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

Department of Pediatrics
2016 Code Changes
Deleted: 13 outdated codes deleted

Revised: 40+ codes reworded to improve clarity

• New: 90625 Cholera Vaccine
• New: 90697 DTap-IPV-Hib-HepB
• New: 90620 Meningococcal, 2 dose schedule
• New: 90621 Meningococcal, 3 dose schedule
Prolonged Services: 2016 UPDATE:

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

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

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

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

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

Under the ‘incident to” provision, clinical staff may provide the new prolonged services CPT codes, 99415 and 99416.

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

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

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

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

• Must check with individual healthcare plans for coverage allowances.
Newborn Care Services

CARE OF THE NORMAL NEWBORN INFANT

• Evaluation and management (E/M) services provided to normal newborns in the first days of life prior to hospital discharge are reported with Newborn Care Services codes. Codes for initial care of the normal newborn include:

CODES FOR THE INITIAL CARE OF THE NORMAL NEWBORN

• 99460 Initial hospital or birthing center care, per day, for E/M of normal newborn infant
• 99461 Initial care per day, for E/M of normal newborn infant seen in other than hospital or birthing center
• 99463 Initial hospital or birthing center care, per day, for E/M of normal newborn infant admitted and discharged on the same date
• Subsequent hospital care for the normal newborn is billed once per day with code 99462.
• Discharge services provided on a date subsequent to admission may be billed with code 99238 or 99239.
Why Does Documentation Matter?

- It’s our agreement with our payors
- Correct coding practice is part of good medical care
- Millions of dollars are lost each year to poor coding practices
Inpatient and Outpatient

Evaluation and Management E/M Documentation and Coding

[Images of CPT and ICD 10-CM books]
The 3 Key Documentation Elements

- Medical Decision Making
- Physical Exam
- History
  Focus on HPI
Per AMA / CPT Guidelines

*Peds can be different: Guidelines were established for adults*

- “For certain groups of patients, the recorded information may vary slightly from that described here.
  - Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.
  - As an example, newborn records may include under history of the present illness (HPI) the details of mother’s pregnancy and the infant’s status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family.
  - In addition, information on growth and development and/or nutrition will be recorded.
    - Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.”
Important!

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

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

  SO . . .

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

• The amount of history and exam should **not** generally alone determine the level.
Medical Necessity

Ignoring how medical decision-making affects E/M leveling can put you at risk.

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

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

CMS:

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

Medical Decision-Making

1. Number of Diagnoses or Treatment Options

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

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

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

3. Table of Risk

- Is the presenting problem self-limited?
- Are procedures required?
- Is there exacerbation of chronic illness?
- Is surgery or complicated management indicated?
- Are prescription medications being managed?
### MDM – Step 3: Risk

<table>
<thead>
<tr>
<th>Min</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• One self-limited / minor problem</td>
<td>• Labs requiring venipuncture</td>
<td>• Rest</td>
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<td></td>
<td>• CXR</td>
<td>• Elastic bandages</td>
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<td></td>
<td>• EKG/ECG</td>
<td>• Gargles</td>
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<td></td>
<td>• UA</td>
<td>• Superficial dressings</td>
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<tr>
<td></td>
<td>• 2 or more self-limited/minor problems</td>
<td>• Physiologic tests not under stress (PFT)</td>
<td>• OTC meds</td>
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<td>• 1 stable chronic illness (controlled HTN)</td>
<td>• Non-CV imaging studies</td>
<td>• Minor surgery w/no identified risk factors</td>
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<tr>
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<td>• Acute uncomplicated illness / injury (simple sprain)</td>
<td>• Superficial needle biopsies</td>
<td>• PT, OT</td>
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<td></td>
<td></td>
<td>• Labs requiring arterial puncture</td>
<td>• IV fluids w/out additives</td>
</tr>
<tr>
<td></td>
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<td>• Skin biopsies</td>
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<td>IP Sub 1</td>
<td>• 1 &gt; chronic illness, mod. Exacerbation, progression or side effects of treatment</td>
<td>• Physiologic tests under stress (stress test)</td>
<td>• Prescription meds</td>
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<td>IP Initial 1</td>
<td>• 2 or more chronic illnesses</td>
<td>• Diagnostic endoscopies w/out risk factors</td>
<td>• Minor surgery w/identified risk factors</td>
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<td>• Undiagnosed new problem w/uncertain prognosis</td>
<td>• Deep incisional biopsies</td>
<td>• Elective major surgery w/out risk factors</td>
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<tr>
<td></td>
<td>• Acute illness w/systemic symptoms (colitis)</td>
<td>• CV imaging w/contrast, no risk factors (arteriogram, cardiac cath)</td>
<td>• Therapeutic nuclear medicine</td>
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<tr>
<td></td>
<td>• Acute complicated injury</td>
<td>• Obtain fluid from body cavity (lumbar puncture)</td>
<td>• IV fluids w/additives</td>
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<td>• 1 &gt; chronic illness, severe exacerbation, progression or side effects of treatment</td>
<td>• CV imaging w/contrast, w/risk factors</td>
<td>• Elective major surgery w/risk factors</td>
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<td>• Acute or chronic illnesses that may pose threat to life or bodily function (acute MI)</td>
<td>• Cardiac electrophysiological tests</td>
<td>• Emergency surgery</td>
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<td>• Abrupt change in neurologic status (TIA, seizure)</td>
<td>• Diagnostic endoscopies w/risk factors</td>
<td>• Parenteral controlled substances</td>
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<td></td>
<td></td>
<td></td>
<td>• Drug therapy monitoring for toxicity</td>
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<td>• DNR</td>
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<td>• Elective major surgery w/risk factors</td>
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<td></td>
<td>• Acute or chronic illnesses that may pose threat to life or bodily function (acute MI)</td>
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<td></td>
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<td></td>
<td>• DNR</td>
</tr>
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</table>
FOUR ELEMENTS of HISTORY

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

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

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

**TWO TYPES:**

- **BRIEF** 1-3 elements above or status of 1-2 diagnosis or conditions
- **EXTENDED** 4 or > elements above or status of 3 or > diagnosis or conditions
4. REVIEW OF SYSTEMS

14 recognized:

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

THREE TYPES:

- PROBLEM PERTINENT (1 SYSTEM)
- EXTENDED (2-9 SYSTEMS)
- COMPLETE (10 SYSTEMS)
3. **PAST, FAMILY, AND SOCIAL HISTORY**
   - Patient’s previous illnesses, surgeries, and medications
   - Family history of important illnesses and hereditary conditions
   - Social history involving work, home issues, tobacco/alcohol/drug use, etc.

**TWO TYPES:**

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

PEARLS FOR HISTORY DOCUMENTATION:

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

• Don’t forget 10-system review!

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

4 TYPES OF EXAMS

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

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

## CODING ORGAN SYSTEMS (OS):
- Constitutional/General
- Eyes
- Ears/Nose/Mouth/Throat
- Respiratory
- Cardiac
- GI
- GU
- Musculoskeletal
- Skin
- Neuro
- Psychiatric
- Hematologic/Lymphatic
1997 Exam Definitions

Problem Focused (PF): 99212 or 99201
- ‘95=1 BA / OS
- ‘97=Specialty and GMS: 1-5 elements identified by bullet.

Expanded Problem Focused (EPF): 99213 or 99202
- ‘95= 2-7 BA / OS
- ‘97=At least 6 elements identified by bullet.

Detailed (D): 99214 or 99203
- ‘95: extended exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)  Novitas 4x4 (4 BA/OS w/ 4 documented exam items each)
- ‘97=Specialty: At least 12 elements identified by bullet

Comprehensive (C): 99215 or 99204 and 99205
- ‘95: general multi-system exam (8 or more organ systems) or complete single organ system (a complete single organ system is undefined by CMS).
- ‘97=Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area.
Using Time to Code

• Time shall be considered for coding an E/M in lieu of H-E-MDM when > 50% of the total billable practitioner visit time is counseling/coordination of care (CCC.)
  • Time is only Face-to-face for OP setting
• Coding based on time is generally the exception for coding.
• It is typically used:
  • Significant exacerbation or change in the patient’s condition,
  • Non-compliance with the treatment/plan,
  • Counseling regarding previously performed procedures or tests to determine future treatment options, or
  • Behavior/school issues.

Required Documentation For Billing:

1. Total time of the encounter excluding separate procedure if billed
   • The entire time to prep, perform and communicate results of a billable procedure to a patient must be carved out of the E/M encounter time!

2. The amount of time dedicated CCC for that patient on that date of service. A template statement would not meet this requirement.
# Time-Based Billing for CCC

## Outpatient Counseling Time:

<table>
<thead>
<tr>
<th>Code</th>
<th>Duration</th>
</tr>
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<tbody>
<tr>
<td>99201</td>
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</tr>
<tr>
<td>99202</td>
<td>20 min</td>
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<tr>
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## Inpatient Counseling Time:

<table>
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<th>Duration</th>
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<tr>
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<td>99254</td>
<td>80 min</td>
</tr>
<tr>
<td>99255</td>
<td>110 min</td>
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</tbody>
</table>
Counseling/Coordination of Care CCC

Proper Language used in documentation of time:

• “I spent ____ minutes with the patient and family and over 50% was in counseling about her diagnosis, treatment options including _______ and ______.”

• “I spent ____ minutes with the patient and family more than half of the time was spent discussing the risks and benefits of treatment with……(list risks and benefits and specific treatment)”

• “This entire ______ minute visit was spent counseling the patient regarding ________ and addressing their multiple questions.

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

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

Patient not seen by you or your billing group in the past three years (as outpatient or inpatient)
TWO MIDNIGHT RULE DECISION TREE FOR MEDICARE PATIENTS

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

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

- **NO**: Is the patient receiving an Inpatient only procedure? (Consult case management)

  - **YES**: Write an Inpatient Order

  - **NO**: Is the patient newly ventilated? (Excluding ventilation during surgery)

    - **YES**: Write an Inpatient Order along with expected length of stay

    - **NO**: Write an order for Outpatient OR Outpatient Observation Status

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

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

Inpatient Hospital

• Subsequent Hospital Care

  Three levels of service: 99231, 99232, 99233

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

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

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

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

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

What’s wrong with this audit?

Day 1: 99223
Day 2: 99233
Day 3: 99233
Day 4: 99233
Day 5: 99233
Day 6: 99239 (discharge to home)
Hospital Discharge

IMPORTANT!

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

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

99223 * PATIENT ADMITTED

99233 * (PT. IS UNSTABLE)

99232 * (PT. HAS DEVELOPED MINOR COMPL.)

99231 * (PT. IS STABLE, RECOVERING, IMPROVING)

99238 * PATIENT DISCHARGED
Hospital Observation Services

• Admission/Discharge on **different** days:
  • 99218: Detailed history/exam, low-complexity MDM
  • 99219: Comprehensive history/exam, moderate MDM
  • 99220: Comprehensive history/exam, high MDM
  • 99217: Observation Discharge

• Admission/Discharge on **same** day:
  • 99234: Detailed history/exam, low-complexity MDM
  • 99235: Comprehensive history/exam, moderate MDM
  • 99236: Comprehensive history/exam, high MDM

*Subsequent Observation: 99224, 99225, 99226 (New 2011)*
Modifiers

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

• Medicare is monitoring these codes!

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

You will be audited if you regularly use these codes! Ensure documentation supports the E/M and significant separate procedure.
Modifier 25 – Be ALERT

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

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

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

• Only a practitioner or coder should assign a modifier 25 to a Claim – Not a biller.
Preventive Visit and E/M Same Day

• "If the problem is significant enough that it would require the patient to come back for another issue if you didn't address it, that's a sign that it could warrant a problem-based E/M code". "In addition, check whether the problem-based visit has its own ICD-10 code. Also, these separate visits typically require some evaluation and treatment such as x-ray or lab tests, and may require a prescription".

• **Example**: The physician performs a preventive medicine visit on a 9-year-old girl (99393). During the visit, he also reevaluates her ADHD and adjusts her medication. Therefore, you'll report 99393 linked to well visit Dx for the preventive medicine visit, along with a problem-based E/M code such as 99213-25 linked to Dx for the ADHD. You'll most likely select the problem-based E/M code on the amount of time spent counseling the patient related to the ADHD problem.
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.
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

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<tr>
<th>Time</th>
<th>Codes</th>
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<td>75-104 min</td>
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<td>105-134 min</td>
<td>99291 x 1 and 99292 x 2</td>
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<tr>
<td>135-164 min</td>
<td>99291 x 1 and 99292 x 3</td>
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</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 (28 days or younger). . .
  - When the neonate or infant improves after the initial day and is transferred to a lower level of care, the transferring physician does not bill a per day intensive care service. Subsequent hospital care (99231–99233) is billed. 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 bills either the critical care services performed (99291–99292) or the intensive care service performed, but not both. The receiving physician bills subsequent inpatient neonatal or pediatric critical care (99469, 99472).
  - For the subsequent care of the sick neonate (present body weight less than 1500 grams) bill **99478**
  - For the subsequent care of the sick neonate (present body weight 1500-2500 grams) bill **99479**
  - For the subsequent care of the sick neonate (present body weight 2501-5000 grams) bill **99480**
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.
Unacceptable TP Documentation

• Assessed and Agree
• Reviewed and Agree
• Co-signed Note
• Patient seen and examined and I agree with the note
• As documented by resident, I agree with the history, exam and assessment/plan
Evaluation and Management (E/M)

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

- Critical Care Hospital Discharge (>30 minutes) or
- E/M codes where more than 50% of the TP time spent counseling or coordinating care

*Medical Student documentation* for billing only counts for ROS and PFSH. All other contributions by the medical student must be re-performed and documented by a resident or teaching physician.
TP Guidelines for Procedures

**Minor** – (< 5 Minutes): For payment, a minor procedure billed by a TP requires that s/he is physically present during the entire procedure.

   **Example:** ‘I was present for the entire procedure.’

**Major** – (>5 Minutes)

- SINGLE Procedure / Surgery — When the teaching surgeon is present or performs the procedure for a single non-overlapping case involving a resident, he/she or the resident can document the TP’s physical presence and participation in the surgery.

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

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

TP must be present during the entire viewing for payment.

- The viewing begins with the insertion and ends with the removal.
- Viewing of the entire procedure through a monitor in another room does not meet the presence requirement.
• TEACHING PHYSICIANS WHO SEEK REIMBURSEMENT FOR OVERSIGHT OF PATIENT CARE BY A RESIDENT MUST PERSONALLY SUPERVISE ALL SERVICES PERFORMED BY THE RESIDENT.

• PERSONAL SUPERVISION PURSUANT TO RULE 59G-1.010(276), F.C.A, MEANS THAT THE SERVICES ARE FURNISHED WHILE THE SUPERVISING PRACTITIONER IS IN THE BUILDING AND THAT THE SUPERVISING PRACTITIONER SIGNS AND DATES THE MEDICAL RECORDS (CHART) WITHIN 24 HOURS OF THE PROVISION OF THE SERVICE.
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."
Top Compliance Issues For Documenting in EMR
PAYORS ARE WATCHING EMR DOCUMENTATION

Once you sign your note, YOU ARE RESPONSIBLE FOR ITS CONTENT
Documentation in EMR

• Every exam component . . .

• Every time you copy forward Family/Social History . . .

• Every HPI and ROS item you document means YOU PERFORMED THEM ON THAT VISIT . . .

• If you document something you did not do . . .

YOU ARE PUTTING YOURSELF AND THE INSTITUTION AT GREAT RISK!
Top Compliance Rules for EMR

Use “Copy Forward” with caution

• Each visit is unique

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

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

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

Don’t dump irrelevant information into your note

• (“the 10-page follow-up note”)

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

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

• Self-explanatory
Top Compliance Rules for EMR

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

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

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

• Cautious with ROS and Exam

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

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

- Demonstrates Medical Necessity
- Know your covered diagnoses for your common labs
Top Compliance Rules for EMR

Individualize every note with a focus on the HPI and Medical Decision Making

• Results is correct coding with the focus of an E/M selection on medical necessity
Copy/Paste Philosophy:

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

• Don’t say Today, Tomorrow, or Yesterday

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

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

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

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

• “Added heparin on 4/26” – uses past tense and specific date for better accuracy
Document the Exam ACTUALLY PERFORMED

• Always better to document “fresh” exam every day

• If copied forward or templated, review the exam closely and make corrections to items you did not perform

• Credibility is questioned when ear exam is documented every day, or when amputee has “2+ pulses in bilateral lower extremities”
Copy / Paste Summary

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

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

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

Who is a NPP?

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

• Collaborative agreement between the NPP and the group they are working with is required.
  • The agreement extends to all physicians in the group.
    • If the NPP is performing procedures it is recommended a physician confirm their competency with performance of the procedure.
• NPPs can bill independent under their own NPI # in all places-of-service and any service included in their State Scope of Practice.
  • Supervision is general (available by phone) when billing under their own NPI number.
  • Medicare and many private insurers credential NPPs to bill under their NPI.
  • Some insurers pay 85% of the fee schedule when billing under the NPP and others pay 100% of the fee schedule.
• Incident-to in the office (POS 11) ONLY
• 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.
Bill Independently and Not Shared

Billing Under The NPP NPI

• Does not require physician presence.
• Can evaluate and treat new conditions and new patients.
• Can perform all services under the state scope-of-practice.
• Can perform services within the approved collaborative agreement.
  • Recommend physician establish competency criteria and demonstration of performance of procedures within the collaborative agreement between the NPP and physician.
“INCIDENT TO”

• “Incident to” services must be an integral part of the patient’s treatment course

• Provided under the physician’s direct personal supervision (Physician must be present in the office suite and be immediately available to provide assistance and direction throughout the time the services are being performed)

• Commonly rendered without charge (included in physician’s professional services)

• Commonly furnished in a physician’s office (not in a hospital setting)

• Auxiliary Personnel must be directly employed by the physician, physician group or entity that employs the physician or may be a leased employee
Established Patient Visits: “Incident to” Billing Requirements

• Incident-to services are those services commonly furnished in a physician’s office that are “incident to” the professional services of a physician.
• Physician must personally perform an initial service for each new condition, make an initial diagnosis, and establish a treatment plan.
• Physician must personally perform subsequent services at a frequency that reflects his/her active participation in and management of the course of the treatment for each medical condition.
• Services must be performed under a physician’s direct personal supervision: (Present in the office suite and immediately available to provide assistance and direction throughout the time the ancillary staff, ARNP, PA is performing the “incident to” services.)
Scribed Notes

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

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

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

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


Scribed Notes

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

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

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

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

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

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

- The following attestation should be entered by provider when closing the encounter:
  - “I was present during the time the encounter was recorded with [patient name]. I have reviewed and verified the accuracy of the information which was performed by me.” [Name of provider][Date and time of entry].
“Whoa—way too much information.”
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
CASE SAMPLES
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 Officer; 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 (24hours a day, seven days a week).

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