



Office of Billing Compliance 2015 Coding, Billing and Documentation Program

Department of Cardiology



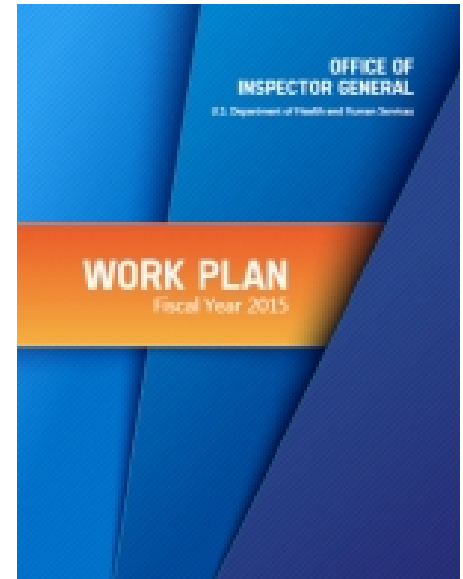
HOT TOPICS IN COMPLIANCE 2015

Documentation in the EHR - EMR

Volume of Documentation vs Medical Necessity

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

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



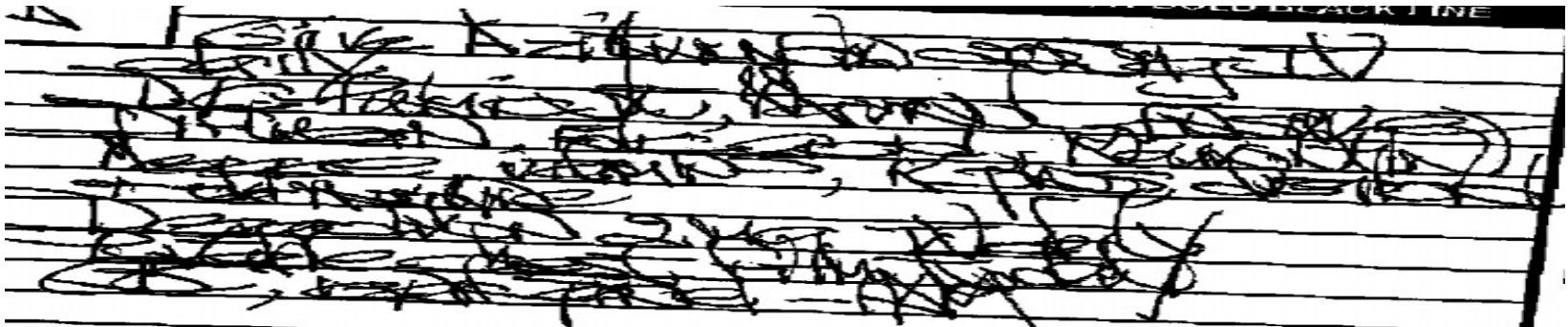
- **REMEMBER:** More volume is not always better in the medical record, especially in the EMR with potential for cutting/pasting, copy forward, pre-defined templates and pre-defined E/M fields. Ensure the billed code is reflective of the actual service provided on the DOS only.

General Principles of Documentation

- **All documentation must be legible to all readers.** Illegible documents are considered not medically necessary if it is useless to provide a continuum of care to a patient by all providers. Documentation is for the all individuals not just the author of the note.
- Per the Centers for Medicare and Medicaid services (CMS) practitioners are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record."
 - CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the date of service.
 - Until the practitioner completes the documentation for a service, including signature, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done, and this includes a signature.
- An addendum to a note should be dated and timed the day the information is added to the medical record and only contain information the practitioner has direct knowledge is true and accurate.

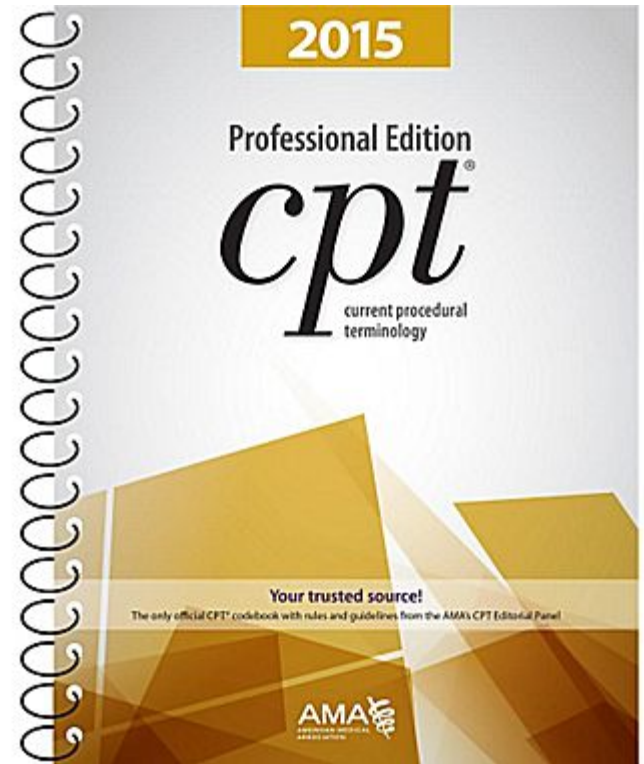
General Principals of Documentation

- 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.

2015 Code Changes and Proposed 2016



Interventional Cardiology C3 Designation

- Starting in 2015, interventional cardiologists can elect to be identified under the C3 designation, a specialty code that will allow for an apples-to-apples comparison of performance scores that get linked to physician profiles.
- That will allow grouping general cardiologists separate from with interventional cardiologists.
- Grouping all cardiology together in the past produced results that often erroneously suggest overutilization among interventionalists. Being able to compare interventional cardiologists with their peers will eliminate the distortion, help identify outliers and improve performance.
- Interventional cardiologists contact need to contact their local carrier if they want their designation changed, a process that will then update their profiles.

Cardiovascular System 2015 Changes

- 33 New Codes

- 26 Extracorporeal Membrane Oxygenation (ECMO) or Extracorporeal Life Support Services (ECLS).
- 4 Pacemaker and Implantable Defibrillator
- 1 Stenting
- 2 Aorta and Great Vessels

- 23 Revised Codes

- 18 Pacemaker and Implantable Defibrillator
- 5 Stenting

- 6 Deleted Codes

- 3 ECMO

Subheading Change & Pacemaker and Implantable Defibrillator

- The 2014 subheading of Pacemaker or Pacing Cardioverter-Defibrillator was replaced by Pacemaker and Implantable Defibrillator.
- There are extensive new and revised notes which include updated definitions as well as additions to the table for Pacemaker and Implantable Defibrillator code selections.
- A new code has been added for the insertion of an implantable defibrillator system, 33270, and one for electrode insertion, 33271. Two new codes were added for the removal (33272) and repositioning (33273) of the electrodes.

Revised Codes – Pacemaker/Implantable Defibrillator

33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator
33223	Relocation of skin pocket for implantable defibrillator
33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)

Revised Codes – Pacemaker/Implantable Defibrillator

33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead
33241	Removal of implantable defibrillator pulse generator only
33243	Removal of single or dual chamber implantable defibrillator electrode(s); by thoracotomy
33244	Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction

Revised Codes – Pacemaker/Implantable Defibrillator

33249	Insertion or replacement of permanent implantable defibrillator system with transvenous lead(s), single or dual chamber
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system

New Codes – Pacemaker/Implantable Defibrillator

33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed
33271	Insertion of subcutaneous implantable defibrillator electrode
33272	Removal of subcutaneous implantable defibrillator electrode
33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode

CPT 2015 moved the codes for subcutaneous implantable cardioverter defibrillators, or SICDs, from Category III (temporary codes 0319T to 0328T to Category I permanent codes.

The new codes 33270 to 33273 for insertion, replacement, and repositioning type services. For device evaluation type services, turn to 93260 to 93261 and for electrophysiologic evaluation, or EP evaluation, see 93644.

ECMO/ECLS

- Twenty-five new codes were added to the new subheading of Extracorporeal Membrane Oxygenation (ECMO) or Extracorporeal Life Support Services (ECLS). These procedures provide cardiac and/or respiratory support to the heart and lungs. The codes represent the services directly related to the cannulation, initiation, management, and discontinuation of the ECMO/ECLS (33946-33989).

Deleted Codes- ECMO	
33960	Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day
33961	; each subsequent day
36822	Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)

New Codes – Extracorporeal membrane oxygenation (ECMO) /extracorporeal life support (ECLS)

33946	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous
33947	; initiation, veno-arterial
33948	; daily management, each day, veno-venous
33949	; daily management, each day, veno-arterial
33951	; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)
33952	; ... 6 years and older ...
33953	; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5
33954	; ...6 years and older
33955	; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 yrs.
33956	;...6 years and older
33957	;reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)
33958	;... 6 years and older ...
33959	reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 yrs.
33962	;... 6 years and older ...
33963	;reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 yrs.
33964	;... 6 years and older ...

New Codes – Extracorporeal membrane oxygenation (ECMO) /extracorporeal life support (ECLS)

33965	;removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age
33966	;... 6 years and older
33969	;removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age
33984	; ... 6 years and older
33985	; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age
33986	; ... 6 years and older
33987	Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS
33988	Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS
33989	Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS

TMVR

- New coding notes pertaining to transcatheter mitral valve repair (TMVR) were added for the subheading Mitral Valve. These notes pertain exclusively to the two new codes added for TMVR, 33418, and add-on code for additional prosthesis during the same session, 33419.

33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis
+33419	; additional prosthesis(es) during same session

Deleted code – Pulmonary Valvotomy, Aorta and Great Vessels & Vein Destruction

33472	Valvotomy, pulmonary valve, open heart; with inflow occlusion
33332	Insertion of graft, aorta or great vessels; with shunt bypass
36469	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face

Sneak Peek at 2016 Proposed Changes

These are only potential code changes. They reflect decisions shown in the [CPT® Editorial Summaries of Panel Actions](#), but the revised code set won't be final or official until later this year.

• 1. What's in Store for Abdominal Aortic Ultrasound Screening?

- If you've been longing for a CPT® code that's specific to abdominal aortic ultrasound screening, you may be in luck in 2016. The Editorial Panel accepted the addition of a code for just this purpose. You're likely to see it in the 767XX range.

• 2. What Will You Use for Non-Coronary IVUS?

- All vascular coders should be keeping a close eye on what happens to coding for intravascular ultrasound (IVUS) coding in 2016. We may be bidding farewell to non-coronary IVUS codes +37250 and +37251 along with their RS&I codes 75945 and +75946.
- Instead we may be using 3725X codes that bundle imaging services.

3. What's Moving From Category III to Category I?

- You may see at least two Cat. III [cardiology codes](#) make the leap to Cat. I in 2016:
- Code 0262T (*Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach*) may make way for a new option in the range 3347X, which includes other pulmonary valve codes.
- Another Cat. III code that may make the sought-after switch to Cat. I is 0311T (*Non-invasive calculation and analysis of central arterial pressure waveforms with interpretation and report*). You may be using a 9300X code in its place.

4. What's New and Not So New in Category III?

- Code 0206T (*Computerized database analysis of multiple cycles of digitized cardiac electrical data from two or more ECG leads, including transmission to a remote center, application of multiple nonlinear mathematical transformations, with coronary artery obstruction severity assessment*) didn't get to find a new home in Cat. I, but it did get an extension to stay in Cat. III.
- Another code you'll be seeing in Cat. III will apply to "imaging of myocardial strain for myocardial malformation detection." You also may see more than 10 new Cat. III codes related to cardiac contractility for modulation of heart rhythm and contractions, and another to report a test for measurement of a protein to assess cardiovascular risk.

5. What Else Could Be Headed Our Way?

- That's not all, folks! Changes to cerebral revascularization codes are likely to trigger revisions to thrombectomy codes 37184, +37186, and 37211. And we're likely to see removal of moderate sedation codes 99143-+99150 so CPT® can offer 15-minute code options instead. Deletion of non-thrombolysis transcatheter infusion therapy codes 37202 and 75896 could be in the works, too.
- Additional meetings for the Panel mean additional chances for new codes, deletions, and other changes — including to coding guidance — before we start applying the new codes on Jan. 1, 2016.

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 :

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

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

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 procedure (or key and critical portions & description of the key and critical portions of the procedure and immediately available)."*

Endoscopy Procedures (excluding Endoscopic Surgery):

TP must be present during the entire viewing for payment.

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

High-Risk Procedures & Diagnostic Services

26

Complex or high-risk procedures: Requires personal (in person) supervision of its performance by a TP and is billable only when the TP is present with the resident for the entire procedure. These procedures typically include cardiac and other interventional services.

- *Example: “Dr. TP (or I) was present for the entire (identify procedure).”*

Diagnostic services with an interpretation: If documented by a resident to be billed by a TP requires that s/he personally document that s/he personally reviewed the images, tracing, slides etc. and the resident’s interpretation and either agrees with it or edits the findings.

- *Example: “I personally reviewed the films (and/or slides etc.) and agree with the resident’s findings.’*

Diagnostic Procedures

- **RADIOLOGY AND OTHER DIAGNOSTIC TESTS**
- **General Rule:** The Teaching Physician may bill for the interpretation of diagnostic Radiology and other diagnostic tests if the interpretation is performed or reviewed by the Teaching Physician with modifier 26 in the hospital setting.
- **Teaching Physician Documentation Requirements:**
- Teaching Physician prepares and documents the interpretation report.
- OR
- Resident prepares and documents the interpretation report
- The Teaching Physician must document/dictate: “I personally reviewed the film/recording/specimen/images and the resident’s findings and agree with the final report”.
- **A countersignature by the Teaching Physician to the resident’s interpretation is not sufficient documentation.**

Orders” Are Required For Any Diagnostic Procedure With a TC / 26 Modifier

- The CPT descriptions of documentation requirements for many ophthalmic diagnostic tests include the phrase, ". . . with interpretation and report." Once the appropriate individual has performed the test, you must document your interpretation of the results somewhere in the medical records. This doesn't have to be anything elaborate.
- It may merely be a brief phrase indicating if a test is "normal," "stable from a previous test" or "mild superior arcuate defect."

Orders” Are Required For Any Diagnostic Procedure With a TC / 26 Modifier

- All services billed for interpretation must include an order (even as a notation in the encounter note for the DOS) and distinct report for in order to bill.
- For Medicare, the Interpretation and Report needs the **Three C’s** to be addressed:
 - **Clinical Findings,**
 - **Comparative Data, when appropriate; and**
 - **Clinical Management**
- There must be a written report that becomes part of the patient’s medical record and this should be as complete as possible.

Global Surgery



Global Service: 1 payment for procedure

Major = Day before procedure thru 90 days after

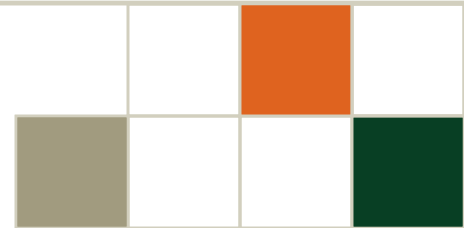
Minor = Day of procedure (some until 10 days after)

Services **Included** In The Global Surgery Fee

- Preoperative visits, beginning with the day before a surgery for major procedures and the day of procedure for minor procedures.
- 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.

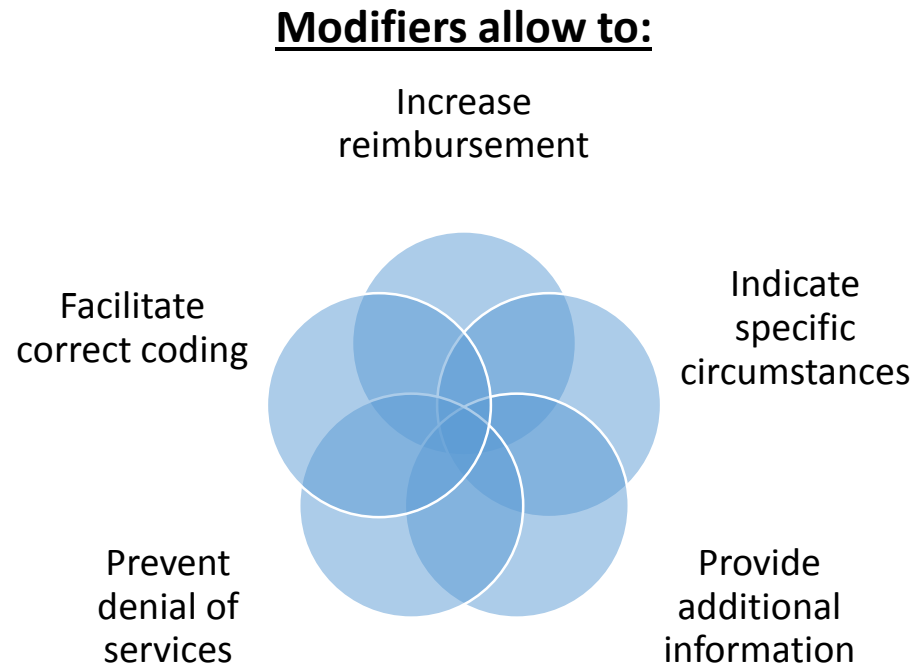
Services Not Included in the Global Surgery Fee

- Visits unrelated to the diagnosis for which the surgical procedure is performed. 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.
- 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.
- 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 Immunosuppressive therapy for organ transplants.



Modifiers: Provider Documentation MUST Support the Use of All Modifiers

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



Documentation in the operative report must support the use of any modifier

Major Surgery Modifier Reminders



Modifier 22

- Services performed are significantly greater than usually required", therefore its use should be exceptional.

Modifier 24

- Separately Identifiable E/M by the Same Physician/Group during the global period.

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 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.*

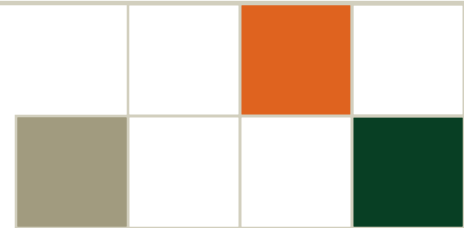
Modifier 62: Co-Surgery

Both are primary surgeons, performing distinct parts of a single reportable procedure (same CPT code) performing the parts of the procedure simultaneously, e.g., heart transplant or bilateral knee replacements. (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

Modifier 66: Team Surgery

- Team-Surgery Surgeries: Highly complex procedures (requiring the skilled services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of the modifier **66** to the basic procedure number used for reporting services. Reimbursement is determined "By Report".



Modifier 82: Physician Assistant Surgeon in a Teaching Hospital

Modifier AS: PA or NP Assistant at Surgery in a Teaching Hospital

- 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

Cardiology Minor Procedure With an E/M

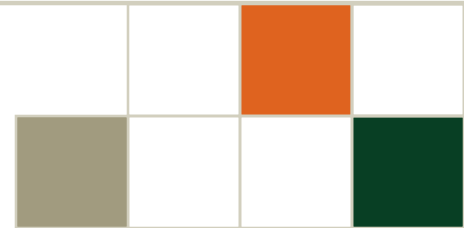
EPs and ICD evaluations / studies have a 000 Global Period

Echo's (including TEEs and TAVR) have a XXX Global Period

Devise interrogations have a XXX Global period

Cardiac Caths have a 000 Global Period

Cardiac Stress Tests have a XXX Global Period



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.
- *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.
- 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: XXX Procedures

- Procedures with a global surgery indicator of “XXX” are not generally covered by global rules and many are diagnostic in nature.
- “XXX” procedures performed by physicians have inherent pre-procedure, intra- procedure, and post-procedure work usually performed each time the procedure is completed.
 - *This work should never be reported as a separate E&M code. Communicating diagnostic results to a patient after the performance of a diagnostic service (if you are also the performing practice for the diagnostic) would not typically be billable if the diagnostic results could have been communicated to a patient over the phone with follow-up instructions*
- With many “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code.
 - This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure.

NCCI Manual: Modifier 25

What this is saying is that the E/M required to address the patient's specific chief complaint(s) is included in the reimbursement for the billable minor procedure. This would include determining the chief complaint(s), taking or updating history, review of systems, examining the patient, past family/social history, diagnosing the problem, making the decision on how to treat the problem, informing the patient, obtaining consent, and providing postop instructions. In summary, none of the aforementioned tasks/processes can be billed for separately if they are related to a billable minor procedure.

The **exception**, is when there is a "separately identifiable" E/M service performed during that visit that goes "above and beyond" the E/M necessary for the billable minor procedure.

Additional Articles of Interest

OIG Cracking Down on Modifier 25 Use

<http://medicaleconomics.modernmedicine.com/medical-economics/news/tags/cms/oig-still-cracking-down-use-modifier-25>

E/M Update: DOJ Targets Improper Use of Modifier 25

http://www.martindale.com/health-care-law/article_Marshall-Dennehey-Warner-Coleman-Goggin_1786564.htm

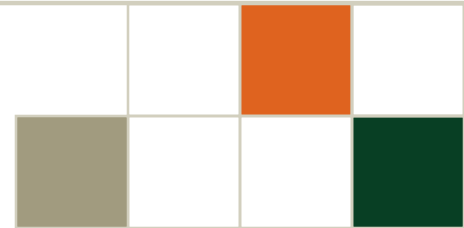
Almost never billable when a patient is pre-scheduled for a procedure

- Here is a **SIMPLE** way to look at it...

Take the chart note for the date of service in question, take a highlighter, and highlight all the documentation related to performing the procedure **including** the documentation required for evaluating, diagnosing, examining the patient, making the decision to perform the procedure in question, performing the procedure, and providing postoperative instructions and any prescriptions. Now, if the remaining documentation from that date of service can stand alone as a billable E/M visit (with all the appropriate elements required), then there is a high probability that this will stand as a “separate and identifiable” E/M visit.

Note: The rules about “separate and identifiable” E/M visits apply to BOTH new patient and established patient E/M visits.

Major or Minor Procedure Modifier Reminders



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.

Modifier GC

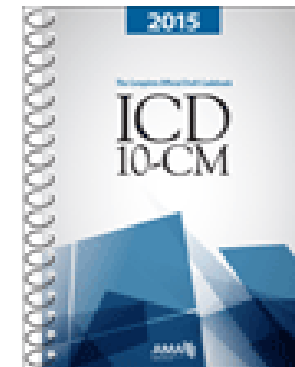
CMS Manual Part 3 - Claims Process - Transmittal 1723

- ▶ 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.

Inpatient, Outpatient and Consultations

Evaluation and Management E/M

Documentation and Coding



New vs Established Patient for E/M

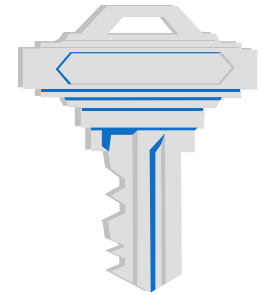
Outpatient Office and Preventive Medicine

<https://questions.cms.gov/faq.php?id=5005&faqId=1969>

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

- "New patient" is a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.
- An interpretation of a diagnostic test, reading an x-ray or EKG etc., (billed with a -26 modifier) in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

E/M Key Components



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

The billable service is determined by the combination of these 3 key components.

- All 3 Key Components are required to be documented for all E/M services.
- For coding the E/M level
 - New OP and initial IP require all 3 components to be **met or exceeded** and
 - Established OP and subsequent IP require 2 of 3 key components to be **met or exceeded and one must be MDM.**

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

Elements of an E/M History

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

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

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

WHY IS THE PATIENT BEING SEEN TODAY

- Review of Systems (**ROS**)
- Past Family, Social History (**PFSH**)

History of Present Illness (HPI)

A KEY to Support Medical Necessity to in addition to MDM

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

Focus upon present illness or reason for the visit!

- HPI drivers:
 - Extent of PFSH, ROS and physical exam performed
- **NEVER DOCUMENT PATIENT HERE FOR FOLLOW-UP WITHOUT ADDITIONAL DETAILS OF REASON FOR FOLLOW-UP. This would not qualify as a CC or HPI.**

HPI

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

OR

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

Review of Systems (ROS)

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

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

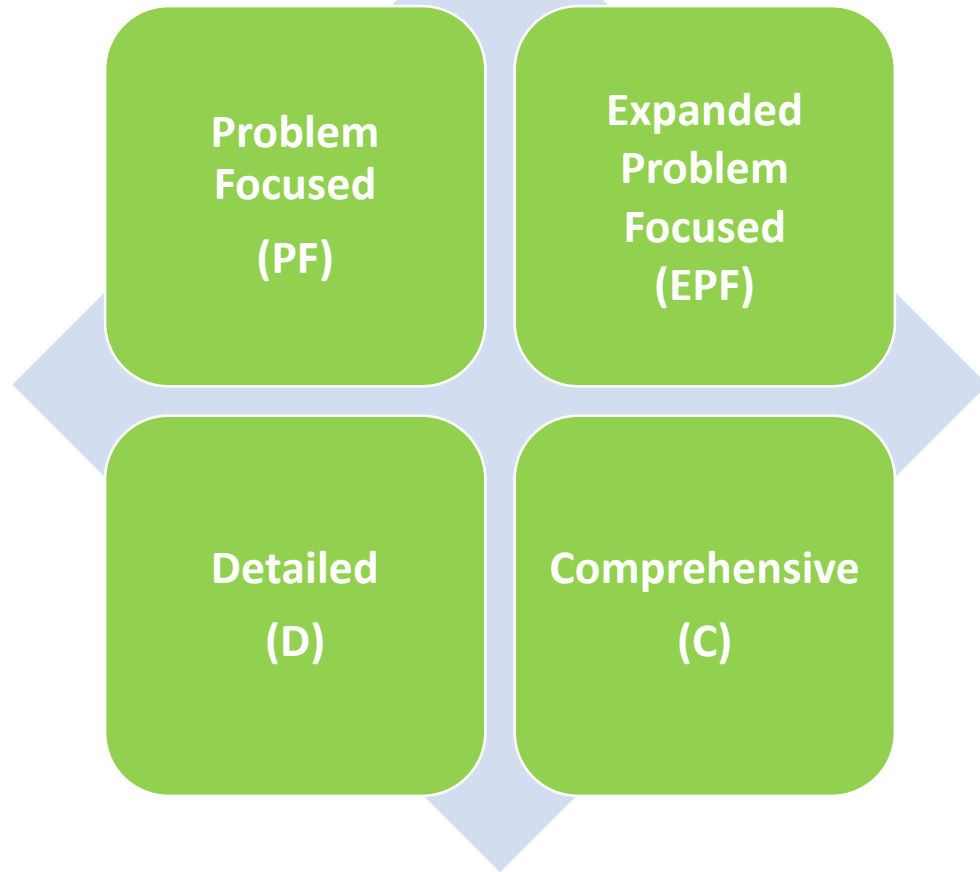
Past, Family, and/or Social History (PFSH)

- **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 Complaint, HPI, or ROS
- **Social history:** May include age appropriate review of past and current activities, marital status and/or living arrangements, use of drugs, alcohol or tobacco and education.

Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services. **Don't use the term "non-contributory" for coding a level of E/M**

Examination

4 TYPES OF EXAMS



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



CARDIOLOGY Examination

Constitutional	<ul style="list-style-type: none"> <input type="checkbox"/> 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) <input type="checkbox"/> General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Eyes	Inspection of conjunctivae and lids (eg, xanthelasma)
ENT & Mouth	Inspection of teeth, gums and palate Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	<ul style="list-style-type: none"> <input type="checkbox"/> Examination of jugular veins (eg, distension; a, v or cannon a waves) Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	<ul style="list-style-type: none"> <input type="checkbox"/> Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) <input type="checkbox"/> Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	Palpation of heart (eg, location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) <ul style="list-style-type: none"> <input type="checkbox"/> Auscultation of heart including sounds, abnormal sounds and murmurs Measurement of blood pressure in two or more extremities when indicated (eg, aortic dissection, coarctation) Examination of: <ul style="list-style-type: none"> <input type="checkbox"/> Carotid arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay) Abdominal aorta (eg, size, bruits) <ul style="list-style-type: none"> <input type="checkbox"/> Femoral arteries (eg, pulse amplitude, bruits) Pedal pulses (eg, pulse amplitude) Extremities for peripheral edema and/or varicosities
Gastrointestinal (Abdomen)	Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
Musculoskeletal	<ul style="list-style-type: none"> <input type="checkbox"/> Examination of the back with notation of kyphosis or scoliosis Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Extremities	
Skin	Inspection and/or palpation of skin and subcutaneous tissue (eg, stasis dermatitis, ulcers, scars, xanthomas)
Neurological/ Psychiatric	Brief assessment of mental status including <ul style="list-style-type: none"> <input type="checkbox"/> Orientation to time, place and person, Mood and affect (eg, depression, anxiety, agitation)



1995 and 1997 Exam Definitions

Problem Focused (PF): 99231, 99212 or 99201

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

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

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

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

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

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

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

Medical Decision Making (MDM)

DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE TODAY!!

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

Step 1:

- **Number of possible diagnosis and/or management options affecting today's visit. List each separate in A/P and address every diagnosis or management option from visit. Is the diagnosis and/or management options :**
 - "New" self-limiting: After the course of prescribed treatment is it anticipated that the diagnosis will no longer exist (e.g. otitis, poison ivy, ...)
 - New diagnosis with follow-up or no follow-up (diagnosis will remain next visit)
 - Established diagnosis that stable, worse, new,

Step 2:

- **Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.**
 - Labs, radiology, scans, EKGs etc. reviewed or ordered
 - Review and summarization of old medical records or request old records
 - Independent visualization of image, tracing or specimen itself (not simply review of report)

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.**
 - # of chronic conditions and are they stable or exacerbated (mild or severe)
 - Rx's ordered or renewed. Any Rx toxic with frequent monitoring?
 - Procedures ordered and patient risk for procedure

Note: The 2 most complex elements out of 3 will determine the overall level of MDM

MDM Step 1: # Dx & Tx Options

Number of Diagnosis or Treatment Options – Identify Each That Effects Patient Care For The DOS

Problem(s) Status	Number	Points	Results
Self-limited or minor (stable, improved or worsening)	Max=2	1	
Est. Problem (to examiner) stable, improved		1	
Est. Problem (to examiner) worsening		2	
New problem (to examiner); no additional workup planned	Max=1	3	
New prob. (To examiner); additional workup planned		4	
Total			

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 2: Amt. & Complexity of Data

Amount and/or Complexity of Data Reviewed – Total the points		
REVIEWED DATA	Points	
Review and/or order of clinical lab tests	1	1 POINT: E- 2, NEW-1,2 IP Level 1
Review and/or order of tests in the radiology section of CPT	1	
Review and/or order of tests in the medicine section of CPT	1	
Discussion of test results with performing physician	1	2 POINTS: E-3, NEW-3 IP Level 1
Decision to obtain old records and/or obtain history from someone other than patient	1	
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	2	3 POINTS: E-4, NEW-4 IP Level 2
Independent visualization of image, tracing or specimen itself (not simply review of report).	2	4 POINTS: E-5. NEW-5 IP –Level 3
Total		

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.

	Presenting Problem	Diagnostic Procedure(s) Ordered	Management Options Selected
Min Risk E-2, New -1 or 2, IP -1	<ul style="list-style-type: none"> One self-limited / minor problem 	<ul style="list-style-type: none"> Labs requiring venipuncture CXR EKG/ECG UA 	<ul style="list-style-type: none"> Rest Elastic bandages Gargles Superficial dressings
Low Risk E-3, NEW-3 IP - 1	<ul style="list-style-type: none"> 2 or more self-limited/minor problems 1 stable chronic illness (controlled HTN) Acute uncomplicated illness / injury (simple sprain) 	<ul style="list-style-type: none"> Physiologic tests not under stress (PFT) Non-CV imaging studies (barium enema) Superficial needle biopsies Labs requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> OTC meds Minor surgery w/no identified risk factors PT, OT IV fluids w/out additives
Mod Risk E-4, NEW-4 IP-2	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> 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 Risk E-5. NEW-5 IP -3	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> CV imaging w/contrast, w/risk factors Cardiac electrophysiological tests Diagnostic endoscopies w/risk factors 	<ul style="list-style-type: none"> Elective major surgery w/risk factors Emergency surgery Parenteral controlled substances Drug therapy monitoring for toxicity DNR

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.

Critical Care



Critical Care: Medical Review Guidelines

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the requirements.

- **Clinical Criterion** – A high probability of sudden, clinically significant or life threatening deterioration of the patient's condition which requires a high level of physician preparedness to intervene urgently
- **Treatment Criterion** – Life or organ supporting interventions that require frequent assessment and manipulation by the physician.
 - Withdrawal of or failure to initiate these interventions would result in sudden, clinically significant / life-threatening deterioration in the patient's condition.

Time spent teaching or by residents may not be used in CC time and NPP time cannot be added to physician time.

- For time based codes, the physician must document the total amount of time spent on any calendar day providing critical care services to a patient. This time may be noncontiguous.
- **Absent exceptional circumstances, generally requiring the skills of different specialty providers,** critical care billed by one provider cannot overlap in time with critical care provided by another provider. The time must be spent on the unit. It may include direct bedside care or time spent discussing the case with consultants or reviewing pertinent laboratory or imaging data.

Time Based CC Codes 99291 and 99292

Time	Codes
< 30 min	Appropriate E/ M code
30-74 min	99291 x 1
75-104 min	99291 x 1 and 99292 x 1
105-134 min	99291 x 1 and 99292 x 2
135-164 min	99291 x1 and 99292 x 3

Time-Based Critical Care

- One can also include time spent getting essential information from family members, but should not include minutes just updating the family on the patient's progress. Such conversations can be via telephone, but must be made from the unit in which the patient is cared for. A summary of such interactions should be entered into the medical record to support the total amount of time in critical care.
- **99291**: Critical care, evaluation and management (E/M) of the critically ill or critically injured patient; first 30-74 min
- **99292**: each additional 30
99291 should be reported by a provider or subspecialty group only once in a calendar day. Critical care time < 30 min in a single day should be reported using the E/M codes **99221-99233**

Critical Care Documentation & Criteria

MM5993 Related Change Request Number: 5993

The TP documentation must include:

- Time the teaching physician spent providing critical care (resident time and time teaching residents does not count toward the 30 minute minimum);
- That the patient was critically ill during the time the TP saw the patient (met clinical criterion of a high probability of sudden, clinically significant or life threatening deterioration of the patient's condition);
- What made the patient critically ill; and
- The nature of the treatment and management provided by the TP (treatment criterion of Life or organ supporting interventions that require frequent assessment and manipulation by the physician.)
- Combination of the TP's documentation and the resident's may support CC provided that all requirements for CC services are met. The TP documentation may tie into the resident's documentation. The TP may refer to the resident's documentation for specific patient history, physical findings and medical assessment as long as additional TP documentation is included to support their CC time.

Procedures Bundled Into Critical Care

- Introduction of needle or intracatheter, vein (36000)
- Venipuncture, age 3 years or older, necessitating physician's skill (36410)
- Collection of venous blood by venipuncture (36591)
- Collection of blood specimen from a completely implantable venous access device (36591)
- Arterial puncture, withdrawal of blood for diagnosis (36600)
- Nasogastric or orogastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report) (43752)
- Radiologic examination, chest; single view, stereo, or two view (71010, 71015, 71020)
- Gastric intubation and aspiration or lavage for treatment (91105)

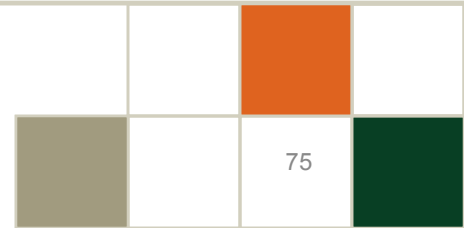
Procedures Bundled Into Critical Care

- Temporary transcutaneous pacing (**92953**)
- Indicator dilution studies with dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (**93561** and **93562**)
- Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day, subsequent day, nursing facility (**94002**, **94003**, **94004**)
- Continuous positive airway pressure ventilation (CPAP), initiation and management (**94662**)
- Continuous negative pressure ventilation, initiation and management (**94662**)
- Noninvasive ear or pulse oximetry for oxygen saturation, single, multiple, or continuous (**94760**, **94761**, **94762**)
- Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data) (**99090**)

Procedures Not Bundled Into Time-Based Critical Care Codes

- These procedures should be reported separately with a **25** modifier appended to the critical care service. The time needed to complete any of these services cannot be counted as critical care time. Separate documentation is needed. Examples include:
- Intubation, endotracheal, emergency procedure (**31500**)
- Tracheostomy, planned (**31600**)
- Bronchoscopy, rigid or flexible (**31622**)
- Thoracentesis, with insertion of tube (**32421, 32422**)
- Insertion of tunneled pleural catheter with cuff (**32550**)
- Cardiopulmonary resuscitation (**92950**)

In-Patient Hospital Care



USING DIFFERENT LEVELS OF CARE

99223 *
PATIENT
ADMITTED

99233 *
(PT. IS
UNSTABLE)

99232 *
(PT. HAS
DEVELOPED
MINOR COMPL.)

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

99238 *
PATIENT
DISCHARGED

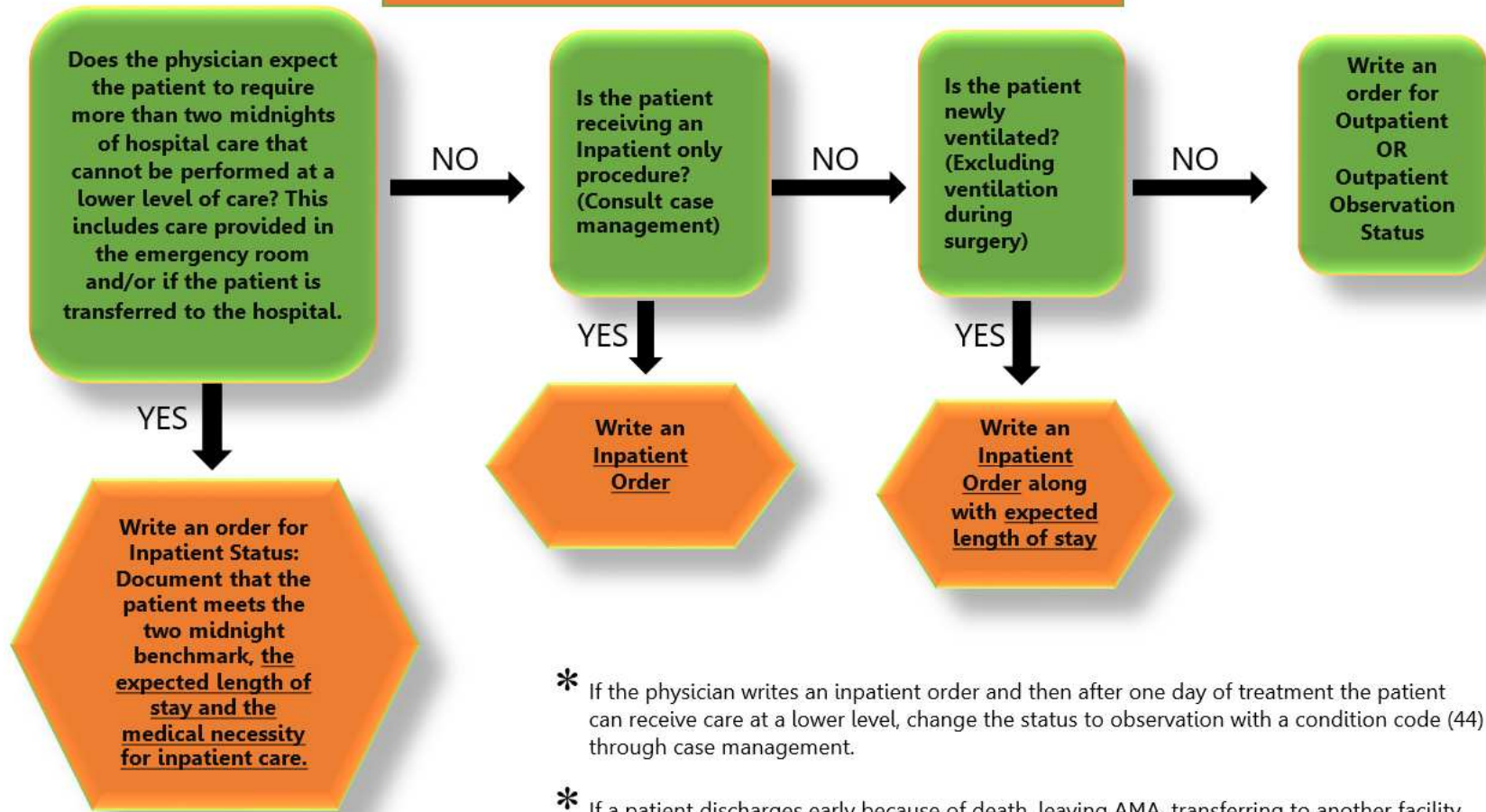
Present on Admission (POA) & Hospital-Acquired Conditions (HAC)

- 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.

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 DECISION TREE FOR MEDICARE PATIENTS



- * If the physician writes an inpatient order and then after one day of treatment the patient can receive care at a lower level, change the status to observation with a condition code (44) through case management.
- * If a patient discharges early because of death, leaving AMA, transferring to another facility or an unforeseen recovery, then the patient should remain in patient with supportive documentation.

Admission to Hospital - Two-Midnight Rule

Exceptions to the Rule

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

Two-Midnight Rule vs Observation Care

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

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

Observation Care Services

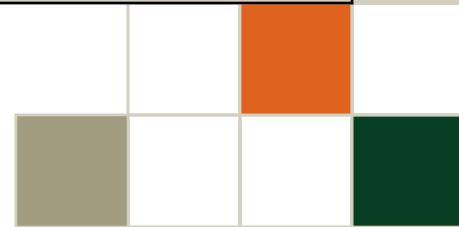
Billing Guidelines

- **Procedure Codes: 99218, 99219, 99220, 99224-99226 and 99234-99236**
- Outpatient observation services require monitoring by a physician and other ancillary staff, which are reasonable and necessary **to evaluate the patient's condition. These services are only considered medically necessary when performed under a specific order of a physician.**
- **Outpatient observation services are not to be used for the convenience of the hospital, its physicians, patients, patients' families, or while waiting placement to another facility.**
- Outpatient observation services, **generally, do not exceed 24 hours.** Some patients may require a second day of observation **up to a maximum of 48 hours.**
- At 24 hours, the physician should evaluate patient's condition to decide if the patient needs to remain in observation for an additional 24 hours.

OBSERVATION CARE SERVICES

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

<u>8 Hours or Less</u>	<u>> 8 Hours < 24 Hours</u>	<u>24 Hours or More</u>
99218-99220 (Initial Observation Care)	99234-99236 (Observation or Inpatient Care)	99218-99220 (Initial Observation Care) 99224-99226 Subsequent Day different calendar day
<u>Same Calendar Date</u> <ul style="list-style-type: none"> • Admission paid ○ Discharge not paid separately 	<u>Same Calendar Date</u> <ul style="list-style-type: none"> • Admission and Discharge Included 	<u>Same Calendar Date</u> <ul style="list-style-type: none"> • Admission paid ○ Discharge not paid separately
<u>Different Calendar Date</u> <ul style="list-style-type: none"> • Admission and Discharge (99217) paid separately 	<u>Different Calendar Date</u> <ul style="list-style-type: none"> • Use codes 99218-99220 • Discharge (99217) paid separately 	<u>Different Calendar Date</u> <ul style="list-style-type: none"> • Admission and Discharge paid separately



Observation Care Services

- Subsequent Observation Care Codes are **TIME-BASED CODES** and time spent at bedside and on Hospital floor unit must be documented by the physician.
- At 48 hours, the physician should re-evaluate patient's condition and decide if patient needs to be admitted to the hospital or discharged home.
- Outpatient observation time begins **when the patient is physically placed in the observation bed. Outpatient observation time ends at the time it's documented in the physician's discharge orders.**

Non-Physician Practitioners (NPP's) or Physician Extenders

Who is a NPP?

Physician Assistant (PA)

Nurse Practitioner (NP)



NPP Agreements & Billing Options

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

Shared Visits

- The shared/split service is usually reported using the physician's NPI.
- When an E/M service is a shared encounter between a physician and a NPP, the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient and can be billed under the physician.
- If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the non-physician's NPI.
- Procedures **CANNOT** be billed shared

Shared Visits Between NPP and Physician

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

1. The physician provides a medically necessary face-to-face portion of the E/M encounter (even if it is later in the same day as the PA/ARNP's portion); and
 2. The physician personally documents in the patient's record the details of their face-to-face portion of the E/M encounter with the patient.
- If the physician does not personally perform and personally and contemporaneously document their face-to-face portion of the E/M encounter with the patient, then the E/M encounter cannot be billed under the physician's name and must be billed under the NPP.
 - The NPP MUST be an employee (or leased) to bill shared. Documentation from a hospital employed NPP may not be utilized to bill a service under the physician.

Bill Independently and Not Shared

Billing Under The NPP NPI

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

“INCIDENT TO”

- “Incident to” services must be an integral part of the patient’s treatment course
- Provided under the physician’s direct personal supervision (Physician must be present in the office suite and be immediately available to provide assistance and direction throughout the time the services are being performed)
- Commonly rendered without charge (included in physician’s professional services)
- Commonly furnished in a physician’s office (not in a hospital setting)
- Auxiliary Personnel must be directly employed by the physician, physician group or entity that employs the physician or may be a leased employee

“INCIDENT TO”

Established Patient Visits: “Incident to” Billing Requirements

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

Scribed Notes

- Record entries made by a "scribe" should be made upon the direction of the physician. A scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently or obtain any information independently except to ROS and PFSH. They cannot obtain the HPI, any portion of the PE or MDM.
- The scribe must note "written by xxxx, acting as scribe for Dr. yyyy." Then, Dr. yyyy indicating that the note accurately reflects work and decisions made by him/her and then authenticate with signature.
- It is inappropriate for an employee of the physician to round at one time and make entries in the record, and then for the physician to see the patient at a later time and note "agree with above...".
- AAMC does not support someone "dictating" as a scribe by an NPP, as scribing is over the shoulder immediate documenter with no services personally performed by the scriber. In this case, the physician should be dictating their own visit. Scribes can do EMRs under their own password.

Scribed Notes

- Individuals can only create a scribe note in an EHR if they have their own password/access to the EHR for the scribe role. Documents scribed in the EHR must clearly identify the scribe's identity and authorship of the document in both the document and the audit trail.
- Scribes are required to notify the provider of any alerts in the EPIC System. Alerts must be addressed by the provider.
- Providers and scribes are required to document in compliance with all federal, state, and local laws, as well as with internal policy.
- Failure to comply with this policy may result in corrective and/or disciplinary action by the hospital and/or department under the University of Miami Medical Group disciplinary policies applicable.
- Verbal orders may neither be given to nor by scribes. Scribes may pend orders for providers based upon provider instructions.
- The following attestation must be entered by the scribe:
 - **“Scribed for [Name of provider] for a visit with [patient name] by [Name of scribe] [date and time of entry].”**
- The following attestation should be entered by provider when closing the encounter:
 - **“I was present during the time 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].”**

ICD-10

Looks like a go!



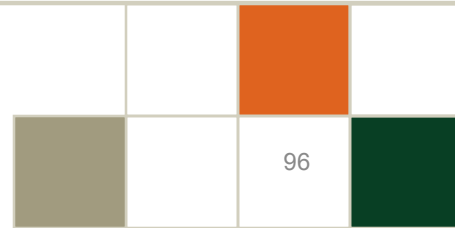
Diagnosis Coding

International Classification of Disease (ICD-10)

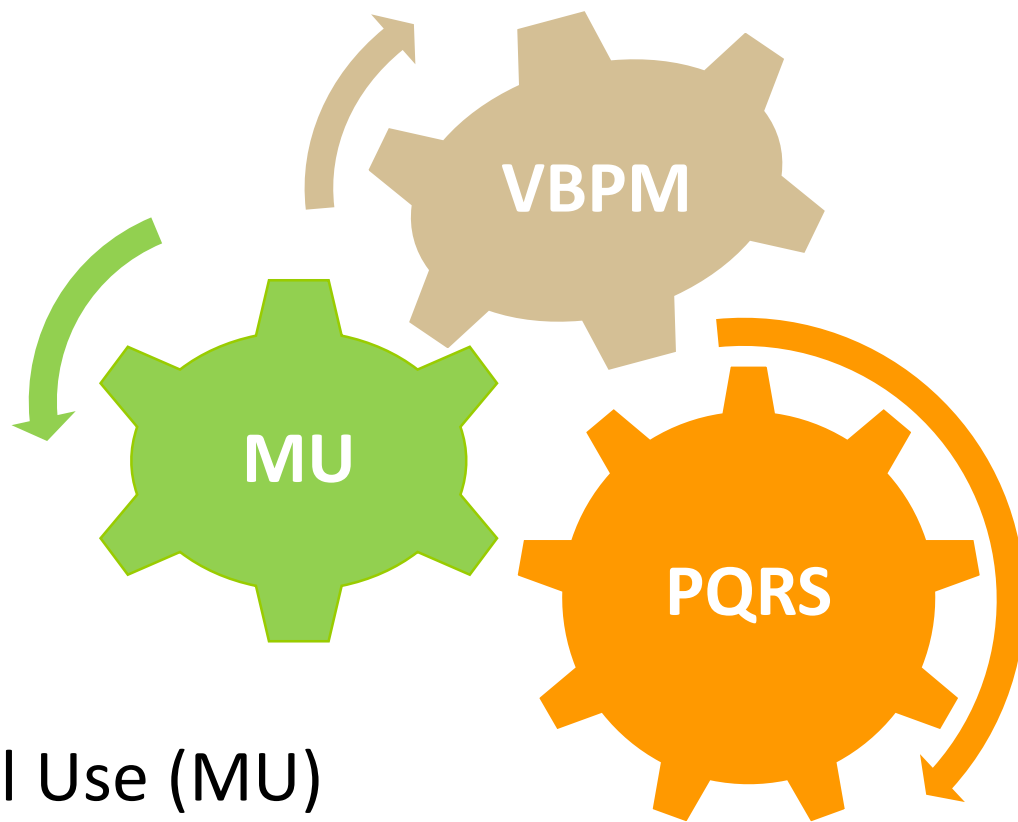
- ICD-10 is scheduled to replace ICD-9 coding system on October 1, 2015.
- ICD-10 was developed because ICD-9, first published in 1977, was outdated and did not allow for additional specificity required for enhanced documentation, reimbursement and quality reporting.
- ICD-10 CM will have 68,000 diagnosis 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

UHealth/UMMG 2015 PQRS

Patient Safety and Quality Office



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

PROGRAM	POTENTIAL MEDICARE PAYMENT REDUCTION					
	2015	2016	2017	2018	2019	2020
Meaningful Use	1%	2%	3%	4%	5%	5%
PQRS	1.5%	2%	2%	2%	2%	2%
VBPM		4%	4%	4%	4%	4%
TOTAL PENALTIES	2.5%	8%	9%	10%	11%	11%

2015 PQRS Eligible Providers

Physicians	Practitioners	Therapists
MD	Physician Assistant	Physical Therapist
DO	Nurse Practitioner	Occupational Therapist
Doctor of Podiatric	Clinical Nurse Specialist*	Qualified Speech-Language Therapist
Doctor of Optometry	CRNA	
DDS	Certified Nurse Midwife	
DMD	Clinical Social Worker	
Doctor of Chiropractic	Clinical Psychologist	
	Registered Dietician	
	Nutrition Professional	
	Audiologists	

PQRS

➤ Reporting Requirements:

- ✓ Reporting Period= Full CY
- ✓ Report **9** Measures from **3** National Quality Strategy Domains

➤ Reporting Options:

- Claims, EHR, **Registry**
 - Individual or GPRO

NATIONAL STRATEGY DOMAINS					
Communication & Care Coordination	Effective Clinical Care	Efficiency & Cost Reduction	Patient Safety	Person & Caregiver-Centered Experience & Outcomes	Community/ Population Health

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

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>, 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).

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 AND SECURITY

- **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 (24hours a day, seven days a week).
- Office of billing Compliance website: **www.obc.med.miami.edu**

QUESTIONS

