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

Urology

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What is a Compliance Program?

**7 Elements of an Effective Compliance Program**

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

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

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

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

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

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

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

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

- False Claims Act
- Health Care Fraud Statute
- Anti-Kickback Statute
- Stark Law
- Sunshine Act
  - Requires manufacturers of drugs, medical devices and biologicals that participate in U.S. federal health care programs to report certain payments and items of value >$10 given to physicians and teaching hospitals.
What is a False Claim?

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

OR

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

One method is to submit a claim form to the government.

This certification forms the basis for a false claim.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)
MEDICAL NECESSITY

Quality & Cost:
Emphasis on Pay-for-Performance
Quality & Cost: Emphasis on Pay-for-Performance PQRS & Meaningful Use

- Practitioner reimbursement will likely be tied to outcomes soon.
- Some experts say that the CMS penalties for not participating in the Physician Quality Reporting System (PQRS) signal that the pay-for-performance trend is not fading away and will likely be adopted by private payers.
- “I think we’re slowly transitioning out of fee-for-service and into a system that rewards for quality while controlling cost,” says Miranda Franco, government affairs representative for the Medical Group Management Association. “The intent of CMS is to have physicians moving toward capturing quality data and improving metrics on [them].”
Quality of Care Data & Registry for AUA

Quality Registry (AQUA)Measures PCPI

- Participation in the Registry during the initial years will have no fee. Any fee that may be introduced in the future would be to cover individual user access to the information system and initial mapping to EHR data fields.

- The AQUA Registry will apply to meet CMS requirements for Physician Quality Reporting System (PQRS) and Qualified Clinical Data Registry (QCDR) reporting starting in 2016. Use of the registry under PQRS and QCDR will avoid negative financial reimbursement from CMS.

- Prostate cancer is one of the most common conditions treated in the field of urology, and the AQUA Registry will offer an opportunity for physicians and practices across the U.S. to collaborate by sharing data to develop an evidence base, in a way that has not been available before.
Medical Necessity
Elective Procedures Alert

When applicable for all prior procedures should be documented:

- List all failed:
  - Therapies in the patients history or operative report
  - Medication trials
  - Prior surgeries, interventions or procedures

Document worsening conditions as evidenced by abnormal test results or decline in functional abilities or why this elective procedure is the best option for the patient if other, lower cost options are available.

Criteria which establishes medical necessity guidelines have been established for many procedures and diagnostic studies.

**DOCUMENT! DOCUMENT!**
Audits are being conducted for all payer types based on the medical necessity of procedures and E/M levels. Procedure are often linked to diagnosis codes and the E/M audits are generally expressed in two ways in conjunction with the needs of the patient:

- Frequency of services (how often the patients are being seen) and,

- Intensity of service (level of CPT code billed).
Elements of Medical Necessity

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

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

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

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

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

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

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

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

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

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

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

- On reviews, the following are targets to call into question EMR documentation is original and accurate:
  - HPI and ROS don’t agree
  - HPI and PE don’t agree
  - CC is not addressed in the PE
  - ROS and PFSH complete on every visit
  - ROS all negative when patient coming for a CC
  - Identical documentation across services (cloning)
  - The lack of or Inappropriate Teaching Physician Attestations
Evaluation and Management E/M
Documentation and Coding
Inpatient, Outpatient and Consultations
New vs Established Patient for E/M
Outpatient Office and Preventive Medicine

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

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

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

• In 2012, the AMA CPT instructions for billing new patient visits include physicians in the same specialty and subspecialty. However, for Medicare E/M services the same specialty is determined by the physician's or practitioner's primary specialty enrollment in Medicare.
E/M Key Components

History (HX)- Subjective information
Examination (PE)- Objective information
Medical Decision Making (MDM)- Linked to medical necessity

The billable service is determined by the combination of these 3 key components with MDM often linked to medical necessity. For new patients all 3 components must be met or exceeded and established patient visits 2 of 3 are required to be met or exceeded. Often when downcoded for medical necessity it is determined that documented History and Exam exceeded what was necessary for the visit.
Elements of an E/M History

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

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

- Focus upon present illness!

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

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

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

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

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

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

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

Don't use the term "non-contributory"
EXAMINATION

- 4 TYPES OF EXAMS

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

<table>
<thead>
<tr>
<th>BODY AREAS (BA):</th>
<th>CODING ORGAN SYSTEMS (OS):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Head, including face</td>
<td>• Genitalia, groin, buttocks</td>
</tr>
<tr>
<td>• Neck</td>
<td>• Back, including spine</td>
</tr>
<tr>
<td>• Chest, including breast and axillae</td>
<td>• Each extremity</td>
</tr>
<tr>
<td>• Abdomen</td>
<td></td>
</tr>
</tbody>
</table>

| • Constitutional/General                  | • GU                                    |
| • Eyes                                    | • Musculoskeletal                       |
| • Ears/Nose/Mouth/Throat                  | • Skin                                  |
| • Respiratory                             | • Neuro                                 |
| • Cardiac                                 | • Psychiatric                           |
| • GI                                      | • 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)

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

Expanded Problem Focused (EPF)

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

Detailed (D)

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

Comprehensive (C)

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

DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE!!

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

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

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

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

Note: The 2 most complex elements out of 3 will determine the overall level of MDM
# Number of Diagnosis or Treatment Options – Identify Each That Effects Patient Care For The DOS

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max=2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner) stable, improved</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. Problem (to examiner) worsening</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max=1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New prob. (To examiner); additional workup planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>
**MDM Step 2**

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

<table>
<thead>
<tr>
<th>REVIEWED DATA</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>
MDM Step 3: Risk

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

- Risk is assessed based on the risk to the patient between present visit and the NEXT time the patient will be seen by billing provider or risk for planned intervention.
<table>
<thead>
<tr>
<th></th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| **Min** |  • One self-limited / minor problem                    |  • Labs requiring venipuncture  
  • CXR  
  • EKG/ECG  
  • UA                                                    |  • Rest  
  • Elastic bandages  
  • Gargles  
  • Superficial dressings                                    |
| **Low** |  • 2 or more self-limited/minor problems  
  • 1 stable chronic illness (controlled HTN)  
  • Acute uncomplicated illness / injury (simple sprain) |  • Physiologic tests not under stress (PFT)  
  • Non-CV imaging studies (barium enema)  
  • Superficial needle biopsies  
  • Labs requiring arterial puncture  
  • Skin biopsies  
  • Non-CV imaging studies (barium enema)  
  • Superficial needle biopsies  
  • Labs requiring arterial puncture  
  • Skin biopsies  
  • Acute uncomplicated illness / injury (simple sprain)     |  • OTC meds  
  • Minor surgery w/ no identified risk factors  
  • PT, OT  
  • IV fluids w/ out additives                               |
| **Mod**  |  • 1 > chronic illness, mod. Exacerbation, progression or side effects of treatment  
  • 2 or more chronic illnesses  
  • Undiagnosed new problem w/ uncertain prognosis  
  • Acute illness w/ systemic symptoms (colitis)  
  • Acute complicated injury                               |  • Physiologic tests under stress (stress test)  
  • Diagnostic endoscopies w/ out risk factors  
  • Deep incisional biopsies  
  • CV imaging w/ contrast, no risk factors (arteriogram, cardiac cath)  
  • Obtain fluid from body cavity (lumbar puncture)  
  • CV imaging w/ contrast, w/ risk factors  
  • Cardiac electrophysiological tests  
  • Diagnostic endoscopies w/ risk factors                 |  • Prescription meds  
  • Minor surgery w/ identified risk factors  
  • Elective major surgery w/ out risk factors  
  • Therapeutic nuclear medicine  
  • IV fluids w/ additives  
  • Closed treatment, FX / dislocation w/ out manipulation  |
| **High** |  • 1 > chronic illness, severe exacerbation, progression or side effects of treatment  
  • Acute or chronic illnesses that may pose threat to life or bodily function (acute MI)  
  • Abrupt change in neurologic status (TIA, seizure)     |  • CV imaging w/ contrast, w/ risk factors  
  • Cardiac electrophysiological tests  
  • Diagnostic endoscopies w/ risk factors                 |  • Elective major surgery w/ risk factors  
  • Emergency surgery  
  • Parenteral controlled substances  
  • Drug therapy monitoring for toxicity  
  • DNR                                                   |
Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2\textsuperscript{nd} circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid.

### Final Result for Complexity

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

<table>
<thead>
<tr>
<th>Type of decision making</th>
<th>STRAIGHT-FORWARD</th>
<th>LOW COMPLEX.</th>
<th>MODERATE COMPLEX.</th>
<th>HIGH COMPLEX.</th>
</tr>
</thead>
</table>
USING DIFFERENT LEVELS OF CARE

- Patient Admitted
  - Patient is Unstable
  - Patient has Developed Minor Compl.
  - Patient is Stable, Recovering, Improving

- Patient Discharged
  - or
  - 99239
Using Time to Code

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

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

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

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

John Doe
MR# 11122234
D.O.S. 9/15/014

Patient counseled regarding health risk, contraceptives, exercise, and usage of medication.

Counseling Time: 20 min.
Total Encounter Time: 30 min.
National ‘12 CMS Data For Speciality E/M

Urology

<table>
<thead>
<tr>
<th>Code</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>2%</td>
</tr>
<tr>
<td>99212</td>
<td>11%</td>
</tr>
<tr>
<td>99213</td>
<td>54%</td>
</tr>
<tr>
<td>99214</td>
<td>29%</td>
</tr>
<tr>
<td>99215</td>
<td>3%</td>
</tr>
</tbody>
</table>

National Dist.
# Top Procedure Codes Billed in Q4 2013

### Top 5 Procedure Codes

<table>
<thead>
<tr>
<th>Top 5 Procedure</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>81000</td>
<td>URINALYSIS, NONAUTO, W/SCOPE</td>
<td>28%</td>
</tr>
<tr>
<td>52000</td>
<td>CYSTOURETHROSCOPY</td>
<td>10%</td>
</tr>
<tr>
<td>51798</td>
<td>MEAS, POST-VOID RES, US, NON-IMAGING</td>
<td>10%</td>
</tr>
<tr>
<td>52332</td>
<td>CYSTOSCOPY, INSERT URETERAL STENT</td>
<td>3%</td>
</tr>
<tr>
<td>51700</td>
<td>IRRIGATION OF BLADDER</td>
<td>2%</td>
</tr>
</tbody>
</table>

All other Procedure Codes: 48%

### Top 5 E&M Codes

<table>
<thead>
<tr>
<th>Top 5 E&amp;M</th>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>OFFICE/OUTPT</td>
<td>46%</td>
</tr>
<tr>
<td>99214</td>
<td>OFFICE/OUTPT</td>
<td>26%</td>
</tr>
<tr>
<td>99204</td>
<td>New Office</td>
<td>10%</td>
</tr>
<tr>
<td>99203</td>
<td>New Office</td>
<td>5%</td>
</tr>
<tr>
<td>99215</td>
<td>OFFICE/OUTPT</td>
<td>4%</td>
</tr>
</tbody>
</table>

All other E/M Codes: 9%
Guidelines for Teaching Physicians, Interns, Residents and Fellows

For Billing Services, All Types of Services Involving a Teaching Physician (TP) Requires Attestations In EHR or Paper Charts
Evaluation and Management (E/M)

E/M IP or OP: TP must personally document at least the following:

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

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

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

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

Medical Student documentation for billing only counts for ROS and PFSH
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
**Procedures**

**Minor** – (< 5 Minutes & 0 -10 Day Global): For payment, a minor procedure billed by a TP requires that s/he is physically present during the entire procedure.

**Example:** "I was present for the entire procedure." i.e. joint injection

**Major** – (>5 Minutes)

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

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

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

TP must be present during the entire viewing for payment.

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

**Example:** "I was present for the entire viewing."
Interventional Procedures

Teaching Physician Documentation of the Surgical Component of the Procedure:

“I personally performed the procedure”; or

“I was present for the entire procedure”

“I was present for the “Key Portions”, which consist of

..................................................”, and remained immediately

Teaching Physician Documentation for the Radiologic Component of the Procedure:

• Teaching Physician prepares and documents/dictates the interpretation report.

• Resident prepares and documents the interpretation report.

• The Teaching Physician must document: “I personally reviewed the film/recording and/or 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.
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.
Working With NP's and PA's (NPP's)

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

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

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

- Procedures must be billed under the performing provider & not the supervisor. They cannot be “shared”
Record entries made by a "scribe" should be made upon dictation by the physician. A scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently or obtain any information independently except to ROS and PFSH. They cannot obtain the HPI, any portion of the PE or MDM.

The scribe must note "written by xxxx, acting as scribe for Dr. yyy." Then, Dr. yyy should sign, indicating that the note accurately reflects work and decisions made by him/her.

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

AAMC does not support someone “dictating” as a scribe by an NPP, as scribing is over the shoulder immediate documenter with no services personally performed by the scribe. In this case, the physician should be dictating their own visit. Scribes can do EMRs under their own password.
Ensure Progress Note Includes Service Provided W/ Description and Results

- **81000** Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
- **52000** Cystourethroscopy (separate procedure)
- **51798** Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging
- **52332** Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
- **51700** Bladder irrigation, simple, lavage and/or instillation
Global Surgery Policy

The concept of a global fee for surgical procedures is a long-established concept under which a single fee is billed and paid for all necessary services normally furnished by a surgeon before, during and after the procedure. Since the fee is based on uniform national relative value, it is necessary to have a uniform national definition of “Global Surgery” to ensure that, nationwide, payment is made for the same amount of work and resources involved in furnishing a specific procedure.
Services Included In The Global Surgery Fee

- Preoperative visits, beginning with the day before a surgery for major procedures and the day of surgery for minor procedures.
- Complications following surgery, which do not require additional trips to the operating room.
- Postoperative visits (follow up visits) during the postoperative period of the surgery that is related to recovery from the surgery.
- Postoperative pain management provided by the surgeon.
Services **Not** Included in Global Surgery Fee

- Visits unrelated to the diagnosis for which the surgical procedure is performed. Append modifier -24 to the E/M code and report the new diagnosis.
- Treatment for the underlying condition or an added course of treatment which is not part of the normal recovery from surgery. Append modifier -24 to the E/M code.
- Diagnostic tests and procedures, including diagnostic radiological procedures (no modifier required).
- Critical Care services (codes 99291 and 99292) unrelated to the surgery, or the critical care is above and beyond the specific anatomic injury or general surgical procedure performed.
Services NotIncluded in Global Surgery Fee

- Treatment for postoperative complications that cause a return trip to the operating room, including ASCs and hospital outpatient departments. Append modifier -78 to the procedure code for the procedure provided in the operating room.
  - An operating room for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite.
- Some supplies and surgical dressings are separately payable under the reasonable charge payment methodology.
- Immunosuppressive therapy for organ transplants.
99024 verses Billable E/M Service

- 99024: Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure
Modifiers

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

Modifiers allow to:

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

Documentation in the operative report must support the use of any modifier.
**Modifier Reminders**

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

*Usually an E&M service is included in the exam performed just prior to and during scheduled procedure. If the E&M service is a separate and identifiable service, the medical record must document medical necessity and modifier 25.*

**Modifier 57:** Significant, Separately Identifiable E/M by the Same Physician/Group on the Day of or within 24 hours of a major procedure.

**Modifier 59:** Distinct Procedural Service: Under certain circumstances, indicate that a procedure or service was independent from the services performed on the same day.

**Modifier GC:** Service involved a resident or fellow. Payment not affected.
Teaching Physician Services That Meet the Requirement for Presence During the Key Portion of the Service.-- In item 24d of Form CMS-1500, the GC modifier must be entered by the physician for Teaching Physician Services rendered in compliance with all the requirements outlined in §15016 of the Medicare Carriers Manual.

Teaching Physician Services that are billed using this modifier are certifying that they have been present during the key portion of the service, and were immediately available during the other parts of the service.

The claim should have the GC modifier even if a RNFA or a PA is working with the resident and teaching physician.
2014 CPT Code Changes

Interprofessional consultations

- The services will typically be provided in complex and/or urgent situations where a timely face-to-face service with the consultant may not be possible. The written or verbal request, its rationale, and the conclusion for telephone/Internet advice by the treating/requesting physician or other qualified health care professional should be documented in the patient’s medical record.

- Medicare allowable $0.00
ICD-10 and Clinical Documentation

• Increased specificity of the ICD-10 codes requires more detailed clinical documentation to code some diagnoses to the highest level of specificity.

• Coding and documentation go hand in hand
  • ICD-10 based on complete and accurate documentation, even where it comes to right and left or episode of care.
  • ICD-10 should impact documentation as physicians are required to support medical necessity using appropriate diagnosis code—this is not an easy situation.
  • Will not change the way a physician practices medicine
HIPAA
Final Reminders for All Staff, Residents, Fellows or Students

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

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

- Also available is The University’s fraud and compliance hotline via the web at www.canewatch.ethicspoint.com or toll-free at 877-415-4357 (24 hours a day, seven days a week).
- Office of billing Compliance website: www.obc.med.miami.edu