BOSTON MEDICAL CENTER

New Provider Coding and Documentation Education

Evaluation and Management (E/M) Services and Teaching Physician Guidelines

Billing Compliance

Corporate Compliance Office

2021

Objectives

New Providers will understand:

I. Overview of Billing Compliance

II. Inpatient, Observation, and ED Coding and Documentation

III. Outpatient Coding and Documentation and 2021 Changes

IV. Teaching Physician Guidelines

V. Other Coding and Documentation Topics

VI. The Process for Auditing New Provider Documentation

I. Overview of Billing Compliance

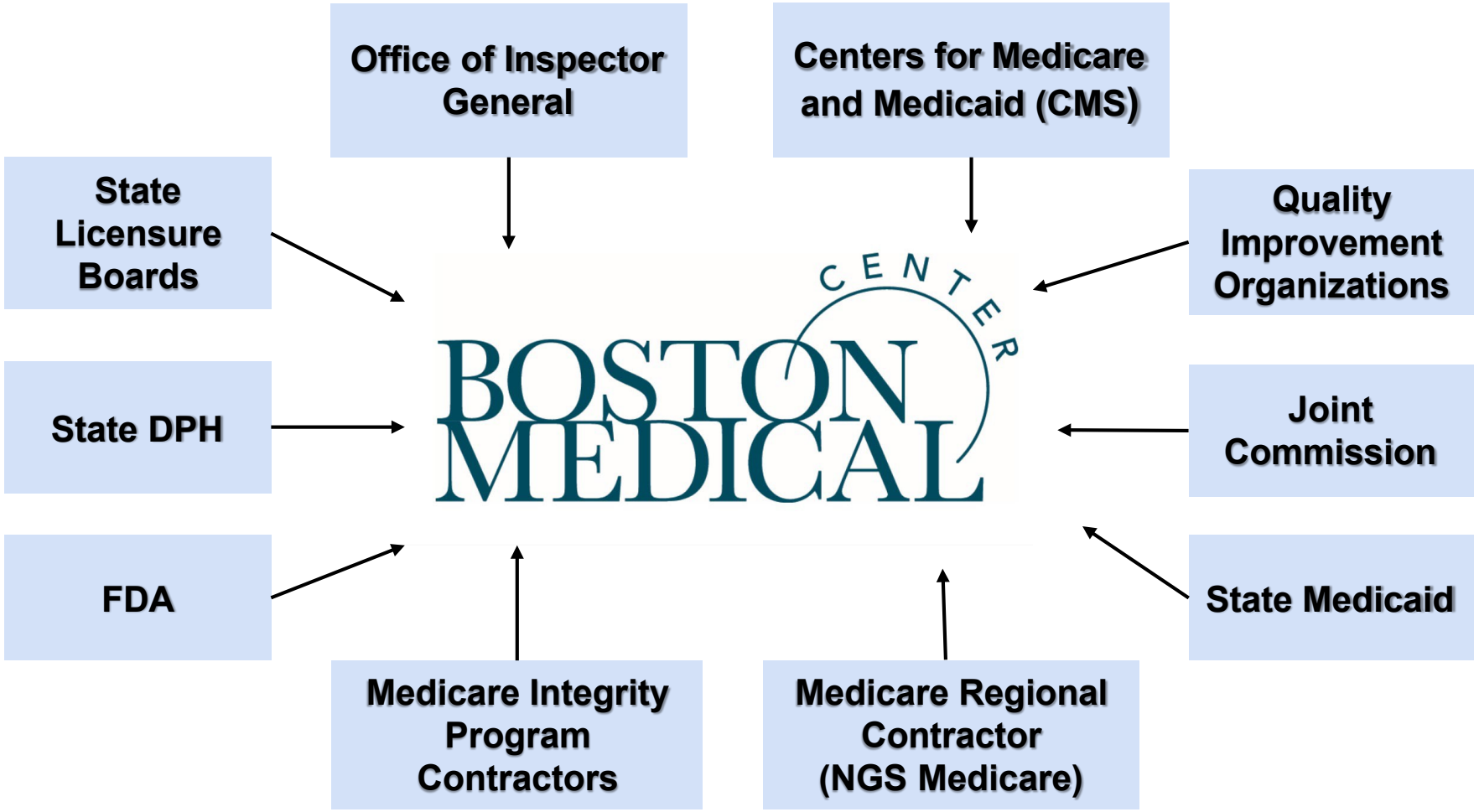
Importance of Compliant Billing

Accuracy and integrity in all billing practices is an essential part of "Exceptional Care" at BMC.

- Boston Medical Center recognizes the importance of maintaining an environment of integrity, honesty and respect.
- We submit claims for services/items that are:
  - Reasonable and medically necessary
  - Properly documented and
  - Support the level of service

Oversight of Healthcare Billing

Partial List of Government Agencies



- We hold the Public's trust as a recipient of government funds.

Accurate Documentation

You can only bill for what your documentation supports.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.

It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.

Documentation should support the level of service reported, rather than the volume of documentation as the primary influence.

Excerpt from the CMS Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1

II. Inpatient, Observation, and ED Coding and Documentation

Inpatient Evaluation and Management Services
Key Components

- **History elements:**
  - —Chief Complaint and History of Presenting Problem
  - —Review of Systems
  - —Past, Family and Social History
- **Exam:**
  - —95 or 97 CMS guidelines
- **Medical Decision Making elements:**
  - —Diagnosis
  - —Data
  - —Risk

  OR
- **Time** (when counseling and/or coordination of care are greater than 50% of the patient-related unit/floor time)
  - —Floor/unit time occurs when the physician is physically present on the patient's hospital floor or unit delivering bedside services to the patient.
  - —Includes both time spent with the patient and time spent working on the patient's chart or discussing his or her care with nurses and others.
  - —Applies to hospital observation services, inpatient hospital care, initial and subsequent hospital consultations, and nursing facility services.

History of Present Illness (HPI)

History of Present Illness: Description of the patient's illness from first sign or symptom to the present

1. Location
2. Quality
3. Severity
4. Duration
5. Context
6. Timing
7. Modifying Factors
8. Associated Signs & Symptoms

Example HPI: Over the **past few weeks**, the patient has experienced **sharp lower back** pain **intermittently**

Duration – Past few weeks
Quality - Sharp
Location – Lower Back
Timing – Intermittently

Four elements of the HPI have been documented in this statement which represents a comprehensive HPI.

Review of Systems (ROS)

The review of systems is an inventory of body systems obtained through a series of questions seeking to investigate the presenting problem

CMS recognizes the following **14 systems**: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, Allergic/Immunologic

- Document all *positive finding(s)* and *pertinent negatives* as relevant to the presenting problem. Ancillary staff may obtain the ROS and you as the provider document your review of this information.
- 4 individually documented ROS elements of the positive findings would support a detailed history (which is between 2-9 elements)
- Documentation of 10 or more systems is a comprehensive ROS.
- If the provider reviews and documents 10 systems and the remaining systems are negative the provider can add a summary statement such as follows: “All other remaining systems have been reviewed and are negative.” It’s insufficient to say “Otherwise negative”

Past Patient, Family & Social History (PFSH)

Past

- Current medications
- Allergies
- Prior:
  - Illnesses
  - Injuries
  - Operations
  - Hospital stays
- Age appropriate:
  - Vaccine status
  - Dietary status

Family

- Specific diseases of family related to problems identified and documented
- Diseases that are hereditary or place the patient at risk
- Age of parents and siblings (if alive) and their current health status, or their age and cause of death if they are deceased* ("non-contributory" wording alone is not given credit)

Social

- Marital status &/or living arrangements
- Level of education
- Sexual history
- Occupational history
- Use of drugs, alcohol and tobacco
- Other relevant social factors

Key Component: Exam

The CMS 1995 Multi-system Exam Guidelines

1. Constitutional
2. Eyes
3. Ears/Nose/Mouth/Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary
10. Neurological
11. Psychiatric
12. Hematologic/Lymphatic /Immunologic

- Problem focused exam of one body area / organ system = Problem focused
- *Limited exam* of 2 – 7 body areas/organ systems = Expanded problem focused
- *Extended exam* of 2 – 7 body areas/organ systems = Detailed
- A general multi-system exam of 8 organ systems = Comprehensive

The CMS 1997 Exam Guidelines includes single system exam for certain specialties such as Psychiatry, Dermatology, Ophthalmology and Neurology.

Key Component: Medical Decision Making (MDM) Diagnoses/Problem(s)

Problem Complexity and Number/ Management Options Considered					
Problem Category	**Number**		**Points**		**Score**
Self-limited or Minor (stable,	Max # 2	X	1	=	
improved or worsening)					
Estab. Prob. (stable, improved)		X	1	=	
Estab. Problem (worsening)		X	2	=	
New Problem (no add. work-up	Max #1	X	3	=	
planned,					
New Prob. (Additional work-up		X	4	=	
planned)				**TOTAL**	

Tally the score for the final diagnosis/problem complexity:

S= Straightforward (< = 1) L= Low (2) M= Moderate (3) H= High (4)

Examples:

- A new problem (to the patient) with work-up planned is considered high complexity (4pts).
- Two worsening problems is also high complexity (2 x 2pts=4pts).
- One worsening problem (2pts) + one improved problem (1pt) is considered moderate complexity = (3pts).

Key Component: MDM - Data

Amount and Complexity of Data: Records, Tests, other Information for review and analys	
Point	**Type of Data**
1	Review and/or order of clinical lab tests
1	Review and/or order of tests in Radiology CPT code range
1	Review and/or order of tests in Medicine CPT code range (EEG, EKG, Pulmon., Echo)
1	Discussion of tests results with performing Physician
2	Independent visualization w/ interpretation of image, tracing or specimen previously
	interpreted by other MD --Not simply review of paper copy report
1	Decision to obtain old records and/or obtain Hx from someone other than patient
2	Review and summarization of old records and/or obtaining Hx from other than patient
	(from an *additional* person) and/or discuss with another health care provider
	TOTAL

- The data complexity is weighted according to the tests reviewed/ordered, discussions with other specialties/ disciplines, and review/summarization of other data/records.
- For the first three bullets, only one point is assigned regardless of the number of tests in that category (Labs, Radiology, Medicine).
- Note that there are three ways to be given the same two points in the last item.

- *Tally the score for the final **data complexity***:

S= Straightforward (< = 1) L= Low (2) M= Moderate (3) H= High (4)

MDM: Table of Risk: The highest level of risk in any one category represented by a bullet on the Table of Risk determines the overall risk

Level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Option(s) Selected
MINIMAL	• One self-limited or minor problem	• Laboratory tests with venipuncture • Chest x-rays • EKG/EEG • Ultrasound	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW	• Two self-limited or minor problems • One stable chronic illness (*e.g. well controlled hypertension, non-insulin dependent diabetes, cataract, BPH*) • Acute uncomplicated illness or injury (*e.g. cystitis, allergic rhinitis, simple sprain*)	• Physiologic tests not under stress (*e.g. PFTs*) • Non-CV imaging with contrast (*e.g. barium enema*) • Laboratory tests with arterial puncture • Skin biopsies	• Minor surgery with no identified risk factors • Over-the- counter drugs • PT/OT • IV fluids without additives
MODERATE	• One or more chronic illnesses with mild (or moderate) side effect, exacerbation, or progression • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (*e.g. lump in breast*) • Acute illness w/ systemic symptoms (*e.g. pyelonephritis, colitis*) • Acute complicated injury (*e.g. head injury with brief loss of consciousness)*	• Physiologic tests under stress (*e.g. cardiac stress test, fetal contraction stress test*) • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • CV study with contrast and no identified risk factors (*e.g. cardiac cath.*) • Obtain fluid from body cavity (*e.g. lumbar puncture, thoracentesis, culdocentesis*)	• Minor surgery with identified risk factors • Elective major surgery with no identified risk factors • Closed reduction of fracture • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives
HIGH	• Illnesses with severe side effects, exacerbation or progression • Acute or chronic illnesses or injuries that poses a threat to life or bodily function, (*e.g. multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure.*) • Abrupt change in neurologic status (*e.g. seizure, TIA, weakness, and sensory loss)*	• CV study with contrast and identified risk factors • Diagnostic endoscopy with identified risk factors • Cardiac electrophysiological tests • Discography	• Elective major surgery with identified risk factors (*e.g. open percutaneous/endoscopic with identified risk factor*) • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Putting it all Together-MDM Complexity

Example 1:

Problem (number/complexity)	S	L	M	**H***
Data (Test/Discussions)	S	L	M	**H****
Risk	S	L	**M*****	H
MDM Level (2 out of 3)	S	L	M	**H** (High)

*A new problem with work-up planned (4pts- H)

** Order Labs (1pt) and Rad (1pt) + review and summarization of old records (2pts) = (4pts- H)

*** Undiagnosed new problem = M

MDM complexity = **HIGH** (2 out of 3)

Example 2:

Problem (number/complexity)	S	L	**M***	H
Data (Test/Discussions)	S	**L****	M	H
Risk	S	L	**M*****	H
MDM Level (2 out of 3)	S	L	**M** (moderate)	H

* 1 worsening problem (2pts) + 1 stable problem (1pt.) = (3pts- M)

** Review labs (1pt) + Rad (1pt) = (2pts- L)

*** Mild /moderate progression = M

MDM complexity = **MODERATE** (2 out of 3)

Example 3:

Problem (number/complexity)	S	L	M	**H***
Data (Test/Discussions)	S	**L****	M	H
Risk	S	L	**M*****	H
MDM Level (2 out of 3)	S	L	**M** (moderate)	H

*2 worsening problems = (4pts- H)

** Ordering/Review of labs (1pt) and radiology(1pt) = (2pts L)

***Prescription drug management =(3pts M)

MDM complexity = **MODERATE**

In this case it's the middle level.

Observation Services

- We have Care Managers and a Physician Advisor who manage this process and advise on Inpatient vs Observation level of care.
- The Physician Advisor will review cases referred by Care Management when it appears the documentation does not support the level of care.
- We are required to have an order for status i.e. Inpatient or Observation.
  - When the provider has an expectation of the hospital stay requiring 2 midnights, or a procedure is on the “inpatient-only” list, an order for Inpatient stay is indicated.
  - When the provider has an expectation that the hospital stay will require less than 2 midnights, an order for Observation is indicated.
  - For elective surgical procedures the choices are SDC, Bedded Outpatient or Inpatient
- If the patient goes home earlier unexpectedly, the physician should **document the reason** in the medical record.

99218 Initial observation care	99224 Subsequent observation care
99219 Initial observation care	99225 Subsequent observation care
99220 Initial observation care	99226 Subsequent observation care
99217 Observation Discharge Day	

Time as the (Alternate) Key Component for Inpatient Visits

- ***Only* when counseling and/or coordination of care dominate the visit** (more than 50% of the patient related unit/floor time), then time may be considered the key or controlling factor. The code is selected based on the physician's patient-related unit/floor time for inpatient visits. This cannot include time off the unit even if it is patient related.
- The duration of the counseling and/or coordination of care may be estimated but that estimate, along with the total duration of the visit must be recorded. Providers must document the specific counseling and/or coordination of care that was provided.
- There is an approved attestation in Epic to facilitate time documentation:
  - **Counseling and/or Coordination of Care > 50% of the *Inpatient* Patient Related Unit/Floor Time:** *I was physically present on the unit for *** minutes providing services for this patient; *** minutes were spent on counseling and/or coordination of care. I discussed with the patient/family and/or other providers the following topics ***.*

AMA Definition

- **Counseling** is a discussion with a patient and /or family concerning one or more of the following areas: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits
  and management (treatment) options; instructions for management (treatment) and /or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; and patient and family education.
- **Coordination of Care** may involve discussions with family, other care-givers, agencies.

- Only the attending/teaching physician time can be reported for time-based codes.

Initial Inpatient Care
(All 3 Components Needed)

3 out of 3 Key Components or use *Time only when counseling and/or coordination of care is >50% of patient related unit/floor time. **Initial Inpatient** Initial Observation Same Day Admit/ Discharge Inpatient Consults	**History***	**Exam***	**Medical Decision Making Complexity***
99221 - 30 Min 99218 – 30 Min 99234 – 40 Min 99253 – 55 Min	**Detailed** Chief Complaint(CC) HPI: 4 ROS: 2-9 PFSH: 1	**Detailed** Extended Exam of affected area and other Organ Systems/ Body Areas (2 - 7)	**Straightforward/Low** 2 out of 3 Problem/ Data/ Risk are Low Complexity
99222 - 50 min 99219 – 50 Min 99235 – 50 Min 99254 – 80 Min	**Comprehensive** Chief Complaint HPI: 4 ROS: 10 PFSH: All 3	**Comprehensive** 8 Organ Systems	**Moderate** 2 out of 3 Problem/ Data/Risk are Moderate Complexity
99223 - 70 min 99220 – 70 Min 99236 – 55 Min 99255 – 110 Min	**Comprehensive** Chief Complaint HPI: 4 ROS: 10 PFSH: All 3	**Comprehensive** 8 Organ Systems	**High** 2 out of 3 Problem/ Data/ Risk are High Complexity

- 99251 – 20 Min – Prob Focused Hx/ Prob Focused Exam/ Straightforward MDM (crosswalks to a 99231)
- 99252 – 40 Min – Exp Prob Focused Hx/ Exp Prob Focused Exam/ Straightforward MDM (crosswalks to a 99231)
- 99234-99236 Same Day Admit/ D/C (Initial inpt / Obs) Pt stay > 8hrs < 24 hrs. Attending provides admit and d/c svc. on same day (two F2F visits)
- **Modifier AI:** The attending/principal physician of record shall append modifier - “AI” in addition to the initial visit code. (99222- AI)

Subsequent Inpatient Care
(2 out of 3 Components Needed)

2 out of 3 Key Components or use *Time only when counseling and/or coordination of care is >50% of patient related unit/floor time. **Subsequent Inpatient** **Subsequent Observation**	**History***	**Exam***	**Medical Decision Making* Complexity**
99231 - 15 min **99224 - 15**	**Problem Focused** Chief Complaint HPI: 1-3 ROS (N/A) PFSH (N/A)	**Problem Focused** 1 Organ Systems/ Body Areas	**Straightforward/Low** 2 out of 3 Problem/ Data/ Risk are Low Complexity Usually the patient is stable, recovering or improving.
99232 - 25 min **99225 - 25**	**Expanded Prob.** Focused Chief Complaint HPI: 1-3 ROS: 1 PFSH: (N/A)	**Expanded Problem** Focused Limited Exam of affected area and Organ Systems/ Body Areas (2 – 7)	**Moderate** 2 out of 3 Problem/ Data/ Risk are Moderate Complexity Usually the patient is responding inadequately to treatment or has minor complications.
99233 - 35 min **99226 - 35**	**Detailed** Chief Complaint HPI: 4 ROS: 2- 9 PFSH: 1	**Detailed** Extended Exam of affected area and Organ Systems/ Body Areas (2 – 7)	**High** 2 out of 3 Problem/ Data/ Risk are High Complexity Usually patient is unstable or has developed significant complication or new problem.

ED Visits

(All 3 Components Needed, Used For Consults to the ED)

3 out of 3 Key Components Required	History*	Exam*	Medical Decision Making* Complexity
99281	**Problem Focused** Chief Complaint HPI: 1 - 3 ROS (N/A) PFSH (N/A)	**Problem Focused** 1 Organ System/Body Area	**Straightforward**
99282	**Exp. Prob. Focused** Chief Complaint HPI: 1-3 ROS: 1 PFSH (N/A)	**Expanded Prob Focused** Limited Exam of affected area and other Organ Systems/ Body Areas (2 – 7)	**Low** 2 out of 3 Problem/ Data /Risk are Low Complexity
99283	**Exp. Prob. Focused** Chief Complaint HPI: 1-3 ROS: 1 PFSH (N/A)	**Expanded Prob Focused** Limited Exam of affected area and other Organ Systems/ Body Areas (2 – 7)	**Moderate** 2 out of 3 Problem/ Data/Risk are Moderate Complexity
99284	**Detailed** Chief Complaint HPI: 4 ROS: 2-9 PFSH: 1	**Detailed** Extended Exam of affected area and Organ Systems/ Body Areas (2 – 7)	**Moderate** 2 out of 3 Problem/ Data/Risk are Moderate Complexity
99285	**Comprehensive** Chief Complaint HPI: 4 ROS: 10 PFSH: All 3	**Comprehensive** 8 Organ Systems	**High** 2 out of 3 Problem/ Data /Risk are High Complexity

Hospital Day Discharge Services

The Discharge Day codes:

CPT Code	Description
99238	Hospital discharge day management; 30 minutes or less
99239	Hospital discharge day management; more than 30 minutes
99217	Hospital observation care discharge services

Documentation of time:

- Documentation of time is required when code 99239, more than 30 minutes is billed when applicable. Time does not have to be continuous. The time statement can say; "I spent 45 minutes for the discharge day management of this patient including exam, discussion and instructions as noted below", for example, in addition to the teaching physician attestation, if applicable
- Only the attending provider time counts towards determining the appropriate level of service.
- There is no requirement to document time for code 99238, 30 minutes or less.

Content of documentation should include the following as appropriate:

- Final exam
- Discussion of hospital stay
- Instructions for continuing care to all relevant caregivers and preparation of discharge records, prescriptions, and referral forms

Prolonged Services: Inpatient

- Prolonged services can be added at any level.

- Code **99356, Prolonged Services, first hour in the inpatient setting** with direct face-to-face patient contact or on the unit/floor which require one hour beyond the usual service, when billed on the same day by the same physician/APP as the companion evaluation and management codes. Minimum 30 minutes
  - Code **99357,** each additional 30 minute unit, can be reported at 15 minutes.

- Code **99358 Prolonged Services** before and/or after direct patient care**,** off the unit/floor or different day.
  - Code **99359,** each additional 30 minute unit, can be report at 15 minutes.

- *There are two approved attestations in EPIC for prolonged services:*

Prolonged Services Attestation
*I provided 30 minutes or more face-to-face prolonged services above and beyond the E/M code services. The total visit time was *** minutes, and began at *** and stopped at *** . The nature of the prolonged services was due to ***.*

Prolonged Services (when >50% of the base E/M service is for counseling and/or coordination of care)
*I provided 30 minutes or more **face-to-face prolonged services** above and beyond the E/M code services. The total visit time was *** minutes, and began at *** and stopped at *** . The nature of the prolonged services was due to ***. The **E/M visit was more than 50% counseling and /or coordination of care** for which the total time was *** minutes and the counseling and/or coordination of care time was *** minutes. The nature of the counseling and/or coordination of care was ***.*

Critical Care: Definition

- A critical illness or injury acutely impairs one or more vital organ systems such that there is *a high probability of imminent or life threatening deterioration in the patient's condition* at the time of the physician's service to the patient.

- Critical care involves *high complexity decision making* to assess, manipulate, and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition.

- Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), *critical care may be provided in life threatening situations when these elements are not present.*

- Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness/injury and the treatment you provide meet this level of care.

- The ICU setting alone is not enough to warrant critical care billing without the critical care severity of the illness and the intensity of service.

Critical Care: Time Reporting

- Attending physician's time spent evaluating, providing care and managing the critically ill or injured patient's care.
- Attending time at the bedside or on the unit and the physician is immediately available to the patient. Time off the unit is not included even if patient-related since the physician is not available to the patient.
- Time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff on the unit/floor, if this time represents the physician's full attention to the management of the critically ill/injured patient.
- The physician cannot provide services to any other patient during the same period of time.
- Discussions with family members or other surrogate decision makers, to obtain a history or to discuss treatment options may be counted toward critical care time since they affect the management of the patient. Routine updates are not counted in time billed.
- Critical care services provided on the same date by physicians representing different medical specialties that are not duplicative services are permitted.
- Concurrent critical care services provided by each physician must be medically necessary and not provided during the same instance of time.

Critical Care: Attestation

- *There is an approved attestation in EPIC for critical care:*

  *I saw and evaluated the patient. I reviewed the findings and assessment with the resident and I agree with the plan as documented in the resident's note; with no changes (or) except as outlined below. The patient is critically ill with ***. I spent *** minutes providing critical care services including ***.*

- The teaching physician may refer to the resident's documentation for history, exam and assessment.
- The teaching physician's required documentation (which this attestation facilitates) is the following :

1. The time the teaching physician spent providing critical care;

2. That the patient was critically ill during the time the teaching physician saw the patient, and what made the patient critically ill; and

3. The nature of the treatment and management provided by the teaching physician.

Critical Care: Code Selection

99291: Critical Care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.

+99292: Each additional 30 minutes (List separately in addition to code for primary service.)

Total Duration of Critical Care Units	
Less than 30 minutes	Appropriate E/M code
30 -74 minutes *(30 minutes – 1 hour 14 minutes)*	Code - 99291
75 - 104 minutes *(1 hour 15 minutes – 1 hour 44 minutes)*	Code - 99291 99292
105 - 134 minutes *(1 hour 45 minutes – 2 hours 14 minutes)*	Code - 99291 99292 x 2
135 - 164 minutes *(2 hours 15 minutes – 2 hours 44 minutes)*	Code - 99291 99293 x 3
165 – 194 minutes *(2 hours 45 minutes – 3 hours 14 minutes)*	Code – 99291 99292 x 4

III. Outpatient Coding and Documentation and 2021 Changes

E/M Changes for 2021 Outpatient Visits
(99202 – 99205; 99212 – 99215)

- The 2021 changes for the outpatient E/M codes are primarily a continuation of the provisions that Medicare has allowed for telehealth billing during the public health emergency (PHE).

- Providers will select new and established outpatient visits (99202 - 99215) based on *total time or medical decision making (MDM).*

  - History and Exam will no longer factor into code selection.

  - Counseling and/or coordination of care will no longer need to dominate the service for time-based coding.

  - There is a new prolonged service code for the outpatient setting for 2021.

- All other E/M services (Inpatient / Observation / ED) will continue to use the current E/M Guidelines for E/M level selection.

General Reminders for Outpatient Visits

- Continue to include the chief complaint to explain the medical necessity for the visit with the reason, such as, patient here for follow-up for shoulder pain (rather than just " here for follow-up").
- Continue to document history and exam as clinically appropriate for the visit.
- Continue to select new versus established outpatient code according to the CPT definitions.

New Patient

- Patient who has not received any face-to-face professional services from the physician/APP or another physician of the same specialty who belongs to the same group practice, within the past 3 years, in any setting or location.

Established Patient

- Patient who has received face-to-face professional services from the physician/APP or another physician of the same specialty who belongs to the same group practice, within the past 3 years, in any setting or location.

Level Selection for Outpatient E/M Visits
by Medical Decision-Making (MDM) (2 out of 3)

2 out of 3	Problem	Data	Risk
99202 **15 - 29** **Min** **99212** **10-19 Min**	**Minimal** 1 self limited or minor problem or injury	**Minimal or None**	**Minimal risk**
99203 **30 - 44** **Min** **99213** **20 - 29** **Min**	**Low** 2 or more self limited or minor problems or 1 stable chronic illness or 1 acute, uncomplicated illness or injury	**Limited - Category 1: Tests and documents** Any 2 of the following categories or 2 within a category: ____Review of prior external note(s) from each unique source ____Review of the result(s) of each unique test ____Ordering of each unique test ***OR* – Category 2:** Assessment requiring an independent historian(s)	**Low risk** of morbidity from additional diagnostic testing or treatment Over the counter drugs management. Minor surgery with no risk factors PT/OT IV fluids without additives
99204 **45 – 59** **Min** **99214** **30 –39**	**Moderate** 1or more chronic illnesses with exacerbation, progression, or side effects of treatment; **OR** 2 or more stable chronic illnesses **OR** 1 undiagnosed new problem with uncertain prognosis; **(e.g., lump in breast)** **OR** 1 acute illness with systemic symptoms; **(e.g., pyelonephritis, pneumonitis, colitis)** **OR** 1 acute complicated injury **(e.g., head injury with brief loss of consciousness)**	**Moderate – Category 1: Tests, documents, or independent historian(s)** Any 3 of the following categories or 3 within a category: ____Review of prior external note(s) from each unique ____Review of the result of each unique test ____Ordering of each unique test Assessment requiring independent historian(s) **OR – Category 2: Independent interpretation of tests** Independent interpretation of a test preformed by another physician/QHCP (not separately reported); **OR – Category 3: Discussion of management or test interpretation** Discussion of management or test interpretation with external physician/other QHCP*/appropriate source (not separately reported)	**Moderate risk** of morbidity from additional diagnostic testing or treatment Examples only: ▪ Prescription Drug management ▪ Decision regarding minor surgery without identified patient or procedure risk factors ▪ Diagnosis of treatment significantly limited by social determinants of health
99205 **60 – 74** **Min** **99215** **40 - 54** **Min**	**High** 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **OR** 1 acute or chronic illness or injury that poses a threat to life or bodily **function (e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure)** An abrupt change in neurologic status (e.g., seizure, TIA, weakness, sensory loss)	**Extensive** *(Must meet the requirements of at least **2 out of 3 Categories** immediately above)* **Qualified Health Care Professional*	**High risk -** of morbidity from additional diagnostic testing or treatment* • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision re: emergency major surgery • Decision regarding hospitalization • DNR Decision or de-escalate of care due to poor prognosis • Drug therapy requiring intensive monitoring for toxicity.

Medical Decision-Making Key Definitions

External:
External records, communications and/or test results from an ***external physician***, other qualified health care professional or facility

Independent historian(s):
An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historian(s) requirement is met.

Independent Interpretation:
The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented, but need not conform to the usual standards of a complete report for the test.

Social determinants of health:
Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Appropriate source:
An appropriate source in regard to the discussion of management or test interpretation includes professionals who are not health care professionals but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher**).** It does not include discussion with family or informal caregivers.

Medical Decision-Making Key Definitions

Drug therapy requiring intensive monitoring for toxicity:
A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for the assessment of therapeutic efficacy. The monitoring should be that which is general accepted practice for the agent, but may be patient specific in some cases. Examples of monitoring that does not qualify include monitoring for glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient om a diuretic as the frequency does not meet the threshold.

Risk:
The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as 'high', 'medium', 'low', or 'minimal' risk and do not require quantification for these definitions, (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

Morbidity:
A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

Medical Decision Making Definitions

Minimal Problem:
A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision.

Limited or minor problem:
A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Stable, Chronic illness:
A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition). 'Stable' for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia.

Acute, uncomplicated illness or injury:
A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

Medical Decision Making Definitions

Chronic illness with exacerbation, progression or side effect of treatment:
A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.

Undiagnosed new problem with uncertain prognosis:
A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.

Acute illness with systemic symptoms:
An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for 'self-limited or minor' or 'acute, uncomplicated.' Systemic symptoms may not be general, but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.

Acute, complicated injury:
An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.

Medical Decision Making Definitions continued

Chronic illness with severe exacerbation, progression, or side effects of treatment:
The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function:
An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

Test:
Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.

External:
External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.

External physician or other qualified healthcare professional:
An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty.

Clinical Examples of Level Selection by Medical Decision-Making (*2 out of 3*)

Examples for 99202/99212- Straightforward

Problems Addressed	Data	Risk
Cold (1 self-limited/minor problem)		Rest (Minimal)

Examples for 99204/99214- Moderate

Problems addressed	Data	Risk
Stable chronic HTN and Diabetes (2 stable chronic illnesses)	CBC, A1C, EKG and Chest x-ray (At least 3 of category 1)	
Broken arm (1 acute complicated injury)		Closed reduction. Homeless, + ETOH use. (Minor surgery, or Social determinants)

Examples for 99203/99213 - Low

Problems Addressed	Data	Risk
GERD (1 stable chronic illness)		Upper GI (Low risk of morbidity diagnostic testing)
Bronchitis (1 acute, uncomplicated illness or injury)	(X-ray, CBC) (Review or order of two unique test)	

Examples for 99205/99215 - High

Problems addressed	Data	Risk
Brain aneurysm (1 acute injury that poses a threat to life or bodily function)		Craniotomy (Decision for emergency major surgery)
Seizure (An abrupt change in Neurological Status)	CBC, EKG + TTE + Discussion of MRI results with provider (3 tests and a discussion with another provider)	

Level Selection for Outpatient E/M Visits by Total Time

CPT Code	2021 Code Total Time (Minutes)	CPT Code	2021 Code Total Time (Minutes)
NEW PATIENT		ESTABLISHED PATIENT	
99201	N/A	99211	N/A
99202	15 - 29	99212	10 - 19
99203	30 - 44	99213	20 - 29
99204	45 - 59	99214	30 - 39
99205	60 - 74	99215	40 – 54

- Total physician/APP time on the day of the encounter includes the following:
  - Preparing to see the patient (e.g., review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering tests, medications or procedures
  - Referring and communicating with other health care professionals
  - Documenting clinical information in the medical record
  - Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)

New (2021) Prolonged Outpatient Service Code

As part of the 2021 E/M code changes, the AMA and CMS has introduced a new prolonged service code.

99417: Prolonged office or other outpatient evaluation and management service(s) beyond the total time of the primary procedure which has been selected using total time, requiring total time **with** or **without direct patient contact** beyond the usual service, on the date of the primary service; *each 15 minutes*

- The new code is appended to the highest level new (99205) or established (99215) outpatient visit codes *only*.
- If time reaches the *highest end of the code time range*, a level 5 new patient visit (**74** minutes) or a level 5 established patient visit (**54** minutes), the new prolonged service code can be appended once 15 minutes of prolonged service is reached.
- Prolonged service of less than 15 minutes should *NOT* be reported.
- +99417 is an add-on code and may be used more than once either by listing the code twice or reporting multiple units.

Outpatient Prolonged Services Time 99205

Total Duration of New Patient Office or Other Outpatient Services (use with CPT code 99205)	Code(s)
60-74 minutes	99205
89-103 minutes	99205 x 1, 99417 x 1
104-118- minutes	99205 x 1, 99417 x 2
119 minutes or more	99205 x 1, 99417 x 3 or more for each additional 15 minutes

Outpatient Prolonged Services Time 99215

Total Duration of New Patient Office or Other Outpatient Services (use with CPT code 99205)	Code(s)
40-54 minutes	99215
69-83 minutes	99215 x 1, 99417 x 1
84-98- minutes	99215 x 1, 99417 x 2
99 minutes or more	99215 x 1, 99417 x 3 or more for each additional 15 minutes

Other Prolonged Outpatient Service Codes

99358 and 99359 Prolonged Services without direct patient contact are reported with codes 99202-99215 when the prolonged service is **on a different date of service.**

99354 and 99355 Prolonged Services with face-to-face patient contact.

They are reported for prolonged services with:

- Psychotherapy codes 90837, 90847;
- Office consultation codes 99241—99245;
- Home visit codes 99341—99350;
- Cognitive assessment code 99483.

IV. Teaching Physician Guidelines

Teaching Physician Guidelines: Definition and Attestation

Definition: Service performed in part by a resident under the direction of a teaching physician

- The following must be true for billing:
  1. The teaching physician saw the patient face-to-face;
  2. The teaching physician performed the service or was physically present during key portion(s) when performed by the resident (teaching physician can decide what is the key portion(s));
  3. The teaching physician references the resident/fellow's note;
  4. The teaching physician has been involved in the management of the care.
- There is an approved **Attestation** in Epic for Teaching Physician services:

  "*I saw and evaluated the patient. I reviewed the findings and assessment with the resident and I agree with the plan as documented in the resident's note; with no changes (or) except as outlined below.*"
- A resident service without a Teaching Physician attestation is an unbillable service.
- **Modifier GC** should be appended to each service that is performed in conjunction with a resident.

Teaching Physician Guidelines: Minor and Major Procedure

Minor Procedure Definition

- A minor procedure is a procedure that takes only a few minutes (approximately 5 minutes or less/ global period of 0-10 days) to complete, for example, simple suture, and involves relatively little decision-making once the need for the procedure is determined.

- Teaching Physician must be present for the entire procedure in order to bill for the procedure (or perform the procedure).

- There is an approved attestation in Epic for minor procedures which reads:

  - "*I was present for the entire procedure"*. This should be reported *in addition* to the standard Teaching Physician attestation, when applicable.

Major Surgery Procedure

- The teaching physician must be physically present during the key portion(s) of the service and must be immediately available to furnish service during the entire procedure.

Teaching Physician Guidelines: Primary Care Exception

Primary Care Exception

- The primary care center is considered the primary location for the patient's health care services.
- Typical areas of Primary Care that qualify for the Exception include: General Internal Medicine, Family Medicine, Pediatrics, Geriatrics, and Obstetrics and Gynecology
- Under the Primary Care Exception, a resident with more than six months in an approved residency program may see the patient without the presence of the teaching physician as long as the teaching physician supervises no more than 4 residents at a time and directs the care from a proximity of immediate availability.
  - The teaching physician should review the medical history and diagnosis, the resident's findings on physical exam, tests or labs as applicable, and the treatment plan during or immediately after each visit.
  - Document the extent of your participation and the review and direction of the services.
  - Levels 1-3 are used for new and established patients
- The GE modifier should be appended to all visits performed under the Primary Care Exception.

Primary Care Exception
During the Public Health Emergency

- During the public health emergency (PHE), Medicare has a provision for the primary care exception for telehealth visits.
- This provision allows the teaching physician to review the patient visit with the resident ***during or after*** the telehealth visit with the patient.
- *Reminder:* for regular telehealth outside the primary care exception, the teaching physician m*ust be on the video call with the patient and the resident*. During the PHE all 5 E/M code levels are allowed.
- Medicare wants the supervision that occurs after the patient call to be via audio and video in order to be as close as possible to in-person supervision.
- For all other telehealth outside of primary care, the teaching physician must be on the actual patient call during the visit.

V. Other Coding and Documentation Topics

Outpatient Consult Visits
(All 3 Components Needed)

3 out of 3 Key Components, or use *Time when counseling and/or coordination of care is > 50% of visit	History*	Exam*	Medical Decision Making* Complexity
99241 – 15 min	**Problem Focused** Chief Complaint HPI: 1-3 ROS (N/A) PFSH (N/A)	**Problem Focused** 1 Organ System/Body Area	**Straightforward**
99242 – 30 Min	**Exp. Prob. Focused** Chief Complaint HPI: 1-3 ROS: 1 PFSH (N/A)	**Expanded Prob Focused** Limited Exam of affected area and other Organ Systems/ Body Areas (2 – 7)	**Straightforward**
99243 – 40 min	**Detailed** Chief Complaint HPI: 4 ROS: 2-9 PFSH: 1	**Detailed** Extended Exam of affected area and Organ Systems/ Body Areas (2 – 7)	**Low** 2 out of 3 Problem/ Data /Risk are Low Complexity
99244 – 60 Min	**Comprehensive** Chief Complaint HPI: 4 ROS: 10 PFSH: All 3	**Comprehensive** 8 Organ Systems	**Moderate** 2 out of 3 Problem/ Data/Risk are Moderate Complexity
99245 – 80 Min	**Comprehensive** Chief Complaint HPI: 4 ROS: 10 PFSH: All 3	**Comprehensive** 8 Organ Systems	**High** 2 out of 3 Problem/ Data /Risk are High Complexity

E/M and Procedure on the Same Day

Discussion of Minor Procedure with E/M

- Use of Modifier 25 indicates a "*significant, separately identifiable E/M service by the same physician on the same day of a procedure* or other therapeutic service."
- An E/M code must be significant, separate and distinct from the procedure in order to bill both the E/M and procedure. In general, Medicare considers E/M services provided on the same day of a procedure to be part of the work of the procedure, and as such, does not make separate payment.
- The exception to that rule is when the E/M documentation supports that there had been a significant amount of additional work above and beyond what the physician would normally provide, and when the visit can stand alone as a medically necessary billable service.
- The decision/initial evaluation to perform a minor surgical procedure is included in the payment for the minor procedure and should not be reported separately as an E/M service.
- The fact that the patient is "new" to the clinician is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure.
- There is an inherent evaluation to each procedure. That work has been calculated in the RVUs assigned to each procedure code.

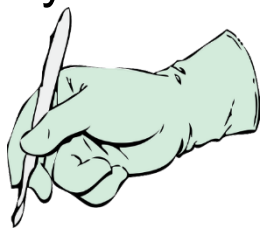
E/M and Procedure on the Same Day

MODIFIER - 25 EXAMPLE

"A patient presents to the office for biopsy of a suspicious skin lesion. During the course of the visit the patient complains of cough and sinus congestion and the physician prescribes medication for an upper respiratory infection".

- Modifier 25 would be appended to the E/M service for the work involved of assessing and treating the separate problem of the upper respiratory infection in addition to reporting the procedure code for the skin biopsy.

- The procedure note should be distinct and stand alone from the E/M key components, even if documented within the same daily progress note.



"Shared Visit" with an Advanced Practice Provider (APP)

- A Shared Visit occurs when the physician and the APP are in the same group practice, either through direct employment or a leased arrangement, and both provide and document a visit with the patient on the same day.
  - —The physician and the APP must each provide a "face-to-face" service. Reviewing the medical record and/or discussing the care with the APP only are *not sufficient to support billing by the attending.*
  - —The shared visit may be billed by either the physician or APP. (APPs include: Physician Assistants (PA), Nurse Practitioners (NP), Clinical Nurse Specialists (CNS) and Certified Nurse Midwives (CNM)).
- **There is an approved physician attestation in EPIC for Shared Visits:**
  - "I *evaluated and examined the patient in conjunction with the advanced practice provider. I reviewed the findings and assessment as outlined and I agree with the plan as documented; with no changes (or) except as outlined below. The history is relevant for ***; my examination shows ***; and my assessment and plan include ***."*
- The physician must document his/her own personal service to the patient and should include an aspect of all three elements: history, physical examination, and medical decision-making (see approved attestation above). It is not appropriate to document only "agree with the (APP's) findings."
- The documentation of the physician's own history, physical examination, and medical decision-making is necessary in order to get paid at 100% of the physician rate. Without the appropriate documentation and required modifiers the visit can only be paid at 85% of the rate.

"Shared Visit" with an Advanced Practice Provider (APP)

- Modifiers are required for all shared visits as they have an impact on payment. For shared/split visits with an NP, the physician adds modifier "SA" and with a PA, modifier "HN".

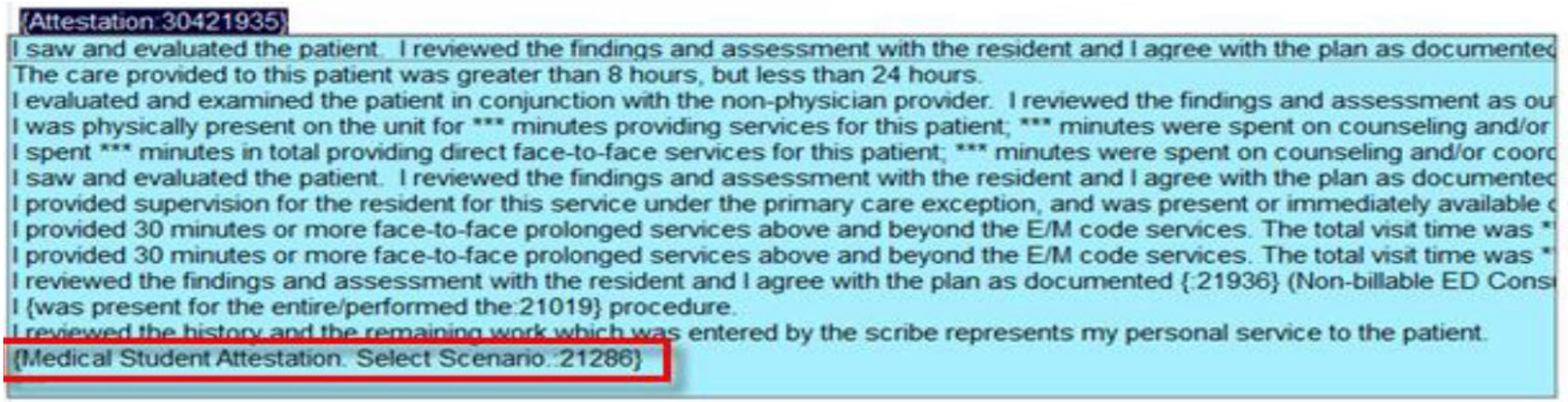
- Some payers do not recognize shared visits, and therefore will pay under the NPI of the provider who performed the service at 85% of the physician rate. The modifiers help to identify these situations.

- Shared visits are not appropriate for either *critical care billing or for procedures*. Critical care services and procedures must be billed under the NPI of the provider who actually performed the service or procedure.

- If the APP performs a procedure on the same day there is a separately identifiable shared E/M visit with the physician, the APP documents and bills the procedure, and the physician may bill the shared visit.

Approved Attestations in Epic

- There are approximately 13 approved provider attestations in EPIC, including teaching physician service with a resident, shared visit with NP/ PA, time based inpatient and outpatient services, critical care services, and prolonged services.



Student Documentation

- Also included is a set of attestations for services that include medical student documentation
- Students may document services in the medical record. The teaching physician may verify student documentation rather than re-document.
- However, the teaching physician (or a resident in a teaching physician supervised visit, meeting the requirements of the teaching physician guidelines) must verify all student documentation or findings, including history, physical exam and/or medical decision making.
- The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed.

Diagnosis Coding

The primary diagnosis should be the diagnosis that is chiefly responsible for the encounter	All diagnoses addressed on a given date should be coded	Make sure the diagnosis matches the services provided and supports medical necessity
Those diagnosis not addressed but managed by another provider can become part of the problem list	Differential diagnoses should be documented, but not coded	Resolved conditions can be coded upon first visit that condition is determined to be resolved; *subsequently, it should not be coded*

Typically, at least **one** element of the bullets below should be documented for each coded diagnosis:

- **M**onitor - signs, symptoms, disease progression, disease regression
- **E**valuate - test results, medication effectiveness, response to treatment
- **A**ssess/Address - ordering of tests, discussion, review records, counseling
- **T**reat - medications, therapies, other modalities

It is important to document all applicable diagnosis for the date of service including any chronic conditions that you monitor, evaluate, assess, or treat in both the inpatient and outpatient setting for clinical accuracy and appropriate payment.

Documentation Quality

Documentation must be coherent (e.g. elements of history must not contradict)**:**

Recent clinical example:

"Occasional dysphagia- worse with solids, but feels that food gets stuck in his chest not throat. Occasional voice changes- feels it is a bit quieter right now."

"Still feels like he always has a mild sore throat, using lozenges. Attributes partially to allergies. Denies heat or cold intolerance, occasional diarrhea and constipation."

Review of Systems

- Constitutional: denies fever or changes in weight.
- Eyes: denies changes in vision, double vision, blurry vision.
- ENT**:** denies *sore throat, dysphagia.*
- Neck: denies neck pain or swelling.

Use caution with copy and paste and follow the *Copy and Paste* policy on the BMC Intranet.

VI. The Process for Auditing New Provider Documentation

New Provider Documentation Audit

Standard Review – 10 claims

Timeline:

- Every new provider will have 10 charts audited subsequent to this training.
- This will occur within 90 days after this training or bill start date.

Pass Rate:

- 80% Accuracy

Examples of Marked Error:

- Incorrect CPT code
- Missing time documentation for a time-based code
- No documentation or required attestation found in the medical record (Reminder, there are approved attestations in Epic for your use.)

Less than 80% Accuracy:

- Individual education session will be scheduled to review the results.
- Your charts will be re-audited after this education.

References

Medicare Learning Network: E&M Services Guide & FAQ:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

Medicare Claims Processing Manual Chapter 12

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

National Government Services

https://www.ngsmedicare.com

CPT 2021: Professional Edition

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Questions?