BOSTON MEDICAL CENTER

New Provider Coding and Documentation Education

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

Billing Compliance
Corporate Compliance Office
2022

Objectives

New Providers will understand:

I. Overview of Billing Compliance

II. Inpatient, Observation, and ED Coding and Documentation

III. Outpatient Coding and Documentation Changes

IV. Teaching Physician Guidelines

V. Other Coding and Documentation Topics

VI. The Process for Auditing New Provider Documentation

I. Overview of Billing Compliance

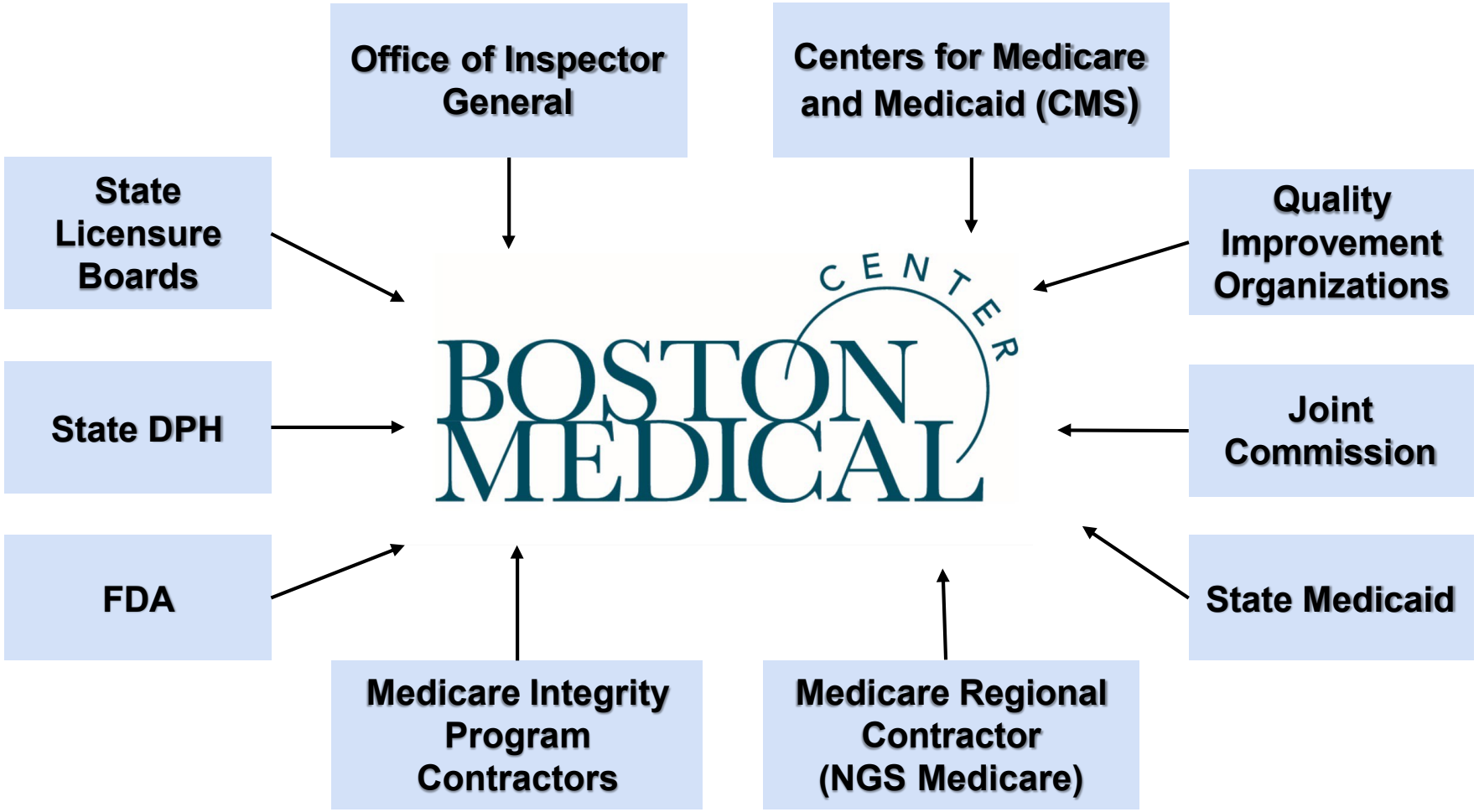
Importance of Compliant Billing

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 Medical, Family and Social History
- **Exam:**
  - —1995 or 1997 CMS guidelines
- **Medical Decision Making elements:**
  - —Diagnoses
  - —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.
- 2-9 individually documented ROS elements of the positive findings supports a detailed history
- 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” or “10 point systems reviewed and are negative.”

Past Medical, Family & Social History (PFSH)

Past Medical

- 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 vs Inpatient 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 an Inpatient stay is indicated.
  - When the provider has an expectation that the hospital stay will require less than 2 midnights, an order for an Observation is indicated.
  - For elective surgical procedures the choices are Surgical Day Care, Bedded Outpatient or Inpatient
- If the patient goes home before 2 midnights, earlier than originally anticipated, the physician **must document the reason** in the medical record, to support the inpatient claim.

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: 1 of 3	**Comprehensive** 8 Organ Systems	**High** 2 out of 3 Problem/ Data /Risk are High Complexity

Global Surgery

Global surgery applies in any setting including; Inpatient hospital; Outpatient hospital; Ambulatory Surgical Center (ASC) and Physician's Office.

❖ When a surgeon visits a patient in an intensive care or critical care unit, Medicare includes these visits in the global surgical package.

There are three types of global surgical packages based on the number of post-operative days.

0-Day Post-operative Period (endoscopies and some minor procedures).

- No pre-operative period; No post-operative days; Visit on day of procedure is generally not payable as a separate service

10-Day Post-operative Period (other minor procedures).

- No pre-operative period; Visit on day of the procedure is generally not payable as a separate service.
- Total global period is 11 days. Count the day of the surgery and the 10 days immediately following the day of the surgery.

90-day Post-operative Period (major procedures).

- One day pre-operative included; Day of the procedure is generally not payable as a separate service.
- Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery.

Note: A new post-operative period begins with the subsequent procedure. This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure.

99024 (Post-operative follow-up visit)

- Practitioners [both physicians and non-physician practitioners (NPPs)] should use code **99024** to report post-operative E/M visits related to the original procedure. This requirement **does not** apply to the preoperative visits within the global period or for services that were not related to the specified surgical service.

99024 will include:

- discharge day management
- other follow-up services related to the original procedure that are included in the global period.

The visits reported with code **99024** are not limited to a particular site of service and may include; inpatient hospital, office, intensive care unit, outpatient clinic, skilled nursing facility, and others. (CPT Assistant, July 2017 Page:9)

Global Surgery Services
Bundled and Not Bundled

Medicare *includes* in the global surgery payment when provided in addition to the surgery:

- Pre-operative visits after the decision is made to operate. For major procedures; the pre-operative visits the day before and day of surgery. For minor procedures; pre-operative visits the day of surgery.
- Intra-operative services that are a usual and necessary part of a surgical procedure
- All additional medical or surgical services required of the surgeon during the post-op period due to complications, which do not require additional trips to the operating room
- Follow-up visits during the post-operative period related to recovery from the surgery
- Post-surgical pain management by the surgeon
- Supplies, except for those identified as exclusions
- Miscellaneous services; dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; changes and removal of tracheostomy tubes.

Not included in the global surgical payment. These services may be billed and paid for separately:

- Initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries is billed separately using the modifier “-57” (Decision for Surgery).
- Services of other physicians related to the surgery, except where the surgeon and other physician(s) agree on transfer of care.
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications.
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiological procedures
- Clearly distinct surgical procedures that occur during the post-operative period which are not re-operations or treatment for complications
- Treatment for post-operative complications requiring a return trip to the Operating Room (OR) includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient’s condition was so critical there would be insufficient time for transportation to an OR).
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Immunosuppressive therapy for organ transplants

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.
  - **Stop and start times must be documented**.
  - **The nature of the prolonged services must be documented in order to demonstrate medical necessity.**
- 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, first hour (same day/ different day)**before and/or after direct patient care**,** off the unit/floor or different day. Minimum 30 minutes
  - Code **+99359,** each additional 30 minute unit, can be report at 15 minutes.
- *Current approved attestation 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 ***.*

III. Outpatient Coding and Documentation and 2021 Changes

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

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

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

  - History and Exam no longer factor into code selection.

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

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

- All other E/M services (Inpatient / Observation / ED/ Consults – in all settings) continue to use the 2020 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 performed 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) External = different specialty.	**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.

MDM Clinical Examples
(2 out of 3) Problem, Data and Risk

Examples for 99202/99212- Straightforward

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

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 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 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 external provider (3 tests and a discussion of management or test interpretation)	

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.

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

- Note that the time is a specific time range rather than an average time and there is no “rounding up.”

- 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)

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

A reminder on the outpatient billing by time: **You no longer need to document "> 50% counseling and coordination of care"** in the outpatient setting**.** This statement is no longer needed, but *you do need to document total time in your progress note.*

A time statement such as:

*I spent a total of *** minutes on the day of the visit. Please see the note for further information on patient assessment and treatment.*

When you have a telemedicine visit, since you are recording the length of the call already, if you decide to base your E/M level on total time, *you would need to document your total time separately in your progress note*, in addition to the recorded length of the call.

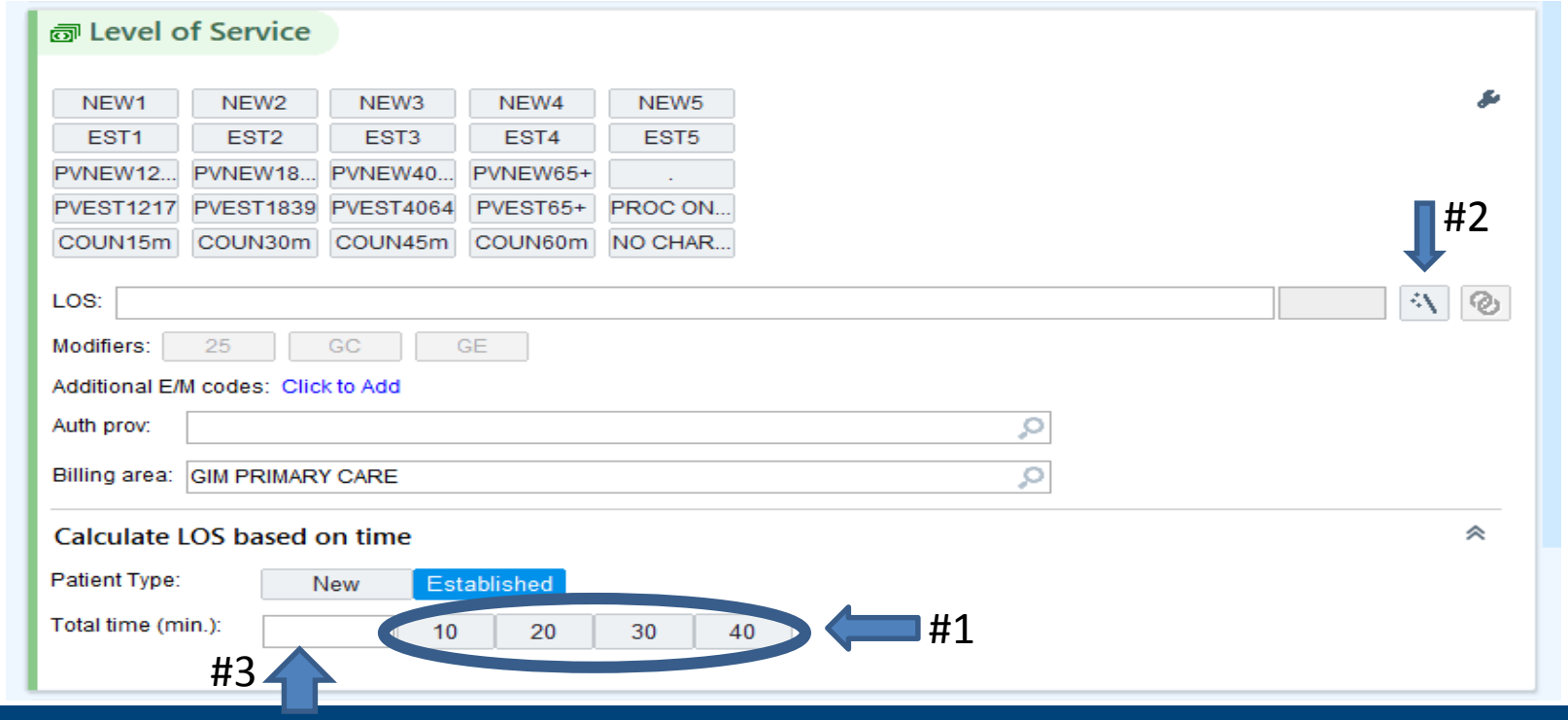
Level Selection for Outpatient E/M Visits by Total Time

Below is the level of service calculator in EPIC. When selecting a visit by time using the calculator, you can do it 3 ways.

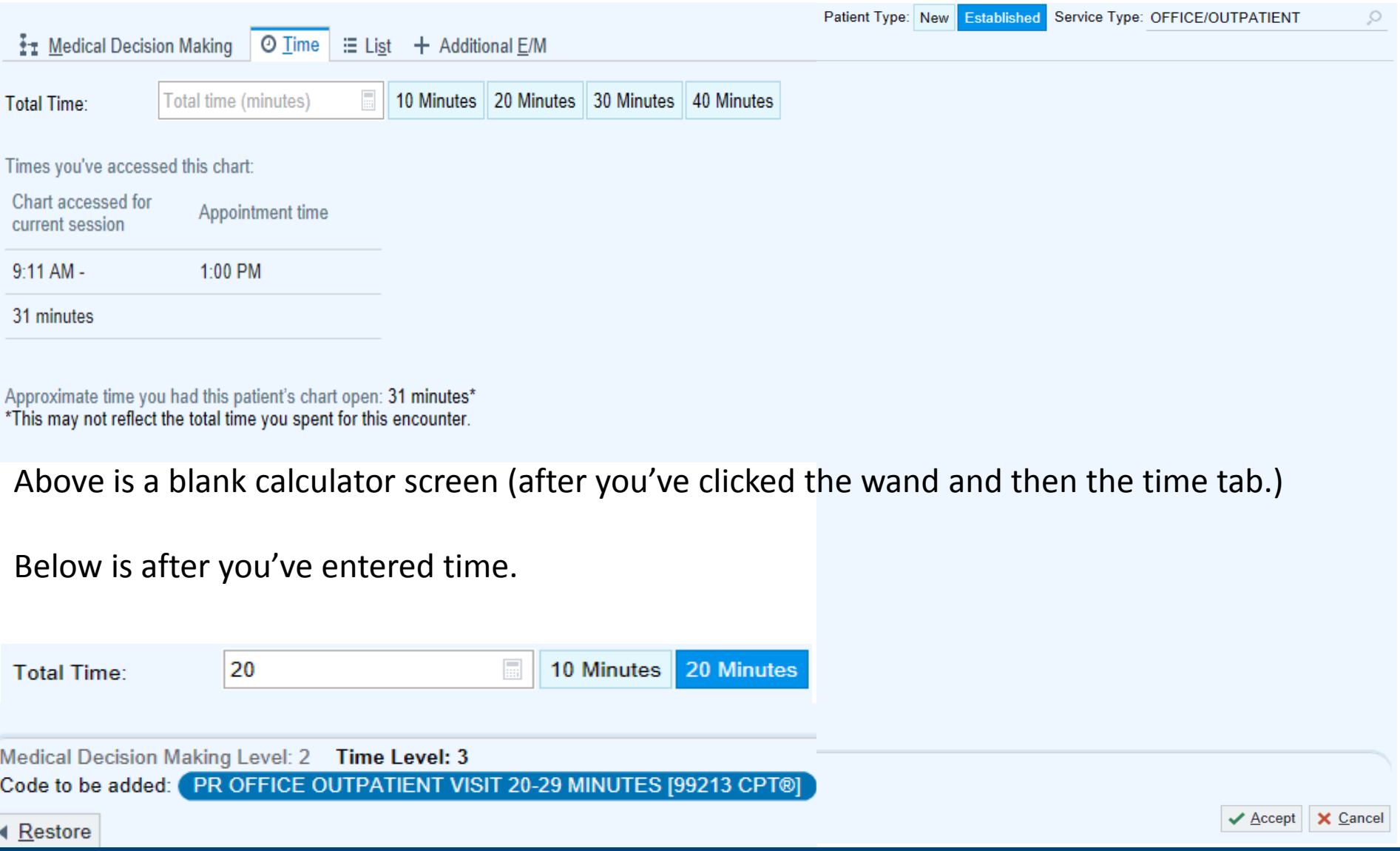
- #1 You can click on the time buttons.
- #2 You can click the wand and enter the time in the calculator itself.
- #3 you can enter the total time in the box.

A time statement such as:

*I spent a total of *** minutes on the day of the visit. Please see the note for further information on patient assessment and treatment.* Will be added for you.



Level Selection for Outpatient E/M Visits by Total Time



Above is a blank calculator screen (after you've clicked the wand and then the time tab.)

Below is after you've entered time.

New Prolonged Outpatient Service Code

As part of the 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

- Medicare requires **Start and Stop** times for all prolonged services codes.
- We are adding a new attestation in Epic soon, until then please make sure to document start and stop times for the prolonged services.

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. (Not covered by Mass Health or Medicare – Medicare is reviewing this code)** Must relate to a previous or future face-to-face E/M.

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.

Teaching Physician Guidelines: Minor and Major Procedure

Endoscopy Procedures

To bill Medicare for endoscopic procedures (excluding endoscopic surgery that follows the surgery policy), the teaching physician must be present during the entire viewing. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

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
  - Welcome to Medicare (G0402) and the annual wellness visits(G0438 – G0439) may also be billed under the primary care exception.
- 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.
- For the duration of the PHE the following services may be performed using the Primary care exception; Levels 1-5 (99202-99215); Telephone E/M (99441-99443); Transitional Care Management (99495 -99496); Communication Based Technology (99421-99423 and 99452) and Remote Evaluation of recorded image/video Est. Patient G2010 & Virtual Check-In G2012

V. Other Coding and Documentation Topics

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 – Examples Supporting E/M in addition to the procedure.

Example #1
"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.

Example #2
"A 75 year old female comes into the office with vaginal bleeding. An ultrasound is done and it is determined that the patient needs an endometrial biopsy due to the growth of the lining of the uterus to determine if the patient may have uterine cancer."

- Modifier 25 would be appended to the E/M service for the work involved of assessing and treating the separate problem of the growth of the lining of the uterus and performing the endometrial biopsy

E/M and Procedure on the Same Day

MODIFIER 25 – Examples Supporting E/M in addition to the procedure

Example #3

"A 57 y.o. male presenting with a laryngeal mass. A laryngeal mass concerning for malignancy and he was referred to an ENT Physician for further management. A flexible nasolaryngoscopy showed a supraglottic mass, centered at the laryngeal epiglottis with limited view of the glottis.
We recommended direct laryngoscopy and esophagoscopy with biopsy of the area of concern, as well as any other areas of abnormality seen on exam. We discussed the risks and benefits in detail, and the need for further treatment including further surgery. We discussed the possibility of difficulty either intubating or extubating the patient and had a lengthy discussion about the possible need for tracheostomy."

- Modifier 25 would be appended to the E/M service for the work involved of assessing and treating the more complicated problem of the Mass above and beyond what would normally transpire.

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

E/M and Procedure on the Same Day

MODIFIER 25 – Examples Not Supporting E/M in addition to the procedure

Example #1

"A 25 year old female is coming back to the office after being diagnosed in a previous visit of genital warts. Patient has cryosurgery to remove the warts with routine follow up as needed."

Example #2

"A 24 y.o. female, referred by a friend, with complaints of nasal deformity that has been present for many years. Does not like the width of the nose, especially the bridge and nostrils. Symptoms associated with this are none. There are no other modifying factors. Historical factors that are relevant: none. Externally, the nose she is happy with the progress. 7 months out. INTERVAL HISTORY: Notes that she is congested all the time. Both sides, this is accompanied by phlegm. And she is constantly sniffling. She did have COVID-19 on Thanksgiving - she experienced symptoms for 10 days. In addition to the E/M code 31231 (Nasal Endoscopy Diagnostic, unilateral or bilateral, separate procedure) is billed. Problem List Items Addressed This Visit: Rhinoplasty: Healing well. We discussed that she is only 7 months out and had thick skin. I recommended massages and observation. The area is soft and compressible, so I am confident that she will get a more refinement as she continues to heal. *Pictures taken today.* Rhinitis, chronic: Evidence of moderate rhinitis and she has a history of significant seasonal allergies. I prescribed a Medrol Dose Pack, Flonase and Ocean Nasal Sprays. She will follow up with me about this over telemedicine in 2 months."

- In example #1 Modifier 25 would not be supported or appended as there is no significant, separately identifiably billed E/M services with this procedure. There is nothing above and beyond or a separate problem.
- In Example #2 the procedure is an incidental part of the E/M and is not supported as separately identifiable and therefore no modifier 25 is supported or appended.

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

- A Shared Visit occurs when the physician and the APP are in the same group practice 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)).
- **<u>Please make sure you use this attestation any time you have a shared visit</u>:**
  - "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".

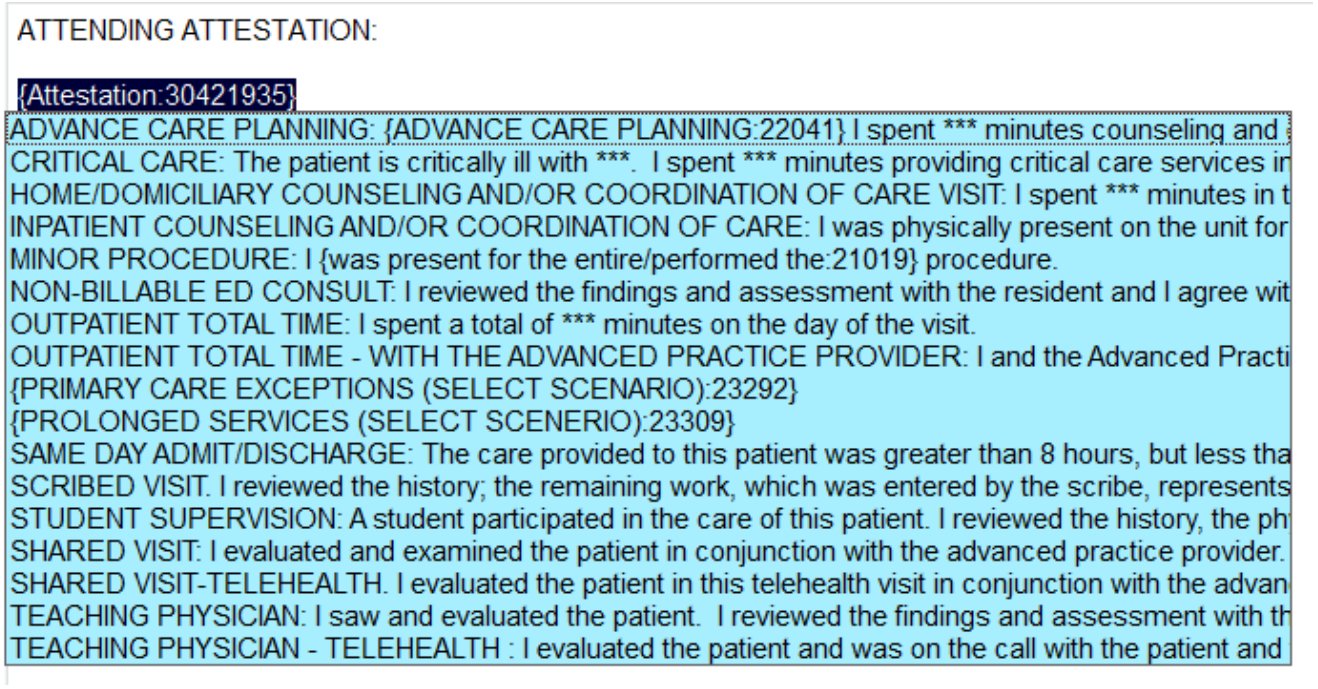
- Some payers do not recognize shared visits, and therefore will pay under the NPI of the provider who performed the service at 85% of the physician rate. The modifiers help to identify these situations.

- 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 22 approved provider attestations now in EPIC, including teaching physician service with a resident, shared visit with NP/ PA, Advance Care Planning, critical care services, and prolonged services.
- When working with a student; the teaching physician reviews and verifies student documentation using one of the student supervision attestations. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making.


ATTENDING ATTESTATION:

{Attestation:30421935}

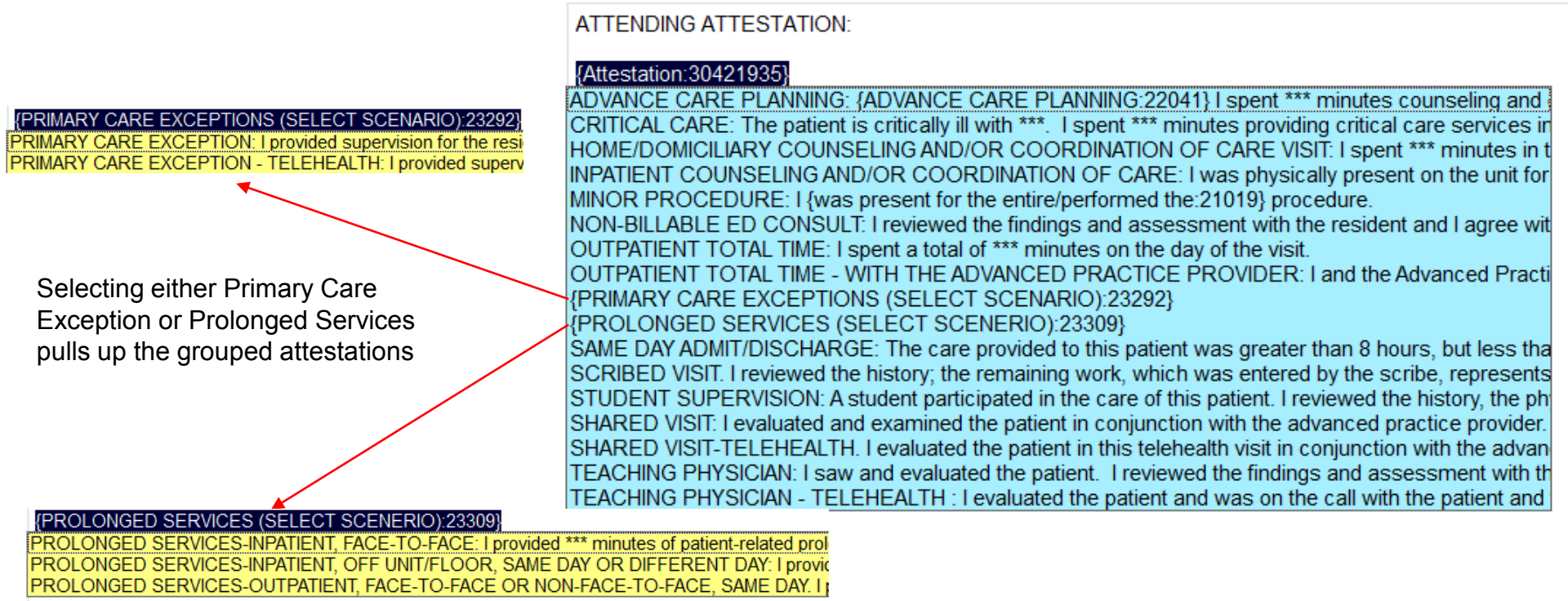
ADVANCE CARE PLANNING: {ADVANCE CARE PLANNING:22041} I spent *** minutes counseling and
CRITICAL CARE: The patient is critically ill with ***. I spent *** minutes providing critical care services in
HOME/DOMICILIARY COUNSELING AND/OR COORDINATION OF CARE VISIT: I spent *** minutes in t
INPATIENT COUNSELING AND/OR COORDINATION OF CARE: I was physically present on the unit for
MINOR PROCEDURE: I {was present for the entire/performed the:21019} procedure.
NON-BILLABLE ED CONSULT: I reviewed the findings and assessment with the resident and I agree wit
OUTPATIENT TOTAL TIME: I spent a total of *** minutes on the day of the visit.
OUTPATIENT TOTAL TIME - WITH THE ADVANCED PRACTICE PROVIDER: I and the Advanced Practi
{PRIMARY CARE EXCEPTIONS (SELECT SCENARIO):23292}
{PROLONGED SERVICES (SELECT SCENERIO):23309}
SAME DAY ADMIT/DISCHARGE: The care provided to this patient was greater than 8 hours, but less tha
SCRIBED VISIT. I reviewed the history; the remaining work, which was entered by the scribe, represents
STUDENT SUPERVISION: A student participated in the care of this patient. I reviewed the history, the ph
SHARED VISIT: I evaluated and examined the patient in conjunction with the advanced practice provider.
SHARED VISIT-TELEHEALTH. I evaluated the patient in this telehealth visit in conjunction with the advan
TEACHING PHYSICIAN: I saw and evaluated the patient. I reviewed the findings and assessment with th
TEACHING PHYSICIAN - TELEHEALTH : I evaluated the patient and was on the call with the patient and

Approved Attestations in Epic

How to Access the New Attending Attestation in Epic

Using the dot phrase ".attestation" or type ".att"

Selecting the attestation using F2 brings up the alphabetical list of attestations:



Selecting either Primary Care Exception or Prolonged Services pulls up the grouped attestations

Advance Care Planning

Advance Care Planning Services - report the face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. *[Health Care Proxy, Durable Power of Attorney, Living Will and Medical Orders for Life Sustaining Treatment (MOLST)]*

99497 - Advance care planning including the explanation and discussion of advance directives such as standard forms by the physician or other qualified health care professional; *first 30 minutes,* face-to-face with the patient, family member(s), and/or surrogate (*billable for 16-45 minutes duration)*

99498 - by the physician or other qualified health care professional; *each additional 30 minutes* (List separately in addition to code for primary procedure) *(billable once 16 additional minutes is reached over the first 30 minutes or = 46 minutes)*

- These services are time-based services, do not involve any active management of problems during the course of the face-to-face service between the provider and a patient, family member, or surrogate and may be reported on the same day as another E/M service.
- Advance Care Planning time and discussion should be documented distinctly and separately from the E/M service even if within the same progress note.

In order to document your time and other aspects of the service the following attestation is a BMC <u>requirement.</u>

In addition to and separate from the time/work of the base E/M code, I spent ***minutes counseling and discussing advanced care directives with the [patient, family member, other surrogate] [with completion of relevant legal forms] [health care proxy, medical orders for live sustaining treatment (MOLST), other] [or without completion of legal forms].

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.

Diagnosis Coding for Risk Adjustment

Accurate Medical Record Documentation and Code Capture

Documentation needs to be sufficient to support and substantiate coding for claims or encounter data.

- Diagnoses **cannot be inferred** from physician orders, nursing notes, lab or diagnostic test results; diagnoses need to be in the medical record.

- Chronic conditions need to be reported every calendar year including key condition statuses (e.g., leg amputation and/or transplant status must be reported each year).
- Chronic conditions that potentially affect the treatment choices considered should be documented.

- Each diagnosis needs to conform to ICD-10 coding guidelines.

    - Include condition specificity where required to explain **severity of illness, stage or progression** (e.g., staging of chronic kidney disease).

Diagnosis Coding for Risk Adjustment

Accurate Medical Record Documentation and Code Capture - Example

Clinical Coding example: A 75 year old female has painful urination and lower abdomen discomfort. She reports a poor appetite. She has mild malnutrition, is frail and has lost two pounds a month for the last nine months. Urinalysis performed today shows E coli white cells, leukocyte esterase and microalbuminuria. Serum creatinine is 1.4. Patient complains of dry itchy skin for the past three months.

Problem List: Stable DM(diabetes mellitus), recurrent major depression, CKD(chronic kidney disease) stage 3.

Plan: Glucophage 500mg bid for DM; Cipro XM 500 mg daily for UTI due to e. coli; Ensure supplements for malnutrition and referral to nephrologist for CKD.

Coding per M.E.A.T Criteria:

B96.20 unspecified E. Coli as the cause of diseases classified elsewhere;
N39.0 UTI site not specified (urinalysis, Cipro XM);
E11.22 Type 2 DM with chronic kidney disease("stable," Glucophage)
N18.3 Chronic Kidney Disease stage 3(moderate)(lab tests , itchy skin, referral)
E44.1 Mild protein-calorie malnutrition (weight loss, Ensure)

*Note - Recurrent Major depression is a risk adjusting diagnosis but because there is no M.E.A.T(active treatment) for depression because it is only documented in the problem list of this note.

(Risk Adjustment Documentation and Coding. Chapter 3. p 64)

Social Determinants of Health and Risk Adjustment

The following codes risk adjust with Medicaid payers and proper documentation must be in the patient's record for that date of service. Select the *most specific* diagnosis. (Z55-Z65)

Z59.0 – Homelessness
Z59.1 – Inadequate housing
Z59.2 – Discord with neighbors, landlord
Z59.4 – Lack of adequate food and safe drinking water

An example would be; *"Patient states she has been living in a shelter for over a month.*"

This documentation should appear in the assessment and plan. Also, the provider of service must be an approved practitioner by CMS to document and diagnose risk adjusted services.

Examples are; Nurse Practitioner (NP); Physician Assistant (PA); Certified Nurse Midwife (CNM); Doctor of Osteopathic Medicine (DO) or a Medical Doctor (MD).

The documentation must show that the patient was monitored/evaluated/assessed/treated (MEAT). Although, a patient may self-report these social determinants of health for regular diagnosis coding via a tool such as the smart form in Epic, with risk adjustment the documentation must live in the assessment and plan and be documented by the allowed provider of service.

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.

VII. Critical Care Coding and Documentation

Critical Care: Definition

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.)

- 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.
- 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.
- Physicians of different specialties that are not duplicative services, are permitted as long as they are medically necessary and *not provided during the same instance of time*.
- Hospital emergency department services are *not paid for the same date* as critical care services when provided by the same physician to the same patient.

Critical Care: Pre-Operative and Post-Operative

Critical care services provided during a global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances. Preoperative and postoperative critical care may be paid in addition to a global fee if:

- The patient is critically ill and requires the constant attendance of the physician; and
- The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed.
- Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.
- In order for codes 99291 or 99292 to be paid for services furnished during the preoperative or postoperative period, modifier “-25” or “-24,” respectively, must be used to indicate that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed.
- When preoperative critical care codes are being billed on the date of the procedure, the diagnosis must support that the service is unrelated to the performance of the procedure.

Examples that *may warrant* Critical Care (AMA/CPT)

- Critical care of a 45-year-old who sustained a liver laceration, cerebral hematoma, flailed chest, and pulmonary contusion after being struck by an automobile.(*Cardiology/Emergency Medicine/Family Practice/General Surgery/Internal Medicine/Pulmonary Medicine*)
- Critical care of a 15-year-old with acute respiratory failure from asthma. (*Cardiology/Emergency Medicine/Family Practice/General Surgery/Internal Medicine/Pulmonary Medicine*)
- Critical care of a 6-month-old with hypovolemic shock secondary to diarrhea and dehydration.(*Cardiology/Emergency Medicine/Family Practice/General Surgery/Internal Medicine/Pulmonary Medicine*)
- Initial hospital visit for a 62-year-old male with history of previous myocardial infarction, comes in with recurrent, sustained ventricular tachycardia. (*Cardiology*)
- Subsequent hospital visit for a 55-year-old male with severe chronic obstructive pulmonary disease and bronchospasm; initially admitted for acute respiratory distress requiring ventilatory support in the ICU. The patient was stabilized, extubated, and transferred to the floor but has now developed acute fever, dyspnea, left lower lobe rhonchi, and laboratory evidence of carbon dioxide retention and hypoxemia. (*Family Medicine*)

Examples that *may warrant* Critical Care (CMS)

- An 81 year old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and pressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
- A 67 year old female patient is 3 days status post mitral valve repair. She develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.
- A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive 2 days after admission.
- A 68 year old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

Example that ***may not warrant*** Critical Care (CMS)

- Daily management of a patient on chronic ventilator therapy does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long term management of the ventilator dependence.

- Patient is admitted to the critical care unit for an insulin infusion, does not meet the criteria for critical care.

- Patient admitted to critical care unit *for close nursing observation* and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose).

- Patient is in a critical, intensive, or specialized care unit who are clinically stable and responding favorably to established interventions.

Procedures and Critical Care on the same day (CMS)

Included in Critical Care Services

- Interpretation of cardiac output measurements (93561, 93562)
- Chest X rays (71045, 71046)
- Pulse oximetry (94760, 94761, 94762)
- Blood gases, and collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data)
- Gastric intubation (43752, 43753)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94002-94004, 94660, 94662)
- Vascular access procedures (36000, 36410, 36415, 36591, 36600).

Any services performed that are not listed above should be reported separately. Facilities may report the above services separately

Not Included in Critical Care Services

- Endotracheal intubation (31500)
- Placement of a flow directed catheter e.g. Swan-Ganz (93503)
- Cardiopulmonary resuscitation (92950)

In addition, please note that time spent performing non-bundled procedures (e.g. spinal tap, endotracheal intubation) cannot be counted toward critical care time, since these procedures are separately billable and payable.

Critical Care: Attestation

- *There is a mandatory attestation in EPIC for critical care (dot phrase ".att" for .attestation):*

  *Critical Care. The patient is critically ill with ***. I spent *** minutes providing critical care services including ***.*

- If you are working with a resident for a patient who is critically ill, you would select a teaching physician attestation *in addition* to the critical care attestation.

  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.

- We will be covering the CMS Teaching Physician rules in an upcoming section in this presentation.
- **Only** the teaching physician time can be counted towards critical care time.
- A combination of the teaching physician's documentation and the resident's documentation may support critical care services. The teaching physician documentation may tie into the resident's documentation and may refer to the resident's documentation for specific patient history, physical findings and medical assessment.
- However, the teaching physician must provide substantive information including:
  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,
  3) What made the patient critically ill, and the nature of the treatment and management provided by the teaching physician. The medical review criteria are the same for the teaching physician as for all physicians

❖ Use of the critical care attestation in Epic helps to support the documentation of the medical necessity of critical care.

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 99292 x 3
165 – 194 minutes *(2 hours 45 minutes – 3 hours 14 minutes)*	Code – 99291 99292 x 4

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

CMS MLN Advance Care Planning Booklet.
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

CMS MLN Global Surgery Booklet.
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GlobalISurgery-ICN907166Printfriendly.pdf

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Questions?