Office of Billing Compliance
2015 Coding, Billing and Documentation Program

Department of Pediatrics
2015 Code Changes

Pediatric Specific CPT Code Changes for 2015
New & Revised Codes

• New
  • **90630** Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
  • **90651** Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use

• Revised
  • **90654** Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use
  • **90721** Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP/Hib), for intramuscular use
  • **90723** Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use
  • **90734** Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivalent, for intramuscular use

• Vaccines/Toxoids (90630, 90651, 90654, 90721, 90723, 90734) identify the vaccine product only. To report the administration of a vaccine/toxoid, the vaccine/toxoid product code must be used in addition to an immunization administration code(s) 90460, 90461, 90471, 90472, 90473, 90474.
New Code 99184

• Inpatient Neonatal and Pediatric Critical Care (99468-99469)
  • Codes 99468, 99469 are used to report the services of directing the inpatient care of a critically ill neonate or infant 28 days of age or younger. They represent care starting with the date of admission (99468) to a critical care unit and subsequent day(s) (99469) that the neonate remains critical. These codes may be reported only by a single individual and only once per day, per patient, per hospital stay in a given facility. If readmitted to the neonatal critical care unit during the same day or stay, report the subsequent day(s) code 99469 for the first day or readmission to critical care, and 99469 for each day of critical care following readmission.
  • ►For initiation of selective head or total body hypothermia in the critically ill neonate, report 99184. ◄ (Codes 99481 and 99482 have been deleted.)

• 99184 Initiation of selective head or total body hypothermia in the critically ill neonate, includes appropriate patient selection by review of clinical, imaging and laboratory data, confirmation of esophageal temperature probe location, evaluation of amplitude EEG, supervision of controlled hypothermia, and assessment of patient tolerance of cooling.
  • ►(Do not report 99184 more than once per hospital stay) ◄
Revised and New Codes 96110 and 96127

Central Nervous System Assessments/Tests (eg, Neuro-Cognitive, Mental Status, Speech Testing)

• Revised: ▲ 96110 Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument.
  • ►(For an emotional/behavioral assessment use code 96127)◄

• New: ● 96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument.
  • ►(For developmental screening, use 96110)◄
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 the 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.
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 and one must be MDM**.

*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.
**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)
**Coding 1995: Physical Exam**

<table>
<thead>
<tr>
<th>BODY AREAS (BA):</th>
<th>CODING ORGAN SYSTEMS (OS):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Head, including face</td>
<td>• Constitutional/General</td>
</tr>
<tr>
<td>• Neck</td>
<td>• GU</td>
</tr>
<tr>
<td>• Chest, including breast and axillae</td>
<td>• Musculoskeletal</td>
</tr>
<tr>
<td>• Abdomen</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>
</tbody>
</table>

- Genitalia, groin, buttocks
- Back, including spine
- Each extremity
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
1995 and 1997 Exam Definitions

**Problem Focused (PF):** 99231, 99212 or 99201

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Step 1:</th>
</tr>
</thead>
</table>
| • Number of possible diagnosis and/or management options affecting today's visit. List each separate 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, |

<table>
<thead>
<tr>
<th>Step 2:</th>
</tr>
</thead>
</table>
| • 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) |

<table>
<thead>
<tr>
<th>Step 3:</th>
</tr>
</thead>
</table>
| • 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

<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</td>
<td>1</td>
</tr>
<tr>
<td>patient</td>
<td></td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone</td>
<td>2</td>
</tr>
<tr>
<td>other than patient and/or discussion of case with another health care provider</td>
<td></td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply</td>
<td>2</td>
</tr>
<tr>
<td>review of report).</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>
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>Min Risk</td>
<td>One self-limited / minor problem</td>
<td>Labs requiring venipuncture, CXR, EKG/ECG, UA</td>
<td>Rest, Elastic bandages, Gargles, Superficial dressings</td>
</tr>
<tr>
<td>Low Risk</td>
<td>2 or more self-limited/minor problems, 1 stable chronic illness (controlled HTN), Acute uncomplicated illness/injury (simple sprain)</td>
<td>Physiologic tests not under stress (PFT), Non-CV imaging studies (barium enema), Superficial needle biopsies, Labs requiring arterial puncture, Skin biopsies</td>
<td>OTC meds, Minor surgery w/no identified risk factors, PT, OT, IV fluids w/out additives</td>
</tr>
<tr>
<td>Mod Risk</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, Acute illness w/systemic symptoms (colitis), Acute complicated injury</td>
<td>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)</td>
<td>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</td>
</tr>
<tr>
<td>High Risk</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 (acute MI), Abrupt change in neurologic status (TIA, seizure)</td>
<td>CV imaging w/contrast, w/risk factors, Cardiac electrophysiological tests, Diagnostic endoscopies w/risk factors</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.
In-Patient Hospital Care
USING DIFFERENT LEVELS OF CARE

99223 *
PATIENT
ADMITTED

99233 *
(P.T. IS
UNSTABLE)

99232 *
(P.T. HAS
DEVELOPED
MINOR COMPL.)

99231 *
(P.T. 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”

*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.*
Admission to Hospital - Two-Midnight Rule

• If the physician expects a patient’s stay to cross at least 2 midnights, and is receiving medically necessary hospital care, the stay is generally appropriate for inpatient admission.

• Must have a clear inpatient order written and signed before discharge. Physician or practitioner must be:
  • Licensed by the state to admit patients to hospitals
  • Granted privileges by the facility to admit
  • Knowledgeable about the patients hospital course, medical care, and current condition at the time of admission

• Must have documentation to support certification
• Anticipated length of stay
• Discharge planning
Admission to Hospital - Two-Midnight Rule

Exceptions to the Rule

• Inpatient only procedures
• Newly initiated acute mechanical ventilation
• Not occurring, as would be anticipated, with a procedure
• Unforeseen Circumstances such circumstances must be documented:
  – Death
  – Transfer to another hospital
  – AMA
  – Unexpected clinical improvement
  – Election of hospice care
Two-Midnight Rule vs Observation Care

If the stay is expected to be 0-1 midnights, the stay is generally inappropriate for an inpatient admission.

If the physician expects the patient to require less than two midnights of hospital care, or if it is uncertain at time of admission how long the patient will be expected to require hospital care, then the patient should be referred to “observation” regardless of the “level of care.”

Without a reasonable expectation of a 2 midnight stay, inpatient admission is NOT dependent of “level of care”.

• For example, the use of telemetry or an ICU bed alone does not justify inpatient admission.
Two-Midnight Rule vs Observation Care

An observation status patient may be admitted to an inpatient status at any time for medically necessary continued care, but the patient can never be retroactively changed from observation to inpatient (replacing the observation as if it never occurred).

Physician orders to "admit to inpatient" or "place patient in outpatient observation" should be clearly written. Be aware that an order for "admit to observation" can be confused with an inpatient admit. Likewise, an order for "admit to short stay" may be interpreted as admit to observation by some individuals and admit to inpatient by others.
Observation Care Services

Billing Guidelines

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

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

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

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

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

- Hospital observation services should be coded and billed according to the time spent in observation status as follows:

<table>
<thead>
<tr>
<th>8 Hours or Less</th>
<th>&gt; 8 Hours &lt; 24 Hours</th>
<th>24 Hours or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>99218-99220</td>
<td>99234-99236</td>
<td>99218-99220</td>
</tr>
<tr>
<td>(Initial Observation Care)</td>
<td>(Observation or Inpatient Care)</td>
<td>(Initial Observation Care)</td>
</tr>
<tr>
<td>99224-99226</td>
<td></td>
<td>99224-99226</td>
</tr>
<tr>
<td>Subsequent Day different calendar day</td>
<td></td>
<td>Subsequent Day different calendar day</td>
</tr>
</tbody>
</table>

- Same Calendar Date
  - Admission paid
  - Discharge **not** paid separately

- Different Calendar Date
  - Admission and Discharge (99217) paid separately

- Same Calendar Date
  - Admission and Discharge Included

- Different Calendar Date
  - Use codes 99218-99220
  - Discharge (99217) paid separately

- Same Calendar Date
  - Admission paid
  - Discharge **not** paid separately

- Different Calendar Date
  - Admission and Discharge paid separately
Observation Care Services

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

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

• Outpatient observation time begins **when the patient is physically placed in the observation bed. Outpatient observation time ends at the time it’s documented in the physician’s discharge orders.**
Teaching Physicians (TP) Guidelines

Billing Services When Working With Residents Fellows and Interns

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

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

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

- Initial Visit: “I saw and evaluated the patient. I reviewed the resident’s note and agree, except that the picture is more consistent with an upper respiratory infection not pneumonia. Will begin treatment with…….”
- Initial or Follow-up Visit: “I saw and evaluated the patient. Discussed with resident and agree with resident’s findings and plan as documented in the resident’s note.”
- Follow-up Visit: “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s finding and plans as written.”
- Follow-up Visit: “I saw and evaluated the patient. Agree with resident’s note, but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

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

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

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

*Medical Student documentation for billing only counts for ROS and PFSH. All other contributions by the medical/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.’

**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, which must be described) of the procedure and immediately available.”

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

TP must be present during the entire viewing for payment.

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

  Example: “I was present for the entire viewing.”
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.**
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."
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.
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.
Critical Care: 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 Criterion** – A high probability of sudden, clinically significant or life threatening deterioration of the patient's condition which requires a high level of physician preparedness to intervene urgently

- **Treatment Criterion** – Life or 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 / life-threatening deterioration in the patient’s condition.

**Time spent teaching or by residents may not be used in CC time and NPP time cannot be added to physician time.**
# Time Based CC Codes 99291 and 99292

<table>
<thead>
<tr>
<th>Time</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30 min</td>
<td>Appropriate E/M code</td>
</tr>
<tr>
<td>30-74 min</td>
<td>99291 x 1</td>
</tr>
<tr>
<td>75-104 min</td>
<td>99291 x 1 and 99292 x 1</td>
</tr>
<tr>
<td>105-134 min</td>
<td>99291 x 1 and 99292 x 2</td>
</tr>
<tr>
<td>135-164 min</td>
<td>99291 x 1 and 99292 x 3</td>
</tr>
</tbody>
</table>
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**
Critical Care Documentation & Criteria

MM5993 Related Change Request Number: 5993

The TP documentation must include:

• Time the teaching physician spent providing critical care (resident time and time teaching residents does not count toward the 30 minute minimum);

• That the patient was critically ill during the time the TP saw the patient (met clinical criterion of a high probability of sudden, clinically significant or life threatening deterioration of the patient's condition);

• What made the patient critically ill; and

• The nature of the treatment and management provided by the TP (treatment criterion of Life or organ supporting interventions that require frequent assessment and manipulation by the physician.)

• Combination of the TP's documentation and the resident’s may support CC provided that all requirements for CC services are met. The TP documentation may tie into the resident's documentation. The TP may refer to the resident’s documentation for specific patient history, physical findings and medical assessment as long as additional TP documentation is included to support their CC time.
Inpatient Neonatal and Pediatric Critical Care

• 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)
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)
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)
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)
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)

: 1 through 4 years
: 5 through 11 years
: 12 through 17 years

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)

: 1 through 4 years
: 5 through 11 years
: 12 through 17 years
Modifiers: 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
- Indicate specific circumstances
- Prevent denial of services
- Provide additional information
- Facilitate correct coding

Documentation in the operative report must support the use of any modifier.
Minor Procedure or Preventive Visit (EPSDT) 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 preventive services, minor procedure or diagnostic service.
- It is *STRONGLY* recommended that 2 separate and distinct notes be included in the medical record to document the preventive service or procedure and then the separate E/M service.

**Additional Articles of Interest:**
- OIG Cracking Down on Modifier 25 Use
- E/M Update: DOJ Targets Improper Use of Modifier 25
Non-Physician Practitioners (NPP’s) or Physician Extenders

Who is a NPP?

- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)
- Optometrist
- PT, OT, SLP
- Nurse Midwives
- Clinical Psychologists
- Clinical Social Workers
NPP Agreements & Billing Options

• Collaborative agreement between the NPP and the group they are working with is required.
  • The agreement extends to all physicians in the group.
    • If the NPP is performing procedures it is recommended a physician confirm their competency with performance of the procedure.
• NPPs can bill independent under their own NPI # in all places-of-service and any service included in their State Scope of Practice.
  • Supervision is general (available by phone) when billing under their own NPI number.
  • Medicare and many private insurers credential NPPs to bill under their NPI.
  • Some insurers pay 85% of the fee schedule when billing under the NPP and others pay 100% of the fee schedule.
• Incident-to in the office (POS 11)
• Shared visit in the hospital or hospital based clinic (POS 21, 22, 23)
Shared Visits

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

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

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

• Procedures CANNOT be billed shared
Shared Visits Between NPP and Physician

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

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

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

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

• The NPP MUST be an employee (or leased) to bill shared. Documentation from a hospital employed NPP may not be utilized to bill a service under the physician.
Not Incident-to or Shared

Billing Under The NPP NPI

- Does not require physician presence.
- Can evaluate and treat new conditions and new patients.
- Can perform all services under the state scope-of-practice.
- Can perform services within the approved collaborative agreement.
  - Recommend physician establish competency criteria and demonstration of performance of procedures within the collaborative agreement between the NPP and physician.
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
Requirements for Billing Routine Costs for 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.*
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 [link]
[link], 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).
Physician “Provider” Quality Reporting (PQRS)
CMS Quality Improvement Programs

- Meaningful Use (MU)
- Physician Quality Reporting System (PQRS)
- 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>
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<tbody>
<tr>
<td>Meaningful Use</td>
<td>1%</td>
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<tr>
<td>PQRS</td>
<td>1.5%</td>
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<tr>
<td>VBPM</td>
<td></td>
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<tr>
<td>TOTAL PENALTIES</td>
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# 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>
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<tr>
<td>DO</td>
<td>Nurse Practitioner</td>
<td>Occupational Therapist</td>
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<tr>
<td>Doctor of Podiatric</td>
<td>Clinical Nurse Specialist*</td>
<td>Qualified Speech-Language Therapist</td>
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<tr>
<td>Doctor of Optometry</td>
<td>CRNA</td>
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<tr>
<td>DDS</td>
<td>Certified Nurse Midwife</td>
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<tr>
<td>DMD</td>
<td>Clinical Social Worker</td>
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<tr>
<td>Doctor of Chiropractic</td>
<td>Clinical Psychologist</td>
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<tr>
<td></td>
<td>Registered Dietician</td>
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<td></td>
<td>Nutrition Professional</td>
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<tr>
<td></td>
<td>Audiologists</td>
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</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>
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
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
HIPAA, HITECH, PRIVACY AND SECURITY

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

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

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

http://www.miami.edu/index.php/professional_development_training_office/learning/ulearn/
• HIPAA, HITECH, Privacy & Security
• Several breaches were discovered at the University of Miami, one of which has resulted in a class action suit. As a result, “Fair Warning” was implemented.

• What is Fair Warning?
  • **Fair Warning** is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.
  • **Fair Warning** protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.
  • **Fair Warning** is an initiative intended to reduce the cost and complexity of HIPAA auditing.

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