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

Department of Radiation Oncology
Why Are We Here?

• To **EDUCATE** and **PROTECT** our providers and organization

• To provide you with every tool you need to maximize compliance and get paid what you deserve

• To update you on the latest CMS/OIG activities
Radiation Oncology

• Use of high-energy ionizing radiation in treatment of:
  • Malignant Neoplasms
    • Curative
    • Control Cell Growth
    • Part of Adjuvant Therapy
      • Prevent recurrence
      • Before, during, and after chemotherapy
  • Certain Non-Malignant Conditions
3 Main Divisions of Radiation Therapy

• External beam radiation therapy (EBRT or XRT) or teletherapy
  • Outside the body
• Brachytherapy or sealed source radiation therapy
  • Placed in the body
  • Temporary or permanent placement
• Systemic radioisotope or unsealed source radiotherapy
  • Given by infusion or orally
Place of Service

- Payment is limited to services in:
  - Office (POS 11)
  - Inpatient hospital (POS 21)
  - Outpatient hospital (POS 22)
    - CR9231
    - POS 19 is for off campus-outpatient hospital
    - POS 22 for on campus-outpatient hospital
  - Freestanding radiation oncology center considered an office
    - For billing purposes = POS 99
Supervision Requirements
What is “Supervision”? CMS defines three levels of physician supervision for hospital outpatient departments:

• General supervision: The physician or non-physician practitioner (NPP) must be available by telephone to provide assistance and direction if needed.

• Direct supervision: The physician or NPP providing supervision must be “immediately available” and “interruptible” to provide assistance and direction throughout the performance of the procedure, but without reference to any particular physical boundary; however, he or she does not need to be present in the room when the procedure is performed.

• Personal supervision: The physician or NPP must be in attendance in the room during the procedure.
Supervision Requirements

Chemotherapy and radiation therapy require direct supervision

• All therapeutic services are subject to CMS’s supervision requirements. Under these requirements, both chemotherapy and radiation therapy require direct supervision in both the hospital outpatient and freestanding settings.

• Certain NPPs (CP, NP, PA, CNS, LCSW, CNM) may supervise therapeutic services that they may personally perform under State law and hospital privileges, subject to their conditions of coverage in 42 CFR Part 410 (except PR/CR/ICR which require a physician)
Supervision Requirements

Physicians and NPPs can provide supervision in hospital outpatient departments

- CMS states that a physician or NPP, such as a nurse practitioner (NP) or physician assistant (PA), must provide direct supervision of therapeutic services. The person providing supervision must be permitted to do so under state law, scope of practice regulations, and their hospital-granted privileges. In addition, he or she must have sufficient knowledge and training to be able "to furnish assistance and direction, not merely manage an emergency."
Does radiation therapy have special requirements?

• CMS does not explicitly state that radiation therapy must be supervised by a radiation oncologist or trained NP, and although many providers have asked for clarification on radiation therapy requirements, CMS has declined to provide clarification. It states only that it requires that “the supervisory physician or non-physician practitioner must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the services or procedure...The supervisory responsibility is more than the capacity to respond to an emergency...”

• If your hospital-based cancer program is currently providing radiation therapy services without specialist supervision, your program leaders should consult with your institution's legal counsel to formulate a policy that they feel is clinically defensible.
Supervision Requirements

For example, if radiation therapy services were being provided in a hospital outpatient department and the radiation oncologist who was supervising those therapeutic services left the hospital campus, a qualified physician or physician practitioner would need to be immediately available to supervise the procedures.

If there is no qualified supervising physician immediately available, no radiation therapy services provided during his/her absence can be covered by Medicare. The services covered under this benefit also include materials and services of technicians.
More stringent requirements in the freestanding setting

- CMS’s supervision requirements set a higher bar for physician offices and freestanding centers than for hospital outpatient departments. Whereas CMS allows NPPs to provide supervision in hospital outpatient departments, a physician is required to supervise these services in the freestanding setting.

- In addition, CMS does not require the supervising practitioner in the hospital outpatient setting to be physically present in the same office suite, just that he or she is "immediately available." In contrast, the supervising physician in the freestanding setting must be present in the office suite or center.
Local Coverage Determinations (LCDs)
Creation and Purpose of LCD

• Local Coverage Determinations (LCDs) are created by the Medicare Administrative Contractor (MAC)
  • Local contractor level
  • Contractor Medical Directors responsibility
• May or may not be associated with a National Coverage Determination (NCD)
  • Assist in determining reasonable and necessary criteria
• LCDs cannot restrict or conflict with an NCDs
  • Or any CMS interpretive manuals
Locating LCDs
IMRT Coverage Criteria

• Patient already received maximum radiation delivered by conventional means

• One or more of the following must be supported in medical record:
  • Target volume irregular shape and close to critical structures that must be protected
  • Volume of interest in location only defined by MRI or CT
  • Important structures close to margin need additional safety and morbidity reduction
IMRT Coverage Criteria (2)

- One or more continued documented criteria:
  - Adjacent area irradiated and abutting portals must be established with high precision
  - Tumor volume margins are concave and close to critical structures
  - Tumor tissue lies in areas with target motion caused by cardiac and pulmonary cycles, with need to protect adjacent normal tissues
  - Non-IMRT would cause grade two or three radiation toxicity in > 15% of radiated cases

- One or more continued documented criteria:
  - Only option to cover volume of interest with narrow margins and protect immediately adjacent structures
  - Dose distributions required that cover extremely concave target geometries
IMRT Coverage Criteria \(^{(3)}\)

- Sparing surrounding normal tissue is essential
- One or more of the following must be supported in medical record:
  1. Important structures close to margin need additional safety and morbidity reduction
  2. Adjacent area irradiated and abutting portals must be established with high precision
  3. Gross Tumor Volume (GTV) margins are concave and close to critical structures
  4. Non-IMRT would cause grad two or three radiation toxicity in > 15% of radiated cases
IMRT Indications

- Current indications include
  - Primary brain tumors and brain metastasis
  - Prostate cancer
  - Lung cancer
  - Pancreas cancer
  - Other upper abdominal sites
    - Special provision for organ motion
  - Spinal cord tumors
  - Head and neck cancer
  - Adrenal tumors
  - Pituitary tumors
  - Some left breast tumors

- With medical necessity documentation
  - Some gynecologic tumors
  - Some genitourinary tumors
  - Some lymphomas, malignant lymph nodes or sarcomas
Clinical Treatment Planning
77261 - 77263

- Prior to specific IMRT treatment plan
  - Interpretation of special testing
  - Tumor localization
  - Treatment volume determinations
  - Treatment time/dosage determinations
  - Choice of treatment modality(ies)
  - Selection of appropriate treatment devices
  - Other procedures such as concurrent or sequential chemotherapy or surgery
Clinical Treatment Planning
77261 – 77263 (2)

• Separately-documented work
  • Itemizing specific services provided
• Review of records, pathology reports and/or imaging studies as basis for claiming either”
  • Higher-level evaluation and management (E/M) services preceding treatment planning, or
  • As a component of this code
• Don’t count planning services under both codes
Simulation-Aided Field Setting
77280 - 77295

• Not reported separately from 77301 regardless of the date of service
  • Only exception IF:
    • Different target volumes are being targeted using different methods of radiation delivery
  • Refer to Chapter Nine of the NCCI Policy Manual Section F #15: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

• Complex simulation – 77290
  • Immobilization device constructed;
  • Isocenter(s) and volume of interest are determined; and
  • CT or other imaging is obtained
Simulation-Aided Field Setting
77280 - 77295

• Simple simulation – 77280
  • Simulation is for the purpose of field verification
  • Not reported separately for IMRT
    • 77301 includes therapeutic radiology simulation-aided field settings
Basic Dosimetry
77300

• Appropriately billed if:
  • Separate and distinct service
    • Over and above IMRT plan
  • Prescribed by treating physician
  • Necessary, independent calculation(s)
    • Outside IMRT parameters
    • Different DOS
IMRT Plan 77301

- IMRT plan requires radiation oncologist’s signed/dated review of computer-generated record
  - CT or MRI based images of the target and all critical structures with representative isodose distributions that characterize the 3-D dose
  - Dose-volume histograms for all target and critical structures
Additional Services

- Teletherapy Isodose Plan (77306, 77307, 77321)
  - Appropriate for another modality
- Brachytherapy Isodose Plan (77316-77318)
  - Appropriate for separate, accompanying brachytherapy modality
Special Dosimetry
77331

• Included in 77301
• Separate fee appropriate
  • Medical necessity is documented
  • Occur at separate time
  • During course of IMRT
Treatment Devices (Blocks)

- Separate and distinct device - 77332-77334
  - From IMRT device
  - Use 77332-77334 as appropriate
  - Modifier 59 if necessary
  - Document specifics

- MLC treatment devise – 77338
  - Multi-leaf collimator (MLC) treatment devise
  - Normally once per IMRT plan
  - Not used with compensator based IMRT
Continuing Medical Physics Consultation 77336

- Weekly continuing medical physics process and reports
  - Of medical physicist
  - Use of report three or four fractions beyond multiple of five
- Don’t use for creation of IMRT plan
Special Medical Radiation Physics Consultation 77370

• Medically necessary
• Documented
• Occur separately than IMRT planning
  • Another modality
Radiation Treatment Delivery
77401, G6004-G6014, 77422-23, 0182T

• Not to be used with G6015 or G6016
• Use prior to or subsequent to IMRT treatment course
  • Different modality
Radiation Treatment Management
77427

• “Weekly” (five-fractions) management of patients

• Radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished. The services need not be furnished on consecutive days. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days.

• Code 77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately.

• Radiation treatment management requires and includes a minimum of one examination of the patient by the physician for medical evaluation and management (e.g., assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab test results with documentation) for each reporting of the radiation treatment management service.

• The professional services furnished during treatment management typically include:
  
  • Review of port films
  • Review of dosimetry, dose delivery and treatment parameters
  • Review of patient treatment set up
Special Treatment Procedure 77470

- Not used for part of IMRT planning
- Appropriately use
  - Respective treatment is being delivered as separate therapy
  - Moderate physician work
  - Considerable practice expense
  - Document specifics

**IMRT Documentation Requirements**

1. Reasonable and necessary requirements
2. Prescription must define:
   - Goals/requirements of treatment plan
   - Specific dose constraints and nearby critical structures
3. Treating physician statement of need for IMRT
4. Signed and dated IMRT inverse plan
   - Meeting prescribed dose constraints
   - Using either DMLC, SMLC, or inverse planned IMRT solid compensators
IMRT Documentation Requirements (2)

5. Target verification methodology includes:
   • Clinical treatment volume (CVT) and planning target volume (PTV)
   • Immobilization and patient positioning
   • Means of dose verification

6. Monitor units (Mus) independently checked before first treatment

7. Documentation of fluence distributions recomputed in phantom, or equivalent methodology consistent with Patient Specific IMRT Treatment Verification

8. Structure movement created by respiration
   • Voluntary breath holding not appropriate
   • Best accomplished with gating technology

9. Clinical treatment planning (77261-77263) should meet specialty criteria
IMRT Delivery

• Specially trained team (based on state scope of license) includes:
  • Radiation Oncologist
  • Medical physicist
  • Dosimetrist
  • Radiation therapist
  • Radiation therapy nurse
Brachytherapy: Non-intracoronar

- Two phases:
  - Insertion of non-radioactive applicators or conduits
  - Loading of radioactive material
- Three clinical formats
  - Interstitial
  - Intracavitary/intraluminal
  - Surface
- May use solid radioactive sources (seed) or liquid colloid isotopes
  - May be temporary or permanent
- High or low dose rate
- Independent or adjunctive treatment
Indications

- **Low Dose Rate (LDR)**
  - Delivered over several days
  - Hospital setting
- **High Dose Rate (HDR)**
  - Delivered in minutes
  - Outpatient basis
- **Pulsed Dose Rate (PDR)**
  - 1-2 hourly schedule over 1-2 day
Treatment Planning
77263

• Designated complex

• Adjunct to External Beam Therapy (EBT)
  • Single complex treatment planning code to encompass both modalities
  • Unless different Provider and POS
Dosimetry
77300

• Calculations made throughout treatment
• Each basic dosimetry calculation submitted for brachytherapy treatment
• 2016 MCCN manual updates:
  • 77300 should not be reported with 77295
  • 77300 are integral to the procedure described by 77295
  • 77300 should not be reported 77767-77772, 77778
Special Treatment Procedure 77470

• Brachytherapy delivery includes
  • Special arrangements operating room/radiation safe ward
  • Coordination with other specialist
  • Preparation and provision of applicators and related equipment
  • Scheduling and integration of physics support
  • Acquisition and preparation of radiation sources
Simulation
77280-77296

• May require use of imaging exams of implanted sources or applicator(s) containing dummy sources
  • Used to develop isodose curves and other dosimetry
  • Bill separately

• Bill 77295
  • When needed parameters are included
  • Precludes use of 77326-77328 for same volume
Isodose Planning
77316-77318

• Determines dose
  • At each source
  • Throughout treatment volume
  • To surrounding normal tissue
Handling>Loading of Radioelement 77790

• Manual loading of isotope required
  • Lose dose rate
• Not separately reportable with any remote after loading codes 77770-77772
Source Application/Placement
77750, 77761 77763, 77778, and 77789

- Selection/placement of after-loading applicators
- Loading/unloading of radioactive sources
- Choice of applicators
- After-loading device placement

Performed by:
- Radiation oncologist alone
- In collaboration with other physicians
Treatment Devices
77332-77334

- Include use of certain templates, molds, or other apparatus
  - Required for specific clinical circumstances
  - Document
- Pre-manufactured, commercially available devices are simple devices
Medical Physics Services
77331, 77336, 77370

- 77331 is special dosimetry
  - Thermoluminescent dosimetry [TLD], microdosimetry
- 77336 = "weekly code"
  - Report 1 for each 5 fractions
  - Report for final 3, 4 or 5 fractions
  - Report for course of only 1 or 2 fractions
- 77370
  - Complex interrelationships of electron and photon ports
  - Complex dosimetric consideration in brachytherapy
    - High dose rate remote afterloader applications
    - Intravascular brachytherapy treatments
    - Interstitial radioactive seed implantation
Breast Brachytherapy by Balloon Catheter(s)

• All three coverage criteria must be met:
  • Tumor < 3 cm, or 2 cm if stage T1
  • No Cancer at surgical margins
  • ≤ 3 lymph nodes containing cancer

• Afterloading balloon catheter
  • Placed during breast surgery - 19297
  • Subsequent session - 19296

• Coverage criteria
  • Prior site of the tumor is a fluid filled seroma (cavity)
  • Seroma is not located directly under the skin
  • Seroma is not large or irregular in shape
  • 19298 - Placement of multiple tube/button type catheters
Limitations

• Do not report radiographs as port-films
• Follow-up visits within 90 days bundled
• Comfort items not charged as treatment devices
  • Pillows, pads, cushions etc.
• Only authorized physicians work with radioactive materials
  • Authorized as a user by Nuclear Regulatory Commission or an Agreement State for brachytherapy
• E/M codes for new patients

• Brachytherapy professional component includes:
  • Hospital admission
  • Subsequent hospital care
  • Discharge summary
Documentation

• Treatment goals
• Patient’s informed consent to treatment
• Reflect each service in a clear, linear and temporally logical form
  • Flow charts
• Available to Medicare upon request
• A written, signed and dated prescription/treatment plan
  • Designed by radiation oncologist
  • Designation of the treatment site
  • Designation of the isotope
  • Designation of the number of source positions
  • Planned dose to each point
2016 Update

• Effective January 1, 2016 CPT added:
  • Group 1: 77770, 77771, 77772, 0395T
  • Group 2: 77767, 77768, 0394T

• Multiple ICD-10 codes removed and/or added from Group 1 to Group 2

• Refer to Latest Updates article posted 12/30/16:
Stereotactic body radiation therapy (SBRT)

- Target lesion localized relative to 3D reference system
  - High degree of anatomic accuracy/precision
- SBRT devices
  - Body frame with external reference markers
  - Implanted fiducial markers
  - CT imaging-based systems
SBRT

• At least one form of image guidance
• **Motion control or "gating" may be used**
• May be fractionated (up to five)
  • Fractions require identical degree of precision, localization and image guidance
• Treatment beyond five fractions not considered SBRT
SBRT Billing

• No more than one treatment delivery code per day
  • Example, a stereotactic approach with IMRT. **Only one** delivery code is to be billed
SBRT Indications

• Lung, liver, kidney, adrenal gland, pancreas or prostate neoplasms:
  • Criteria for primary and metastatic tumors
  • Other radiotherapies cannot be as safely or effectively utilized
  • Tumor can be targeted with acceptable risk
  • Chemotherapy exhausted or not feasible for tumor histology showing germ cell or lymphoma
  • Other forms of focal therapy cannot be as safely or effectively utilized
SBRT Indications

• SBRT for prostate cancer only:
  • Other forms of first line therapy are not available or feasible since other forms have known long term success and complication rates; and
  • All of the criteria listed on previous slide are documented in the medical record; or
  • Patient enrolled in approved clinical study listed in ClinicalTrials.Gov
SBRT Indications

• Other neoplasms
  • Primary definitive SBRT – not covered
  • Recurrence after conventional radiation modalities – may be covered
Limitations

• Treatment unlikely to result in clinical cancer control and/or functional improvement
• Patients with wide-spread cerebral or extra-cranial metastases
• Patients with poor performance status
  • Karnofsky Performance Status less than 40
Documentation Requirements

• Support medical necessity and frequency
• Patient history/physical
• Functional status
• Karnofsky Performance Status
• Date and current treatment dose
• Radiation oncologist evaluation and management decisions
Utilization

• 77435 - only once per course of treatment of SBRT
• 77373 - once per day of treatment
  • Regardless of number of sessions/lesions
Stereotactic Radiosurgery (SRS)

- Distinct discipline
  - Utilizes externally generated ionizing radiation
  - Inactivate or eradicate defined target(s)
    - Head or spine
    - Without incision
  - Usually single session, maximum of five
  - Use guidance and immobilization

- Multidisciplinary team
  - Neurosurgeon
  - Radiation oncologist
  - Medical physicist
Bundled into SRT and SRS

• Both SRT and SRS procedures include the following components:
  1. Position stabilization
  2. Imaging for localization
  3. Computer assisted tumor localization
  4. Treatment planning - number of isocenters, number, placement and length of arcs or angles, beam size and weight, etc
  5. Isodose distributions, dosage prescription and calculation
  6. Setup and accuracy verification testing
  7. Simulation of prescribed arcs or fixed portals
  8. Radiation treatment delivery
Billing for Neurosurgeons

- Following codes allowed for neurosurgeons only when:
  - Present
  - Medically necessary
  - Fully participating
- 61796, 61797, 61798, 61799, 61800, 63620 and 63621
- Medical records must clearly document need
Billing for Radiation Oncologist

• SRS management codes:
  • 77432 - single fraction SRS
    • Once per treatment course
    • Fully participating
  • 77435 - two to five fractions
• Cannot bill 77432 and 77435 for same course of therapy
• May bill other 77xxx codes
• May bill one surgery code
  • 61796, 61798 or 63620
• Not in conjunction with the radiation (77 xxx) series codes
Additional Billing

• 77300 Basic dosimetry
  • One unit per arc in a linear accelerator, or
  • One unit per shot in cobalt-60 system
  • If unit exceed six detailed explanation of medical necessity in medical record

• 77334 Treatment devices
  • One unit per collimator in linear accelerator, or
  • One unit per each helmet in cobalt-60 system
  • If unit exceed six detailed explanation of medical necessity in medical record
Indications for SRS

1. Primary central nervous system malignancies, generally under 5 cm
2. Primary/secondary tumors involving the brain/spine parenchyma, meninges/dura, or immediately adjacent boney structures
3. Benign brain/spinal tumors such as meningiomas, acoustic neuromas, pituitary adenomas, and pineal cytomas
4. Cranial arteriovenous malformations and hemangiomas
5. Other cranial non-neoplastic conditions for which it has been proven effective
Indications for SRS

6. As a boost treatment for larger cranial or spinal lesions that have been treated initially with EBRT or surgery

7. Metastatic brain or spine lesions, generally limited in number, with stable systemic disease

8. Relapse in a previously irradiated cranial or spinal field where the additional stereotactic precision is required to avoid unacceptable vital tissue radiation
Limitations

• Coverage denied for the following
  1. Treatment for other than a severe symptom or serious threat to life or critical functions, not responsive or reasonably amenable to another therapy
  2. Treatment unlikely to result in functional improvement or clinically meaningful disease stabilization
  3. Patients with wide-spread cerebral or extra-cranial metastases
  4. Karnofsky Performance Status less than 40
Limitations

5. Stereotactic cingulotomy as means of psychotherapy
   • Considered investigational

6. ICD-10-CM code G25.0, essential tremor
   • Patient who cannot be controlled with medication
   • Major systemic disease or coagulopathy
   • Unwilling or unsuited for open surgery
   • Unilateral thalamotomy
   • Gamma Knife pallidotomy - non-covered
Documentation Requirement

• Support medical necessity and frequency
• Patient history/physical
• Functional status
• Karnofsky Performance Status
• Date and current treatment dose
• Radiation oncologist and neurosurgeon evaluation and management decisions
• Radiation oncologist and medical physicist evaluation and management decisions
Utilization

• 77435 - only once per course of therapy
  • Equal to or less than five fractions
• 77432 - only once per course of treatment
  • Regardless of number of cranial (and spinal) lesions
• 77435 and 77432 cannot be bill for same course of therapy
Stereotactic radiosurgery (SRS) and Stereotactic Body Radiation Therapy (sbrt)

Indications for Cranial Lesions Only

1. Primary central nervous system malignancies, lesions < 5 cm
2. Primary and secondary tumors involving the brain or spine
3. Benign brain tumors and spinal
4. Cranial arteriovenous malformations, cavernous malformations, and hemangiomas
5. Other cranial non-neoplastic conditions
6. Metastatic brain or spine lesions, with stable systemic disease
   • Karnofsky Performance Status 40 or greater
7. Relapse in previously irradiated cranial or spinal field
   • Additional stereotactic precision required to avoid unacceptable vital tissue radiation
SRS/SBRT Limitations
Cranial Lesions Only

• Not considered medically necessary and will deny:
  • Treatment for other than severe symptom or serious threat to life or critical functions
  • Treatment unlikely to result in functional improvement or clinically meaningful disease stabilization
  • Patients with wide-spread cerebral or extra-cranial metastases with limited life expectancy
  • Karnofsky Performance Status less than 40 or ECOG greater than 3
  • Cobalt-60 pallidotomy is non covered
SRS/SBRT Limitations
Cranial Lesions Only

• Basic dosimetry 77300
  • One unit per arc in a linear accelerator
  • One unit per shot in Cobalt-60 system
    • Maximum 10 units

• Treatment devices 77334
  • One unit per collimator in a linear accelerator
  • One unit per helmet in Cobalt-60 system
  • Units greater than six detailed explanation required in medical record
SBRT Indications

• Primary tumors of and tumors metastatic to:
  • Lung, liver, kidney, adrenal gland, or pancreas as well as for pelvic and head and neck tumors that have recurred after primary irradiation

• Each of the following criteria must be met:
  • Patient's condition justifies aggressive treatment to primary cancer or, for metastatic disease, justifies aggressive local therapy to one or more discrete deposits of cancer
  • Other radiotherapy cannot be safely or effectively utilized
  • Tumor burden completely targeted with acceptable risk to critical normal structures
  • Chemotherapy exhausted/EBRT ineffective or inappropriate for tumor histology showing germ cell or lymphoma
SBRT Indications

• Other Neoplasms
  • Tumors in or near previously irradiated regions, if high level of precision and accuracy is needed
  • If high dose per fraction treatment is indicated
  • Low or intermediate risk prostate cancer
    • May be covered if patient enrolled in IRB-approved clinical trial
    • May be covered if patient enrolled in clinical registry
SBRT Limitations

• Primary treatment of lesions of bone, breast, uterus, ovary, and other internal organs are non-covered
  • May be covered for setting of recurrence after conventional modalities

• SBRT not considered medically necessary:
  1. Treatment unlikely to result in clinical cancer control and/or functional improvement
  2. Tumor cannot be targeted without risk to critical structures
  3. Karnofsky Performance Status less than 40 or ECOG status of three or worse
Active LCD Policies

• FCSO - L33410 - Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)

• WPS - L34599 - Stereotactic Computer Assisted Volumetric and/or Navigational Procedures
Noteworthy and References
Bundled Services*

• Radiation Therapy Treatment management bundled services/codes include:
  • Anesthesia
  • Dosage verification
  • Infected skin care
  • Nutritional counseling
  • Pain management

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<th>99211-99215</th>
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<td>11920-11922</td>
<td>16000-16030</td>
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*Not all inclusive
Helpful Hints

• Signatures (complete and legible) needed
  • Need to be dated
  • Documentation
  • Treatment sheets
  • Dose Calculations (showing your work)

• Orders Required for any service not entirely performed by you. Some examples include:
  • Simulations
  • Continuing Medical Physics Consultation
  • Dose Calculations
  • IGRT

• Read LCD policies
  • Diagnosis codes listed
  • Documentation instructions

• Global payment to Ambulatory Surgical Center (ASC)
  • If services allowed and applicable supervision requirements met
Most Identified Issues in Audits by CCI

• Lack of Medical Necessity Documented for IGRT
• Images were not reviewed prior to the next treatment
• Images were not reviewed prior to the final treatment
• Lack of documentation of physician involvement with verification simulations
CMS Removing Edit of 77295 & 77300

• After the diligent work of several radiation oncology societies CMS has agreed to delete the NCCI Edit which created a procedure-to-procedure edit with column one CPT code 77295, 3-dimensional radiotherapy plan, including dose-volume histograms, and column two code 77300, basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician.

• When this edit was implemented on January 1, 2016, code 77300 was considered integral to the 3D plan and no longer billable with code 77295 by hospitals, physicians or freestanding cancer centers.

• According to CMS, the edit will be deleted in the July 1, 2016, release of the NCCI edit updates. In addition, the deletion will be retroactive to January 1, 2016, the implementation date of the edit.

• CMS will also revise the National Correct Coding Initiative Policy Manual for Medicare (Medicaid) Services, Chapter IX (Radiation Oncology), subsection 17 of the 2017 version of the Manual.

• Providers (hospitals, physicians and freestanding cancer centers) should continue to track and capture the supported work of code 77300 during the 3D planning process. When the transmittal is released, providers will be able to submit those charges, along with the retroactive charges, for payment and in accordance with documentation guidelines and published Medically Unlikely Edits (MUEs).
“Telling Time by the Breast” - Radiation Oncology News

• **March 2016 Radiation Oncology News**: Rebecca Hill BSRT (T) Excerpt from article

• We learn how to tell time when we’re young, yet, like many childhood lessons, it’s a skill we may not expect will apply to other aspects of our life later on. At first, learning how to use a clock might be a challenge but using one to apply a diagnosis code to breast cancer is fairly simple.
  
  • Even though it’s easy, providers can often fail to accurately assign the proper diagnosis code for patients diagnosed with breast cancer. The result: improperly diagnosed patients, which can affect data for research as well as reimbursement. Chapter 23 of the Medicare Claims Processing Manual instructs, “Proper coding is necessary on Medicare claims because codes are generally used in determining coverage and payment amounts.”

• Here’s an example of documentation featuring the information needed—including a clock-face-position reference—to apply an accurate diagnosis code sequence of C50.211 and Z17.1: “Ms. Smith presents today with right-sided infiltrating ductal carcinoma of the breast that is ER negative, PR negative and located in the 1 o’clock position.” Another example reads, “Ms. Doe was previously diagnosed with ER/PR positive invasive carcinoma of the left breast, having a 3 cm lesion in the lower outer quadrant at the 5 o’clock position biopsied and excised with negative margins.”

• This information allows the patient to be properly assigned the diagnosis codes C50.512 and Z17.0. Despite adequate information being available to allow for proper coding, it’s not uncommon to see these types of cases coded simply C50.811 and C50.812 or C50.911 and C50.912, respectively. These examples don’t pertain to in situ breast cancer, of course, which is included in a different section of codes found in the D05.00-D05.92 section of the neoplasm family.

• In other instances, oncology providers may fail to identify the location of breast cancer as well as other detailed information needed to assign an appropriate diagnosis code. Information necessary to code to the highest level of specificity regarding breast cancer is cell type, gender, laterality, quadrant and ER +/- . Without this data, staff may use unspecified codes or even the incorrect diagnosis code. Frequently, the physician’s evaluation and management documentation don’t include the information necessary to identify the highest level of specificity. In these cases, staff should locate the missing information to avoid assigning an unspecified code.

• If used appropriately, ICD-10-CM offers many benefits, including increased measures of quality, research, patient safety and overall care, reduction of audits and value-based payments.
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 physician/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.”
Diagnostic Procedures

• **RADIOLOGY AND OTHER DIAGNOSTIC TESTS**

• **General Rule:** The Teaching Physician may bill for the interpretation of diagnostic Radiology and other diagnostic tests if the interpretation is performed or reviewed by the Teaching Physician with modifier 26 in the hospital setting.

• **Teaching Physician Documentation Requirements:**
  - Teaching Physician prepares and documents the interpretation report.
  - OR
  - Resident prepares and documents the interpretation report
  - The Teaching Physician must document/dictate: “I personally reviewed the film/recording/specimen/images and the resident’s findings and agree with the final report”.

• **A countersignature by the Teaching Physician to the resident’s interpretation is not sufficient documentation.**
Orders” Are Required For Any Diagnostic Procedure With a TC / 26 Modifier

• The CPT descriptions of documentation requirements for many ophthalmic diagnostic tests include the phrase, ".

• . . with interpretation and report." Once the appropriate individual has performed the test, you must document your interpretation of the results somewhere in the medical records. This doesn't have to be anything elaborate.

• It may merely be a brief phrase indicating if a test is "normal," "stable from a previous test" or "mild superior arcuate defect."
Orders” Are Required For Any Diagnostic Procedure With a TC / 26 Modifier

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

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

• There must be a written report that becomes part of the patient’s medical record and this should be as complete as possible.
Evaluation & Management (E/E)
The 3 Key Documentation Elements

- History
  - Focus on HPI

- Medical Decision Making

- Physical Exam
Important!

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

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

**SO . . .**

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

• The amount of history and exam should **not** generally alone determine the level.
Ignoring how medical decision-making affects E/M leveling can put you at risk.

• According to the Medicare Claims Processing Manual, chapter 12, section 30.6.1:

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

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

CMS:

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

1. Number of Diagnoses or Treatment Options

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

Multiple active problems?
New problem with additional workup?
Are problems worse? = HIGHER COMPLEXITY
Medical Decision-Making

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, Elastic bandages, Gargles, Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>2 or more self-limited/minor problems</td>
<td>Physiologic tests not under stress (PFT)</td>
<td>OTC meds, Minor surgery w/no identified risk factors, PT, OT, IV fluids w/out additives</td>
</tr>
<tr>
<td>OP Level 3</td>
<td>1 stable chronic illness (controlled HTN)</td>
<td>Non-CV imaging studies, Superficial needle biopsies</td>
<td></td>
</tr>
<tr>
<td>IP Sub 1</td>
<td>Acute uncomplicated illness / injury (simple sprain)</td>
<td>Labs requiring arterial puncture, Skin biopsies</td>
<td></td>
</tr>
<tr>
<td>IP Initial 1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Mod                  | 1 > chronic illness, mod. Exacerbation, progression or side effects of treatment | Physiologic tests under stress (stress test)       | 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 |
| OP Level 4           | 2 or more chronic illnesses                               | Diagnostic endoscopies w/out risk factors           |                                               |
| IP Sub 2             | Undiagnosed new problem w/uncertain prognosis             | Deep incisional biopsies                           |                                               |
| IP Initial 2         | Acute illness w/systemic symptoms (colitis)               | CV imaging w/contrast, no risk factors (arteriogram, cardiac cath) |                                               |
|                      | Acute complicated injury                                  | Obtain fluid from body cavity (lumbar puncture)    |                                               |

| High                 | 1 > chronic illness, severe exacerbation, progression or side effects of treatment | CV imaging w/contrast, w/risk factors, Cardiac electrophysiological tests | Elective major surgery w/risk factors, Emergency surgery, Parenteral controlled substances, Drug therapy monitoring for toxicity, DNR |
| OP Level 5           | Acute or chronic illnesses that may pose threat to life or bodily function (acute MI) | Diagnostic endoscopies w/risk factors               |                                               |
| IP Sub 3             | Abrupt change in neurologic status (TIA, seizure)         |                                                    |                                               |
| IP Initial 3         |                                                          |                                                    |                                               |
Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid.

### Final Result for Complexity

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

Type of decision making

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

• Chief Complaint (CC:)
• History of Present Illness (HPI)
• Review of Systems (ROS)
• Past/Family/Social History (PFSHx)
1. **Chief Complaint**
   - Concise statement describing reason for encounter
     - “back pain”
     - “follow-up for numbness”
   - Can be included in HPI

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

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

**TWO TYPES:**

**BRIEF**
1-3 elements above or status of 1-2 diagnosis or conditions

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

14 recognized:

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

THREE TYPES:  

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

**TWO TYPES:**

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

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

• Don’t forget **10-system review**!

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

4 TYPES OF EXAMS

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

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

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

• Cardiovascular
• Musculoskeletal
• Ears, Nose, Mouth and Throat
• Neurological
• Eyes
• Skin

• Psychiatric
• Genitourinary (Female) (Male)
• Respiratory
• Hematologic / Lymphatic / Immunologic
• General Multi-system Exam
1995 and 1997 Exam Definitions

Problem Focused (PF): 99231, 99212 or 99201
- ‘95: Limited exam of the affected body area or organ system. (1 BA/OS)
- ‘97=Specialty and GMS: 1-5 elements identified by bullet.

Expanded Problem Focused (EPF): 99232, 99213 or 99202
- ‘95: Limited exam of affected BA/OS & other symptomatic/related OS.(2-7 BA/OS)
- ‘97=Specialty and GMS: At least 6 elements identified by bullet.

Detailed (D): 99233, 99221, 99214 or 99203
- ‘95: Extended exam of affected BA/OS and other symptomatic/related OS.(2-7 BA/OS)
- 97=Specialty: At least 12 elements identified by bullet (9 for eye and 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.
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>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10 min</td>
</tr>
<tr>
<td>99202</td>
<td>20 min</td>
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<tr>
<td>99203</td>
<td>30 min</td>
</tr>
<tr>
<td>99204</td>
<td>45 min</td>
</tr>
<tr>
<td>99205</td>
<td>60 min</td>
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<tr>
<td>99241</td>
<td>15 min</td>
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<tr>
<td>99242</td>
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<tr>
<td>99214</td>
<td>25 min</td>
</tr>
<tr>
<td>99215</td>
<td>40 min</td>
</tr>
</tbody>
</table>

## Inpatient Counseling Time:

<table>
<thead>
<tr>
<th>Code</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
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<tr>
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<td>50 min</td>
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<tr>
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<td>70 min</td>
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<tr>
<td>99254</td>
<td>80 min</td>
</tr>
<tr>
<td>99255</td>
<td>110 min</td>
</tr>
</tbody>
</table>
Proper Language used in documentation of time:

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

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

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

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

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

Patient not seen by you or your billing group in the past three years (as outpatient or inpatient)
Minor Procedure With an E/M
Modifier 25 – Be ALERT

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

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

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

• Only a practitioner or coder should assign a modifier 25 to a Claim – Not a biller.
Modifier 25 – Be ALERT

• **When Not to Use the Modifier 25**
  
  • When billing for services performed during a postoperative period if related to the previous surgery
  
  • When there is only an E/M service performed during the office visit (no procedure done)
  
  • When on any E/M on the day a “Major” (90 day global) procedure is being performed
  
  • When a minimal procedure is performed on the same day unless the level of service can be supported as significant, separately identifiable. All procedures have “inherent” E/M service included.
  
  • When a patient came in for a scheduled procedure only
A Medicare patient is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner. If the order is not properly documented in the medical record, the hospital may not submit a claim for Part A payment.

Meeting the 2 midnight benchmark does not, in itself, render a patient an inpatient or serve to qualify them for payment under Part A. Rather, as provided in our regulations, a beneficiary is considered an inpatient (and Part A payment may only be made) if they are formally admitted as such pursuant to an order for inpatient admission by a physician or other required practitioner (Dentist, Podiatrist).

The order must be furnished by a physician or other practitioner (“ordering practitioner”) who is: (a) licensed by the state to admit inpatients to hospitals, (b) granted privileges by the hospital to admit inpatients to that specific facility, and (c) knowledgeable about the patient’s hospital course, medical plan of care, and current condition at the time of admission. The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision.

The ordering practitioner is not required to write the order but must sign the order reflecting that he or she has made the decision to admit the patient for inpatient services before the patient is discharged from the hospital or within 7 days of admission, whichever comes first.
Hospital Inpatient Admission Orders

• If certain non-physician practitioners and residents/fellows working within their residency program are authorized by the state in which the hospital is located to admit inpatients, and are allowed by hospital by-laws or policies to do the same, the ordering attending practitioner may allow these individuals to write inpatient admission orders on his or her behalf, but must counter-sign the order prior to patient’s discharge from the hospital.

• In countersigning the order, the ordering attending practitioner approves and accepts responsibility for the admission decision. This process may also be used for physicians (such as emergency department physicians) who do not have admitting privileges but are authorized by the hospital to issue temporary or “bridge” inpatient admission orders.
TWO MIDNIGHT RULE DECISION TREE FOR MEDICARE PATIENTS

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**
          - **NO**

* 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)
Discharge Day Codes –
Teaching Physician Time Only!

- **CPT 99238:** TP’s management of patient’s D/C took < 30 minutes.

- **CPT 99239:** Differs from 99238 because it requires documentation of time > 30 minutes spent managing the patient (final exam, Rx management, POC after D/C).
  - The hospital discharge day management codes are to be used to report:
    - the total duration of time spent by a physician for final hospital discharge of a patient.
    - The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the physician on that date is not continuous,
    - Instructions for continuing care to all relevant caregivers, and
    - Preparation of discharge records, prescriptions and referral forms.

**EXAMPLE:** “I saw and evaluated the patient today and agree with resident note. Discharge instructions given to patient and Rx’s. To F/U in 5 days in clinic”

The hospital required discharge summary is not documentation of patient discharge management for billing a 99238 or 99239 unless there is a statement that indicates that the attending personally saw the patient and discussed discharge plans on the day the code was billed.
Hospital Discharge

IMPORTANT!

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

• If less than 30 minutes: 99238
• If more than 30 minutes: 99239 (TIME must be documented)
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
Top Compliance Issues For Documenting in EMR
PAYORS ARE WATCHING EMR DOCUMENTATION

Once you sign your note, YOU ARE RESPONSIBLE FOR ITS CONTENT
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
Copy/Paste Philosophy:

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

• Don’t say Today, Tomorrow, or Yesterday

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

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

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

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

- “Added heparin on 4/26” – uses past tense and specific date for better accuracy
Copy / Paste Summary

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

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

• Make sure your note reflects the reality and accuracy of the service each day
"I hear there's a new ICD-10 code for carpal tunnel syndrome caused by clicking too many times in an EMR system."
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.
• Shared visit in the hospital or hospital based clinic (POS 19, 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, Consultations nor Critical Care Services **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.**
Shared Visits Between NPP and Physician

In order to bill under the physician name and NPI#,

- Sufficient medical record documentation is the key to proper reimbursement. In all cases, documentation must substantiate the medical necessity of the shared/split visit; support the level of E/M code submitted, and the medical record should contain enough detail to allow a reviewer to:
  - identify both providers
  - link the physician notes to those of the NPP’s note
  - confirm that the physician and the NPP both saw the patient face-to-face
  - include legible/electronic signature(s)
  - include legible signatures from both providers (in case of paper records)

Following examples that would adequately meet physician documentation requirements for a split/shared visit:

- “I have personally performed a face to face diagnostic evaluation on this patient. My findings are as follows: ...Patient presents with abscess, onset 3 days ago. Has tried a warm compress; hot shower for relief. Exam shows right gluteal abscess 3cm warm tender and fluctuant. Incision and drainage not indicated, started on MRSA antibiotic coverage" Signed by Attending Physician

- “I have personally performed a face to face evaluation on this patient. I have reviewed and agree with the care plan. History and Exam by me shows: abdomen was tender to touch, no rebound. Labs /CT scan negative. IM Toradol given for pain. Pt discharged home.”
  Signed by Attending Physician

- “I have personally seen and evaluated Ms. X with (ARNP name). “My examination shows XYZ”. “Based on the findings, my plan is to schedule the patient for tumor ablation.”
  Signed by Attending Physician
Shared Visits Between NPP and Physician

Examples of physician documentation that would not adequately meet the shared/split visit requirements:

- "I have personally seen and examined the patient independently, reviewed the ARNPs/PAs history, exam and medical decision making and agree with the assessment and plan as written" signed by the physician.
- "Patient seen" signed by the physician
- "Seen and examined" signed by the physician
- "Seen and examined and agree with above (or agree with plan)" signed by the physician
- "As above" signed by the physician
- Documentation by the NPP stating "The patient was seen and examined by myself and Dr. X., who agrees with the plan" with a co-sign of the note by Dr. X.
- No comment at all by the physician or only a physician signature at the end of the note.

In the last three examples, the physician is only documenting that he/she agrees with the findings that the NPP has already documented. The documentation does not show that the physician had face-to-face contact with the patient or that he/she performed any of the history, exam or medical decision making elements. The guidelines require that there must be documentation of the face-to-face portion of the E/M encounter between the patient and the physician. The medical record should clearly identify the part(s) of the E/M service that were personally provided by the physician and those that were provided by the NPP.

Note: The physician must personally document his/her involvement in the patient’s care and cannot leave his/her documentation, of the visit, to the NPP.
Bill Independently and Not Shared

Billing Under The NPP NPI

• Does not require physician presence.
• Can evaluate and treat new conditions and new patients.
• Can perform all services under the state scope-of-practice.
• Can perform services within the approved collaborative agreement.
  • Recommend physician establish competency criteria and demonstration of performance of procedures within the collaborative agreement between the NPP and physician.
Current CMS Florida First Coast Audits

• Prepayment review for CPT® code 99291:
  • In response to continued Comprehensive Error Rate Testing (CERT) errors and risk of improper payments a prepayment threshold edit for CPT® code 99291 claims submitted on or after March 15, 2016, that will apply to all providers.

• Prepayment review for CPT® codes 99232 and 99233
  • Data indicates specialties internal medicine and cardiology are the primary contributors to the CERT error rate for subsequent hospital care services. The new audit will be based on a threshold of claims submitted for payment by cardiology and internal medicine specialties for 99232 and 99233. The audit will be implemented for claims processed on or after March 15, 2016.

• Prepayment review for CPT® codes 99222 and 99223
  • First Coast conducted a data analysis for codes 99222 and 99223 (initial hospital care). Implementing a prepayment review audit for CPT 99222 by all specialties; and CPT 99223 billed cardiology specialty. The audit will be implemented for claims processed on or after April 7, 2016.

• Prepayment review for CPT® codes 99204, 99205, 99215 and 99285 all specialties
  • 99214 – Post-payment review
HIPAA, HITECH, PRIVACY AND SECURITY

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

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

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

http://www.miami.edu/index.php/professional_development__training_office/learning/ulearn/
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)
“Whoa—_way too much information.”
Available Resources at University of Miami, UHealth and the Miller School of Medicine

• If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:

• Helenmarie Blake-Leger, AVP of Compliance & Chief Privacy Officer
  Phone: (305) 243-6000
• Iliana De La Cruz, RMC, Director Office of Billing Compliance
• Gema Balbin-Rodriguez, Associate Director Office of Billing Compliance
  • Phone: (305) 243-5842
  • Email: Officeofbillingcompliance@med.Miami.edu

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

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