Office of Billing Compliance
2015 Coding, Billing and Documentation Program

Department of Urology
2015 Code Changes

No Urology Specific CPT Code Changes for 2015
Documentation in the EHR - EMR
Volume of Documentation vs Medical Necessity

Annually OIG publishes it "targets" for the upcoming year. Included is EHR Focus and for practitioners could include:

- **Pre-populated Templates and Cutting/Pasting**
- **Documentation containing inaccurate or incomplete or not provided information in the medical record**

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

• All documentation must be legible to all readers.

• Complete and timely
  • Including signature

• Addendum: Dated and timed day added
  • Practitioner has direct knowledge is true and accurate.
URODYNAMICS

- Procedures have 0 global days
- E/M services provided on the same date of service as a urodynamic study require modifier -25
- Medicare pays for most urodynamic studies that you order and perform. Private insurers may limit the number of urodynamic studies they allow.
- If you perform the professional component only, append modifier -26 (if you perform the test in a facility setting or use equipment other than your own)
- If you perform a video study, bill for the contrast material injection into the bladder using 51600 and the voiding cystourethrogram and the reading thereof using 74455.
Simple vs. Complex CMG

For a simple CMG, which involves the physician placing a small catheter in the bladder, filling the bladder by gravity, and measuring capacity and storage pressures using a spinal manometer, you'll report 51725.

If the physician performs a complex CMG in which he fills the bladder through a catheter and measures the pressure with calibrated electronic equipment, you'll report 51726 instead.
Simple vs Complex UFR

When the physician observes a patient's urine flow using a stopwatch to assess the flow, you should report 51736 for a simple UFR.

If the physician uses electronic equipment to measure the flow, you'll submit 51741.
EMG Studies

The physician may perform an EMG study in which he/s places patch electrodes around the urethral sphincter to measure electrical and muscular activity of the perineal muscles and the urinary sphincter. You'll report 51784 for this test.

If the urologist does a needle EMG during which he/s places needles into the pelvic floor to measure muscle activity during bladder filling and at rest, you should instead report 51785.
Voiding Pressures

When the physician measures pressure during voiding, you should choose a code based on whether he/s measures the VP just in the bladder (51728) or in the bladder and abdomen simultaneously (+51797).
When you do a urodynamics study during the global period of another procedure, it is a diagnostic test. Unfortunately, payers consider the urodynamics tests as surgical codes, so you will need a modifier to ensure payment. That modifier should be **modifier 79 (Unrelated procedure or service by the same physician or other qualified healthcare professional during the postoperative period)**. If your diagnosis code for your microwave is 600.01, benign prostate hypertrophy with obstruction, your diagnosis for your urodynamic study may be codes such as atonic urinary bladder (596.4) or urinary retention (788.20). These should be different from the diagnoses codes for the microwave therapy.
Bladder Scan

- **51798 (xxx)** Measurement of post-voiding residual urine **and/or** bladder capacity by ultrasound, non-imaging
  - Residual urine and/or bladder capacity is measured by ultrasound after the patient has voided. Operation of the scanner is done simply by directing the scanning head over the suprapubic area while the patient is lying down in the supine position. The software built in to the scanner calculates the post-void residual urine volume immediately and also does calculations for the bladder capacity based on the individual's bladder shape and not on fixed geometric formulas.
  - When performing a post-voiding residual (PVR) using a hand-held unit with a simple printout, use CPT® code 51798 for Medicare and commercial carriers.
  - If patient is unable to void, be specific in documentation and if results are questionable due to inability to void and will need to be repeated, consider if medical necessity is met for the procedure for billing.
Bladder Ultrasound

• 76857 (xxx) Ultrasound, pelvic (nonobstetric), real time with image documentation limited or follow-up is a diagnostic ultrasound used to examine one specific organ, such as the bladder. The medical necessity should be documented for this diagnostic ultrasound.
  • This code should not be used if the intent of the test is to obtain a PVR.
  • Utilized when an actual image of the bladder is obtained and evaluated for abnormalities. For example, in addition to reporting on post-residual volume, one would be expected to comment on the presence of bladder diverticula when present.
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
Orders” Are Required For Any Diagnostic Procedure With a TC / 26 Modifier

• The CPT descriptions of documentation requirements for many urologic 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" and/or “free from rapid changes in amplitude”. 
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.
Teaching Physicians (TP) Guidelines
Billing Services When Working With Residents Fellows and Interns

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

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

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

- Initial Visit: “I saw and evaluated the patient. I reviewed the resident’s note and agree, except that the picture is more consistent with an upper respiratory infection not pneumonia. Will begin treatment with........”

- Initial or Follow-up Visit: “I saw and evaluated the patient. Discussed with resident and agree with resident’s findings and plan as documented in the resident’s note.”

- Follow-up Visit: “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s finding and plans as written.”

- Follow-up Visit: “I saw and evaluated the patient. Agree with resident’s note, but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

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

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

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

*Medical Student documentation for billing only counts for ROS and PFSH. All other contributions by the medical/optometry student must be re-performed and documented by a resident or teaching optometrist.*
Unacceptable TP Documentation

- Assessed and Agree
- Reviewed and Agree
- Co-signed Note
- Patient seen and examined and I agree with the note
- As documented by resident, I agree with the history, exam and assessment/plan
TP Guidelines for Procedures

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

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

**Major** – (>5 Minutes)

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

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

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

TP must be present during the entire viewing for payment.

- The viewing begins with the insertion and ends with the removal.

- Viewing of the entire procedure through a monitor in another room does not meet the presence requirement.

  Example: *“I was present for the entire viewing.”*
Overlapping Surgeries: CMS Requires

2 Overlapping Surgeries - CMS will pay for two overlapping surgeries, but the teaching surgeon must be present during the critical or key portions of both operations. Consequently, the critical or key portions may not take place at the same time.

- The teaching surgeon must **personally document** in the medical record that he/she was physically present during the critical or key portion(s) of both procedures.

- When a TP is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, **he or she must arrange for another qualified attending surgeon to immediately assist the resident in the other case should the need arise (this cannot be a resident or fellow.)**

- **In the case of 3 concurrent surgical procedures, the role of the teaching surgeon in each of the cases is classified as a supervisory service** to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule.

MCM 15505(4)(a)(2)
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.
Modifier GC
CMS Manual Part 3 - Claims Process - Transmittal 1723

- Teaching Physician Services That Meet the Requirement for Presence During the Key Portion of the Service when working with a resident or fellow

- Teaching Physician Services that are billed using this modifier are certifying that they have been present during the key portion of the service.
Global Surgery
Global Service: 1 Payment for Procedure

Major = Day before procedure thru 90 days after
Minor = Day of procedure (some until 10 days after)

Services Included In The Global Surgery Fee

• Preoperative visits, beginning with the day before a major procedures and the day of the procedure for minor procedures.
  • *If patient has initial visit and the decision for surgery is made to perform surgery within 24 hours, bill the E/M with a -57 modifier.*

• Complications following procedure, which do not require additional trips to the operating room.

• Postoperative visits (follow up visits) during the postoperative period of the procedure 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 procedure is performed. Append modifier -24 to the E/M code and report the new diagnosis. This is for 10 or 90 day Global periods.

• 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).

• 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.
Some Procedures Have Certain Other Services

- Cleansing, shaving and prepping of skin
- Draping and positioning of patient
- Insertion of intravenous access
- Moderate sedation administration by the physician performing a procedure
- Local, topical or regional anesthesia administered by the physician performing the procedure

PROCEDURE(S): Many Questions

- Unbundled, inclusive mutually exclusive
- Co-surgeon vs. assistant surgeon
- Application of multiple guidelines
- Repeat, unrelated, staged? Site(s)
- Indications for surgery

REPAIR (Closure) Classifications

- Simple, • Intermediate, • Complex

Instructions:
- Measure and record in cm
- Add lengths in same classification & anatomic sites grouped together
Modifiers: Provider Documentation MUST Support the Use of All Modifiers

Documentation in the procedure report must support the use of any modifier.

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

**Modifiers allow to:**

- Increase reimbursement
- Indicate specific circumstances
- Facilitate correct coding
- Prevent denial of services
- Provide additional information
Minor Procedure With an E/M
# Urology Minor Procedures

<table>
<thead>
<tr>
<th>Global Days</th>
<th>CPT Code</th>
<th>CPT Descriptor</th>
</tr>
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<tbody>
<tr>
<td>000</td>
<td>52000</td>
<td>CYSTOURETHROSCOPY</td>
</tr>
<tr>
<td>XXX</td>
<td>51798</td>
<td>MEAS, POST-VOID RES, US, NON-IMAGING</td>
</tr>
<tr>
<td>000</td>
<td>51720</td>
<td>INSTILL ANTICANCER AGENT IN BLADDER</td>
</tr>
<tr>
<td>XXX</td>
<td>76872</td>
<td>ECHO, TRANSRECTAL</td>
</tr>
<tr>
<td>000</td>
<td>55700</td>
<td>BIOPSY OF PROSTATE, NEEDLE/PUNCH</td>
</tr>
<tr>
<td>000</td>
<td>51700</td>
<td>IRRIGATION OF BLADDER</td>
</tr>
<tr>
<td>000</td>
<td>51728</td>
<td>COMPLEX CYSTOMETROGRAM VOIDING PRESSURE STUDIES</td>
</tr>
<tr>
<td>000</td>
<td>51784</td>
<td>ANAL/URINARY MUSCLE STUDY</td>
</tr>
<tr>
<td>XXX</td>
<td>96372</td>
<td>PR INJECTION, THERAP/PROPH/DIAGNOST, IM OR SUBCUT</td>
</tr>
</tbody>
</table>
Modifier 25: 000 or 010 Global Days

• If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. A global XXX it is typically a diagnostic procedure.

• In general E/M services on the same date of service as the minor surgical procedure are included in the payment for the procedure.

• The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service.

• However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25.

• As of 2014 if a minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure in and of itself.
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.
Major Surgery Modifier Reminders
| Modifier 22 | Services performed are significantly greater than usually required", therefore its use should be exceptional. |
| Modifier 52 | Surgeries for which services performed are significantly less than usually required may be billed with the "-52" modifier |
| Modifier 53 | Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. Documentation describing the circumstances requiring the discontinuation of a procedure in the report is required. |
| Modifier 58 | Staged or planned related surgical procedures done during the global period of the first procedure. Procedure may have been: Planned prospectively or at the time of the original procedure; More extensively than the original procedure; or for therapy following a diagnostic surgical procedure. A new post-operative period begins when the next procedure in the series is billed. |
## Modifier 62: Co-Surgery

Two surgeons (usually with different skills) with specialized skills act as co-surgeons. Both are primary surgeons, performing distinct parts of a single reportable procedure (same CPT code) performing the parts of the procedure simultaneously. (pays 125% of fee schedule)

Co-surgery may be required because of the complexity of the procedure and/or the patient’s condition. The additional surgeon is not working as an assistant, but is performing a distinct part of the procedure. Each surgeon dictates his/her operative note describing his/her involvement in the procedure.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>78</td>
<td>Return To The Operating Room For A Related Procedure During The Post-Operative Period</td>
</tr>
<tr>
<td>79</td>
<td>Unrelated Procedure or Service by the Same Physician During the Postoperative Period</td>
</tr>
</tbody>
</table>

- **Modifiers 78 and 79** are used to indicate:
  - **Return To The Operating Room For A Related Procedure During The Post-Operative Period** used to indicate the performance of a procedure during the postoperative period or on the same day as the original procedure to treat complications, which required return to the operating room.
  - **Unrelated Procedure or Service by the Same Physician During the Postoperative Period**:
    - Modifier 79 indicates the performance of a procedure or service during a post-operative period was unrelated to the post-operative care of the original procedure.
    - Does not apply to assistant at surgery services.
• In general, the services of assistants for surgeries furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service is non-payable.

• However, it is covered if such services are exceptional medical circumstances. The TP must document in the operative note that a qualified resident was unavailable for the procedure and Documentation of qualifying circumstances must be included in the operating report.

• Only one OP report is required and the primary attending physician must document in their OP report the specific participation of the assistant (Dr. XXX assisted me throughout the entire procedure...”)

• If the assistant is a physician append modifier 82 to their claim. If the assistant is a PA append an AS modifier to their claim.
No Modifier Required If 2 Physicians Performing Unique Surgery CPT Codes on the Same Patient

• If surgeons of different specialties are each performing a different procedure (with specific CPT-4 codes), multiple surgery rules do not apply. If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services only.

• If some portions of the surgery care provided with unique CPT codes and others with co-surgery or assistant, then claim could include CPT codes both with and without modifiers.
Minor or Major Procedure Modifier
Modifier 59: Distinct Procedural Service

- Designates instances when **distinct** and **separate multiple services** are provided to a patient on a single date of service and should be paid separately.
- Modifier-59 is defined for use in a wide variety of circumstances to identify:
  - Different encounters Different anatomic sites (Different services (Most commonly used and frequently incorrect).
- **4 new modifiers to define subsets of Modifier-59:**
  - **XE - Separate Encounter**, a service that is distinct because it occurred during a separate encounter. Used infrequently and usually correct.
  - **XS - Separate Structure**, a service that is distinct because it was performed on a separate organ/structure. Less commonly used and can be problematic.
    - Biopsy on one lesion and excision on another. Biopsy is "bundled" into excision, therefore must properly bill biopsy CPT with a 59 modifier to indicate separate structure.
  - **XP – Separate Practitioner**, a service that is distinct because it was performed by a different practitioner.
  - **XU – Unusual non-overlapping service**, the use of a service that is distinct because it does not overlap usual components of the main service.

Only a practitioner or coder should designate a modifier 59 to a claim (not a biller) based exclusively on the procedure note details – not OP report headers.
Inpatient, Outpatient and Consultations

Evaluation and Management E/M

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

• “New patient" is a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.
  • If MFM is a separate specialty group they could be “consulted” to see a patient.
E/M Key Components

• History (H) - Subjective information
• Examination (E) - Objective information
• Medical Decision Making (MDM) – The assessment, plan and patient risk

The billable service is determined by the combination of these 3 key components.
• All 3 Key Components are required to be documented for all E/M services.
• For coding the E/M level
  • New OP and initial IP require all 3 components to be met or exceeded and
  • Established OP and subsequent IP require 2 of 3 key components to be met or exceeded.

When downcoded for “medical necessity” on audit, it is often determined that documented H and E exceeded what was deemed “necessary” for the visit (MDM.)
Elements of an E/M History

The extent of information gathered for history is dependent upon clinical judgment and nature of the presenting problem.

Documentation of the patient’s history includes some or all of the following elements:

- Chief Complaint (CC) and History of Present Illness (HPI) are required to be documented for every patient for every visit

  **WHY IS THE PATIENT BEING SEEN TODAY**

- Review of Systems (ROS)

- Past Family, Social History (PFSH)
History of Present Illness (HPI)  
A KEY to Support Medical Necessity to in addition to MDM

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

• **NEVER DOCUMENT PATIENT HERE FOR FOLLOW-UP WITHOUT ADDITIONAL DETAILS OF REASON FOR FOLLOW-UP.**
  
  • This would not qualify as a CC or HPI.
Focus on the Present Illness or Reason for the Encounter
HPI

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

OR

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

- Constitutional
- Eyes
- Respiratory
- Ears, nose, mouth, throat
- Cardiovascular
- Musculoskeletal
- Gastrointestinal
- Genitourinary
- Psychiatric
- Integumentary
- Neurologic
- Allergy/Immunology
- Endocrine
- Hematologic/Lymphatic

ROS is an inventory of specific body systems in the process of taking a history from the patient. The ROS is designed to bring out clinical symptoms which the patient may have overlooked or forgotten. In theory, the ROS may illuminate the diagnosis by eliciting information which the patient may not perceive as being important enough to mention to the physician relative to the reason for the visit.
Past, Family, and/or Social History (PFSH)

• **Past history:** The patient’s past medical experience with illnesses, surgeries, & treatments. May also include review of current medications, allergies, age appropriate immunization status

• **Family history:** May include a review of medical events in the patient’s family, such as hereditary diseases, that may place a patient at risk or specific diseases related to problems identified in the Chief Compliant, HPI, or ROS

• **Social history:** May include age appropriate review of past and current activities, marital status and/or living arrangements, use of drugs, alcohol or tobacco, education and military service.

Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services. **Don't use the term "non-contributory" for coding a level of E/M**
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
<table>
<thead>
<tr>
<th>GU Examination for Male and Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Constitutional</strong></td>
</tr>
<tr>
<td>- Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)</td>
</tr>
<tr>
<td>- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)</td>
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<tr>
<td><strong>Neck</strong></td>
</tr>
<tr>
<td>- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)</td>
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<tr>
<td>- Examination of thyroid (e.g., enlargement, tenderness, mass)</td>
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<tr>
<td><strong>Respiratory</strong></td>
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<tr>
<td>- Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)</td>
</tr>
<tr>
<td>- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)</td>
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<tr>
<td><strong>Cardiovascular</strong></td>
</tr>
<tr>
<td>- Auscultation of heart with notation of abnormal sounds and murmurs</td>
</tr>
<tr>
<td>- Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)</td>
</tr>
<tr>
<td><strong>Gastrointestinal (Abdomen)</strong></td>
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<tr>
<td>- Examination of abdomen with notation of presence of masses or tenderness</td>
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<tr>
<td>- Examination for presence or absence of hernia</td>
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<tr>
<td>- Examination of liver and spleen</td>
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<tr>
<td>- Obtain stool sample for occult blood test when indicated</td>
</tr>
<tr>
<td><strong>Genitourinary</strong></td>
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<tr>
<td>- FEMALE:</td>
</tr>
<tr>
<td>- Includes at least seven of the following eleven elements identified by bullets:</td>
</tr>
<tr>
<td>- Inspection and palpation of breasts (e.g., masses or lumps, tenderness, symmetry, nipple discharge)</td>
</tr>
<tr>
<td>- Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses</td>
</tr>
<tr>
<td>- Pelvic examination (with or without specimen collection for smears and cultures) including:</td>
</tr>
<tr>
<td>- External genitalia (e.g., general appearance, hair distribution, lesions)</td>
</tr>
<tr>
<td>- Urethral meatus (e.g., size, location, lesions, prolapse)</td>
</tr>
<tr>
<td>- Urethra (e.g., masses, tenderness, scarring)</td>
</tr>
<tr>
<td>- Bladder (e.g., fullness, masses, tenderness)</td>
</tr>
<tr>
<td>- Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)</td>
</tr>
<tr>
<td>- Cervix (e.g., general appearance, lesions, discharge)</td>
</tr>
<tr>
<td>- Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)</td>
</tr>
<tr>
<td>- Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)</td>
</tr>
<tr>
<td>- Anus and perineum</td>
</tr>
<tr>
<td>- MALE:</td>
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<tr>
<td>- Inspection of anus and perineum</td>
</tr>
<tr>
<td>- Examination (with or without specimen collection for smears and cultures) of genitalia including:</td>
</tr>
<tr>
<td>- Scrotum (e.g., lesions, cysts, rashes)</td>
</tr>
<tr>
<td>- Epididymidis (e.g., size, symmetry, masses)</td>
</tr>
<tr>
<td>- Testes (e.g., size, symmetry, masses)</td>
</tr>
<tr>
<td>- Urethral meatus (e.g., size, location, lesions, discharge)</td>
</tr>
<tr>
<td>- Penis (e.g., lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities)</td>
</tr>
<tr>
<td>- Digital rectal examination including:</td>
</tr>
<tr>
<td>- Prostate gland (e.g., size, symmetry, nodularity, tenderness)</td>
</tr>
<tr>
<td>- Seminal vesicles (e.g., symmetry, tenderness, masses, enlargement)</td>
</tr>
<tr>
<td>- Sphincter tone, presence of hemorrhoids, rectal masses</td>
</tr>
</tbody>
</table>
1995 and 1997 Exam Definitions

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

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

Detailed (D): 99233, 99221, 99214 or 99203
- '95: Extended exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- 97: Specialty: At least 12 elements identified by bullet (9 for eye and psyc)

Comprehensive (C): 99222, 99223, 99215 or 99204 and 99205
- '95: General multi-system exam (8 or more organ systems) or complete single organ system (a complete single organ system is undefined by CMS).
- '97: Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area.
Medical Decision Making
DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE!!

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

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

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

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

Note: The 2 most complex elements out of 3 will determine the overall level of MDM
## MDM Step 1: # Dx & Tx Options

### 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>56</td>
</tr>
</tbody>
</table>
## MDM Step 2: Amt. & Complexity of Data

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

<table>
<thead>
<tr>
<th>REVIEWED DATA</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than 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>57</td>
</tr>
</tbody>
</table>

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

2 POINTS:  
- E-3, NEW-3  
- IP Level 1

3 POINTS:  
- E-4, NEW-4  
- IP Level 2

4 POINTS:  
- E-5, NEW-5  
- IP –Level 3
MDM Step 3: Risk Table for Complication

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

**DG:** Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

Risk is assessed based on the risk to the patient between present visit and the NEXT time the patient will be seen by billing provider or risk for planned intervention.
<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min Risk E-2, New –1 or 2, IP -1</td>
<td>• One self-limited / minor problem</td>
<td>• Labs requiring venipuncture • CXR • EKG/ECG • UA</td>
<td>• Rest • Elastic bandages • Gargles • Superficial dressings</td>
</tr>
<tr>
<td>Low Risk E-3, NEW-3 IP - 1</td>
<td>• 2 or more self-limited/minor problems • 1 stable chronic illness (controlled HTN) • Acute uncomplicated illness / injury (simple sprain)</td>
<td>• Physiologic tests not under stress (PFT) • Non-CV imaging studies (barium enema) • Superficial needle biopsies • Labs requiring arterial puncture • Skin biopsies</td>
<td>• OTC meds • Minor surgery w/no identified risk factors • PT, OT • IV fluids w/out additives</td>
</tr>
<tr>
<td>Mod Risk E-4, NEW-4 IP-2</td>
<td>• 1 &gt; chronic illness, mod. Exacerbation, progression or side effects of treatment • 2 or more chronic illnesses • Undiagnosed new problem w/uncertain prognosis • Acute illness w/systemic symptoms (colitis) • Acute complicated injury</td>
<td>• Physiologic tests under stress (stress test) • Diagnostic endoscopies w/out risk factors • Deep incisional biopsies • CV imaging w/contrast, no risk factors (arteriogram, cardiac cath) • Obtain fluid from body cavity (lumbar puncture)</td>
<td>• Prescription meds • Minor surgery w/identified risk factors • Elective major surgery w/out risk factors • Therapeutic nuclear medicine • IV fluids w/additives • Closed treatment, FX / dislocation w/out manipulation</td>
</tr>
<tr>
<td>High Risk E-5, NEW-5 IP –3</td>
<td>• 1 &gt; chronic illness, severe exacerbation, progression or side effects of treatment • Acute or chronic illnesses that may pose threat to life or bodily function (acute MI) • Abrupt change in neurologic status (TIA, seizure)</td>
<td>• CV imaging w/contrast, w/risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies w/risk factors</td>
<td>• Elective major surgery w/risk factors • Emergency surgery • Parenteral controlled substances • Drug therapy monitoring for toxicity • DNR</td>
</tr>
</tbody>
</table>
Using Time to Code Counseling / Coordinating Care (CCC)

Time shall be considered for coding an E/M in lieu of H-E-MDM when > 50% of the total billable practitioner visit time is CCC. Time is only Face-to-face for OP setting.

Coding based on time is generally the exception for coding. It is typically used when there is a significant exacerbation or change in the patient’s condition, non-compliance with the treatment/plan or counseling regarding previously performed procedures or tests to determine future treatment options.

Required Documentation For Billing:
1. Total time of the encounter excluding separate procedure if billed
   - The entire time to prep, perform and communicate results of a billable procedure to a patient must be carved out of the E/M encounter time!
2. The amount of time dedicated to counseling / coordination of care
3. The specific nature of counseling/coordination of care for that patient on that date of service. A template statement would not meet this requirement.
Counseling /Coordinating Care (CCC)?

Documentation must reflect the specific issues discussed with patient present.

Proper Language used in documentation of time:

• “I spent ____ minutes with the patient and over 50% was in counseling about her diagnosis, treatment options including _______ and ______.”
• “I spent ____ minutes with the patient more than half of the time was spent discussing the risks and benefits of treatment with……(list risks and benefits and specific treatment)”
• “This entire ______ minute visit was spent counseling the patient regarding ________ and addressing their multiple questions.

Total time spent and the time spent on counseling and/or coordination of care must be documented in the medical record.
Non-Physician Practitioners (NPP’s) or Physician Extenders

Who is a NPP?

Physician Assistant (PA)
Nurse Practitioner (NP)
Clinical Nurse Specialist (CNS)
Optometrist
PT, OT, SLP
Nurse Midwives
Clinical Psychologists
Clinical Social Workers
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”
Scribes
Scribed Notes

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

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

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

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

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

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

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

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

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

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

- The following attestation should be entered by provider when closing the encounter:
  
  - “I was present during the time with [patient name] was recorded. I have reviewed and verified the accuracy of the information which was performed by me.” [Name of provider][Date and time of entry].
In-Patient Hospital Care
Present on Admission (POA) & Hospital-Acquired Conditions (HAC)

• POA is defined as being present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter (including emergency department, observation, or outpatient surgery) are considered POA;

• Under the Hospital-Acquired Conditions—Present on Admission (HAC-POA) program, accurate coding of hospital-acquired conditions (HACs) and present on admission (POA) conditions is critical for correct payment.

• The importance of consistent, complete documentation in the medical record from any and all Physicians/Practitioners involved in the care and treatment of the patient is used to determine whether a condition is POA;

• It is crucial that physicians/practitioners document all conditions that are present on admission;

• The Hospital must include the POA indicator on all claims that involve Medicare inpatient admissions. The hospital is subject to a law or regulation that mandates the collection of POA indicator information.
Discharge Day Codes - **TP Time Only!**

- **CPT 99238:** TP’s management of patient’s D/C took < 30 minutes.
- **CPT 99239:** Differs from 99238 because it **requires documentation of time > 30 minutes** spent managing the patient (final exam, Rx management, POC after D/C).

  - The hospital discharge day management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the physician on that date is not continuous, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.

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

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

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

• Must have a clear inpatient order written and signed before discharge. Physician or practitioner must be:
  • –Licensed by the state to admit patients to hospitals
  • –Granted privileges by the facility to admit
  • –Knowledgeable about the patients hospital course, medical care, and current condition at the time of admission
• Must have documentation to support certification
• Anticipated length of stay
• Discharge planning
Two-Midnight Rule vs Observation Care

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>8 Hours or Less</th>
<th>&gt; 8 Hours &lt; 24 Hours</th>
<th>24 Hours or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>99218-99220</td>
<td>99234-99236</td>
<td>99218-99220</td>
</tr>
<tr>
<td>(Initial Observation Care)</td>
<td>(Observation or Inpatient Care)</td>
<td>(Initial Observation Care)</td>
</tr>
<tr>
<td>Same Calendar Date</td>
<td>Same Calendar Date</td>
<td>Same Calendar Date</td>
</tr>
<tr>
<td>- Admission paid</td>
<td>- Admission and Discharge Included</td>
<td>- Admission paid</td>
</tr>
<tr>
<td>o Discharge <strong>not</strong> paid separately</td>
<td>o Discharge <strong>not</strong> paid separately</td>
<td>o Discharge paid separately</td>
</tr>
<tr>
<td>Different Calendar Date</td>
<td>Different Calendar Date</td>
<td>Different Calendar Date</td>
</tr>
<tr>
<td>- Admission and Discharge (99217) paid separately</td>
<td>- Use codes 99218-99220</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Discharge (99217) paid separately</td>
<td>- Admission and Discharge paid separately</td>
</tr>
</tbody>
</table>
ICD-10

Looks like a go!
Diagnosis Coding
International Classification of Disease (ICD-10)

• ICD-10 is scheduled to replace ICD-9 coding system on October 1, 2015.
• ICD-10 was developed because ICD-9, first published in 1977, was outdated and did not allow for additional specificity required for enhanced documentation, reimbursement and quality reporting.
• ICD-10 CM will have 68,000 diagnosis codes and ICD-10 PCS will contain 76,000 procedure codes.
• This significant expansion in the number of diagnosis and procedure codes will result in major improvements including but not limited to:
  • Greater specificity including laterality, severity of illness
  • Significant improvement in coding for primary care encounters, external causes of injury, mental disorders, neoplasms, diabetes, injuries and preventative medicine.
  • Allow better capture of socio-economic conditions, family relationships, and lifestyle
  • Will better reflect current medical terminology and devices
  • Provide detailed descriptions of body parts
  • Provide detailed descriptions of methodology and approaches for procedures
Clinical Trials
Requirements for Billing Routine Costs for Clinical Trials

Effective for claims with dates of service on or after January 1, 2014 it is mandatory to report a clinical trial number on claims for items/services provided in clinical trials/studies/registries, or under CED.

Professional

• For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) (do not use CT on the electronic claim, e.g., 12345678) when a clinical trial claim includes:
  • ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
  • Modifier Q0 (investigational clinical service provided in a clinical research study that is in an approved clinical research study) and/or
  • Modifier Q1 (routine clinical service performed in a clinical research study that is in an approved clinical research study), as appropriate (outpatient claims only).

Hospital

• For hospital claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:
  • Condition code 30;
  • ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
  • Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Items or services covered and paid by the sponsor may not be billed to the patient or patient’s insurance, this is double billing.
WHO IS RESPONSIBLE FOR OBTAINING APPROVAL FROM THE MAC(S) FOR AN INVESTIGATIONAL DEVICE EXEMPTION (IDE) CLINICAL TRIAL?

- The principal investigator (PI) is responsible for assuring that all required approvals are obtained prior to the initiation of the clinical trial. For any clinical study involving an IDE, the PI must obtain approval for the IDE clinical trial from the Medicare Administrative Contractor (MAC) for Part A / Hospital.

- Additionally, for clinical studies involving an IDE, the PI is responsible for communicating about the trial and the IDE to the Medicare Part B (physician) MAC.

- Once approval has been received by the MAC, the following needs to take place:
  - The Study must be entered in the Velos System within 48 hours.
  - The PI is responsible for ensuring that the IDE or the no charge device is properly set up in the facility charge master to allow accurate and compliant charging for that device before any billing will occur.
Investigational Device Exemption (IDE)

Hospital Inpatient Billing for Items and Services in Category B IDE Studies

• Payment for the device may not exceed the Medicare-approved amount for a comparable device that has been already FDA-approved.

Routine Care Items and Services

• Hospital providers shall submit claims for the routine care items and services in Category B IDE studies approved by CMS (or its designated entity) and listed on the CMS Coverage Website, by billing according to the clinical trial billing instructions found in §69.6 of this chapter [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf), and as described under subsection D (“General Billing Requirements”).
Investigational Device Exemption (IDE)

Category B Device. On a 0624 revenue code line, institutional providers must bill the following for Category B IDE devices for which they incur a cost:

• Category B IDE device HCPCS code, if applicable
• Appropriate HCPCS modifier
• Category B IDE number

• Charges for the device billed as covered charges

• If the Category B IDE device is provided at no cost, outpatient prospective payment system (OPPS) providers must report a token charge in the covered charge field along with the applicable HCPCS modifier (i.e., modifier – FB) appended to the procedure code that reports the service to furnish the device, in instances when claims processing edits require that certain devices be billed with their associated procedures. For more information on billing ‘no cost items’ under the OPPS, refer to chapter 4, §§20.6.9 and 61.3.1 of this manual.
WHEN THE TRIAL ENDS OR REACHES FULL ENROLLMENT?

When the trial ends, whether due to reaching full enrollment or for any other reason, the PI must work with their department resource and/or the relevant Revenue Integrity Office (s) to inactivate the item in the charge master so that it may no longer be used.

If the device is approved by the FDA and is no longer considered investigational or a Humanitarian Device Exemption (HDE) and will continue to be used at UHealth, the PI must work with their department resource and/or the relevant Revenue Integrity Office (s) to inactivate the investigational device in the charge master and to ensure that a new charge code is built for the approved device. At this point, ongoing maintenance responsibility would transfer to the relevant Revenue Integrity Office (s).
Physician “Provider”
Quality Reporting (PQRS)
CMS Quality Improvement Programs

- Meaningful Use (MU)
- Physician Quality Reporting System (PQRS)
- Value Based Payment Modifier (VBPM)
## CMS Quality Programs
### Medicare Part B Payment Reductions

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>POTENTIAL MEDICARE PAYMENT REDUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful Use</td>
<td>1%</td>
</tr>
<tr>
<td>PQRS</td>
<td>1.5%</td>
</tr>
<tr>
<td>VBPM</td>
<td>4%</td>
</tr>
<tr>
<td><strong>TOTAL PENALTIES</strong></td>
<td><strong>2.5%</strong></td>
</tr>
</tbody>
</table>
## 2015 PQRS Eligible Providers

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Practitioners</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>Physician Assistant</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>DO</td>
<td>Nurse Practitioner</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Doctor of Podiatric</td>
<td>Clinical Nurse Specialist*</td>
<td>Qualified Speech-Language Therapist</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
<td>CRNA</td>
<td></td>
</tr>
<tr>
<td>DDS</td>
<td>Certified Nurse Midwife</td>
<td></td>
</tr>
<tr>
<td>DMD</td>
<td>Clinical Social Worker</td>
<td></td>
</tr>
<tr>
<td>Doctor of Chiropractic</td>
<td>Clinical Psychologist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Registered Dietician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nutrition Professional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audiologists</td>
<td></td>
</tr>
</tbody>
</table>
Reporting Requirements:
- Reporting Period = Full CY
- Report 9 Measures from 3 National Quality Strategy Domains

Reporting Options:
- Claims, EHR, Registry
- Individual or GPRO

<table>
<thead>
<tr>
<th>NATIONAL STRATEGY DOMAINS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication &amp; Care Coordination</td>
</tr>
<tr>
<td>Efficiency &amp; Cost Reduction</td>
</tr>
<tr>
<td>Person &amp; Caregiver-Centered</td>
</tr>
<tr>
<td>Experience &amp; Outcomes</td>
</tr>
</tbody>
</table>
Physician Impact

*Workflow and documentation changes*

**TO DO:**
- Study Measure Specifications
- Ensure documentation meets measure requirements
- Bill PQRS quality code when required in MCSL/UChart
- Document chronic conditions/secondary diagnoses
- Use UChart Smart Phrases
- Ensure medical support staff completes required documentation
HIPAA, HITECH, PRIVACY AND SECURITY

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

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

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

http://www.miami.edu/index.php/professional_development__training_office/learning/ulearn/
• HIPAA, HITECH, Privacy & Security

Several breaches were discovered at the University of Miami, one of which has resulted in a class action suit. As a result, “Fair Warning” was implemented.

• What is Fair Warning?

• Fair Warning is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.

• Fair Warning protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.

• Fair Warning is an initiative intended to reduce the cost and complexity of HIPAA auditing.

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