the PI must obtain approval for the IDE clinical trial from the Medicare Administrative Contractor (MAC) for Part A / Hospital.

Additionally, for clinical studies involving an IDE, the PI is responsible for communicating about the trial and the IDE to the Medicare Part B (physician) MAC.

Once approval has been received by the MAC, the following needs to take place:

• The Study must be entered in the Velos System within 48 hours.
• The PI is responsible for ensuring that the IDE or the no charge device is properly set up in the facility charge master to allow accurate and compliant charging for that device before any billing will occur.
Investigational Device Exemption (IDE)

Hospital Inpatient Billing for Items and Services in Category B IDE Studies

• Payment for the device may not exceed the Medicare-approved amount for a comparable device that has been already FDA-approved.

Routine Care Items and Services

• Hospital providers shall submit claims for the routine care items and services in Category B IDE studies approved by CMS (or its designated entity) and listed on the CMS Coverage Website, by billing according to the clinical trial billing instructions found in §69.6 of this chapter [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuels/downloads/clm104c32.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuels/downloads/clm104c32.pdf), and as described under subsection D ("General Billing Requirements").
Investigational Device Exemption (IDE)

Category B Device. On a 0624 revenue code line, institutional providers must bill the following for Category B IDE devices for which they incur a cost:

• Category B IDE device HCPCS code, if applicable
• Appropriate HCPCS modifier
• Category B IDE number
• Charges for the device billed as covered charges
• If the Category B IDE device is provided at no cost, outpatient prospective payment system (OPPS) providers must report a token charge in the covered charge field along with the applicable HCPCS modifier (i.e., modifier – FB) appended to the procedure code that reports the service to furnish the device, in instances when claims processing edits require that certain devices be billed with their associated procedures. For more information on billing ‘no cost items’ under the OPPS, refer to chapter 4, §§20.6.9 and 61.3.1 of this manual.
WHEN THE TRIAL ENDS OR REACHES FULL ENROLLMENT?

When the trial ends, whether due to reaching full enrollment or for any other reason, the PI must work with their department resource and/or the relevant Revenue Integrity Office (s) to inactivate the item in the charge master so that it may no longer be used.

If the device is approved by the FDA and is no longer considered investigational or a Humanitarian Device Exemption (HDE) and will continue to be used at UHealth, the PI must work with their department resource and/or the relevant Revenue Integrity Office (s) to inactivate the investigational device in the charge master and to ensure that a new charge code is built for the approved device. At this point, ongoing maintenance responsibility would transfer to the relevant Revenue Integrity Office (s).
UHealth/UMMG 2015 PQRS

Patient Safety and Quality Office
CMS Quality Improvement Programs

- Meaningful Use (MU)
- Physician Quality Reporting System (PQRS)
- Value Based Payment Modifier (VBPM)

[Diagram showing the interconnections between Meaningful Use (MU), Physician Quality Reporting System (PQRS), and Value Based Payment Modifier (VBPM)]
## CMS Quality Programs
### Medicare Part B Payment Reductions

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>POTENTIAL MEDICARE PAYMENT REDUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful Use</td>
<td>1%</td>
</tr>
<tr>
<td>PQRS</td>
<td>1.5%</td>
</tr>
<tr>
<td>VBPM</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL PENALTIES</strong></td>
<td><strong>2.5%</strong></td>
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</tbody>
</table>
Physician “Provider”
Quality Reporting (PQRS)
## 2015 PQRS Eligible Providers

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Practitioners</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>Physician Assistant</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>DO</td>
<td>Nurse Practitioner</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Doctor of Podiatric</td>
<td>Clinical Nurse Specialist*</td>
<td>Qualified Speech-Language Therapist</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
<td>CRNA</td>
<td></td>
</tr>
<tr>
<td>DDS</td>
<td>Certified Nurse Midwife</td>
<td></td>
</tr>
<tr>
<td>DMD</td>
<td>Clinical Social Worker</td>
<td></td>
</tr>
<tr>
<td>Doctor of Chiropractic</td>
<td>Clinical Psychologist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Registered Dietician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nutrition Professional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audiologists</td>
<td></td>
</tr>
</tbody>
</table>
PQRS

- Reporting Requirements:
  - Reporting Period = Full CY
  - Report 9 Measures from 3 National Quality Strategy Domains

- Reporting Options:
  - Claims, EHR, Registry
  - Individual or GPRO

<table>
<thead>
<tr>
<th>NATIONAL STRATEGY DOMAINS</th>
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<tbody>
<tr>
<td>Communication &amp; Care Coordination</td>
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</table>

UJHealth
UNIVERSITY OF MIAMI
MILLER SCHOOL OF MEDICINE
Physician Impact

Workflow and documentation changes

**TO DO:**
- Study Measure Specifications
- Ensure documentation meets measure requirements
- Bill PQRS quality code when required in MCSL/UChart
- Document chronic conditions/secondary diagnoses
- Use UChart Smart Phrases
- Ensure medical support staff completes required documentation
HIPAA, HITECH, PRIVACY AND SECURITY

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

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

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

  http://www.miami.edu/index.php/professional_development__training_office/learning/ulearn/
• HIPAA, HITECH, Privacy & Security

Several breaches were discovered at the University of Miami, one of which has resulted in a class action suit. As a result, “Fair Warning” was implemented.

• What is Fair Warning?

• Fair Warning is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.

• Fair Warning protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.

• Fair Warning is an initiative intended to reduce the cost and complexity of HIPAA auditing.

• UHealth has policies and procedures that serve to protect patient information (PHI) in oral, written, and electronic form. These are available on the Office of HIPAA Privacy & Security website: http://www.med.miami.edu/hipaa
Available Resources at University of Miami, UHealth and the Miller School of Medicine

• If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  • Gemma Romillo, Assistant Vice President of Clinical Billing Compliance and HIPAA Privacy; or
  • Iliana De La Cruz, RMC, Director Office of Billing Compliance
    • Phone: (305) 243-5842
    • Officeofbillingcompliance@med.miami.edu

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

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