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Coding for New Physicians / APPs

Corporate Compliance

Timeline for New Physicians/APPs

Day 1

- Introduction to Compliance Program
- Coding & Documentation for New Providers

Days 15-60

- Review of recent documentation
- On-site follow-up
- General Q & A
- Specialty specific topics
- “At the elbow” shadowing

Day 60

- Baseline audit

Days 70-90

- Post-audit meeting
- General Q & A

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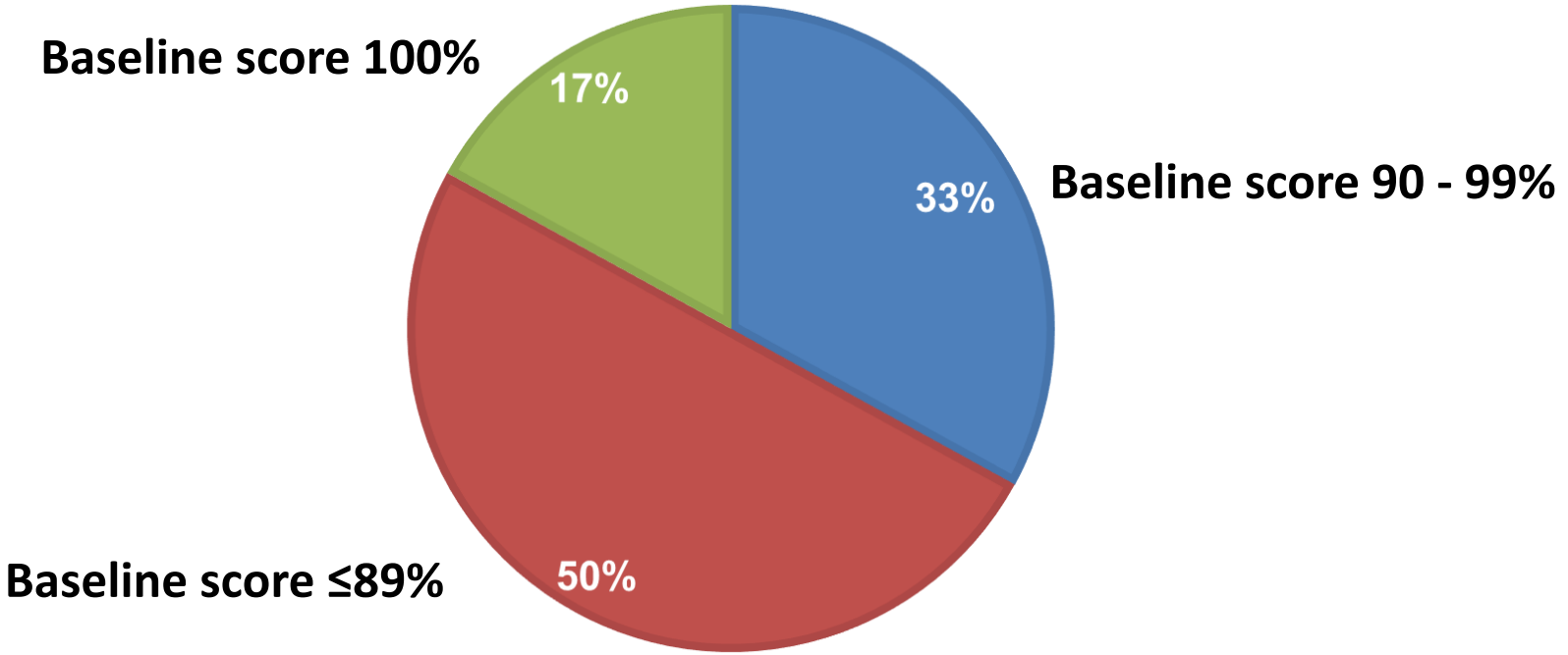
2016 Baseline* Audit Scores



*The baseline audit is performed for all new Physicians/APPs within 60 days of joining Atrium Health. It provides an opportunity to examine a Physician/APP's documentation, identify issues, make recommendations to improve documentation, address any questions the Physician/APP may have, and tailor any additional education, beyond the basic Coding and Documentation program presented to new Physicians/APPs during Orientation.

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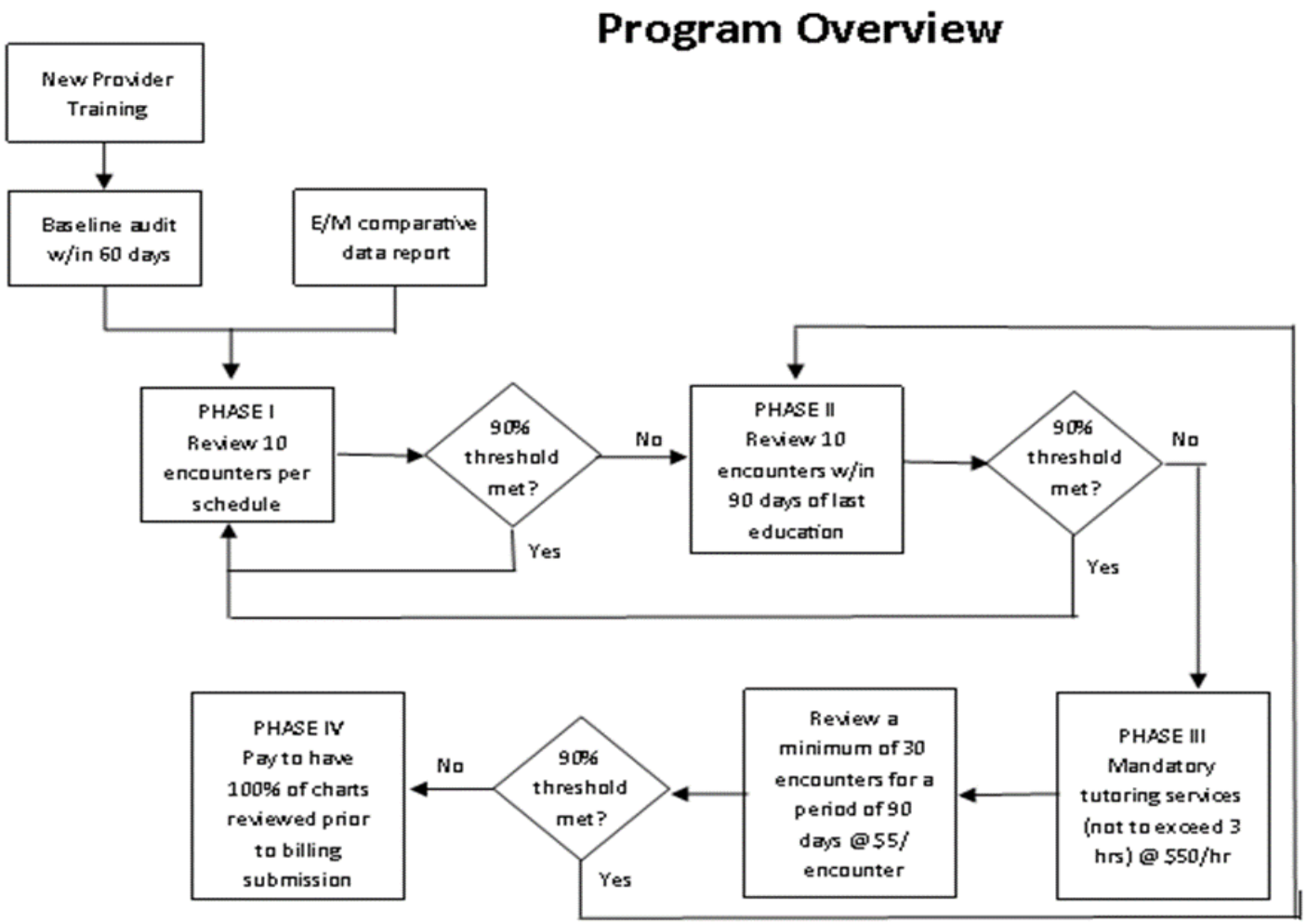
Compliance Program Overview



Compliance Program Overview

Phase Process

At the conclusion of each Physician/APP review, the audit is scored and the compliance rate determines the "Phase" for the Physician/APP. The phases are defined as:

- ***Phase 1***. Compliance threshold (90%) met or exceeded
- ***Phase 2***. Audit score falls below the 90% compliance threshold
- ***Phase 3***. Two (or more) consecutive audits fall below the 90% compliance threshold
- ***Phase 4***. Three (or more) consecutive audits fall below the 90% compliance threshold

Compliance Program Overview

Scoring

When scoring a Physician/APP's chart review findings, a "points" system is used. Points are weighted to reflect the risk that the error represents. Typically, ten (10) encounters are reviewed per Physician/APP; each encounter is valued at 100 points, for a total of 1,000 possible points per audit.

The "points" scoring methodology allows Physician Compliance/Coding Support to prioritize education and follow up review based on identified risk(s).

- ***Low risk error:*** 40 point deduction. Reviewer changed the E/M code by one level
- ***Moderate risk error:*** 80 point deduction. E/M code change > one level, E/M code category changed
- ***High risk error:*** 100 point deduction. Missing or insufficient documentation to support any E/M service or procedure

Compliance Program Overview

Audit Finding	Points	Description
Delete CPT	-100	No medical record documentation to support CPT code
E/M No Code	-100	No medical record documentation to support an E/M service
CPT Change – Overcode	-80	Medical record documentation supports a different CPT code than selected, resulting in an overcode
E/M Category Change – Overcode	-80	Medical record documentation supports an E/M code from a different E/M category, resulting in an overcode
E/M Undercoded by 2-4 levels	-80	Medical record documentation supports a higher level E/M code than selected
E/M Overcoded by 2-4 levels	-80	Medical record documentation supports a lower level E/M code than selected
E/M Undercoded by 1 level	-40	Medical record documentation supports a higher level E/M code than selected
E/M Overcoded by 1 level	-40	Medical record documentation supports a lower level E/M code than selected

Compliance Program Overview

- Physician Compliance/Coding Support use Evaluation and Management (E/M) comparative data to evaluate Physicians/APPs' coding patterns and identify trends where additional analysis may be needed. These dashboard reports include all payers and are updated monthly for the following E/M code categories:
  - New and established patients
  - Inpatient and outpatient consults
  - Hospital admissions and subsequent visits

- The Code Distribution Index (CDI) and Physician E/M Profile dashboard reports are available on eLink. Although the dashboard reports have proven valuable in assessing Physicians/APPs' code selection tendencies in order to appropriately schedule audits, shadowing and education, the appropriateness of a Physician/APP's code selection can only be determined through chart review

Urgent Alert – New Law Impacts South Carolina Physicians/APPs

South Carolina's state legislators have been working to help control an opioid epidemic that is impacting communities across the United States. Effective May 19, 2017, prescribers who practice in South Carolina:

- Must now review a patient's controlled substance prescription history, as maintained in the prescription monitoring program, **BEFORE the practitioner issues a prescription** for a Schedule II controlled substance
- The new law only applies to a patient who is seen in South Carolina, and does not apply when a South Carolina patient is seen by a North Carolina Physician/APP

Urgent Alert – New Law Impacts South Carolina Physicians/APPs

North Carolina Prescribers:

Under a separate South Carolina Medicaid regulation issued April 1, 2016, North Carolina Physicians/APPs issuing any controlled substance (DEA Schedules II through IV) for a **South Carolina Medicaid patient must "first evaluate the beneficiary's controlled substance history through SCRIPTS."** Of note, South Carolina Medicaid defines their service area as "within 25 miles of the state line."

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Additional Information About Today's Topics

- Streaming videos are available that cover most of the topics addressed today. You may access them on the Atrium Health intranet:
  PhysicianConnect > Education > Coding & Documentation
  - Most are approximately 10 minutes in duration
  - These are updated as needed to reflect changes in regulations, so please review them periodically
- Additional educational material can also be viewed by accessing this link, including:
  - The current edition and archives of *The Link* newsletter
  - Job aids
  - Code Distribution Index (CDI)
  - Physician E/M Profiles

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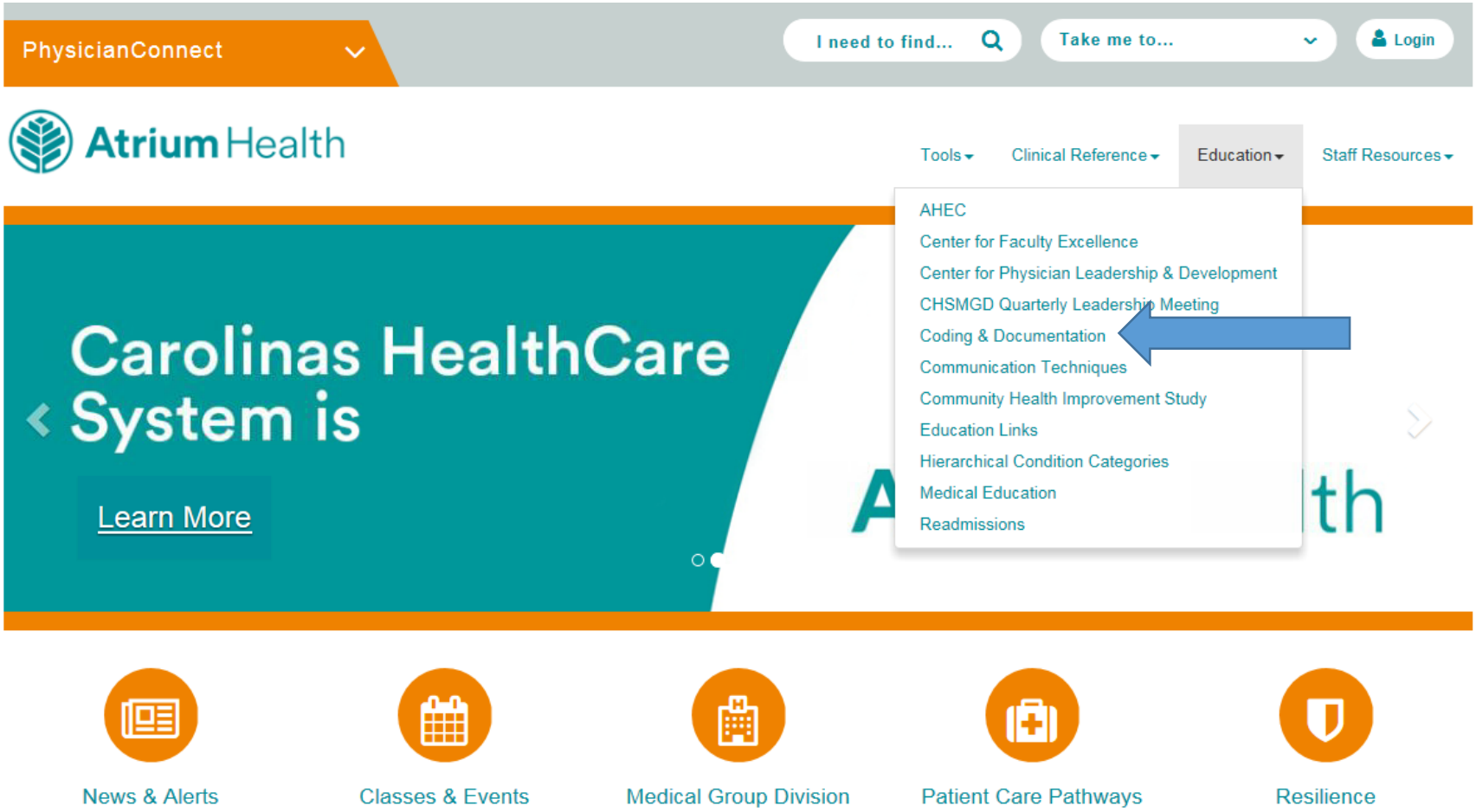
Accessing Coding & Documentation Resources via Physician Connect



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Today's Agenda

- E/M Coding Key Elements:
  - History
  - Examination
  - Complexity of Medical Decision Making (MDM)
- Medical Necessity
- Time-based billing
- Putting it all together: Selecting your code
- Reporting Advance Clinical Practitioner services
- Additional coding and documentation topics:
  - Critical care services
  - Consultations
  - EMR cautions
  - Signature requirements
  - Timeliness of documentation
  - Scribes
  - Diagnosis Coding
  - Related claims
  - Research

Select any link to advance to that topic. Use the ⬅ to return to the agenda.

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Today's Agenda

Appendices

A. Teaching Physicians, Residents, & Medical Students
B. Primary Care Exception
C. Preventive Medicine Visits
D. Preventive/Split Services
E. Smoking Cessation Counseling
F. Commonly Performed Office Procedures
G. Advance Care Planning
H. Telehealth Services
I. Alcohol/Substance Abuse, Brief Intervention, & Referral to Treatment Services (SBIRT)
J. Transitional Care Management (TCM)
K. Home Health Face-to-Face Requirements (Medicare)
L. Advanced Beneficiary Notice of Non-Coverage (ABN)

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Evaluation and Management (E/M) Services

- Includes services such as office visits, hospital visits, and consultations
- Documentation requirements developed jointly by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS):
    - *1995 Evaluation and Management Documentation Guidelines*
    - *1997 Evaluation and Management Documentation Guidelines*

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Evaluation and Management (E/M) Services

Guiding Principles

1. Do what is medically necessary
2. Document what you do
3. Bill for what you document
4. Ensure billing reflects *who* provided the service

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History

History

Consists of four subcomponents:

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, and Social History (PFSH)

Chief Complaint

- *A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter*
  - Establishes the medical necessity for the visit
    - Not necessarily an acute condition; follow up of chronic conditions is permitted
    - Be sure to state what is being followed, e.g., “Patient is here for follow up of hypertension”

History of Present Illness (HPI)

- HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present
- Documentation guidelines use eight indicators to describe the HPI

History of Present Illness (HPI)

- **Location** – where is the problem?
- **Duration** – how long has the problem existed?
- **Quality** – what descriptive terms or characteristics describe the problem (e.g., “sharp” pain, “productive” cough)?
- **Severity** – how bad is the problem?
- **Timing** – when does the problem occur?
- **Context** – what was happening when the patient was injured or became ill?
- **Modifying factors** – what treatments has the patient tried?
- **Associated signs and symptoms** – what other symptoms does the patient describe?

Example - History of Present Illness (HPI)

Patient presents with severe, stabbing back pain he has experienced intermittently for one month. The pain began after a fall while playing soccer. Patient has taken Motrin with minimal relief. He also complains of right leg tingling.

Indicator	From Example
Location	*Back*
Quality	*Stabbing*
Severity	*Severe*
Duration	*One month*
Timing	*Intermittently*
Context	*Fall while playing soccer*
Modifying Factors	*Minimal relief with Motrin*
Associated Signs and Symptoms	*Right leg tingling*

Example - History of Present Illness (HPI)

The patient presents for follow-up. The patient is completely asymptomatic from a cardiovascular standpoint. Denies chest pain, shortness of breath, syncope or near syncope.

Indicator	From Example
Location	
Quality	
Severity	
Duration	
Timing	
Context	
Modifying Factors	
Associated Signs and Symptoms	***No chest pain, shortness of breath, syncope, or near syncope***

History of Present Illness (HPI)

- Only portion of the history that **must** be recorded by the Physician/APP
- Unacceptable comments include:
  - "See nurse's notes"
  - "Agree with above"
- If a nurse (or other ancillary staff) records the information, Physician/APP must re-state it, adding or amending as appropriate
- High level codes in most categories require documentation of a minimum of four indicators (i.e., extended HPI)

Alternative HPI: Chronic Conditions

- Documentation of the status of **three** chronic conditions is considered equivalent to documenting **four or more** HPI indicators
- The **status** of the conditions must be documented
  - e.g., well-controlled hypertension, DM with increasing a.m. blood sugars, worsening osteoarthritis pain

Review of Systems (ROS)

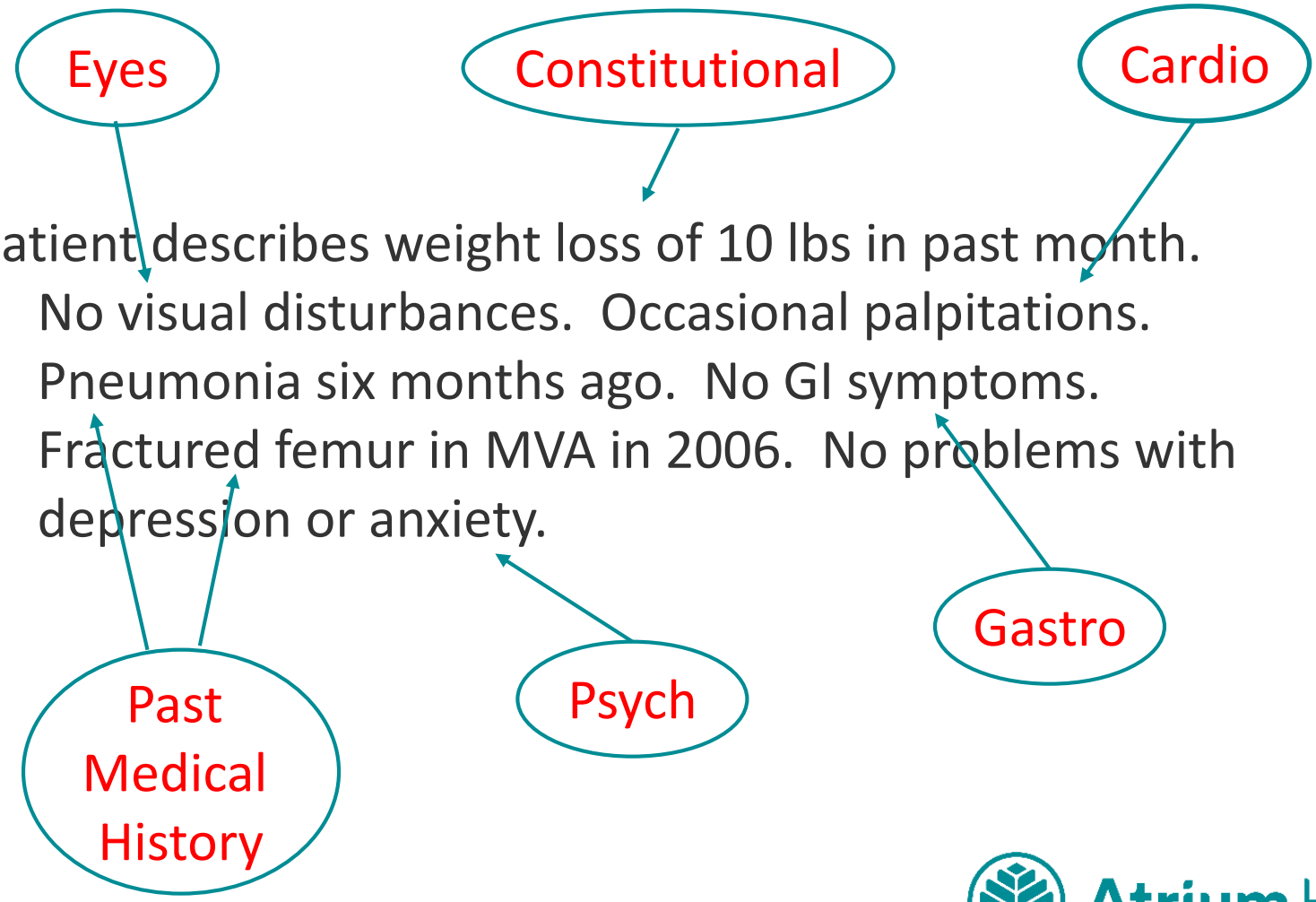
- The ROS is an inventory of body systems obtained through a series of questions seeking to identify **signs and/or symptoms** which the patient may be experiencing or has experienced
- Think *"review of symptoms"*

Review of Systems (ROS)

Fourteen systems are available for review:

- Constitutional
- Eyes
- ENT
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary-Skin/Breast
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Example – Review of Systems (ROS)



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Example – Review of Systems (ROS)

- Constitutional: Denies fever, no chills. Weight loss of 5lbs
- Respiratory: Mild shortness of breath
- Cardiovascular: Negative
- Gastrointestinal: Denies diarrhea, constipation
- Genitourinary: Frequent urination at night
- All other systems reviewed and negative at this time

This is appropriate documentation of a Complete Review of Systems

- Positives, pertinent negatives, and a summary statement have been documented

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Example - Review of Systems (ROS)

ROS: Other than what is stated in the HPI, all others are negative

This statement may be counted as a complete ROS ***only*** if there is at least one comment in the HPI that can be counted as ROS

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Review of Systems (ROS)

- Who can record the Review of Systems?
  - ROS can be recorded by ancillary staff in the EMR
  - ROS can be obtained from the information completed by the patient on the patient history form
    - The patient history form should be reviewed and modified as needed, signed or initialed, and dated by the Physician/APP.
    - It should also be referenced in the Physician/APP's note. (e.g., "Please refer to scanned patient history form, dated and reviewed by me today")

Review of Systems (ROS)

- When you do a *medically necessary* full review of systems, you may document your positive and pertinent negative findings and then state "All others negative" and receive credit for all 14 systems
  - Do not state "All others *noncontributory*"
- It is not expected that a Physician/APP would always document "all others negative" since that level of detail is not always medically necessary

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Review of Systems (ROS)

- If you are using a handwritten template and the "all others negative" box is checked without positives or pertinent negatives noted, it is not considered a complete ROS
  - Must document at least one system
- A straight line through check boxes does not count on a handwritten form or template
- High level codes in most categories require documentation of 10 or more systems for ROS

Past, Family, Social History (PFSH)

- Past Medical History:
  - Current medications, past surgeries, past illnesses
- Family History:
  - Family medical history relating to patient's current illness; high risk or hereditary diseases that may place the patient at risk
- Social History:
  - Use of tobacco or alcohol, living arrangements, occupation, marital status

Past, Family, Social History (PFSH)

- Who can record the PFSH?
  - PFSH can be recorded by ancillary staff in the EMR
  - PFSH can be recorded from the information on the patient history form
    - The patient history form should be reviewed and modified as needed, signed or initialed, and dated by the Physician/APP. It should also be referenced in the Physician/APP's note. (e.g., "Please refer to scanned patient history form, dated and reviewed by me today")

Past, Family, Social History (PFSH)

- Stating “negative,” “noncontributory,” “unremarkable,” or “unknown” is not considered sufficient documentation
    - Specific information must be described
    - Although Canopy options currently include: noncontributory, negative, not significant, etc., you will need to identify specific aspects of PFSH
    - Example: family history negative for lung cancer
- If the family history is unknown (e.g., adoption), document the reason and credit will be given
    - Example: Family history unknown due to adoption.
- Most high level codes require documentation of all three components

Example - Past, Family, Social History

New patient presents for evaluation of chest pain.

Past medical history: MI in 2012, and CVA in 2014

Family history: Father deceased from MI at age 53, mother still living but in poor health (lung cancer)

Social history: Patient smokes two packs of cigarettes per day, drinks socially on occasion

✓ This is appropriate documentation of a Complete PFSH

- All three areas of history are addressed

Example - Past, Family, Social History

Patient presents for evaluation of headaches

Past medical history: Hypertension and gastroesophageal reflux

Family history: Non-contributory

Social History: Patient smokes a half pack of cigarettes per day, denies alcohol use or drug abuse

Only Past Medical history and Social history are documented properly

- “negative,” “noncontributory,” “unremarkable,” or “unknown” are not considered sufficient

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Four History Levels

Problem Focused: 1 HPI

Expanded Problem Focused: 1 HPI and 1 ROS

Detailed: 4 HPI, 2 – 9 ROS, 1 PFSH*

Comprehensive: 4 HPI, 10 ROS, all 3 PFSH**

* *For subsequent inpatient care, the PFSH is not necessary for a Detailed History*

** *For Emergency Room visits, 2 of 3 of the PFSH is required for a Comprehensive History*

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History Levels
Detailed vs. Comprehensive

Detailed History	Comprehensive History
• Chief Complaint	• Chief Complaint
• 4+ HPI indicators	• 4+ HPI indicators
• 2 - 9 ROS	• **10 or more ROS**
• 1 of PFSH	• **All 3 of PFSH**

If the documentation supports a detailed history instead of a comprehensive history, the code supported may be as much as two levels lower. Compare various code levels on your laminated card, for example 99221 – 99223

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Key Points to Remember

- A chief complaint must be documented for every encounter
- HPI must be documented by the Physician/APP, not ancillary staff
- The patient or office staff may record the ROS and PFSH on a patient history form. The Physician/APP must review, sign or initial, and date the form and refer to it in his/her documentation
- Past, family and social history may *not* be described as “noncontributory”, “negative” or “unknown”
- If family history is unknown, documentation of the reason will support the family history and credit will be given for that component

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Key Points to Remember

- If the history is unobtainable from the patient or other source, the record should state so and describe the patient's condition or other circumstance which precludes obtaining the history. Credit will then be given for a comprehensive history
    - "Patient is a poor historian" is not considered adequate support for a comprehensive history
- Coding and documentation risk areas include:
    - Not documenting four HPI indicators for higher level codes
    - Missing family history
    - Incomplete review of systems, i.e., fewer than 10 organ systems addressed for higher level codes

History – Let's Practice

Patient presents for evaluation of back and neck pain. Involved in a MVA last night where he was t-boned by another car who ran a red light. Was hit on driver's side door and airbags deployed. Considerable pain from left neck, left shoulder and left rib cage. Also experiencing on and off dizziness and blurry vision. Has been taking 800mg of ibuprofen with limited relief. No numbness, tingling, sob, or nausea. Non-smoker.

Review of Systems

Constitutional: Negative
Eyes: Negative except as indicated in HPI
Hematologic/Lymphatic: Bruising left shoulder
Cardiovascular: No chest pain

Allergies: NKA

Medications: lisinopril 10 mg oral tablet: 10mg, 1 tablet daily.

Family history negative.

History – Let's Practice

Chief complaint: Back and neck pain

HPI:
- Location = left neck, shoulder and rib cage
- Quality =
- Severity = considerable
- Duration = last night
- Timing = on and off
- Context = involved in a MVA
- Associated Sign/Sx = dizziness and blurry vision
- Modifying Factor = ibuprofen 800mg

ROS = Constitutional, Eyes, Hematologic/Lymphatic, Cardiovascular, Neurologic, Respiratory, Gastrointestinal

Past Hx = NKA, medications
Family Hx =
Social Hx = non-smoker

Detailed history

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History – Let's Practice

A 50 year old female presents to the office with her husband. She is complaining of abdominal pain with nausea for one week. Pain and nausea occur several times daily following meals. Pain is not relieved with antacids. The patient reports occasional diarrhea following eating fatty foods. No constipation, no burning or pain with urination and no fever. All other systems are negative. The patient quit smoking recently. She has no drug allergies. Patient's mother had ulcers.

History – Let's Practice

Chief complaint: Abdominal pain

HPI:
- Location =
- Quality =
- Severity =
- Duration = one week
- Timing = several times daily, occasional
- Context = following eating fatty foods
- Associated Sign/Sx = nausea, diarrhea
- Modifying Factor = not relieved by antacids

Comprehensive history

ROS = Constitutional, gastrointestinal, genitourinary, summary statement

Past Hx = allergies
Family Hx = conditions related to chief complaint
Social Hx = smoking status, marital status

Examination

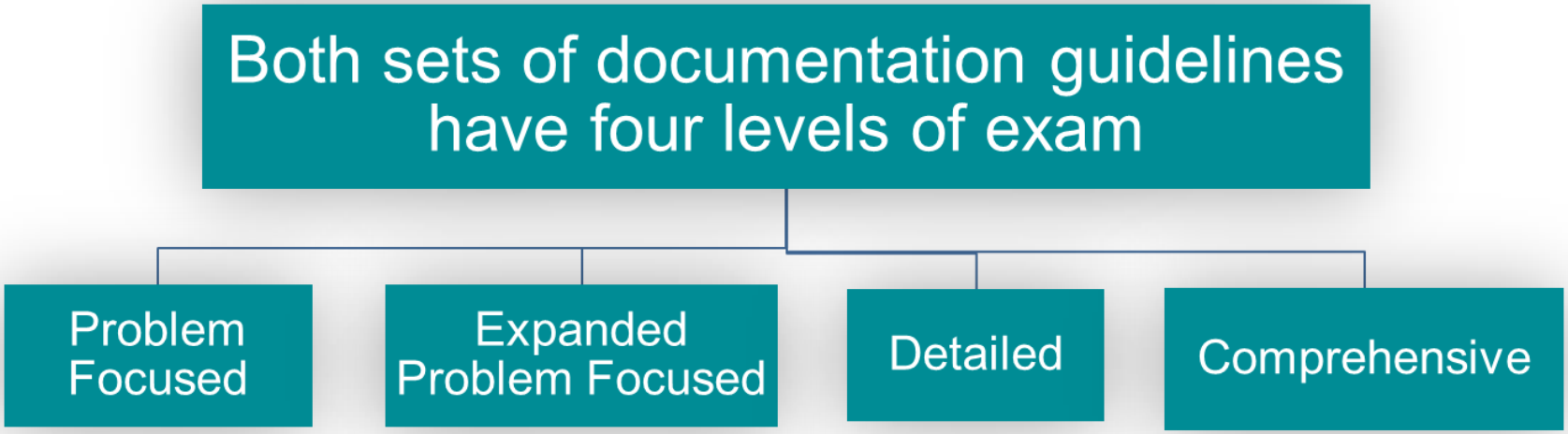
Examination

1995 documentation guidelines:

- Body areas or organ systems

1997 documentation guidelines:

- Bullet points



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1995 Exam Guidelines

- **Body Areas**
  - Head, including face
  - Neck
  - Chest, including breasts & axillae
  - Abdomen
  - Genitalia, groin, buttocks
  - Back, including spine
  - Each extremity

Note: *For purposes of determining the level of exam documented*, there is no "mixing and matching" of body areas and organ systems. Only one or the other will be used. Body areas may not be used to support a comprehensive exam.

- **Organ Systems**
  - Constitutional (3 vital signs, general appearance)
  - Eyes
  - Ears, nose, mouth and throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Skin
  - Neurologic
  - Psychiatric
  - Hematologic/lymphatic/immunologic

Levels of Examination (1995)

Level	Description	Components
Problem-Focused	Limited exam of affected body areas or organ systems	1 body area or organ system
Expanded Problem-Focused	Exam of affected body areas or organ systems & other symptomatic or related organ systems	2-7 body areas or organ systems
Detailed	Extended exam of affected body areas or organ systems & other symptomatic or related organ systems	2-7 body areas or organ systems with at least one described in detail
Comprehensive	Complete multi-system exam	8 or more organ systems *

* Body areas may not be used to support a comprehensive exam

Expanded Problem Focused vs. Detailed 1995 Guidelines

- Both levels require documentation of examination of 2 to 7 organ systems
- ***Detailed exam*** requires documentation of examination of 2 to 7 organ systems with detailed findings documented about at least **one** system
  - Generally, for one organ system record 3 or more distinct exam findings that require separate actions by the Physician/APP plus findings for at least one other organ system

Examples of What Constitutes a Detailed Exam 1995 Guidelines

Documentation of the following plus information about at least one additional organ system. (Not an exhaustive list.)

1. Gastrointestinal • Soft, nontender, nondistended • Positive bowel sounds • No hepatosplenomegaly • No hernias or masses	**2. Neurological** • Cranial nerves II – XII intact • DTRs intact • Sensation intact in all extremities
3. ENT • Tympanic membranes intact • Nasal mucosa swollen, nasal discharge appears yellow • Pharynx appears inflamed	**4. Psychiatric** • Alert and oriented x 3 • Recent memory intact, remote memory unclear • Appears very anxious

Note: Not all organ systems will qualify for a detailed exam.

For additional examples, please contact your compliance auditor/educator.

Exam Examples
1995 Guidelines

Expanded Problem Focused	Detailed	Comprehensive
Wt 219 lbs, BP 165/95, pulse 82 Lungs clear Heart regular rate and rhythm ***3 Organ Systems with no detail***	Wt 219 lbs, BP 165/95, pulse 82 No JVD, no carotid bruits Lungs clear Heart regular rate and rhythm Extremities no edema, distal pulses intact ***3 Organ Systems; with detail regarding cardiovascular system***	Wt 219 lbs, BP 165/95, pulse 82 Alert and oriented x 3 HEENT benign Lungs clear Heart regular rate and rhythm Abdomen soft, nontender Skin no rashes or lesions ***8 Organ Systems***

1995 Exam – Let's Practice

Physical Exam

- **Constitutional:** No acute distress; Temp-97.5°F, Pulse-78 BPM, Systolic BP-132mmHg, Diastolic BP-89mmHg, SpO2-99%
- **Respiratory:** Lungs clear to auscultation
- **Cardiovascular:** Normal rate & rhythm
- **Gastrointestinal:** Soft, non-tender, non-distended
- **Integumentary:** Warm, intact
- **Neurologic:** Alert & oriented
- **Psychiatric:** Alert & oriented x 3

EXPANDED PROBLEM-FOCUSED EXAM

6 organ systems documented with no detail

** No credit given for Neurologic – duplicate finding in Psychiatric**

1995 Exam – Let's Practice

Physical Exam

- **Constitutional:** No acute distress; Temp-97.5°F, Pulse-78 BPM, Systolic BP-132mmHg, Diastolic BP-89mmHg, SpO2-99%
- **Eyes:** PERRLA
- **Respiratory:** Lungs clear to auscultation
- **Cardiovascular:** Normal rate & rhythm
- **Gastrointestinal:** Soft, non-tender, non-distended, no hepatosplenomegaly, no hernias, active bowel sounds
- **Integumentary:** Warm, intact
- **Psychiatric:** Alert & oriented x 3

DETAILED EXAM

7 organ systems documented
with detail in the Gastrointestinal system

1995 Exam – Let's Practice

Physical Exam

- **Constitutional:** No acute distress; Temp-97.5°F, Pulse-78 BPM, Systolic BP-132mmHg, Diastolic BP-89mmHg, SpO2-99%
- **Eyes:** PERRLA
- **Respiratory:** Lungs clear to auscultation
- **Cardiovascular:** Normal rate & rhythm, no JVD, no edema
- **Gastrointestinal:** Soft, non-tender, non-distended
- **Integumentary:** Warm, intact
- **Neurologic:** No focal deficits, DTRs intact
- **Psychiatric:** Alert & oriented x 3

COMPREHENSIVE EXAM

8 organ systems documented

1997 Exam Guidelines

One general multi-system exam and ten single organ system or “specialty” exams are available

- General Multi-System
- Cardiovascular
- Ear, Nose & Throat
- Eye
- Genitourinary (Female)
- Genitourinary (Male)
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

See your handouts for a copy of the General Multi-System exam

1997 Exam
Multi-Specialty vs. Specialty

General Multi-System Exam:

- **Problem Focused =**
  1-5 bullets
- **Expanded Problem Focused =**
  6-11 bullets
- **Detailed =**
  at least 12 bullets in 2 or more organ systems
- **Comprehensive =**
  18 bullets (at least 2 bullets from each of 9 organ systems)

Specialty Exams:

- **Problem Focused =**
  1-5 bullets
- **Expanded Problem Focused =**
  6-11 bullets
- **Detailed =**
  at least 12 bullets (for eye and psych exams, at least 9 bullets)
- **Comprehensive =**
  every bullet in all shaded boxes & at least 1 bullet from each unshaded box

Exam Example
1997 Guidelines

Wt 219 lbs, BP 165/95, pulse 82 — Const – 1 bullet

No JVD, no carotid bruits — CV – 2 bullets

Lungs clear — Resp – 1 bullet

Heart regular rate and rhythm — CV – 1 bullet

Extremities no edema, distal pulses intact — CV – 2 bullets

Alert and oriented x 3 — Psych – 1 bullet

8 bullets = Expanded Problem Focused exam

Using 1995 criteria = Detailed exam

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Examination:
Coding and Documentation Risk Areas

- The most common risk areas of the exam portion of Physicians/APPs' documentation involves insufficient documentation of the number of organ systems or detail within those organ systems required to support the level of service billed including:
  - Fewer than 8 organ systems for new office visit codes 99204 and 99205, consult levels 99244 and 99245, initial inpatient care (admissions) codes 99222 and 99223, and initial observation care codes 99219 and 99220
  - Documentation of only an expanded problem focused exam (2 to 7 organ systems with no detail) for 99214 and 99233

Complexity of Medical Decision Making (MDM)

Medical Decision Making (MDM)

Refers to the complexity of establishing a diagnosis and/or selecting a management option based on:

A. *Number of possible diagnoses and/or treatment options*
B. *Amount and/or complexity of data obtained, reviewed, or analyzed*
C. *Risk of significant complication, morbidity and/or mortality; including comorbidities associated with the presenting problems(s), diagnostic procedures(s), and/or possible management options*

MDM formula

2 out of 3 of ABC = MDM

Two out of three of the components must meet or exceed the requirements to reach a given level of decision-making

A	**Number of Diagnoses or Treatment Options**
B	**Amount and/or Complexity of Data**
C	**Risk associated with patient's condition**

A = Number of Diagnoses or Treatment Options

Consider the problems addressed during the encounter

- Decision making may be easier for an established problem that was previously evaluated and treated by the Physician/APP than for a new problem
- Established problems that are improving are less complex than worsening problems or problems that are not improving as expected

A = Number of Diagnoses or Treatment Options

A		Number of Diagnoses or Treatment Options		
Problems to Examining Provider		Points	X # of Problems	= Score
Self-limited or minor (stable, improved or worsening)		1	Max=2	
Established problem (to examiner); stable, improved		1		
Established problem (to examiner); worsening		2		
New problem (to examiner); no additional workup planned		3	Max=1	
New problem (to examiner); additional workup planned		4		
Total				

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Additional Info About How Diagnoses are Counted

- New problem “to examiner”
  - Physicians/APPs will receive 3 or 4 point credit when evaluating a problem for the first time, even if that problem was previously treated by another Physician/APP within the same group practice

B = Amount and/or Complexity of Data

- Consider the data reviewed, discussions held about the patient, and tests ordered during the encounter
- The more data addressed during the encounter, the more complex the decision-making

B = Amount and/or Complexity of Data

B Data to be Reviewed	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT (includes nuclear med)	1
Review and/or order of tests in the medicine section of CPT (e.g., EKG, cardiac cath, non-invasive vascular studies, pulmonary function studies)	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain additional history from someone other than patient	1
Review and summarization of old records and/or additional history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report) previously or subsequently interpreted by another physician	2
Total	

Additional Info About How Data is Counted

- Review and summarization of old records:
  - Must include brief summary of relevant information from old records
  - Credit is given for review and summary of *another Physician/APP's medical records (different practice/group/specialty*) but not review and summary of a Physician/APP's *own* previous records

Additional Info About How Data is Counted

- Discussion of case with another health care Physician/APP:
  - Must document what was discussed
  - Does not include discussion with nursing staff or supervising physician by Advanced Clinical Practitioner or Resident
  - Does not include discussion with other Physicians/APPs in same practice when “handing off” care of patient at end of shift

Additional Info About How Data is Counted

- Independent visualization of image, tracing or specimen
  - Notice the word "*independent*"
  - Includes tests conducted and billed for by *another* physician
  - Credit is not given for visualization of results of tests conducted and billed for by Physician/APP documenting the E/M service or otherwise billing for professional interpretation (e.g., x-ray)

"Personal review of image shows …"

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C = Risk Associated with Patient's Condition

- See Table of Risk on the audit tool handout
- Based on three components:
  - *Presenting problem(s)*
  - *Diagnostic procedure(s) ordered*
  - *Management option(s) selected*

KEY POINT TO REMEMBER!
RISK ≠ Complexity of MDM

C = Risk Associated with Patient's Condition

- Highest of 3 components determines level of risk
- Consider the risk related to the disease process anticipated between the present encounter and the next one
- The assessment of risk related to diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment
- If evaluating and treating an ongoing problem, clearly document the severity of the problem during that encounter

C = Risk Associated with Patient's Condition

- All surgical procedures have inherent risk. Consider the risk factors that exceed those usually associated with the procedure
- Identified factors associated with surgical procedures that indicate high risk include:
  - Advanced age or debility
  - Extremely young age (under the age of one)
  - Prior surgical difficulties
  - Underlying cardiac or pulmonary disease

C = Risk Associated with Patient's Condition

Management Options: Drug Therapy Requiring Intensive Monitoring for Toxicity

- Drugs that have a narrow therapeutic window and a low therapeutic index may exhibit toxicity at concentrations close to the upper limit of the therapeutic range and may require intensive clinical monitoring
- On medical review, to consider therapy with one of these drugs as a high risk management option, we would expect to see documentation in the medical record of drug levels obtained at appropriate intervals
- Administration of cytotoxic chemotherapy is always considered **high risk** under management options when monitoring of blood cell counts is used as a surrogate for toxicity

C = Risk Associated with Patient's Condition

Examples of drugs that may need to have drug levels monitored for toxicity (this is not an all-inclusive list)

Drug Category	Drugs in that Category	Treatment Use
Cardiac	Digoxin, Amiodarone	Arrhythmias, CHF
Anticoagulants	Coumadin, IV Heparin	Prevention of thrombosis
Antiepileptic	Phenobarbital, Valproic Acid	Prevention of seizures
Bronchodilators	Theophylline, Caffeine	Asthma, COPD
Anti-Cancer	All cytotoxic agents	Rejection prevention, autoimmune disorders
Immunosuppressant	Tacrolimus, Cyclosporine	Malignancies
Antibiotics	Vancomycin, Gentamycin	Bacterial infections that are resistant to less toxic antibiotics
Insulin/Anti-Diabetic	IV Insulin drip	Hyperglycemia

Calculate the MDM

Patient seen today for follow up of well controlled hypertension and diabetes. Prescriptions written for refills.

A →	**Number of Diagnoses** (2 established, stable)	**2 points**
B →	**Data**	**NONE**
C →	**Risk Table** (Rx drug management and 2 stable chronics)	**MODERATE**

Calculate the MDM

Final Result of Complexity

Draw a line down the column with **2 or 3** circles and circle decision making level OR draw a line down the column with the middle circle and circle the decision making level.

A	**Number diagnoses or treatment options**	**≤ 1 Minimal**	**2 Limited**	**3 Multiple**	**≥ 4 Extensive**
B	**Amount and complexity of data**	**≤ 1 Minimal or low**	**2 Limited**	**3 Moderate**	**≥ 4 Extensive**
C	**Highest risk**	**Minimal**	**Low**	**Moderate**	**High**
Type of decision making		Straight-Forward	**Low Complexity**	Moderate Complexity	High Complexity

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Calculate the MDM

Patient returns to the office with well-controlled diabetes and reports lingering cough. A chest x-ray is taken in the office and the Physician/APP reviews and finds left lower lobe pneumonia. Prescriptions are given for an antibiotic and corticosteroid. Physician/APP also asked patient to monitor and log blood sugars while on the Prednisone.

A → **Number of Diagnoses**

(1 established, stable)	**1 point**
(1 new with work-up)	**4 points**

B → **Data**

(chest x-ray)	**1 point**

C → **Risk Table**

(Acute illness w/systemic symptoms)	**MODERATE**
(1 stable chronic)	
(Rx drug management)	

Calculate the MDM

Final Result of Complexity

Draw a line down the column with **2 or 3** circles and circle decision making level OR draw a line down the column with the middle circle and circle the decision making level.

A	**Number diagnoses or treatment options**	**≤ 1 Minimal**	**2 Limited**	**3 Multiple**	**≥ 4 Extensive**
B	**Amount and complexity of data**	**≤ 1 Minimal or low**	**2 Limited**	**3 Moderate**	**≥ 4 Extensive**
C	**Highest risk**	**Minimal**	**Low**	**Moderate**	**High**
Type of decision making		Straight-Forward	Low Complexity	**Moderate Complexity**	High Complexity

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Calculate the MDM

Patient presents to PCP complaining of severe shortness of breath. Patient's pulse ox is 86%. PCP does chest x-ray and compares it to last chest x-ray performed by patient's pulmonologist, also documenting personal review of the image.

A → **Number of Diagnoses**
(1 new with work-up) **4 points**

B → **Data**
(chest x-ray) **1 point**
(pulse ox – medicine section) **1 point**
(Independent visualization) **2 points**

C → **Risk Table**
(Acute illness that may pose threat to life) **HIGH**

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Calculate the MDM

Final Result of Complexity

Draw a line down the column with **2 or 3** circles and circle decision making level OR draw a line down the column with the middle circle and circle the decision making level.

A	**Number diagnoses or treatment options**	**≤ 1 Minimal**	**2 Limited**	**3 Multiple**	**≥ 4 Extensive**
B	**Amount and complexity of data**	**≤ 1 Minimal or low**	**2 Limited**	**3 Moderate**	**≥ 4 Extensive**
C	**Highest risk**	**Minimal**	**Low**	**Moderate**	**High**
Type of decision making		Straight-Forward	Low Complexity	Moderate Complexity	**High Complexity**

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Calculate the MDM

Physician/APP is making daily rounds and finds patient's infected decubitus ulcer is worse. She orders CBC with diff and glucose level. She reviews blood cultures showing infection. IV Vancomycin is ordered.

A → **Number of Diagnoses**
(1 established, worsening) **2 points**

B → **Data**
(glucose, CBC/diff, blood cultures) **1 point**

C → **Risk Table**
(Chronic w/mild exacerbation) **HIGH**
(Toxic drug requiring monitoring)

Calculate the MDM

Final Result of Complexity

Draw a line down the column with **2 or 3** circles and circle decision making level OR draw a line down the column with the middle circle and circle the decision making level.

A	**Number diagnoses or treatment options**	**≤ 1 Minimal**	**2 Limited**	**3 Multiple**	**≥ 4 Extensive**
B	**Amount and complexity of data**	**≤ 1 Minimal or low**	**2 Limited**	**3 Moderate**	**≥ 4 Extensive**
C	**Highest risk**	**Minimal**	**Low**	**Moderate**	**High**
Type of decision making		Straight-Forward	**Low Complexity**	Moderate Complexity	High Complexity

Calculate the MDM

Hospitalist is called to see patient who remains unconscious after a fall that occurred 1 hour ago. Physician/APP orders Head CT scan, CMP, CBC with Diff, Ammonia Level, and EKG and intravenous fluids for hydration.

A → **Number of Diagnoses**

(1 new with work-up) **4 points**

B → **Data**

(CMP, CBC/diff, ammonia) **1 point**

(Head CT) **1 point**

(EKG) **1 point**

C → **Risk Table**

(Acute injury that may pose threat to life) HIGH

(IV fluids w/o additives)

Calculate the MDM

Final Result of Complexity

Draw a line down the column with **2 or 3** circles and circle decision making level OR draw a line down the column with the middle circle and circle the decision making level.

A	**Number diagnoses or treatment options**	**≤ 1 Minimal**	**2 Limited**	**3 Multiple**	**≥ 4 Extensive**
B	**Amount and complexity of data**	**≤ 1 Minimal or low**	**2 Limited**	**3 Moderate**	**≥ 4 Extensive**
C	**Highest risk**	**Minimal**	**Low**	**Moderate**	**High**
Type of decision making		Straight-Forward	Low Complexity	Moderate Complexity	**High Complexity**

Medical Decision Making: Coding and Documentation Risk Areas

- The most common risk areas of the MDM portion of Physicians/APPs' documentation includes:
  - Not listing all problems addressed during the encounter
  - Not clearly describing the severity of the problems addressed during the encounter including whether they are worsening or not improving as expected
  - Incomplete documentation of the data reviewed especially discussions with other healthcare Physicians/APPs and personal review of images, tracings and specimens

Medical Necessity

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Medical Necessity - The Why

"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation entered in the medical record should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record."[1]

[1] Medicare Carriers Manual, IOM 100-4, Chapter 12, Section 30.6.1.A
http://www.cms.hhs.gov/transmittals/downloads/R178CP.pdf

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What is Medical Necessity?

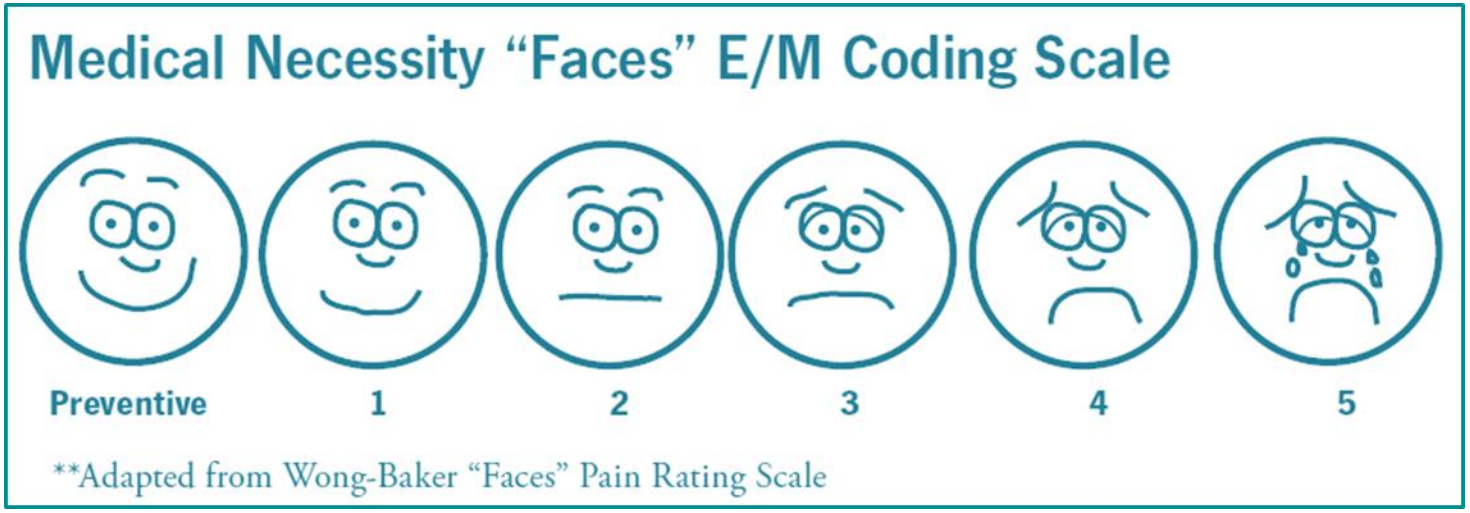
- Medicare defines medically necessary services as “healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine”
- An important requirement to receive payment for services is to establish medical necessity by documenting the following facts and findings:
  - Severity of the signs/symptoms or diagnosis exhibited by the patient
  - Probable outcome for the patient, and how that risk equates to the diagnosis being evaluated
  - Need for diagnostic studies and/or therapeutic interventions to evaluate the patient’s presenting problem or current medical condition
- Documentation of all medical care should accurately reflect the need for and outcome of treatment

Medical Necessity

- Medical necessity relates to whether a service is considered appropriate in a given circumstance
- Services provided to a patient must be reasonable, necessary, and appropriate based on clinical standards of care
- It is the necessity of the service versus the volume of the documentation that determines the level of service which should be reported
  - Although performing a comprehensive history and exam may be a Physician/APP's style of practice it may not be considered medically necessary and, therefore, not billable

Medical Necessity

The five levels of service in office visits can be visualized using the same logic as a pain chart



- Levels 3 – 5 are usually reported for sick patients and lower levels of service are reported for patients with minor or controlled conditions

Time-Based Billing

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Time-Based Billing

- Time is considered the controlling factor and can be used to determine the E/M code when ***greater than 50% of the total encounter time*** is spent in ***counseling and/or coordination of care***
  - Outpatient = Face-to-face time with the patient
  - Inpatient = Floor or unit time devoted to patient
- See your matrix card to determine the total number of minutes associated with various codes

Key elements are irrelevant if you are coding based on time.

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Time-Based Billing

- To code based on time, you **must** document the following:
  - Total time spent on encounter
  - Statement that over half the visit was spent in counseling/coordination of care
  - What was discussed, if counseling, OR what was done for coordination of care

Note: Time accumulates for the individual billing Physician/APP only. Multiple Physicians/APPs' time may **not** be combined for purposes of time-based billing, regardless of relationship (e.g., resident/fellow, APP)

Time-Based Billing

- Counseling includes discussion with the patient regarding:
  - Diagnosis, prognosis, treatment options, etc.
  - Discussion of psychiatric issues
  - Instructions for management and/or follow up
  - Diagnostic results, impressions, and/or recommended diagnostic studies

Time-Based Billing

- Coordination of care includes:
  - Discussion with physicians or APPs from other practices to coordinate treatment for patient, discussion with hospice or rehab hospital regarding placement, etc.
- Coordination of care does **NOT** include:
  - Discussion with the nurses, your supervising physician if you are an APP, or the residents if you are their teaching/attending physician
  - Time spent reviewing old records

Example: Time-Based Billing

New pt c/o new onset depressive episode. Remote h/o major depressive d/o, not requiring tx since 2005. PMH otherwise unremarkable, NKDA. No other complaints. Pt presents with list of anti-depressant medications found online. We reviewed each option in detail r/t potential side effects, and pt desires trial of venlafaxine HCl. Pt also expresses interest in outpt "talk therapy." Provided list of mental health Physicians/APPs participating in her insurance plan. Pt to call w/in 2 wks to report impact of rx on mood; RTC 4 wks or sooner if needed. **Total of 45 minutes spent with pt, greater than 50% of which was spent in discussion of tx options for depression.**

Time-based billing documentation supports 99204

(Key elements alone would support only 99201)

Example: Time-Based Billing

Inpt Consult: Pt with ongoing gross hematuria, weight loss, and sickle cell trait which could be suggestive of an underlying malignancy. Upon exam, patient has fullness in perineal area. Explained how sickle cell trait can be related to renal medullary carcinoma and renal papillary necrosis, both of which can cause gross hematuria. CT w/ contrast was negative. Will obtain a CT urography to better evaluate other causes. Will repeat hgb electrophoresis and order hemolysis labs. **Total of 80 minutes spent with pt and floor time, > than 50% of which was spent discussing tx options for unexplained gross hematuria, reviewing labs & CT images.**

Time-based billing documentation supports 99254

(Key elements alone would support only 99251)

Onsite Training is Available

- If you wish to receive onsite training, please indicate your interest on the Evaluation Form (question #5). Your assigned Auditor/Educator will coordinate the onsite follow-up session.
- The onsite session could include:
  - Review and discussion of your recent documentation
  - Shadowing
  - Specialty-specific services
    - e.g., preventive services, prenatal visits, common procedures

Putting it All Together: Choosing a Code Level

Office Visit Codes

New vs. Established Patient Office Visits

- AMA CPT® definition:

  *A **new** patient is one who has <u>not</u> received any professional (face-to-face) services from the physician/ qualified health care professional or another physician/ qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.*[1]

[1] CPT 2018, Professional Edition, AMA pg.4

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New vs. Established Patient Office Visits

- AMA CPT ® definition:

  *An **established** patient is one who has received professional (face-to-face) services from the physician/ qualified health care professional or another physician/ qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.*[1]

- The location where the services were provided previously is irrelevant.

[1] CPT 2018, Professional Edition, AMA pg.4

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NEW PATIENT OFFICE VISIT CODES 99201-99205 (3 OF 3 KEY ELEMENTS)

CPT Code	History	Exam	Complexity of MDM	Average Time
99201	HPI = 1 – 3	1 organ system	Minimal/ straight-forward	10 min
99202	HPI = 1 - 3 ROS = 1	2 – 7 organ systems	Minimal/ straight-forward	20 min
99203	HPI = 4+ ROS = 2 – 9 PFSH = 1	2 – 7 organ systems with one in detail	Low	30 min
99204	HPI = 4+ ROS = 10+ PFSH = all 3	8+ organ systems	Moderate	45 min
99205	HPI = 4+ ROS = 10+ PFSH = all 3	8+ organ systems	High	60 min

ESTABLISHED PATIENT OFFICE VISIT CODES 99211-99215 (2 OF 3 KEY ELEMENTS)

CPT Code	History	Exam	Complexity of MDM	Average Time
99211	NON-MD VISIT (e.g., RN visit). May not require the presence of an MD. MD must review and sign note.			5 min
99212	HPI = 1 – 3	1 organ system	Minimal/ straight-forward	10 min
99213	HPI = 1 - 3 ROS = 1	2 – 7 organ systems	Low	15 min
99214	HPI = 4+ ROS = 2 - 9 PFSH = 1	2 – 7 organ systems with one in detail	Moderate	25 min
99215	HPI = 4+ ROS = 10+ PFSH = 2	8+ organ systems	High	40 min

The Differences Between 99213 and 99214

Key Element	Subcomponent of Key Element	99213	99214
History	History of the present illness	1 – 3 indicators	4 + indicators
	Review of systems	1 system	2 – 9 systems
	Past, family and social history	n/a	1 of the components
Exam		2 – 7 organ systems	2 – 7 organ systems with one described in detail
Decision-making complexity (2 of the 3 subcomponents must be documented)	Number of diagnoses or management options	2 points	3 points
	Amount and/or complexity of data	2 points	3 points
	Risk associated with the patient's condition	Low	Moderate

OFFICE CONSULTATION CODES 99241-99245 (3 OF 3 KEY ELEMENTS)

CPT Code	History	Exam	Complexity of MDM	Average Time
99241	HPI = 1 - 3	1 organ system	Minimal/ straight-forward	15 min
99242	HPI = 1 - 3 ROS = 1	2 – 7 organ systems	Minimal/ straight-forward	30 min
99243	HPI = 4+ ROS = 2 – 9 PFSH = 1	2 – 7 organ systems with one in detail	Low	40 min
99244	HPI = 4+ ROS = 10+ PFSH = all 3	8+ organ systems	Moderate	60 min
99245	HPI = 4+ ROS = 10+ PFSH = all 3	8+ organ systems	High	80 min

Inpatient Hospital Visit Codes

2 Midnight Rule (Medicare)

Documentation requirements:

- Physician expectation that patient will require medically necessary services for 2 or more midnights
- Admission order must be authenticated prior to patient's discharge (APPs and Residents may not sign admission orders using their proxy signature authority)
- History and Physical must document the intensity, severity and risk indicators, supporting why the patient cannot safely be treated in an outpatient setting

"2 Midnight Rule" overview video available at:

Coding for New Physicians/APPs - All Documents

Exception: *Medicare Inpatient Only (MIO) procedure list is updated annually, and lists services that must be performed as inpatient - even if patient does not stay two midnights*

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INITIAL HOSPITAL VISIT
99221-99223 (3 OF 3 KEY ELEMENTS)

CPT Code	History	Exam	Complexity of MDM	Average Time
99221	HPI = 4+ ROS = 2 – 9 PFSH = 1 *	2 – 7 organ systems with one in detail	Low	30 min
99222	HPI = 4+ ROS = 10+ PFSH = all 3	8+ organ systems	Moderate	50 min
99223	HPI = 4+ ROS = 10+ PFSH = all 3	8+ organ systems	High	70 min

**** Medical Staff Rules and Regulations require documentation of the patient's Past Medical History***

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SUBSEQUENT HOSPITAL VISITS
99231-99233 (2 OF 3 KEY ELEMENTS)

CPT Code	History	Exam	Complexity of MDM	Average Time
99231	HPI = 1 – 3	1 organ system	Low	15 min
99232	HPI = 1 - 3 ROS = 1	2 - 7 organ systems	Moderate	25 min
99233	HPI = 4+ ROS = 2 - 9	2 - 7 organ systems with one in detail	High	35 min

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SUBSEQUENT HOSPITAL VISITS
99231-99233 (2 OF 3 KEY ELEMENTS)

CPT Code	Patient
99231	Stable, recovering or improving
99232	Responding inadequately to therapy or has developed a minor complication
99233	Unstable or has developed a significant complication or significant new problem

Discharge Day Management Codes

CPT Code	Time	Documentation Required
99238	Up to 30 minutes	Does not require documentation of time
99239	> 30 minutes	Requires documentation of the total time spent – *not just "more than 30 minutes"*

- Includes total time spent by Physician/APP for patient discharge
- Includes final exam, discussion with patient and caregivers, preparation of prescriptions and referral forms, documentation in chart and dictation of discharge summary
- Physicians/APPs of the same specialty and group can combine their time to report 99239

Be sure to document the <u>total time spent</u> in the medical record if you are billing 99239

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INPATIENT CONSULTATION CODES
99251-99255 (3 OF 3 KEY ELEMENTS)

CPT Code	History	Exam	Complexity of MDM	Average Time
99251	HPI = 1 – 3	1 organ system	Minimal/ straight-forward	20 min
99252	HPI = 1 - 3 ROS = 1	2 – 7 organ systems	Minimal/ straight-forward	40 min
99253	HPI = 4+ ROS = 2 – 9 PFSH = 1	2 – 7 organ systems with one in detail	Low	55 min
99254	HPI = 4+ ROS = 10+ PFSH = all 3	8+ organ systems	Moderate	80 min
99255	HPI = 4+ ROS = 10+ PFSH = all 3	8+ organ systems	High	110 min

Observation Care Codes

Observation Care Codes

- Documentation must indicate the patient is in “observation status”
- The series of observation care codes used depends on the number of calendar days the patient is in observation status and may be affected by the amount of time the patient spent in observation

Observation Care Codes

Timing Of Care	1 calendar day < 8 hours	1 calendar day 8+ hours	2 calendar days	3 or more calendar days
Report	99218 – 99220 only	99234 – 99236 only	1st day: 99218 -99220 2nd day: 99217	1st day: 99218 – 99220 2nd + days: 99224 – 99226 Last day: 99217

INITIAL OBSERVATION CARE CODES 99218-99220 (3 OF 3 KEY ELEMENTS)

CPT Code	History	Exam	Complexity of MDM	Average Time
99218	HPI = 4+ ROS = 2 – 9 PFSH = 1	2 – 7 organ systems with one in detail	Low	30 min
99219	HPI = 4+ ROS = 10+ PFSH = all 3	8 organ systems	Moderate	50 min
99220	HPI = 4+ ROS = 10+ PFSH = all 3	8 organ systems	High	70 min

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SUBSEQUENT OBSERVATION CARE CODES 99224-99226 (2 OF 3 KEY ELEMENTS)

CPT Code	History	Exam	Complexity of MDM	Average Time
99224	HPI = 1 – 3	1 organ system	Low	15 min
99225	HPI = 1 - 3 ROS = 1	2 - 7 organ systems	Moderate	25 min
99226	HPI = 4+ ROS = 2 – 9	2 – 7 organ systems with one in detail	High	35 min

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Observation Care Discharge

For patients who are in observation status for two or more calendar days, the last day should be reported using:

99217 Observation care discharge

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Same Day Observation Care Codes 99234-99236 (3 of 3 key elements)

CPT Code	History	Exam	Complexity of MDM	Average Time
99234	HPI = 4+ ROS = 2 – 9 PFSH = 1	2 – 7 organ systems with one in detail	Low	40 min
99235	HPI = 4+ ROS = 10+ PFSH = all 3	8 organ systems	Moderate	50 min
99236	HPI = 4+ ROS = 10+ PFSH = all 3	8 organ systems	High	55 min

Advanced Clinical Practitioners (APPs) And Split/Shared Services

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Split/Shared Visits

A split/shared visit is defined by Medicare as:

> ***"A medically necessary encounter with a patient where the physician <u>and</u> a qualified non-physician practitioner each personally perform a substantive portion of an E/M visit, face-to-face with the same patient, on the same date of service"***

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Split/Shared Visits

- A substantive portion of an E/M visit involves documentation of **at least one** of the three key components (history, exam, or medical decision-making)
- The physician and the qualified APP must be in the same group practice or be employed by the same employer

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Split/Shared Visits

- Split/shared visits are allowed in the following settings:
  - INPATIENT SETTING
  - OUTPATIENT HOSPITAL DEPARTMENTS
  - PROVIDER BASED CLINICS

- Split/shared billing is not allowed in the free-standing office setting

Split/Shared Visits

The following services may not be split/shared:

- New Patient Office Visits in a free-standing medical practice

  Note that split/shared new patient office visits ARE allowed in a hospital outpatient department or provider-based clinic
- Critical Care Services
- IPPE (Initial Preventive Physical Exam)
- Procedures
- Nursing Facility Services
- Home Care Services
- Domiciliary Care Services

It is important to note that Medicare's prohibition against split/shared consult services goes away with Medicare's elimination of the CPT consult codes

Documentation Requirements for Split/Shared Visits

- The physician and the APP must both see the patient face-to-face and perform *at least one* of the three key elements of the E/M service on the same day
- Both the APP and physician should document their individual portion of the service in the medical record
  - It would not be appropriate for the physician to copy/paste the APP's documentation
- A combination of the documentation by both Physicians/APPs can be used to support the E/M code billed

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Documentation Requirements for Split/Shared Visits

- If the physician only reviews and co-signs the chart without performing a portion of the E/M service, it is inappropriate to bill a “split/shared visit”
- The APP should bill the service directly under their name and Physician/APP number if the physician only co-signs the note

A physician’s co-signature or brief attestation that he/she “saw the patient; examined the patient; agree with the APP” is **not** sufficient evidence of a face-to-face visit and participation in the patient’s care

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Split/Shared Visits

Services reported based on time may not be split/shared

- Multiple Physicians/APPs' time may not be combined for purposes of time-based billing, regardless of their relationship (e.g., MD/APP)

Exception: Medicare permits discharge day management code 99239 to be split/shared

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Split/Shared Visits – *Non-Medicare Patients*

In the inpatient setting, an APP can see a non-Medicare patient and document an E/M encounter and if the physician reviews and co-signs the note, the service can be billed under the physician's name and provider number

Exception: BCBS of North Carolina and NC Medicaid require that any service provided by an APP be reported directly by the APP

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Billing for APP Services

- It is critical that the work performed by APPs is captured accurately in the billing system
  - If an APP participates in a service their name must be listed as the service provider
- The billing system determines which name appears on the claim based on the payer

Billing System	GECB	Encompass
The name of the individual who actually provided the service should always be listed in this field	Provider	Service Provider
The name of the supervising physician should be listed in this field	Attending	Billing Provider

Billing for APP Services

When is the APP's name required to be entered in the 'Provider' or 'Service Provider' field?

- Any time the APP performs any portion of an E/M service beyond gathering the Review of Systems and Past/Family/Social Histories
  - History of Present Illness
  - Physical Examination
  - Medical Decision Making
  - Counseling and/or coordination of care
- Any time the APP performs a non-E/M service (i.e., interpretation of an EKG or x-ray, wound repair, or other surgical procedure)

Provider Charge Workflow (PCW)

- PCW allows Physicians/APPs to capture their hospital charges electronically
- The APP places the order for the charge and indicates the supervising physician on the order
- The physician ***cannot*** place the order and indicate that the service was shared with an APP

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Other Coding and Documentation Topics

Critical Care Services

A coding job aid is available on eLink for your reference

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Critical Care Documentation

- To bill the critical care codes, the documentation must support the following:
  - The patient's condition must be ***life threatening or*** he or she must be in ***imminent*** **danger of organ failure**
  - High complexity decision-making
- The following ***must*** be documented:
  - Condition of the patient
  - Details of the assessment, treatment plan and any other services provided
  - Amount of time spent providing critical care

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Critical Care Codes

Critical Care Time	CPT Code(s)	Documentation Requirements
< 30 minutes	**Use other appropriate E/M code**	Document whatever is required for the CPT code selected
30 – 74 minutes	**99291**	Documentation of 30 – 74 minutes of critical care services
75 – 104 minutes	**99291 and 99292**	Documentation of 75 – 104 minutes of critical care services
105 – 134 minutes	**99291 and 99292 x 2**	Documentation of 105 – 134 minutes of critical care services
135 – 164 minutes	**99291 and 99292 x 3**	Documentation of 135 – 164 minutes of critical care services

Please ask for your billing staff's assistance in determining the correct codes for time spent beyond 164 minutes.

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Critical Care Documentation

- Using the codes:
  - 99291 cannot be reported more than once per date of service by physicians of the same specialty from the same practice
  - Time spent treating the patient does *not* have to be continuous
  - Critical care time may not be split/shared between an MD and an APP
  - Critical care time performed by a resident may not be billed
- Simply noting that the patient's condition is "unstable" does not support use of the code(s)
- Not all visits to a patient in the ICU qualify as Critical Care services
- If you provide a service that can be billed using another CPT code during the critical care encounter, you must subtract the time spent performing that service from the time used to determine the critical care code(s)

Consultations

Consult vs. Transfer of Care

- A consultation is defined as:
  - A request for opinion or advice regarding evaluation and/or management of a specific problem

    OR
  - An initial encounter conducted to determine whether to accept responsibility for ongoing management of the patient's entire care or the care of a specific condition or problem
- Must be provided at the request of another healthcare Physician/APP or appropriate source
  - Documentation should specify who requested the consultation

Consult vs. Transfer of Care

- Transfer of care is defined as:
  - The transfer of complete or specific care of a patient from one physician to another physician or healthcare Physician/APP
- Consultation codes should *not* be reported when a Physician/APP has agreed to accept responsibility for care of a patient ***before*** the initial evaluation
- If a consultation is provided, a written report documenting your findings must be provided to the requesting Physician/APP as a:
  - Part of a common (shared) medical record,
  - Separate letter, or
  - Copy of consultation report via cc:

EMR Cautions

EMR Cautions

- The Atrium Health *Physician IT Advisory Committee* (PITAC) has released a “document integrity” statement highlighting potential risks associated with the use of EMR systems including Canopy
- Utilization of copy/paste, copy forward, macro functionality/tools and voice recognition software in an EMR can be great time savers, but they must be used with caution

Be sure to carefully review and update each note or report when these EMR tools are used so that the documentation accurately reflects all the services performed for that day’s encounter

Voice Recognition Technology

- Exercise caution when using voice recognition technology (e.g., “Dragon”)
- Voice-dictated notes are held to the same standards as those generated by any other means
- Physicians/APPs are responsible for proofreading all elements of their note to ensure accuracy
- The use of phrases (disclaimers) meant to excuse a Physician/APP’s responsibility for errors in the medical record by attributing these to technological problems provide no protection from consequences of documentation errors

Voice Recognition Technology

Examples of "disclaimers" seen in EMR

This note was dictated with Dragon voice recognition technology and may contain erroneous phrases or words.

There may be some typographical errors generated by the transcription software that may have been missed despite a reasonable effort to identify and correct them. Please contact me if further clarification is needed.

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Template Inconsistencies

History of Present Illness
29 yo patient presents to the clinic today with congestion and **cough** since last week. Patient reports that she has been taking Advil and Robitussin with no relief. Patient denies shortness of breath or chest pain.

Review of Systems
Constitutional: No Fever
HEENT: No sore throat
Respiratory: **No cough**
Lymph: No swollen glands

Template Use

Templates are an effective mechanism for documenting quantitative data such as a patient's ROS (Review of Systems). However, failure to update a template that is pre-populated with, for example, negative responses, when the patient has a contradictory positive response to a question as recorded in the HPI (History of Present Illness) section, or failure to remove a negative response when the question was never asked, creates an erroneous record entry and can potentially lead to improper patient care or payment.

Template Inconsistencies

Procedure History
Back surgery
Hysterectomy
Left BKA

Family History
Mother- Hypertension
Sister- Breast Cancer

Social History
Alcohol – Denies

Physical Exam
Breast- no mass, no tenderness
Uterus: within normal limits
Vagina: No prolapse, no cystocele
Abdomen: soft, non-tender, non distended

When using a pre-completed note template or macro (i.e., charting by exception), the Physician/APP must remember to:

- Update any item when the response differs from the pre-loaded response (e.g., from negative to positive, or normal to abnormal);
- Remove any item(s) not performed.

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Boilerplate & Blanket Statements

Assessment and Plan

Diagnosis: **Pinkeye**
Prescription written for gentamicin ophthalmic. Encouraged to call the office or return if worse or no improvement.

More than ½ of a 60 minute total encounter time was spent in counseling and coordination of care.

- It is unlikely that a 60 minute visit was required for treatment of conjunctivitis
- When selecting an E/M code based on time, the documentation must detail what was discussed if counseling the patient, or what services were done for coordination of care
- Such statements should NOT be prepopulated on every note

Copy Paste

07/14 Impression and plan

Will order a CT scan of the abdomen, CBC labs and CRP. continue Zofran.

07/15 Impression and plan

Will order a CT scan of the abdomen, CBC labs and CRP. continue Zofran.

07/16 Impression and plan

Will order a CT scan of the abdomen, CBC labs and CRP. continue Zofran.

Every note should reflect that day's encounter with the patient. It is unlikely that the impression and plan would be exactly the same for consecutive visits. The Physician/APP will only receive credit once for the above statements.

Copy Forward

Chief Complaint

Follow-up visit – abdominal pain

History of the present illness

29 year old male presents with GI problems. He was seen previously by another practice and was diagnosed with IBS. I reviewed the report of his last colonoscopy and it was without findings. His grandfather had colon cancer. He is not a smoker. He is employed with Atrium Health and is happy with his job. He is married and has 15 kids. His last labs revealed a GGT of 128.

The HPI portion of the note should capture the patient's experience in their own words. This should not be pulled through and copied from a previous note. Unless the patient is unable to communicate, your HPI documentation should reflect what has been going on with the patient from the previous encounter to the current encounter.

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Specific Medical Documentation Matters

- Ensure that the documentation in the patient's medical record is specific
- Statements such as "failed outpatient therapy, admit for spinal fusion" are simply not sufficient evidence of medical necessity for the admission of the surgery

Medicare Signature Requirements

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Medicare Signature Requirements

- Medicare requires that services *provided or ordered* be authenticated by the author. There are two acceptable methods of authentication:
  - Handwritten signature
  - Electronic signature
- Rubber stamp signatures are *not* acceptable

Timeliness of Documentation

Timeliness of Documentation

Service	Best Practice	Minimum Standard
Outpatient – Office		
All encounters	Same day	3 business days
Inpatient/ ED/ Urgent Care		
H&P	Same shift	24 hours
Discharge summary	Same shift	24 hours
Progress notes	Same shift	24 hours
Consults	Same shift	24 hours
ED/Urgent notes	Same shift	24 hours
Procedure/OP notes	At completion	At completion
Attending co-signature	Same shift	48 hours

The Medical Records Standards can be found on PhysicianConnect/Education/Coding & Documentation

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Timeliness of Documentation

Effect on audit -

- Documentation not completed within 7 calendar days from the date of service will result in a 100 point deduction

Effect on revenue -

- Documentation not completed by the 30th calendar day from the date of the patient encounter is no longer a billable service

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Atrium Health Medical Group Medical Records Standards

- Physicians/APPs need to ensure that their documentation of care for our patients is accurate, complete, and available for clinical and financial use by others within a reasonable timeframe
- Documentation of all patient encounters the same day as the visit is ideal, and should be the goal of every Physician/APP
- Physician/APP notes must be authenticated (signed, not just saved) in order to be visible to others
- Documentation should be formatted in a manner which allows a Physician/APP to rapidly locate an assessment and plan without scrolling through multiple pages of imported data
- Some practices may impose a more rigid standard based on their specialty and/or operational needs

Scribes

Definition of a Scribe

- A scribe is an individual who is present during the Physician/APP's performance of a clinical service and who documents everything said during the course of the service

"A human tape recorder"

Before engaging the services of a scribe, it is imperative that you become familiar with the Scribe Policy

Visit PhysicianConnect > Education > Coding & Documentation > Scribe Policy and watch the video at PhysicianConnect > Education > Coding & Documentation > eLink > Coding for New Providers > 14.Scribes

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Role of a Scribe

- A scribe may ***not*** interject their own opinions or observations regardless of their background or clinical training
- A scribe may collect the Review of Systems (ROS) and Past, Family and Social History (PFSH) but otherwise should not take part in the service
- Other than collecting and recording the ROS and PFSH, any entries made in the record by a scribe should only be made upon dictation by the physician or APP at the time of service

NOTE: Although Medicare and other payers may permit residents and medical students to serve as scribes, the Atrium Health scribe policy does not allow residents, interns, fellows, or medical students to act as scribes when on active rotation

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Documentation Required By the Scribe

- The scribe must record a personal, dated note that:
  - Identifies the individual as the scribe of the service
  - Attests that the notes are recorded contemporaneously in the presence of the physician or APP performing the services
  - Identifies the physician or APP performing the service
- An example of acceptable scribe documentation follows:

  "I, scribe's name, am acting as scribe for Physician/APP's name."

Documentation Required By the Physician or APP

- The billing Physician/APP is ultimately responsible for all documentation and must verify that the scribe's entry accurately reflects the service provided
- The Physician/APP's documentation should contain the following statement followed by his or her signature:
  - "I have reviewed the above documentation for accuracy and completeness and I agree with the above documentation."

Scribes and the Electronic Medical Record (EMR)

- Scribes must log into an EMR using their own log-in and password information
  - It is not appropriate for the Physician/APP to log in to the EMR and then allow the scribe access to the system
- Scribe language has been built into Canopy

Diagnosis Coding

The Importance of Diagnosis Coding

- Diagnosis codes should support the medical necessity for the service provided
- Diagnosis codes selected for billing purposes should *always* be supported by documentation in the patient's medical record
- Code assignment is not based on clinical criteria used by the Physician/APP to establish the diagnosis but by Physician/APP's statement that the condition exists
  - The Physician/APP's statement that the patient has a condition is sufficient
- Incorrect diagnosis coding can have a direct impact on compliance as well as revenue

Impact of Documentation on Diagnosis Coding (Pro Fee Coding)

- Currently, physician (pro fee) services are paid based on the fee associated with the CPT/HCPCS code reported while the diagnosis code typically is used to convey the medical need for a service
- With the introduction of **Hierarchical Condition Categories** (HCC), developed for Risk Adjustment payment models where health cost expenditures will be predicted based on the patient demographics and health status, diagnosis code(s) need to capture, now more than ever before, the acuity, severity and chronicity of patient conditions

For more information regarding HCC, please visit the HCC website on PhysicianConnect:

http://physicianconnect.carolinas.org/HCC

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Impact of Documentation on Diagnosis Coding (Pro Fee Coding)

- Risk adjustment data is obtained from diagnosis codes reported via claims in all healthcare settings such as inpatient, outpatient facility, and physician office).
- Report all diagnosis codes you are currently treating or managing to the highest level of specificity known during each patient encounter.
- Diagnosis codes are grouped into Hierarchical Condition Categories (HCCs)
- HCCs reset each calendar year, so it is extremely important to document and code each comorbidity that is evaluated by you every calendar year.

General Diagnosis Coding Guidelines

Since a coder (or physician) may only code what is available in the Physician/APP's documentation, it is important for Physicians/APPs to keep the following in mind when documenting (and coding) a patient's encounter

- Document (and code) all diagnoses that directly impact the treatment plan for the presenting problem
  - "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)"
  - Current diagnoses being managed by the billing Physician/APP should be documented even when a patient is presenting for his/her annual wellness visit
    - (**Note:** The inclusion of these diagnoses does not, by default, mean that a preventive split visit should be billed. Only when a significant and separately identifiable E/M visit is performed should an E/M visit also be reported)

General Diagnosis Coding Guidelines

- Document (and code) conditions to the highest degree of certainty known for each encounter/visit
  - When a diagnosis has not yet been confirmed/established, document what is known
    - e.g., patient's signs and symptoms, abnormal test results, etc.
  - In the ambulatory setting, a coder may ***not*** code a diagnosis listed as "probable", "suspected", "rule out", etc.
    - a medical record entry by the Physician/APP of "*Probable Angina*" when the patient presented to the practice with chest pain, would likely be coded as "*Chest Pain*"

General Diagnosis Coding Guidelines

- Ensure your documentation includes all the pertinent details known about a health condition since insufficient clinical information can result in the assignment of an *unspecified* code
- Consider the following when documenting your note:
  - Anatomical location, including laterality
  - Severity (e.g., acute, chronic, controlled, uncontrolled, stage, etc.)
  - Timing (e.g., continuous, intermittent, etc.)
  - Associated conditions
  - Contributing factors
  - Comorbidities
  - Cause and effect relationship (e.g., due to hypertension)
  - Agent and/or organism
  - Depth/stage for wounds and ulcers
  - Complications/manifestations
  - Trimester of pregnancy (*unless* the pregnancy is incidental to the encounter)
  - Episode of care (e.g., initial, subsequent, sequela) – Injuries and Poisoning

General Diagnosis Coding Guidelines

- Document (and code) any factors that may influence the patient's health status and/or treatment
  - Tobacco use, Alcohol use
  - Long term, current use of insulin
  - History of organ transplant – *specify organ*
  - Presence of device – *specify device* (e.g., heart assist device)
  - Acquired absence of digit or limb – *specify site* (e.g., history of below knee amputation)
  - Late effect, sequelae (e.g., hemiplegia following a stroke)
  - Remission status

General Diagnosis Coding Guidelines

- Review and edit information copied/pasted from a previous patient encounter and include only the information that is pertinent to the decision making for the current encounter
- Copying forward diagnoses that do not impact the presenting problem(s) for the current visit can inappropriately result in the coding of a diagnosis/ condition that was previously treated and no longer exists

General Diagnosis Coding Guidelines

Common chronic conditions and the documentation requirements for accurate ICD-10-CM code assignment

- **Asthma**
  - **Severity** – document asthma severity as either intermittent, mild persistent, moderate persistent or severe persistent
  - **Type** – exercise induced or cough variant as other types of asthma; documentation should specify type
  - **Acute exacerbation** – documentation should state if the asthma is in acute exacerbation
  - **Status asthmaticus** – is defined as an acute exacerbation of asthma that remains unresponsive to initial treatment with bronchodilators
  - **Infection** – a superimposed infection may be present; this should clearly be documented by the Physician/APP

General Diagnosis Coding Guidelines

Common chronic conditions and the documentation requirements for accurate ICD-10-CM code assignment

- **Hypertension**
  - **Primary or secondary** – Secondary hypertension is due to an underlying condition. Two codes are required to report secondary hypertension, one to identify the underlying etiology and one from category *I15 Secondary hypertension*
  - **Controlled/uncontrolled** – Describe the status of hypertension and do not change the code assignment. The correct code for these terms describing hypertension is *I10 Essential (primary) hypertension*
  - **Transient** – A temporary elevation of blood pressure that is not a true diagnosis of hypertension. Assign code *R03.0 elevated blood pressure reading without a diagnosis of hypertension*

General Diagnosis Coding Guidelines

- **Hypertension (continued)**
  - **Complications** – Document all complications showing the cause and effect relationship between the two conditions (i.e. due to hypertension, hypertensive, caused by hypertension). When hypertension and chronic kidney disease appear together, a cause and effect relationship is assumed in ICD-10. The following coding guidance applies to hypertensive complications:
    - I11 Hypertensive heart disease, use additional code from category I50 Heart Failure if present
    - I12 hypertensive chronic kidney disease, use additional code from category I50 Heart Failure if present and use additional code from category N18 Chronic Kidney Disease to identify the stage
    - I60 – I69 Hypertensive cerebrovascular disease, code also I10 Essential (Primary) Hypertension
    - H35.0 Hypertensive retinopathy, code also I10 Essential (Primary) Hypertension

General Diagnosis Coding Guidelines

Common chronic conditions and the documentation requirements for accurate ICD-10-CM code assignment

- **Diabetes mellitus (DM)**
  - **Type –** Physicians/APPs must document the type of diabetes in ICD-10-CM:
    - E08 Diabetes mellitus due to an underlying condition, code first the underlying condition such as, congenital rubella, Cushing's syndrome, pancreatitis, etc.
    - E09 Drug or chemical induced diabetes mellitus, code first poisoning due to drug or toxin, if applicable. Use additional code for adverse effect, if applicable, to identify drug
    - E10 Type 1 diabetes mellitus, that due to pancreatic islet B cell destruction. Also known as "juvenile diabetes"
    - E11 Type 2 diabetes mellitus, use for diabetes not otherwise specified
    - E13 Other specified diabetes mellitus, includes that due to genetic defects and secondary diabetes not classified elsewhere

General Diagnosis Coding Guidelines

- **Diabetes mellitus (DM)** (continued)
  - **Body system affected** – Diabetes may affect multiple body systems. Physicians/APPs should document each body system in which diabetes has caused complications. Apply as many diabetes codes as needed to fully describe each body system/manifestation documented
  - **Complications affecting that body system** – Physicians/APPs must continue to document the cause and effect relationship between diabetes and any body systems affected by the condition. Some examples include: diabetes with neuropathy, diabetic retinopathy, and nephropathy due to diabetes
  - **Insulin use** – Document all treatment aimed at diabetes and/or its complications. If insulin is used to treat the patient long term, then apply code Z79.4 (long term, current use of insulin)

General Diagnosis Coding Guidelines

Example:

- Osteoporosis
  - With current pathological fracture (M80)
    - Age related (M80.0)
      - Shoulder (M80.01)
        - » Right (M80.011)
        - » Left (M80.012)
      - Humerus (M80.02)
        - » Right (M80.021)
        - » Left (M80.022)
      - Lower Leg (M80.06)
        - » Right (M80.061)
        - » Left (M80.062)

Appropriate 7th digit is added to each of these codes	
A	Initial encounter for fracture
D	Subsequent encounter for fracture with routine healing
G	Subsequent encounter for fracture with delayed healing
K	Subsequent encounter for fracture with nonunion
P	Subsequent encounter for fracture with malunion
S	Sequela

Who Codes What and Why

Facility/Inpatient coding reflects all diagnoses and procedures associated with the entire episode of care

- Codes assigned by corporate division coders
- Code assignment based on physician documentation
  - Unlimited number of secondary diagnoses and used for:
    - Severity of Illness and Risk of Mortality
    - Value Based Purchasing
    - Patient Safety Indicators
    - DRG/reimbursement

Professional Fee/Inpatient coding reflects the physician work for each daily encounter with associated diagnoses

- Codes assigned by:
  - Physicians based on interpretation of level of service, OR
  - Centralized coders based on operative reports or procedure notes
- Diagnosis codes used to support Medical Necessity
- CPT codes used for reimbursement

Medical Office coding reflects physician work for each appointment

- Codes assigned by physicians
- Diagnosis codes used to support Medical Necessity
- CPT codes used for reimbursement

Transmittal 540
“Related” Claims

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“Related” Claims

- Allows the Medicare Administrative Contractor (MAC) and Zone Program Integrity Contractors (ZPIC) to have the discretion to deny other “related” claims submitted before or after the claim in question. If documentation associated with one claim can be used to validate another claim, those claims may be considered “related.”

Example:

When the Part A inpatient surgical claim is denied as not reasonable and necessary, the MAC may recoup the surgeon’s reimbursement for Part B services. For services where the patient’s History and Physical, physician progress notes, or other hospital record documentation does not support the medical necessity for performing the procedure, postpayment recoupment may occur for the performing physician’s Part B service.

Are You Involved in Research?

Federal Regulations' Definition of "Research"

- **Research**: A *systematic investigation*, including research development, testing and evaluation designed to develop or contribute to *generalizable knowledge.*
- **Human Subject**: living individual about whom an investigator obtains data and/or identifiable information. May either receive intervention or control, as a healthy individual or a patient.
- Studies may involve:
  - Patient interviews
  - Follow-up contact of patients to determine the effectiveness of a program or a treatment, including mailed questionnaires
  - Chart review and analysis of computer-stored clinical and administrative data to assess quality of care, and
  - Randomized trials of experimental drugs, devices, and procedures

Federal Regulations and “Research”

- Quality Improvement Projects, Chart Reviews, patient recruitment, data access by outside entities, questions you may already know the answers to…
  - ALL may be research, or may become research at some point.
- Atrium has many resources available to ensure that we do research the right way:
  - IRB (internal and external)
  - OCTR (monitors/educators)
  - Sponsored Programs Administration (Research Finance)
  - Research Compliance
  - Research Privacy

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Research

Please call the Office of Clinical an Translational Research (OCTR):

704-355-0642

Please reach out before starting a project that may be research-

We are here to help!

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Additional Information Available in Appendices

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Appendices

Select any link to advance to that topic.
Use the ← to return to this slide.

Appendix	Topic
A	Teaching Physicians, Residents, & Medical Students
B	Primary Care Exception
C	Preventive Medicine Visits
D	Preventive/Split Services
E	Smoking Cessation Counseling
F	Commonly Performed Office Procedures
G	Advance Care Planning
H	Telehealth Services
I	Alcohol/Substance Abuse, Brief Intervention, & Referral to Treatment Services (SBIRT)
J	Transitional Care Management (TCM)
K	Home Health Face-to-Face Requirements (Medicare)
L	Advanced Beneficiary Notice of Non-Coverage (ABN)

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APPENDIX A

Teaching Physicians, Residents & Medical Students

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Teaching Physician Guidelines for Medicare

Medicare

- To bill Medicare for services provided by residents, the teaching physician must:
  - See the patient, and
  - Provide appropriate documentation
- Modifier –GC should be appended to the CPT code(s) to indicate that the Teaching Physician services rendered are in compliance with all of the requirements outlined in Section 15016 of the Medicare Carriers Manual

Teaching Physician Guidelines for Medicare

Medicare

- At a *minimum*, the teaching physician should document:
  - Patient was seen and examined either with or without the resident,
  - The patient's case was discussed with the resident, and
  - Whether the teaching physician agrees with the resident's assessment and plan
  - If the teaching physician does not agree with the resident's assessment and plan, he/she must state what changes should be made
- Each resident must sign his or her own documentation

Teaching Physician Guidelines for Medicare

- Suggested documentation from the Medicare website includes:
  - *"I saw and evaluated the patient. Discussed with Dr. Resident and agree with the findings and plan as written."*
  - *"I saw and evaluated the patient. Discussed with Dr. Resident, I agree with the findings and treatment plan as documented in Dr. Resident's note except…."*

For additional information refer to the Billing & Documentation Manual, Residents Section located on the eLink Corporate Compliance & Coding Support SharePoint site

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Teaching Physician Guidelines for Medicare

- The following examples represent *unacceptable* documentation for a Medicare patient:
  - *"Agree with above."*
  - *"Rounded, reviewed, agree."*
  - *"Discussed with Dr. Resident. Agree."*
  - *"Seen and agree."*
  - *"Patient seen and evaluated."*

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Teaching Physician Guidelines for Medicare

Medicare

- If the Medicare patient is not evaluated by the teaching physician, no professional charge can be submitted

- *Exception to this rule:* Certain Family Practice and Internal Medicine practices are set up as *Primary Care Exception* locations

The Primary Care Exception is addressed in Appendix B of this presentation

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Medicare Requirements – Residents Performing Major Surgeries (Including Endoscopies)

- The teaching physician must be:
  - Present for all critical and key portions of the procedure, and
  - Immediately available to furnish services during the entire procedure
- The teaching physician's presence is *not* required during the opening and closing of the surgical field unless these activities are considered to be key and critical and require his or her presence

Medicare Requirements – Residents Performing Minor Procedures

- A “minor procedure” is defined as a procedure that takes five minutes or less to complete and involves relatively little decision making once the need for the procedure has been determined
- The teaching surgeon must be present for the entire procedure in order to bill for the service

Teaching Physician Guidelines

Non-Medicare Patients

- At a minimum, the teaching physician must:
  - Review the resident's documentation, and
  - Co-sign the note
- It is recommended that the teaching physician document his or her evaluation of the patient
- Each resident must sign his or her own documentation

Teaching Physician Guidelines for Medicare

Medical Students

- Medicare will allow the contribution of medical student documentation provided the following criteria are met:
  - Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past medical, family, social history) must be performed in the physical presence of a teaching physician or medical resident
  - Students may document services in the medical record, however, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam, and/or medical decision making

Teaching Physician Guidelines for Medicare

Medical Students

- To bill Medicare for services provided by medical students, the teaching physician must:
  - See the patient, and
  - Personally perform (or re-perform) the physical exam and medical decision making of the E/M service, but may verify any student documentation of them in the medical record, rather than re-documenting this work

APP Students

- Medicare's policy for medical students does not extend to other students such as Nurse Practitioner or Physician Assistant students
- Documentation that relies on NP or PA student documentation, with the **exception of ROS and PFSH**, cannot be used to support a billed E/M service

If you link to a NP or PA student's documentation, you will receive credit only for the ROS and PFSH documented by the student

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APPENDIX B

Primary Care Exception

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Primary Care Exception

- The Exception Rule permits teaching physicians providing E/M services with a GME program that has been granted a Primary Care Exception, to bill Medicare for lower and mid-level E/M services furnished by residents in the absence of a teaching physician. The Exception Rule does *not* apply to procedures or any services other than the lower and mid-level E/M services listed below:
  - CPT codes 99201 – 99203
  - CPT codes 99211 – 99213
- If a service other than that listed above needs to be furnished, then the general teaching physician policy applies

Modifier –GE (*This service has been performed by a resident without the presence of a teaching physician under the primary care exception*) should be appended to the E/M codes billed

Primary Care Exception – What's Required?

- **Residents:**
  - ***Must*** have completed at least six (6) months of a GME approved residency program
- **Teaching physicians:**
  - May ***not*** supervise more than four (4) residents at any given time
  - Must direct the care from a proximity that would constitute immediate availability
  - Should have primary medical responsibility for the patient(s) being cared for by the residents
  - Should have no other responsibilities (including supervision of other personnel) at the time the service is being provided by the resident

Primary Care Exception – Documentation

- **Teaching physician:**
  - Must write a personal note indicating that he/she has reviewed information from the resident's history, exam, assessment and plan, and any labs/tests/records, etc.
  - Documentation must indicate that the review took place while the patient was in the clinic or immediately after the resident saw the patient

Primary Care Exception – Documentation

- Teaching physician:
  - Documentation should clearly indicate the extent of the teaching physician's participation in the review and direction of services furnished to each Medicare patient
  - In order for resident's documentation to be counted toward the documentation requirement for the code selected, the teaching physician must review and link to the resident's note

Primary Care Exception – Documentation

- Suggested notes might include:
  - *Case discussed with Dr. Resident at the time of the visit. Dr. Resident's history and exam show _____. Significant test results are _____. I agree with the diagnosis of _____ and plan of care to _____ per his/her note.*
- Append the –GE modifier to the E/M code to signify that the teaching physician was not present during the E/M service being billed, but that all requirements for such billing have been met in accordance with the Primary Care Exception Rule

APPENDIX C

Preventive Medicine Visits

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Preventive Medicine Visits

Definition of Service

- A comprehensive preventive medicine service includes an age and gender appropriate history and examination
- Preventive counseling, anticipatory guidance, and risk factor reduction interventions are typically provided during the exam
- Vaccines, laboratory services, and other screening tests may be performed during the encounter and are usually reported in addition to the preventive visit

Preventive Medicine Visits

- Seven codes are available in each of the two subcategories
- Patient status (new vs. established) and age are the determining factors for code selection

New Patient	
99381	Younger than 1 year
99382	1-4 years
99383	5-11 years
99384	12-17 years
99385	18-39 years
99386	40-64 years
99387	65 years and older

Established Patient	
99391	Younger than 1 year
99392	1-4 years
99393	5-11 years
99394	12-17 years
99395	18-39 years
99396	40-64 years
99397	65 years and older

APPENDIX D

Preventive/Split Services

A coding job aid is available on eLink for your reference.

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Preventive/Split Services

- Preventive split visits may occur if during the course of a preventive encounter, the Physician/APP identifies a *significant* new problem or exacerbation of chronic condition(s) requiring *additional work over and above the normal preventive service,* or an abnormality is discovered during the course of the encounter that needs to be evaluated/addressed
- If the documentation conveys that two distinct services were provided – the preventive encounter *and* a problem-oriented service – two codes can be reported
  - Problem-oriented E/M code (99201 – 99215) with modifier -25, and the
  - Preventive service code (99381 – 99397)

Preventive/Split Services

- An issue is considered a “significant issue” when a new problem or an exacerbation of a pre-existing condition is discovered during the patient evaluation and the Physician/APP determines the problem requires additional work to perform the key components of the problem-oriented office visit code
- Remember that if you are considering billing a ***new*** patient encounter as a preventive split, ***all three key components*** (history, exam, and the complexity of the medical decision-making) ***must support the problem-oriented office visit code*** selected for billing
- Simply refilling medications for stable chronic conditions does not constitute a separate medically necessary problem-oriented E/M encounter

Preventive/Split Services

- The level of the problem-oriented E/M code is based on the "additional work" performed over and above what normally would be performed during the preventive encounter
- Any work performed as part of the preventive encounter cannot be included when determining the level of the problem-oriented E/M code
- Billing the problem-oriented visit based on time
  - Documentation regarding the time spent providing the problem-oriented encounter must be included
  - "*Spent ___ minutes face-to-face with the patient addressing non-preventive conditions, and greater than 50% of that time was spent in counseling and/or coordination of care*"
  - Must state specifically what was discussed during counseling and/or what was done for coordination of care

Example - Preventive/Split Services

History: Patient presents for annual exam. He also complains of sharp pain in upper right abdomen for two weeks, primarily after eating. Patient also endorses increased belching and heartburn but denies nausea and vomiting. Patient has history of gallstones. *(More information included …)*

Exam: Patient is alert and oriented, in no acute distress. PERRLA. TMs clear. Lungs CTA, RRR, no edema. Normal gait and station. Normal sensation, DTRs. No obvious rashes or lesions.

Hypoactive bowel sounds, right upper quadrant guarding and tenderness. Enlarged spleen with palpable liver edge. No hernia.

Assessment and Plan:

Preventive exam: Counseled patient on healthy diet and exercise, use of seatbelt. Recommended sunscreen use, full skin exam in 6 months. Screening labs reviewed. Up-to-date on immunizations.

Abdominal pain: Order CBC, CMP, creatinine, hepatic function. If results are abnormal, obtain gallbladder ultrasound. Advised avoidance of fatty and spicy foods.

Preventive/Split Services and ICD-10-CM

- In ICD-10-CM, the diagnosis codes for preventive encounters distinguish between a preventive exam ***with abnormal findings*** and a preventive exam ***without abnormal findings***
- An abnormal finding consists of:
  - A significant new complaint or symptom described by the patient,
  - An abnormal finding upon examination of the patient, or
  - An acute exacerbation of a chronic condition

Preventive/Split Services and Medicaid

NC Medicaid

- Beneficiaries 20 years of age or younger may receive a preventive exam and a sick visit on the same date of service
  - Preventive split visits are not covered for patients 21 years of age and older
- Physicians/APPs must create separate notes for each service in order to support medical necessity
- Only services performed *above and beyond* the preventive visit may be used to determine the sick visit level

APPENDIX E

Smoking Cessation Counseling

A coding job aid is available on eLink for your reference.

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Smoking Cessation Counseling

Smoking cessation codes are defined based on the number of minutes spent providing counseling to the patient

**** The number of minutes spent providing the service must be documented ****

CPT Code	Description
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

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Smoking Cessation Counseling

- Medicare coverage criteria include:
  - Counseling must be provided by a physician or an Advanced Clinical Practitioner (APP)
  - Physician/APP must document intervention methods recommended
  - Patient must be alert and competent
  - Counseling is covered in both inpatient and outpatient settings
  - Medicare co-payment, co-insurance and deductible are waived

Smoking Cessation Counseling

Medicare will cover two smoking cessation attempts per year

- Each attempt includes a maximum of 4 intermediate or 4 intensive sessions for a total of 8 sessions per 12-month period

Medicare Asymptomatic Diagnosis Codes

F17.210 – F17.211 Nicotine dependence, cigarettes

F17.220 – F17.221 Nicotine dependence, chewing tobacco

F17.290 – F17.291 Nicotine dependence, other product

Z87.891 Personal history of nicotine dependence (may not be reported with F17.2xx codes)

Medicare Symptomatic Diagnosis Codes

T65.211A – T65.214A Toxic effect of chewing tobacco

T65.221A – T65.224A Toxic effect of tobacco cigarettes (use additional code for exposure to 2nd hand smoke Z57.31, Z77.22)

T65.291A – T65.294A Toxic effect of tobacco and nicotine

Smoking Cessation Counseling

For Commercial payers, benefits may vary by payer and individual plan

US Department of Health and Human Services published the Clinical Practice Guidelines for the "5" A's of brief intervention:

1. Ask about tobacco use
2. Advise to quit
3. Assess willingness to make a quit attempt
4. Assist in quit attempt
5. Arrange follow up

APPENDIX F

Commonly Performed Office Procedures

Commonly Performed Office Procedures and Services

- Cerumen Removal*
- EKGs*
- Ultrasounds
- X-rays*
- Laceration (Wound) Repairs*
- Incision and Drainage (I&D)
- Foreign Body Removal

* A coding job aid is available on eLink for your reference

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Cerumen Removal 69209

- Patient must be symptomatic and/or the impacted cerumen must be impeding proper evaluation of signs or symptoms experienced by the patient
- Documentation must illustrate that the service required significant time and effort and was *performed via irrigation/lavage*
- Service may be performed either by clinical staff (RN, LPN, CNA, CMA) or the Physician/APP
- For bilateral procedure, report 69209 with modifier -50

Cerumen Removal 69210

- Patient must be symptomatic and/or the impacted cerumen must be impeding proper evaluation of signs or symptoms experienced by the patient
- Documentation must illustrate significant time and effort was spent and *use of an instrument was required* to accomplish the procedure
- Service must be performed by a physician or Advanced Clinical Practitioner (PA, NP)
- For bilateral procedure, report 69210 with modifier -50

Cerumen Removal

Diagnosis codes for reporting cerumen removal services:

ICD-10-CM diagnosis code options:

- H61.20 Impacted cerumen, unspecified ear
- H61.21 Impacted cerumen, right ear
- H61.22 Impacted cerumen, left ear
- H61.23 Impacted cerumen, bilateral

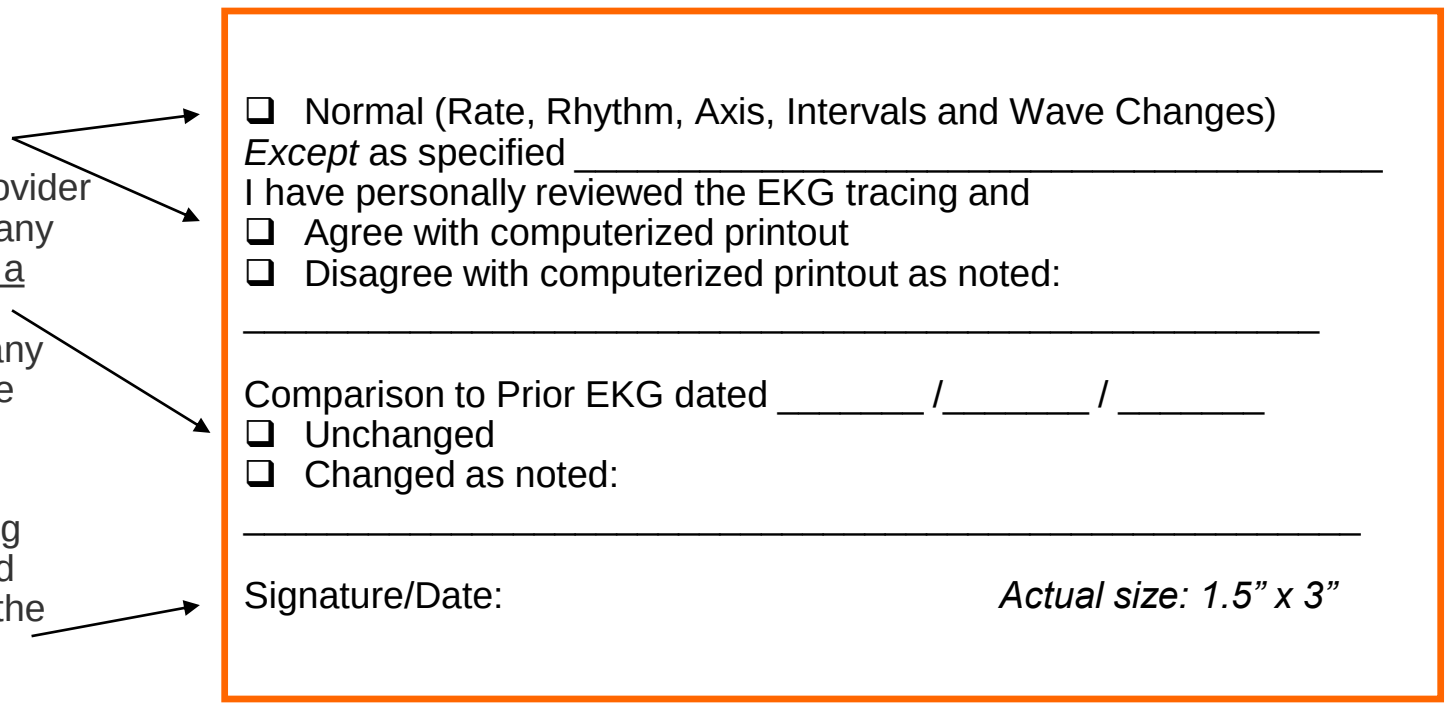
EKG Documentation Requirements

- A specific order for the test must be documented and signed
- The documentation must indicate that the test is reasonable and medically necessary
- The Physician/APP must document the cognitive work performed in the analysis of the EKG tracing
- A complete documented interpretation and report must be prepared and signed by the Physician/APP
- Merely signing the computerized EKG printout and noting “agree” is not sufficient to support an interpretation and report

EKG Label

The following label is designed to meet the minimum documentation requirements

- In addition to recording his findings, the interpreting provider should notate any comparison to a prior EKG documenting any changes on the EKG label.
- The interpreting provider should sign and date the EKG label.



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EKGs and Rhythm Strips: The Codes

- 93000 12 lead; tracing with interpretation and report
- 93005 12 lead; tracing only
- 93010 12 lead; interpretation and report only

- 93040 1 – 3 leads; tracing with interpretation and report
- 93041 1 – 3 leads; tracing only
- 93042 1 – 3 leads; interpretation and report only

** It is not appropriate to report 93042
for reviewing telemetry monitoring strips.**

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Ultrasound Documentation Requirements

- A specific order for the test must be documented and signed
- The documentation must indicate that the test is reasonable and medically necessary
- The Physician/APP must document the cognitive work performed in the analysis of the ultrasound images
- A complete documented interpretation and report must be prepared and signed by the Physician/APP
- Merely signing the computerized ultrasound report and noting “agree” is not sufficient to support an interpretation and report

Ultrasound Label

The following label is designed to meet the minimum documentation requirements

- The interpreting Physician/APP should record his review and interpretation on the label.
- The interpreting Physician/APP should sign and date the label.

I have personally reviewed the ultrasound images and
- ❑ **Agree with the examination report**
- ❑ **Disagree with the examination report as noted:**

_____

Conclusion/Clinical Impression:
- ❑ **Normal**
- ❑ **Abnormal (*specify*)** _____

Provider Signature/Date _____

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X-Ray Documentation Requirements

- When a *global* x-ray code is billed, the following must be documented:
  - The reason for the x-ray,
  - The body area or anatomical location x-rayed,
  - The number of views taken,
  - The findings (including any incidental findings),
  - The Physician/APP's conclusions and clinical impression,
  - The date of service, and
  - The Physician/APP's signature

X-Rays

- Professional component
  - Reading and interpretation of images
  - Written report of findings
- Technical component
  - Use of equipment and supplies
  - Use of staff and facility

Global Service

- Over-read
  - A quality assurance measure *only,* not separately billable

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Wound (Laceration) Repairs

- Wound closure utilizing sutures, staples, or tissue adhesives such as Dermabond
  - *Simple repair* (12001 – 12018) – used when wound is superficial and requires a simple one-layer closure
  - *Intermediate repair* (12031 – 12057) – used when wound requires *layered closure* of deeper layers of subcutaneous tissue and superficial fascia in addition to skin closure; also can be used for single layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter
  - *Complex repair* (13100 – 13153) – includes repairs that require more than a layered closure
    - *Note that these are not typically done in an office setting*

Selecting Wound Repair Codes

- Wound repairs are coded based on anatomical site, and type and length of repairs
- The repaired wound should be measured and recorded in centimeters
- When repairing multiple wounds, add together lengths of wounds from grouped anatomical sites repaired using same method (e.g., simple repair) and select one code
- When repairing multiple wounds from different grouped anatomical sites and/or using different methods (e.g., one with a simple repair, another with an intermediate repair), select individual codes as necessary to represent the services performed

Selecting Wound Repair Codes

- Placement of adhesive strips to close a laceration is *not* billable as a wound repair and would be considered simply a portion of an E/M service
- Use of *Dermabond* adhesive may be reported as a simple repair
- Suture removal following a laceration repair is included in the wound repair itself and should not be separately billed

Selecting Wound Repair Codes

Example: Patient is in an MVA where they sustain a laceration on their forehead and another laceration on their arm. The laceration on the forehead measures 3.1 cm and is repaired using a simple repair. The laceration on the arm measures 5.2 cm and is closed using an intermediate repair (layered closure). The CPT codes for this scenario are:

12032 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities; 2.6 cm to 7.5 cm*

12013-59 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm*

Incision and Drainage (I&D) Codes

- I&D services performed in an office setting are typically found in the *Integumentary Section* of the CPT book
- Codes include the following:

  10060 I&D of abscess, simple or single

  10061 I&D of abscess, complicated or multiple

  10140 I&D of hematoma, seroma or fluid collection

  10160 Puncture aspiration of abscess, hematoma, bulla, or cyst
- Typically no wound closure is needed although a simple drain may be required
- Includes use of topical anesthesia

Incision and Removal of a Foreign Body

- Services performed in the office setting include the following:

  10120 Incision and removal of foreign body, subcutaneous tissues; simple

  10121 Incision and removal of foreign body, subcutaneous tissues; complicated

- To support billing of these codes, the documentation must indicate that it was necessary to make a simple incision or to extend the edges of the wound in order to remove the foreign body
- If the foreign body can be removed simply by grasping it with forceps and pulling it out, the service is not separately billable and is considered part of the E/M service

APPENDIX G

Advance Care Planning

A coding job aid is available on eLink for your reference.

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Advance Care Planning

- Advance Care Planning is essentially the explanation and discussion of advance directives, including standard forms (with completion of such forms, when performed)
- Advance Care Planning may be provided and reported by a:
  - Physician
  - Advanced Clinical Practitioner (e.g., NP, PA)
- Other staff members may assist with certain aspects of the service

Advance Care Planning: General Requirements

- Requires a **face-to-face** visit with the physician or Advanced Clinical Practitioner and a patient, family member, or surrogate
- Counseling and discussion of advanced directives may or may not include completion of relevant legal documents
- Since this is a time-based service, time must be documented by the Physician/APP
- Services may be provided using a team-based approach by including other staff under the order and medical management of the patient's treating physician

Advance Care Planning: General Requirements

- Order and/or plan of care is necessary and must be documented
- Physician and/or Advanced Clinical Practitioner participates and contributes to the provision of this service
- Advance Care Planning services are voluntary and beneficiaries should be given a clear opportunity to decline if they prefer to receive assistance and/or counseling from other nonclinical sources outside the Medicare program
- Co-pay and deductible **DO** apply unless the service is provided during an Annual Wellness Visit (AWV)

Advance Care Planning: Reporting in the Office Setting (POS 11)

"Incident to" guidelines applicable

- A signature macro may be used by the supervising Physician/APP when the Advance Care Planning service is performed "incident to":
  - *"In addition to providing direct supervision, I have actively managed, participated and contributed to the delivery of the advance care planning service."*
- This statement would only need to be used when the Advance Care Planning service is performed "incident to"
- In cases where the Physician/APP bills directly, only the Physician/APP's signature is needed in addition to their documentation

Advance Care Planning: Reporting in the Office Setting (POS 11)

"Incident to" guidelines applicable

- When Advance Care Planning services are performed "incident to", there needs to be evidence of the following in the medical record:
  - Physician initiates request/order for advance care planning
  - Beneficiary's approval
  - Advance Care Planning services furnished under supervisory physician's overall direction and control
  - Physician activity/involvement frequently enough to reflect active participation/management
  - Physician's involvement should be documented in the medical record
  - Physician must be on-site and immediately available (i.e., direct supervision)

Advance Care Planning: Reporting in the Office Setting (POS 11)

- Medicare requires direct physician supervision (i.e., immediately available and in the office suite)
- May be billed separately with Annual Wellness Visit
- Modifier -33 should be appended to the service code
- No copay or deductible applies when performed during an AWV
- May be reported during Transitional Care Management (TCM), Chronic Care Management (CCM), or global surgery period
- May be reported in the same session with other E/M services – Except when performed during a “Welcome to Medicare” (IPPE) service

Advance Care Planning: Reporting in the Hospital of NF Setting

- "Incident to" criteria **not** applicable
- Must be personally performed and reported by the Physician or qualified healthcare professional (i.e., NP or PA)
- May be reported in the same session with other E/M services – Except when performed during critical care, neonatal critical care, pediatric critical care, initial and continuing intensive care services

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Advance Care Planning

CPT Code	Description
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate
+ 99498	each additional 30 minutes

APPENDIX H

Telehealth Services

A coding job aid is available on eLink for your reference.

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Telehealth Services

- Documentation of a telehealth service should be the same as that required for any in-person patient encounter. However, the documentation must also include the following:
  - A statement that the service was provided via telemedicine,
  - Location of the patient,
  - Location of the Physician/APP,
  - Name of any referring Physician/APP, and
  - The names of all Physicians/APPs present during the telemedicine service and their role in the patient's care

Telehealth Services

- For payment, Medicare requires an "*interactive telecommunications*" system that at a minimum includes audio and video for 2-way, real-time communication
  - Virtual care services, where the patient initiates the encounter via a computer, iPad, iPhone, etc., are not considered "telehealth" services for the purposes of Medicare payment

Virtual Visit **(On-line Medical Evaluation with Patient)**	Patient initiates audiovisual contact with Physician/APP via iPad, iPhone, computer, etc.
eVisit **(On-line Medical Evaluation with Patient)**	Patient initiates electronic communication with Physician/APP via iPad, iPhone, computer, etc.
TeleMedicine **(Face-to-Face with Patient via audiovideo communication)**	Physician/APP at 'originating' site (patient location) initiates contact w/'distant' site Physician/APP using 2-way, synchronous audiovideo telecommunication technology

Telehealth Services

Originating Site:

- The site where the beneficiary is located at the time the telehealth service is being furnished
- Approved telehealth sites:
  - Physician Office
  - Hospital
  - Critical Access Hospital
  - Rural Health Clinics
  - Federally Qualified Health Centers
  - Skilled Nursing Facilities
  - Community Mental Health Centers
  - Hospital-based or Critical Access Hospital-based Renal Dialysis Centers (including satellites)

***Note*: Independent renal dialysis facilities are not eligible as originating sites**

- As of 2016, the Primary Enterprise hospital locations eligible for the telehealth originating site charge and payment are Anson, Kings Mountain, Cleveland, and Stanly

Distant Site:

- The site where the Physician/APP, providing the professional service, is located at the time the telehealth service is provided

Telehealth Services

Telehealth Modifiers

Modifier	Description
-GT	Via interactive audio and video telecommunication systems
-95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

- By appending a –GT modifier, the distant site Physician/APP is certifying that a covered telehealth service was furnished
- The -95 modifier indicates that a service has been performed that meets the “interactive communications” requirements of a telehealth service

Telehealth Services

Telehealth Modifiers

Effective 10-1-2018 Medicare will no longer accept the –GT modifier

- A computer edit will remove the modifier when Medicare is the payer

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APPENDIX I

Alcohol/Substance Abuse Screening, Brief Intervention, and Referral to Treatment Services (SBIRT)

A coding job aid is available on eLink for your reference.

SBIRT Overview

- **S**creening – use a tool to identify risky substance use behaviors, such as the *Single Question Screen* or the *Quick Screen*
- **B**rief **I**ntervention – focus on increasing patient awareness and changing behavior to prevent progression of substance abuse when a hazardous behavior pattern is identified
- **R**eferral and **T**reatment – facilitate access to more advanced treatment options and support

SBIRT Coverage

Medicare covers medically necessary SBIRT services when performed in a physician office or outpatient hospital department

Medicare	Commercial Payer	Description
G0442	**96160**	**Administration and interpretation** of health risk assessment instrument (i.e. DAST or AUDIT)
G0396	**99408**	Alcohol and/or substance abuse structured screening and brief intervention services; **15 to 30 minutes**
G0397	**99409**	Alcohol and/or substance abuse structured screening and brief intervention services; **greater than 30 minutes**

* G0396 and G0397 (CPT codes 99408 and 99409) are time based codes; therefore the amount of time spent providing these services must be documented

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SBIRT with an E/M Service

- If a significant and separately identifiable E/M service is provided during the same encounter as SBIRT, both services may be reported
- Modifier -25 should be appended to the E/M code
- Appropriate documentation must be present in the medical record to support reporting the E/M visit and SBIRT services

APPENDIX J

Transitional Care Management (TCM) Services

A coding job aid is available on eLink for your reference.

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Transitional Care Management Services

- Purpose of these services is to ensure that patients whose medical and/or psychosocial conditions **require moderate or high complexity decision-making** are seen in a physician's office following discharge rather than be at risk for readmission
- Can be billed only once in the 30 days following discharge by a *single community Physician/APP*
- The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living support *by providing first contact and continuous access*
- The transitional care period commences upon the date of discharge and continues for the next 29 days

Transitional Care Management Services

- **Require one face-to-face visit within a specified time frame in combination with non face-to-face services**
- **Medication reconciliation and management must occur no later than the date of the face-to-face visit**
- May be reported for new or established patients during transitions described below

From	To
• Inpatient hospital setting (acute, rehab, long-term acute), • Partial hospitalization programs, • Hospital observation, or • Skilled nursing facility (SNF)	Patient's community setting (home, domiciliary, rest home or assisting living facility)*

TCM codes may not be billed for patients discharged to a SNF

Transitional Care Management Services

- Transitional care management services codes

CPT Code	Required elements per code description
99495	• **Communication** (direct contact, telephone, electronic) with the patient and/or caregiver **within 2 business days of discharge*** • Medical decision making of **at least moderate complexity** during the service period • **Face-to-face visit** with Physician/APP **within 14 calendar days of discharge**

* *Communication may be made by licensed clinical staff under the Physician/APP's direction*

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Transitional Care Management Services

- Transitional care management services codes

CPT Code	Required elements per code description
99496	• **Communication** (direct contact, telephone, electronic) with the patient and/or caregiver **within 2 business days of discharge*** • Medical decision making of **at least high complexity** during the service period • **Face-to-face visit** with Physician/APP **within 7 calendar days of discharge**

* *Communication may be made by licensed clinical staff under the Physician/APP's direction*

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Transitional Care Management Services

- Non face-to-face services include:

Performed by Clinical Staff under direction of provider
▪ Communication (with patient, family members, guardian or caretaker, surrogate decision makers and/or other professionals) regarding aspects of care within 2 business days of discharge OR 2 separate unsuccessful (documented) attempts at communication ▪ Communication with home health agencies and other community services utilized by the patient ▪ Patient and/or family/caretaker education to support self-management, independent living, and ADL ▪ Assessment and support for treatment regimen adherence and medication management ▪ Identification of available community and health resources ▪ Facilitating access to care and services needed by the patient and/or family

Transitional Care Management Services

- Non face-to-face services include:

Performed by Physician or Advanced Clinical Practitioner
▪ Obtaining and reviewing the discharge information (discharge summary or continuity of care documents) ▪ Reviewing need for or follow up on pending diagnostic tests and treatments ▪ Interaction with other qualified healthcare professionals who will assume or reassume care of the patient's system-specific problems ▪ Education of patient, family, guardian, and/or caregiver ▪ Establishment or reestablishment of referrals and arranging for needed community resources ▪ Assistance in scheduling any required follow up with community providers and services

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Transitional Care Management Services

- E/M services ***after*** *the first face-to-face visit* may be billed separately
- The first face-to-face visit is part of the TCM service and may not be separately billed
- A Physician/APP that bills for a procedure with a 10 or 90-day global period may not also report the TCM code when performed within the postoperative management period
- If another admission and discharge occur within the initial 30-day period following a discharge, a second TCM code may not be reported

Transitional Care Management Services

- The following services may not be reported during the time period covered by the TCM codes:
  - Care plan oversight (G0181, G0182, 99339, 99340, and 99374-99380)
  - Prolonged services without direct patient contact (99358 and 99359)
  - Anticoagulant management (99363 and 99364)
  - Medical team conferences (99366 – 99368)
  - Education and training (98960-98962, 99071 and 99078)
  - Telephone services (98966 – 98968 and 99441 – 99443)
  - End stage renal disease services (90951 – 90970)
  - Online medical evaluation services (98969 and 99444)
  - Preparation of special reports (99080)
  - Analysis of data (99090 and 99091)
  - Complex chronic care coordination services (99487 – 99489)
  - Chronic care management services (99490)
  - Medication therapy management codes (99605-99607)
  - Home and Outpatient INR monitoring (93792-93793)

APPENDIX K

Home Health Face-to-Face Requirements (Medicare)

A coding job aid is available on eLink for your reference.

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Home Health Face-To-Face Requirements (Medicare)

- Physician or APP certifying a patient's eligibility for the home health benefit must have a face-to-face encounter with the patient
- Face-to-face encounter *must* occur during following timeframes:
  - 90 days prior to the home health care start date OR
  - 30 days after the home health care start date
- Medical record documentation must include:
  - Description of patient's clinical condition during the encounter AND
  - How the patient's clinical condition supports the homebound status and the need for skilled services
- If the Physician/APP's documentation does not support home health, services may be denied

Home Health Face-To-Face Requirements (Medicare)

Example:

Ms. Smith is temporarily homebound following a total knee replacement on xx/xx/xxxx. She is currently walker dependent with painful ambulation. PT is needed to restore her ability to walk without support.

National statistics released by Medicare Administrative Contractors (MACs) indicate that over 80 percent of the home health claim denials are due to insufficient physician narratives related to a patient's home bound status and need for skilled care

APPENDIX L

Advance Beneficiary Notice of Non-Coverage (ABN)

A coding job aid is available on eLink for your reference.

Atrium Health

Advance Beneficiary Notice of Non-Coverage (ABN)

- When a determination is made that a service is not reasonable and necessary, a Medicare beneficiary is not liable for payment *unless* the beneficiary received written notice (i.e., ABN) of possible non-coverage in advance of receiving the service
- The ABN gives the patient notice that Medicare may not pay for a test or service and an opportunity to make an informed decision about whether to proceed with the test or service

Advance Beneficiary Notice of Non-Coverage (ABN)

- ABNs should NOT be obtained if there is **not** a specific, identifiable reason to believe that Medicare will not pay for the service(s)
- Blanket ABNs are not acceptable
- An ABN or waiver should ***never*** be obtained from a **Medicare Advantage** patient

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Questions?

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