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

Pediatrics

Prepared by:
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What is a Compliance Program?

7 Elements of an Effective Compliance Program

- A centralized process to promote honest, ethical behavior in the day-to-day operations of an organization, which will allow the organization to identify, correct, and prevent illegal conduct.
- It is a system of: FIND – FIX – PREVENT

The University of Miami implemented the Billing Compliance Plan on November 12, 1996. The components of the Compliance Plan are:

1. Policies and Procedures
2. Having a Compliance Officer and Compliance Committees
3. Effective Training and Education
4. Effective Lines of Communication (1-877-415-4357 or 305-243-5842)
5. Disciplinary Guidelines
6. Auditing and Monitoring
7. Detect Non-Compliance Issues and Develop Corrective Action Plans
The Government

• In order to address fraud and abuse in the Healthcare Field, the government has on-going reviews and investigations nationally to detect any actual or perceived waste and abuse.

• The Government does believe that the majority of Healthcare providers deliver quality care and submit accurate claims. However, the amount of money in the healthcare system, makes it a prime target for fraud and abuse.

Centers for Medicare and Medicaid Services (CMS) Estimates > $50 Billion In “Payment Errors” Annually in Healthcare

OIG reported that in FY 2013 that $5.8 billion was recovered from auditing providers
Health Care Laws

There are five important health care laws that have a significant impact on how we conduct business:

- False Claims Act
- Health Care Fraud Statute
- Anti-Kickback Statute
- Stark Law
- Sunshine Act
  - Requires manufacturers of drugs, medical devices and biologicals that participate in U.S. federal health care programs to report certain payments and items of value >$10 given to physicians and teaching hospitals.
False Claims Act : United States Code Title 31 §3729-3733

What is a False Claim?

- A false claim is the knowing submission of a false or fraudulent claim for payment or approval or the use of a false record that is material to a false claim.

OR

- Reckless disregard of the truth or an attempt to remain ignorant of billing requirements are also considered violations of the False Claims Act.
How do you create a False Claim?

One method is to submit a claim form to the government

This certification forms the basis for a false claim.
HOT TOPICS IN COMPLIANCE
2014
Audits are being conducted for all payer types based on the medical necessity of E/M levels. The audits are generally expressed in two ways:

- Frequency of services (how often the patient is seen) and,
- Intensity of service (CPT level).
Elements of Medical Necessity

- CMS’s determination of medical necessity is separate from its determination that the E/M service was rendered as billed.

- Complexity of documented co-morbidities that clearly influenced physician work.

- Physical scope encompassed by the problems (number of physical systems affected by the problems).
E/M Coding: Volume of Documentation versus Medical Necessity

• Word processing software, the electronic medical record, and formatted note systems facilitate the "carry over" and repetitive "fill in" of stored information.

• Even if a "complete" note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service.

• Information that has no pertinence to the patient's situation at that specific time cannot be counted.
Office of the Inspector General (OIG) Audit Focus

Annually OIG publishes it "targets" for the upcoming year. Included is:

• **Cutting and Pasting Documentation in the EMR**

REMEMBER: More volume is not always better in the medical record, especially in the EMR with potential for cutting/pasting, copy forward, pre-defined templates and pre-defined E/M fields. Ensure the billed code is reflective of the service provided on the DOS.
What We Found: CMS and its contractors had adopted few program integrity practices specific to EHRs

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

Recommendations
• First, CMS should provide guidance to its contractors on detecting fraud
• Second, CMS should direct its contractors to use providers’ audit logs.
Medical Record Documentation Standards

Pre EMR: “If it isn’t documented, it hasn’t been done.”
- Unknown

Post EMR: “If it was documented, was it done and was it medically necessary to do.”
- Reviewers
EMR Documentation Pitfalls

- On reviews, the following are targets to call into question EMR documentation is original and accurate:
  - HPI and ROS don’t agree
  - HPI and PE don’t agree
  - CC is not addressed in the PE
  - ROS and PFSH complete on every visit
  - ROS all negative when patient coming for a CC
  - Identical documentation across services (cloning)
  - The lack of or Inappropriate Teaching Physician Attestations
Practitioner reimbursement will likely be tied to outcomes soon.

Some experts say that the CMS penalties for not participating in the Physician Quality Reporting System (PQRS) signal that the pay-for-performance trend is not fading away and will likely be adopted by private payers.

“I think we’re slowly transitioning out of fee-for-service and into a system that rewards for quality while controlling cost,” says Miranda Franco, government affairs representative for the Medical Group Management Association. “The intent of CMS is to have physicians moving toward capturing quality data and improving metrics on [them].”
Evaluation and Management E/M

Documentation and Coding

Inpatient, Outpatient and Consultations
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., Procedure) from the same physician or another physician in the same group practice (same group NPI# and physician specialty) within the previous three years.

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

- In 2012, the AMA CPT instructions for billing new patient visits include physicians in the same specialty and subspecialty. However, for Medicare E/M services the same specialty is determined by the physician's or practitioner's primary specialty enrollment in Medicare.
The billable service is determined by the combination of these 3 key components with MDM often linked to medical necessity. For new patients all 3 components must be met or exceeded and established patient visits 2 of 3 are required to be met or exceeded. Often when downcoded for medical necessity it is determined that documented History and Exam exceeded what was necessary for the visit.
Elements of an E/M History

- The extent of information gathered for history is dependent upon clinical judgment and nature of the presenting problem. Documentation of the patient’s history includes some or all of the following elements:
  - Chief Complaint (CC)
    - WHY IS THE PATIENT BEING SEEN TODAY
  - History of Present Illness (HPI),
  - Review of Systems (ROS),
  - Past Family, Social History (PFSH).
History of Present Illness (HPI)
A KEY to Support Medical Necessity to in addition to MDM

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

- Focus upon present illness!

- HPI drivers:
  - Extent of PFSH, ROS and physical exam performed
  - Medical necessity for amount work performed and documented & Medical necessity for E & M assignment
HPI

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

OR

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

- 1 ROS documented = Pertinent
- 2-9 ROS documented = Extended
- 10 + = Complete (or documentation of pertinent positive and negative ROS and a notation “all others negative”. This would indicate all 14 ROS were performed and would be complete.)

Record positives and pertinent negatives. Never note the system(s) related to the presenting problem as "negative". When using "negative" notation, always identify which systems were queried and found to be negative.
Past, Family, and/or Social History

- **Past history**: the patient’s past experience with illnesses, surgeries, & treatments
- **Family history**: a review of medical events in the patient’s family, such as hereditary diseases, that may place a patient at risk
- **Social history**: age appropriate review of past and current activities

Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services.

Don't use the term "non-contributory"
### Scoring E/M History

**CHIEF COMPLAINT:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Severity</th>
<th>Timing</th>
<th>Modifying Factors</th>
<th>Brief (1-3)</th>
<th>Extended 4 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Duration</td>
<td>Context</td>
<td>Associated signs and symptoms</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### ROS (Review of systems):

- **Constitutional** (wt loss, etc)
- Ears, nose, mouth, throat
- GI
- Integumentary (skin, breast)
- Endo
- Eyes
- Card/vasc
- GU
- Neuro
- Hem/Lymph
- Resp
- MS
- Psych
- All/immuno
- All others negative

### PFSH (past medical, family, social history) areas:

- Past history (the patient’s past experiences with illness, operations, injuries and treatments)
- Family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk)
- Social history (an age appropriate review of past and current activities)

**Complete PFSH:**

**10 or more systems, or some systems with statement all others neg.
2 hx areas: a) Estab pts. Office (outpt) care; domiciliary care; home care
b) Emergency dept c) Subsequent nursing facility
3 hx areas: a) New pts. Office (outpt) care; domiciliary care; home care
b) Consultations c) Initial hospital care d) Hospital observation
e) Comprehensive nursing facility assessments**

<table>
<thead>
<tr>
<th>PROBLEM FOCUSED (PF)</th>
<th>EXP. PROB. FOCUSED (EPF)</th>
<th>DETAILED (D)</th>
<th>COMPREHENSIVE (C)</th>
</tr>
</thead>
</table>

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EXAMINATION

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

<table>
<thead>
<tr>
<th>BODY AREAS (BA):</th>
<th>CODING ORGAN SYSTEMS (OS):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Head, including face</td>
<td>• Genitalia, groin, buttocks</td>
</tr>
<tr>
<td>• Neck</td>
<td>• Back, including spine</td>
</tr>
<tr>
<td>• Chest, including breast and axillae</td>
<td>• Each extremity</td>
</tr>
<tr>
<td>• Abdomen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Constitutional/General</td>
</tr>
<tr>
<td></td>
<td>• GU</td>
</tr>
<tr>
<td></td>
<td>• Musculoskeletal</td>
</tr>
<tr>
<td></td>
<td>• Skin</td>
</tr>
<tr>
<td></td>
<td>• Neuro</td>
</tr>
<tr>
<td></td>
<td>• Psychiatric</td>
</tr>
<tr>
<td></td>
<td>• Hematologic/Lymphatic</td>
</tr>
<tr>
<td></td>
<td>• Eyes</td>
</tr>
<tr>
<td></td>
<td>• Ears/Nose/Mouth/Throat</td>
</tr>
<tr>
<td></td>
<td>• Respiratory</td>
</tr>
<tr>
<td></td>
<td>• Cardiac</td>
</tr>
<tr>
<td></td>
<td>• GI</td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td>Conjunctivae and lids; Pupils and irises (eg, reaction to light and accommodation, size and symmetry); Optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)</td>
</tr>
<tr>
<td>Ears, Nose, Mouth and Throat</td>
<td>External ears and nose (eg, overall appearance, scars, lesions, masses); Otoscopic external auditory canals and tympanic membranes; Hearing (eg, whispered voice, finger rub, tuning fork); Nasal mucosa, septum and turbinates; Lips, teeth and gums; Oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx</td>
</tr>
<tr>
<td>Neck</td>
<td>Neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus); Thyroid (eg, enlargement, tenderness, mass)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement); Percussion of chest (eg, dullness, flatness, hyperresonance); Palpation of chest (eg, tactile fremitus); Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Palpation of heart (eg, location, size, thrills); Auscultation of heart with notation of abnormal sounds and murmurs; Carotid arteries (eg, pulse amplitude, bruits); Abdominal aorta (eg, size, bruits); Femoral arteries (eg, pulse amplitude, bruits); Pedal pulses (eg, pulse amplitude); Extremities for edema and/or varicosities</td>
</tr>
<tr>
<td>Chest/Breast</td>
<td>Breasts (eg, symmetry, nipple discharge); Palpation of breasts and axillae (eg, masses or lumps, tenderness)</td>
</tr>
<tr>
<td>Gastrointestinal (Abdomen)</td>
<td>Abdomen with notation of presence of masses or tenderness; Liver and spleen; Hernia (presence or absence); Anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses; Obtain stool sample for occult blood test (when indicated)</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>MALE: Scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass); Penis (exam of); Digital rectal prostate gland (eg, size, symmetry, nodularity, tenderness)</td>
</tr>
<tr>
<td></td>
<td>FEMALE: Pelvic examination (with or without specimen collection for smears and cultures), including: External genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele); Urethra (eg, masses, tenderness, scarring); Bladder (eg, fullness, masses, tenderness); Cervix (eg, general appearance, lesions, discharge); Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support); Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)</td>
</tr>
<tr>
<td>Lymphatic</td>
<td>Palpation of lymph nodes in two or more areas: Neck; Axillae; Groin; Other</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Gait and station; Digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes); Joints, bones and muscles of one or more of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. Includes: Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions; Range of motion with notation of any pain, crepitation or contracture; Stability with notation of any dislocation (luxation), subluxation or laxity; Muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements</td>
</tr>
<tr>
<td>Skin</td>
<td>Skin and subcutaneous tissue (eg, rashes, lesions, ulcers); Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)</td>
</tr>
<tr>
<td>Neurologic</td>
<td>Test cranial nerves with notation of any deficits; Deep tendon reflexes with notation of pathological reflexes (eg, Babinski); Sensation (eg, by touch, pin, vibration, proprioception)</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Description of patient’s judgment and insight; Brief mental status including: Orientation to time, place and person, Recent and remote memory, Mood and affect (eg, depression, anxiety, agitation)</td>
</tr>
</tbody>
</table>
1995 and 1997 Exam Definitions

**Problem Focused (PF)**
- ’95: a limited exam of the affected body area or organ system. (1 BA/OS)
- ‘97=Specialty and GMS: 1-5 elements identified by bullet.

**Expanded Problem Focused (EPF)**
- ’95: a limited exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- ‘97=Specialty and GMS: At least 6 elements identified by bullet.

**Detailed (D)**
- ’95: extended exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- 97=Specialty: At least 12 elements identified by bullet (9 for eye and psyc) GNS= At least 2 bullets from each of 6 areas or at least 12 in 2 or more areas.

**Comprehensive (C)**
- ’95: general multi-system exam (8 or more organ systems) or complete single organ system (a complete single organ system is undefined by CMS).
- ‘97=Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area. GMS: At least 2 elements with bullet from each of 9 areas/systems.
Medical Decision Making

DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE!!

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

**Step 1:**
- Number of possible diagnosis and/or the number of management options.

**Step 2:**
- Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.

**Step 3:**
- The risk of significant complications, morbidity, and/or mortality with the patient’s problem(s), diagnostic procedure(s), and/or possible management options.

Note: The 2 most complex elements out of 3 will determine the overall level of MDM.
## MDM Step 1

### 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>
</tbody>
</table>

Total

1 POINT: E- 2, NEW-1,2
2 POINTS: E-3, NEW-3
3 POINTS: E-4, NEW-4
4 POINTS: E-5, NEW-5
# MDM Step 2

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

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

**Total**

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

2 POINTS: E-3, NEW-3

3 POINTS: E-4, NEW-4

4 POINTS: E-5. NEW-5
MDM Step 3: Risk

- The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.
  - DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

- Risk is assessed based on the risk to the patient between present visit and the NEXT time the patient will be seen by billing provider or risk for planned intervention.
<table>
<thead>
<tr>
<th>State</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| **Min** | • One self-limited / minor problem | | • Rest  Elastic bandages  
Gargles  Superficial dressings |
| | | | |
| **Low** | • 2 or more self-limited/minor problems  
• 1 stable chronic illness (controlled HTN)  
• Acute uncomplicated illness / injury (simple sprain) | • Physiologic tests not under stress (PFT)  
• Non-CV imaging studies (barium enema)  
• Superficial needle biopsies  
• Labs requiring arterial puncture  
• Skin biopsies | • OTC meds  
• Minor surgery w/no identified risk factors  
• PT, OT  
• IV fluids w/out additives |
| | | | |
| **Mod** | • 1 > chronic illness, mod. Exacerbation, progression or side effects of treatment  
• 2 or more chronic illnesses  
• Undiagnosed new problem w/uncertain prognosis  
• Acute illness w/systemic symptoms (colitis)  
• Acute complicated injury | • Physiologic tests under stress (stress test)  
• Diagnostic endoscopies w/out risk factors  
• Deep incisional biopsies  
• CV imaging w/contrast, no risk factors (arteriogram, cardiac cath)  
• Obtain fluid from body cavity (lumbar puncture) | • Prescription meds  
• Minor surgery w/identified risk factors  
• Elective major surgery w/out risk factors  
• Therapeutic nuclear medicine  
• IV fluids w/additives  
• Closed treatment, FX / dislocation w/out manipulation |
| **High** | • 1 > chronic illness, severe exacerbation, progression or side effects of treatment  
• Acute or chronic illnesses that may pose threat to life or bodily function (acute MI)  
• Abrupt change in neurologic status (TIA, seizure) | • CV imaging w/contrast, w/risk factors  
• Cardiac electrophysiological tests  
• Diagnostic endoscopies w/risk factors | • Elective major surgery w/risk factors  
• Emergency surgery  
• Parenteral controlled substances  
• Drug therapy monitoring for toxicity  
• 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 2\textsuperscript{nd} circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid.

### Final Result for Complexity

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

<table>
<thead>
<tr>
<th>Type of decision making</th>
<th>STRAIGHT-FORWARD</th>
<th>LOW COMPLEX.</th>
<th>MODERATE COMPLEX.</th>
<th>HIGH COMPLEX.</th>
</tr>
</thead>
</table>
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
Discharge Day Codes - *TP 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.
Using Time to Code

Time shall be considered for coding an E/M level when greater than 50% of total Teaching Physician visit time is Counseling / Coordinating Care –

Total time must be Face-to-face for OP and floor time / face-to-face for IP
What Is Counseling /Coordinating Care (CCC)?

A Discussion of:

- Diagnostic results, impressions, and/or recommended studies
- Prognosis
- Risks and benefits of management
- Instructions for treatment and/or follow-up
- Importance of compliance

Required Documentation:

- Total time of the encounter
- The amount of time dedicated to counseling / coordination of care
- The nature of counseling/coordination of care

John Doe MR# 11122234
D.O.S. 9/15/014
Patient counseled regarding health risk, contraceptives, exercise, and usage of medication.

Counseling Time: 20 min.
Total Encounter Time: 30 min.
Prolonged Services: To bill must be > than 30 minutes associated with E/M code time

- **OUTPATIENT: 99354-99355** Prolonged practitioner service requiring face-to-face contact beyond the usual service.
  - 99354 is used to report a total duration of an additional 30-60 minutes on any given date.
  - 99355: add on code to 99354 to report each additional 15-30 minutes.

- **INPATIENT: 99356-99357** Prolonged physician service requiring unit/floor time beyond the usual service.
  - 99356 is used to report a total duration of an additional 30-60 minutes on any given date.
  - 99357: add on code to 99356 to report each additional 15-30 minutes.

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

A counseling visit when time will be the deciding factor, prolonged services can only be added to the highest level of E&M in the category.
National ‘12 CMS Data For Speciality E/M

Pediatric Medicine

- 99211: 3%
- 99212: 7%
- 99213: 43%
- 99214: 40%
- 99215: 6%

National Dist.
## Top Procedure Codes Billed in 2013

<table>
<thead>
<tr>
<th>Top 5 Procedure</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>93010</td>
<td>ELECTROCARDIOGRAM REPORT</td>
<td>9%</td>
</tr>
<tr>
<td>93325</td>
<td>DOPPLER COLOR FLOW VELOCITY MAP</td>
<td>8%</td>
</tr>
<tr>
<td>01922</td>
<td>ANESTH,CAT/MRI SCAN or RADIATN THERAPY</td>
<td>7%</td>
</tr>
<tr>
<td>92587</td>
<td>DISTORT PRODUCT EVOKED OTOACOUSTIC EMISNS LIMITD</td>
<td>5%</td>
</tr>
<tr>
<td>93321</td>
<td>DOPPLER ECHO HEART,LIMITED,F/U</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top 5 E&amp;M</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td>OFFICE/OUTPT</td>
<td>20%</td>
</tr>
<tr>
<td>99233</td>
<td>SUBSEQUENT HOSPITAL</td>
<td>17%</td>
</tr>
<tr>
<td>99232</td>
<td>SUBSEQUENT HOSPITAL</td>
<td>13%</td>
</tr>
<tr>
<td>99215</td>
<td>OFFICE/OUTPT</td>
<td>9%</td>
</tr>
<tr>
<td>99213</td>
<td>OFFICE/OUTPT</td>
<td>8%</td>
</tr>
</tbody>
</table>

All other E/M Codes: 67%

Total: 100.0%
Routine Physical Exam: Preventive

- Periodic comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, coded as new or established patient; infant to 65 years & older.
Preventive Services

When a practitioner sees an asymptomatic patient for a head-to-toe routine physical, the correct procedure code to report is 99381-99395 (periodic preventive medicine evaluation and management) or EPSDT.

The extent and focus of the services will largely depend on the age of the patient.

If an abnormality/ies is encountered or a pre-existing problem is addressed in the process of performing this preventive medicine evaluation and management service, 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 Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.
Preventive Services

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

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.

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.
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)

Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90673</td>
<td>(Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV₃), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use)</td>
</tr>
<tr>
<td>90686</td>
<td>(Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use)</td>
</tr>
<tr>
<td>90688</td>
<td>(Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use)</td>
</tr>
</tbody>
</table>
Working With NP's and PA's (NPP's)

The NP or PA MUST BE AN EMPLOYEE OF THE PRACTICE AND CANNOT BE A HOSPITAL EMPLOYEE TO UTILIZE ANY OF THEIR DOCUMENTATION FOR PHYSICIAN BILLING AS SHARED

- Shared visit with an NPP may be billed under the physician's name only if:
  - The physician provides a face-to-face portion of the visit and
  - The physician personally documents in the patient's record the portion of the E/M encounter with the patient they provided.

- If the physician does not personally perform or personally and contemporaneously document their face-to-face portion of the E/M encounter with the patient, then the E/M encounter may only be billed under the PA/ARNP's name and provider number.

- Procedures must be billed under the performing provider & not the supervisor. They cannot be “shared”
Scribed Notes: Medicare Bulletin

- Record entries made by a "scribe" should be made upon dictation by 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 xxxx, acting as scribe for Dr. yyyy." Then, Dr. yyyy should sign, indicating that the note accurately reflects work and decisions made by him/her.

- 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.
Guidelines for Teaching Physicians, Interns, Residents and Fellows

For Billing Services, All Types of Services Involving a Teaching Physician (TP) Requires Attestations In EHR or Paper Charts
E/M IP or OP: TP must personally document at least the following:

- That s/he performed the service or was physically present during the key or critical portions of the service when performed by the resident; AND
- The participation of the teaching physician in the management of the patient.

Example: ‘I saw and examined the patient and agree with the resident’s note...’

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

- Critical Care Hospital Discharge (>30 minutes) or
- E/M codes where more than 50% of the TP time spent counseling or coordinating care
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
Minor – (<5 Minutes & 0-10 Day Global): For payment, a minor procedure billed by a TP requires that s/he is physically present during the entire procedure.

Example: "I was present for the entire procedure."

Endoscopy Procedures (excluding Endoscopic Surgery):

TP must be present during the entire viewing for payment.

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

Example: "I was present for the entire viewing."

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 (or key and critical portions) of the procedure and immediately available.”

Medical Student documentation for billing only counts for ROS and PFSH.
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.
Allergy Testing

- **95165**  Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)
  
  - These codes report the physician's preparation of an antigen for allergen immunotherapy and the provision of the antigen extract itself.
  
  - These codes also include the providing physician's calculations for the concentration and volume to be used in the dosage based upon the patient's previous skin test results and personal history.
  
  - These codes do not, however, include the administration of the allergen therapy. The number of doses must be specified and the vial(s) (series of vials from a treatment board or one multiple dose vial) from which the dose may be drawn is irrelevant. Report the code based on the type of preparation, i.e., the number of different venoms contained in a single administered injection of the extract.
  
  - Report 95145 for a dose containing one single stinging insect venom, 95146 for an extract containing two single stinging insect venoms, 95147 for three, 95148 for four, and 95149 for five single stinging insect venoms in one dose extract. Code 95165 reports single or multiple antigens (not stinging insect), and 95170 is for a whole body extract of a biting insect or other arthropod.
Allergy Testing

- 95024  Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests
  - The physician injects suspected allergenic substances into the skin to determine the patient's specific allergies. The immediate skin reaction is documented. This code includes test interpretation and physician report.
Sleep Studies

- **95782** – Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

- **95783** – Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist
Sleep Studies

- These pediatric codes are to be used for patients younger than age 6 undergoing diagnostic testing or initiation of PAP therapy for sleep-disordered breathing attended by a technologist in the sleep center. They recognize the additional monitoring parameters utilized for pediatric polysomnography, including capnography, the lower patient to technologist ratio typical for these young patients, and the greater intensity of work necessary to obtain and evaluate pediatric sleep data. Additionally, these pediatric patients typically are recorded during nine hours of total sleep time during sleep testing.
Sleep Studies

- Diagnostic and PAP studies for pediatric patients age six and older should continue to be billed using the previously existing CPT codes (95810 and 95811). The 2012 AASM Manual for the Scoring of Sleep and Associated Events (V 2.0) outlines the technical requirements for pediatric polysomnography and the appropriate methods for scoring pediatric studies. The manual is available as an online subscription and additionally as a printed manual, and is highly recommended as a primary resource for sleep technologists.
Sleep Studies

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- Diagnostic and PAP studies for pediatric patients age six and older should continue to be billed using CPT codes (95810 and 95811).
Monitored anesthesia care (MAC) must be requested by the attending physician, made known to the patient, and performed in accordance with the institution's accepted procedures.

In some institutions, physicians other than anesthesiologists are credentialed or otherwise qualified to provide MAC for certain diagnostic or therapeutic procedures. Medicaid will reimburse physicians other than anesthesiologists for provision of MAC billed with the following anesthesia CPT codes: 00635, 00740, 00810, and 01922.

To be reimbursed for MAC, the anesthesiologist or other qualified physician must meet the following requirements:

- Perform a pre-anesthetic examination and evaluation;
- Prescribe the required anesthesia;
- Personally participate in or have medical direction of the entire plan of care;
- Be continuously physically present when personally participating in the case;
- Be in close proximity to allow for availability for diagnosis and treatment of emergencies when medically directing a case;
- Observe all institutional regulations pertaining to anesthesia services; and
- Furnish all the usual services that are performed by an anesthesiologist.
Medical Review Guidelines

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the requirements.

- **Clinical Condition Criterion**
  - There is a high probability of sudden, clinically significant, or life threatening deterioration in the patient’s condition which requires the highest level of physician preparedness to intervene urgently.

- **Treatment Criterion**
  - Life and organ supporting interventions that require frequent assessment and manipulation by the physician.
  - Withdrawal of, or failure to initiate these interventions would result in sudden, clinically significant or life threatening deterioration in the patient’s condition.
CC is a Time Based Code

- When the patient is unable or clinically incompetent to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment or limitation(s) of treatment may be reported as critical care, provided that the conversation bears directly on the management of the patient. Documentation of countable time spent with family must indicate what was discussed and for what period of time.

- Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient.

- Time spent performing separately reportable procedures should not be included in total critical care time.

Time spent teaching residents may not be counted towards CC time. The TP’s progress note must document the total time they were providing critical care services and their documentation must support critical care.
Billing Requirements

• “Full Attention” – the physician cannot provide care to any other patient during the same time period.

• Time spent with or for the individual patient must be recorded in the patient’s record and must be 30 minutes or greater by an individual teaching practitioner.

• All critical care time provided by members of the department for each calendar day is added together for billing. However, at least one physician must document at least 30 minutes personally provided for time based critical care.
  • Two physicians cannot both provide 15 minutes each during the day and bill critical care.
Critical Care: Two types of codes exist for critical care: time-based and non-time based. Time-based codes (99291, 99292). There are six other codes, which can only be used in filing for neonatal and pediatric critical care (99468-99476).

- For time based codes, the physician must document the total amount of time spent on any calendar day providing critical care services to a patient. This time may be noncontiguous. Absent exceptional circumstances, generally requiring the skills of different specialty providers, critical care billed by one provider cannot overlap in time with critical care provided by another provider. The time must be spent on the unit. It may include direct bedside care or time spent discussing the case with consultants or reviewing pertinent laboratory or imaging data.
Time-Based Critical Care

- One can also include time spent getting essential information from family members, but should not include minutes just updating the family on the patient’s progress. Such conversations can be via telephone, but must be made from the unit in which the patient is cared for. A summary of such interactions should be entered into the medical record to support the total amount of time in critical care.

- **99291**: Critical care, evaluation and management (E/M) of the critically ill or critically injured patient; first 30-74 min
- **99292**: each additional 30

  99291 should be reported by a provider or subspecialty group only once in a calendar day. Critical care time < 30 min in a single day should be reported using the E/M codes **99221-99233**
The same definitions for critical care services apply for the adult, child, and neonate.

Codes 99468 and 99469 are used to report...
  • Critical care services provided by a second physician of a different specialty...

When the critically ill neonate or pediatric patient improves and is transferred to a lower level of care, the transferring physician does not report a per day critical care service. Subsequent hospital care (99231–99233) or critical care services (99291–99292) are reported as appropriate based on the condition of the neonate or child. The receiving physician reports subsequent intensive care (99478–99480) or subsequent hospital care (99231–99233) services as appropriate based on the condition of the neonate or child.
Initial and Continuing Intensive Care Services

- Code **99477** represents the initial day of inpatient care. . .
  - When the neonate or infant improves after the initial day and is transferred to a lower level of care, the transferring physician does not report a per day intensive care service. Subsequent hospital care (**99231–99233**) is reported. When the neonate or infant becomes critically ill on a day when initial or subsequent intensive care services have been performed and is transferred to a critical care level of care performed by a different physician, the transferring physician reports either the critical care services performed (**99291–99292**) or the intensive care service performed, but not both. The receiving physician reports subsequent inpatient neonatal or pediatric critical care (**99469, 99472**).
  - For the subsequent care of the sick neonate report **99477**
Procedures Bundled Into Critical Care

- Introduction of needle or intracatheter, vein (36000)
- Venipuncture, age 3 years or older, necessitating physician’s skill (36410)
- Collection of venous blood by venipuncture (36591)
- Collection of blood specimen from a completely implantable venous access device (36591)
- Arterial puncture, withdrawal of blood for diagnosis (36600)
- Nasogastric or orogastric tube placement, requiring physician’s skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report) (43752)
- Radiologic examination, chest; single view, stereo, or two view (71010, 71015, 71020)
- Gastric intubation and aspiration or lavage for treatment (91105)
Procedures Bundled Into Critical Care

- Temporary transcutaneous pacing (92953)
- Indicator dilution studies with dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (93561 and 93562)
- Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day, subsequent day, nursing facility (94002, 94003, 94004)
- Continuous positive airway pressure ventilation (CPAP), initiation and management (94662)
- Continuous negative pressure ventilation, initiation and management (94662)
- Noninvasive ear or pulse oximetry for oxygen saturation, single, multiple, or continuous (94760, 94761, 94762)
- Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data) (99090)
Procedures Not Bundled Into Time-Based Critical Care Codes

- These procedures should be reported separately with a 25 modifier appended to the critical care service. The time needed to complete any of these services cannot be counted as critical care time. Separate documentation is needed. Examples include:
  - Intubation, endotracheal, emergency procedure (31500)
  - Tracheostomy, planned (31600)
  - Bronchoscopy, rigid or flexible (31622)
  - Thoracentesis, with insertion of tube (32421, 32422)
  - Insertion of tunneled pleural catheter with cuff (32550)
  - Cardiopulmonary resuscitation (92950)
Neonatal and Pediatric Critical Care Code Bundles

- All the procedures noted for time-based critical care, but additional services are bundled. Examples of these include:
  - Venipuncture, younger than age 3 years, necessitating physician’s skill, including femoral or jugular vein, scalp vein, or other vein (36400, 36405, 36406), or standard venipuncture (36420, 36600)
  - Transfusion of blood components (36430, 36440)
  - Catheterization of umbilical vein or artery, for diagnosis or therapy, newborn (36510, 36660)
  - Central vessel catheterization, peripheral vessel catheterization, or other arterial catheters (36555, 36000, 36140, 36620)
  - Oral or nasogastric tube placement (43752)
Neonatal and Pediatric Critical Care Code Bundles

- Endotracheal intubation (31500)
- Lumbar puncture (62270)
- Suprapubic bladder aspiration, bladder catheterization (51000, 51701, 51702)
- Ventilation management services (94002, 94003, 94004)
- Surfactant administration (94610)
- CPAP (94660)
- IV fluid administration (90760, 90761)
- Bedside pulmonary function testing (94375)
- Pulse oximetry (94760, 94761, 94762)
Examples of Procedures Not Bundled Into Neonatal and Pediatric Critical Care Codes

- Exchange transfusion (36450)
- Planned tracheostomy (31600)
- Bronchoscopy (31622)
- Thoracentesis, with insertion of tube (32421, 32422)
- Cardiopulmonary resuscitation (92950)
Acceptable Criteria for High Flow O₂ Therapy:

- What documentation is required to support critical care billing for infants on high flow cannulae?
  - 1. An arterial blood gas sample on room air that demonstrates hypoxemia (PaO₂ below 60 mmHg, or below the normal range for the specific patient in question)
  - 2. An arterial saturation SaO₂ on room air below or equal to 92%
  - 3. Medical emergencies where symptoms are evident:
    - a. tissue hypoxia may be reasonably expected to be part of the problem due to shock, pulmonary edema, or drug overdose
    - b. Physical symptoms of tissue hypoxia (e.g., cyanosis, tachycardia, confusion, etc)
    - c. Trauma victims with chest injuries, head injuries, blood loss, etc.
    - d. Prophylactic use in patients with symptoms, which indicate pending hypoxemia (e.g., suspected myocardial infarction).
High Flow Oxygen Delivery System

- Additional indications for neonatal and pediatric use:
  - a. Neonates < 1000 grams requiring oxygen flow rates > 1lpm with adequate spontaneous breathing effort
  - b. Neonates > 1000 grams requiring oxygen flow rates > 2lpm with adequate spontaneous breathing effort
  - c. Neonates or infants with an oxygen requirement > 2lpm or > 50% with adequate spontaneous breathing effort
  - d. Pediatric patients with an oxygen requirement > 4lpm or > 50% with adequate spontaneous breathing effort
High Flow Oxygen Documentation

- Documentation of the time of initiation of therapy, evaluation of the patient's hypoxemia via arterial blood gases or pulse oximetry saturation, physical signs of cyanosis or response to a medical emergency, pulse rate, respiratory rate, liter per minute of oxygen flow and FlO2 must be performed at each bedside visit.

- The patient's cardiopulmonary status should be evaluated routinely to determine the dosage of oxygen required.

- To bill critical care, NICU or PICU codes the documentation must support the patient was critically ill.
• What documentation is required for critical care “per day” codes vs. “hourly” critical care codes?

  • Hourly codes must include the time spent by the teaching physician providing critical care.
  • Both per-day and hourly codes require documentation by the teaching physician to support the services they provided on each date-of-service billed

• Some documentation of rationale for critical care time may not be clearly indicated in the medical record for coding.

  • If the documentation is unclear the service should not be billed.
Does documentation for the “per day” codes need to show that the patient was in critical condition when the TP saw the patient as is necessary for the hourly codes?

- Yes
Codes for Neonatal Car Seat/Bed Testing for Airway Integrity

- **94780** Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate, and respiratory rate, with interpretation and report; 60 minutes
- (Do not report **94780** for less than 60 minutes.)
- **94781** each additional full 30 minutes
- (List separately in addition to code for primary procedure.)
- (Use **94781** in conjunction with **94780**.)
Guidelines for Reporting 94780 and 94781

- Continual nursing observation with continuous recording of pulse oximetry, heart rate, and respiratory rate is required. Vital signs and observations must be reviewed and interpreted, and a written report must be generated by the physician.

- Codes 94780 and 94781 may be reported with discharge day management (99238–99239), subsequent hospital care (99231–99233), hourly critical care (99291, 99292), pediatric critical transport service (99466, 99467), or office or outpatient visit (99201–99215) codes when performed on the same calendar day.
Guidelines for Reporting 94780 and 94781

- Codes are bundled with the global neonatal and pediatric initial and subsequent critical care and initial and continuing intensive care codes (99468–99476 and 99477–99480) and cannot be separately reported.
- Codes are reported based on the total time spent and documented.
- Code 94780 is reported for the first 60 minutes. If less than 60 minutes is spent in the procedure, code 94780 may not be reported.
- Each additional full 30 minutes (ie, not less than 90 minutes) is reported with code 94781.
## Examples

<table>
<thead>
<tr>
<th>Clinical Vignette</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A neonate born at 36 weeks' gestation requires a car seat test on the date of discharge from the hospital. The physician documents that 40 minutes was spent on discharge activities and 65 minutes was spent on car seat testing.</td>
<td>99239 Hospital discharge day management; more than 30 minutes 94780 Car seat/bed testing for airway integrity, neonate; 60 minutes</td>
</tr>
<tr>
<td>A neonate born at 34 weeks' gestation requires a car seat test prior to discharge from the hospital. The newborn receives 90 minutes of testing, which is documented in the medical record.</td>
<td>99231–99233 Subsequent hospital care 94780 Car seat/bed testing for airway integrity, neonate; 30 minutes 94781 Car seat/bed testing for airway integrity, neonate; each additional full 30 minutes</td>
</tr>
<tr>
<td>A neonate born at 35 weeks' gestation did not receive a car seat test during her hospitalization. Car seat testing is required and performed in the physician's office. A total of 60 minutes is spent on the procedure.</td>
<td>99201–99215 New or established office/outpatient service 94780</td>
</tr>
</tbody>
</table>
CPT Codes **99460-99465** are used to report the services provided to normal newborns (birth through the first 28 days).

Use of the normal newborn codes is limited to the initial care of the newborn in the first days after birth prior to home discharge.

The E/M Codes **99460-99465** for the newborn include maternal and/or fetal and newborn history, newborn physical examination(s), ordering of diagnostic tests and treatments, meetings with the family, and documentation in the medical record.

When delivery room attendance services (**99464**) or delivery room resuscitation services (**99465**) are required, report these in addition to normal newborn services E/M codes **99460-99465**.
For E/M services provided to newborns who are other than normal, bill the codes for hospital inpatient services (99221-99223) and neonatal intensive and critical care services (99466-99469, 99477-99480).

When normal newborn services are provided by the same physician on the same date that the newborn later becomes ill and receives additional intensive or critical care services, report the appropriate E/M code with modifier 25 for these services in addition to the normal newborn code.

Procedures (eg; 54150, newborn circumcision) are not included with the normal newborn codes, and when performed, should be reported in addition to the newborn services.
99460: Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant

99462: Subsequent hospital care, per day, for evaluation and management of normal newborn

99463: Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date

For **newborn hospital discharge services** provided on a date subsequent to the admission date, bill hospital discharge codes 99238 (TP’s management of patient’s D/C took < 30 minutes.) or 99239 (TP’s management took > 30 minutes managing the patient (final exam, Rx management, POC after D/C). For 99239 time in record must be documented by the TP.
Delivery/Birthing Room Attendance and Resuscitation Services (99464-99465)

99464: Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn
   (99464, may be billed in conjunction with 99460, 99468, 99477)

99465: Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output
   (99465 may be billed in conjunction with 99460, 99468, 99477)

Procedures that are performed as a necessary part of the resuscitation [eg, intubation, vascular lines] are billed separately in addition to 99465. In order to report these procedures, they must be performed as a necessary component of the resuscitation and not as a convenience before admission to the neonatal intensive care unit)
**Modifier Reminders**

**Modifier 25:** Significant, Separately Identifiable E/M by the Same Physician/Group on the Day of a minor Procedure: on the day a procedure the patient's condition required a significant, separately identifiable E/M service above and beyond the usual care associated with the procedure that was performed. **EX: Billing Preventive and E/M Same day**

**Documentation must support significant time & effort**

**Modifier GC:** Service involved a resident or fellow. Payment not affected.
ICD-10 and Clinical Documentation

- Increased specificity of the ICD-10 codes requires more detailed clinical documentation to code some diagnoses to the highest level of specificity.
  - Coding and documentation go hand in hand
    - ICD-10 based on complete and accurate documentation, even where it comes to right and left or episode of care.
    - ICD-10 should impact documentation as physicians are required to support medical necessity using appropriate diagnosis code—this is not an easy situation.
  - Will not change the way a physician practices medicine
## Pediatrics

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Description</th>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>034.0</td>
<td>Streptococcal sore throat</td>
<td>J02.0</td>
<td>Streptococcal pharyngitis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J03.00</td>
<td>Acute streptococcal tonsillitis, unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J03.01</td>
<td>Acute recurrent streptococcal tonsillitis</td>
</tr>
</tbody>
</table>
HIPAA
Final Reminders for All Staff, Residents, Fellows or Students

- **Health Insurance Portability and Accountability Act – HIPAA**
  - Protect the **privacy** of a patient’s personal health information
  - Access information for business purposes only and only the records you need to complete your work.
  - Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  - **PHI is protected even after a patient’s death!!!**
  - **Never share your password with anyone and no one use someone else’s password for any reason, ever –even if instructed to do so.**
    - If asked to share a password, report immediately.
Any Questions
Available Resources at University of Miami, UHealth and the Miller School of Medicine

• If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  • Gemma Romillo, Assistant Vice President of Clinical Billing Compliance and HIPAA Privacy; 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