BOSTON MEDICAL CENTER

New Provider Coding and Documentation Education

Billing Compliance
Corporate Compliance Office

Objectives

New Providers will understand:

I. **Overview of Billing Compliance**

II. **Evaluation and Management Coding and Documentation**

III. **Teaching Physician Guidelines**

IV. **Other Coding and Documentation Topics**

V. **The Process for Auditing New Provider Documentation**

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

Documentation Quality

Documentation must be consistent (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.

Evaluation and Management Services

- Providers select services based on *total time or medical decision making (MDM).*

  - History and Exam no longer factor into code selection, but must be performed as clinically appropriate for the visit.
  - Continue to include the chief complaint to explain the medical necessity for the visit with the reason, patient here for follow-up for shoulder pain (rather than just " here for follow-up").
  - Counseling and/or coordination of care no longer need to dominate the service for time-based coding. The phrase >50% counselling and coordination of care is no longer necessary in any setting.
  - Total time on the date of the Inpatient encounter is by Calendar Date.
  - When using MDM or Total time for Inpatient code selection a continuous service that transitions over two calendar dates a single service is reported.
  - If the service spans the transition of 2 calendar dates Inpatient care is reported as a single service on one calendar date. If the service is continuous before and through midnight, all of the time may be reported on the date of service.
  - Select new versus established outpatient code according to the CPT definitions.
  - Select initial versus subsequent encounter according to the CPT definitions.

Evaluation and Management Services
New and Established Patients

- For the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services.

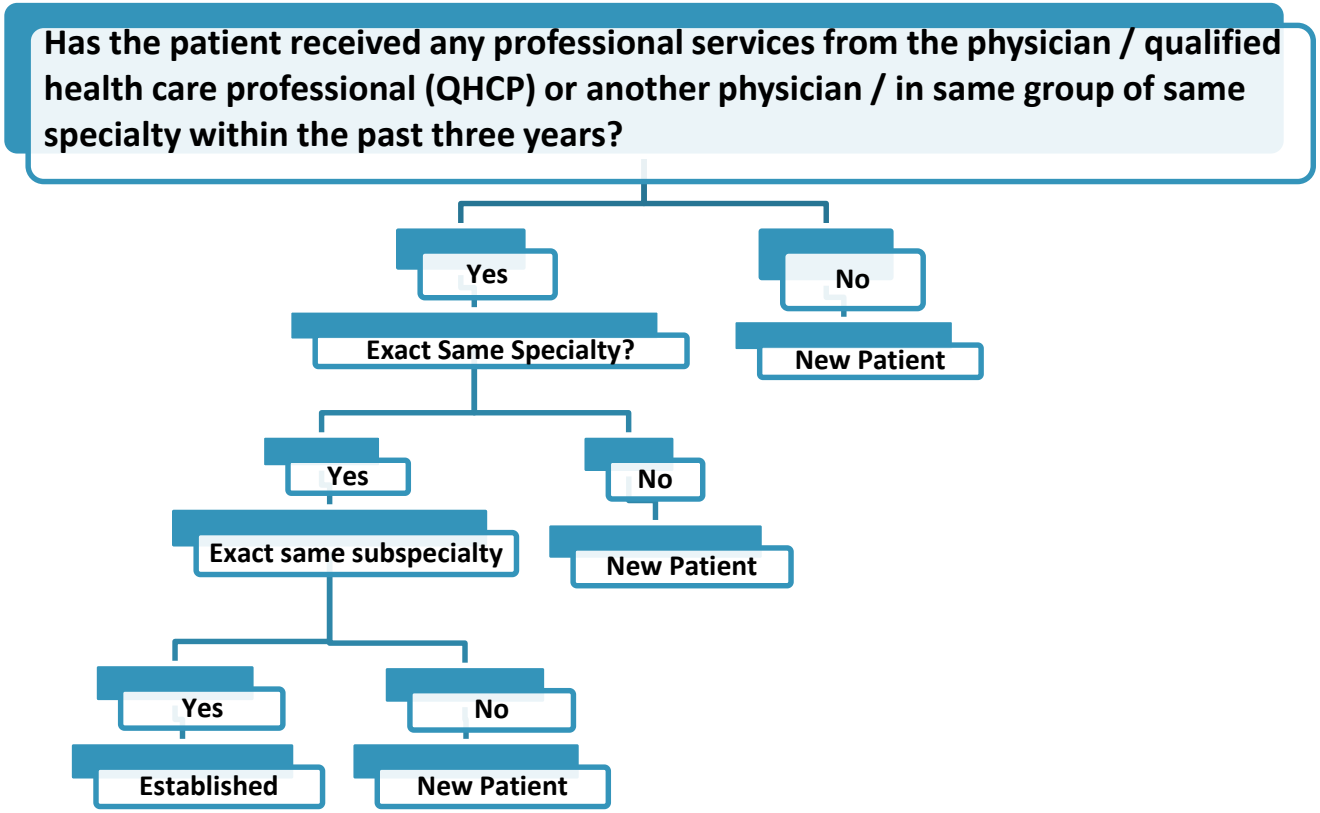
New Patient

- 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.

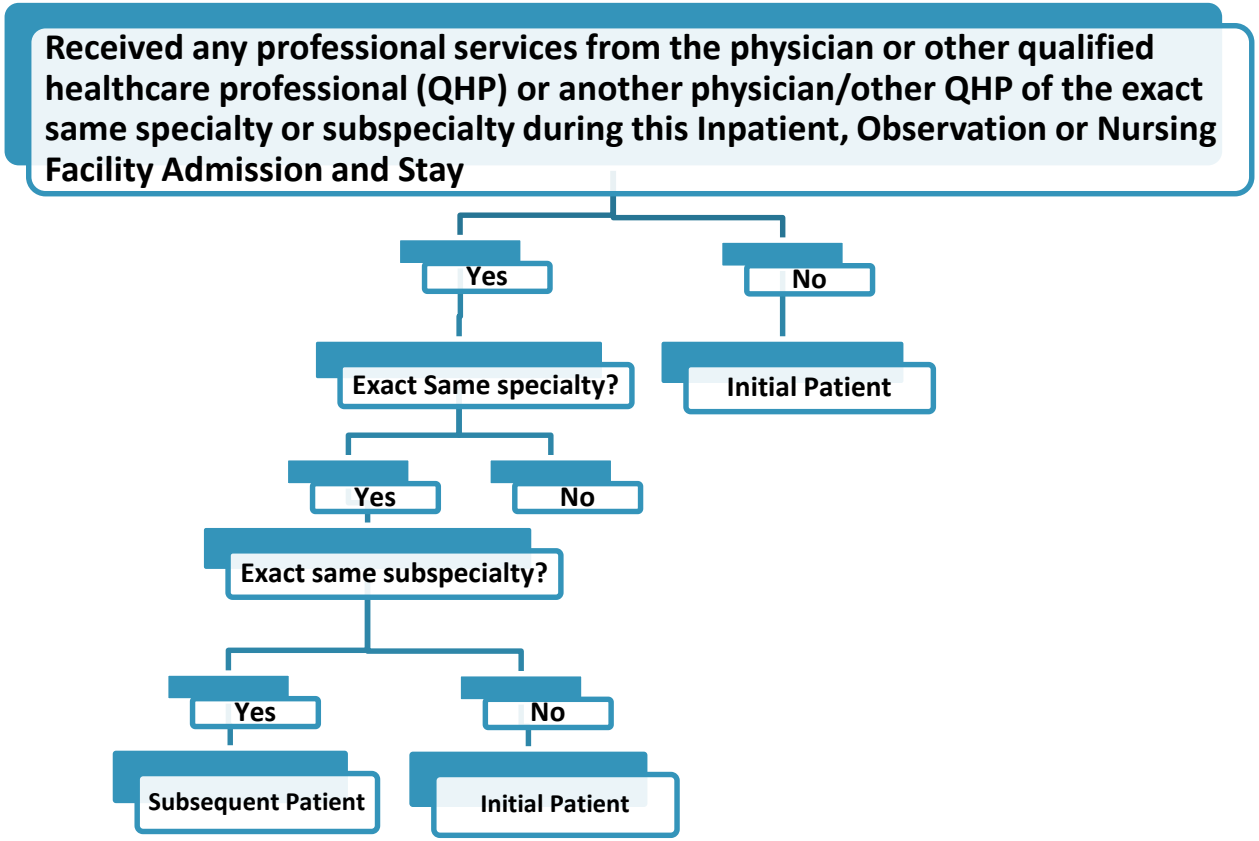
Established Patient

- 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.

New vs. Established Patient Decision Tree



Initial vs. Subsequent Patient Decision Tree



Level Selection for E/M Visits by Total Time

- When using total time on the date of an outpatient encounter, the time is a specific time range rather than an average time and there is no “rounding up.”
- When using total time on an inpatient, observation, nursing facility or home encounter, the time indicators are a threshold that must be met or exceeded.

- 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)
- Do not count time spent on the following:
  - The performance of other services that are reported separately
  - Travel
  - Teaching that is general and not limited to discussion that is required for the management of a specific patient

Medical Decision Making (MDM)

➢There are 4 types of MDM:

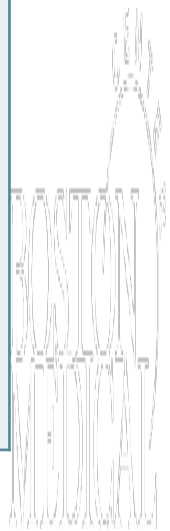
1. Straightforward
2. Low
3. Moderate
4. High

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by 3 elements:

1. The number and complexity of problem(s) that are addressed during the encounter
2. The amount and/or complexity of data to be reviewed and analyzed. These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter
3. The risk of complications and/or morbidity or mortality of patient management.

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

Level	Problem	Data	Risk
Straightforward	Minimal 1 self limited or minor problem or injury	Minimal or None	Minimal risk
Low	Low 2 or more self limited or minor problems or 1 stable chronic illness or 1 acute, uncomplicated illness or injury 1 stable, acute illness; or 1 acute uncomplicated illness or injury requiring inpatient or observation level of care	Limited – (Must meet the requirements of at least 1 out of 2 categories) Category 1: Tests and documents Any combination of 2 from the following: ___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



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

Level	Problem	Data	Risk
Moderate	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 – (Must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) Any combination of 3 from the following: ___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)	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
High	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 listed in detail above) **Category 1 -** Tests, documents, or independent historian(s); **Category 2 -** Independent Interpretation of tests; **Category 3 -** Discussion of management or test interpretation with an external physician/ other QHCP/ appropriate source. External = different specialty. *Qualified Health Care Professional ** Document the source and location of the test and with whom you discussed the results.	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 or escalation of hospital-level care • DNR Decision or to de-escalate of care due to poor prognosis • Drug therapy requiring intensive monitoring for toxicity. • Parenteral controlled Substances

MDM – Problem, Data and Risk

Example 1:

- ✓ Patient presents with cough, congestion and body aches; no fever reported.
- ✓ Ordered a rapid flu test and Covid 19 test
- ✓ Tests were negative diagnosed with a cold and told to go home and rest and drink lots of fluids.

1 self-limited/minor problem	S	L	M	H
2 unique lab tests	S	L	M	H
Minimal Risk of Morbidity with treatment or testing	S	L	M	H

For CPT coding, 2 of the 3 MDM elements need to be met or exceeded in order to select the level

MDM = Straightforward

MDM – Problem, Data and Risk

Example 2:

- ✓ Patient with worsening fatigue over the past several weeks along with complaints of headache and coldness to hands and feet. Discussed in length with patient's adult daughter as patient is unreliable due to advancing dementia.
- ✓ Ordered a CBC
- ✓ Patient is at low risk of morbidity from testing and treatment.

1 undiagnosed new problem	S	L	(M)	H
1 unique test; Assessment requiring an independent historian(s)	S	(L)	M	H
Low risk of morbidity from additional testing / treatment	S	(L)	M	H

For CPT coding, 2 or the 3 MDM elements need to be met or exceeded in order to select the level

MDM = LOW

MDM – Problem, Data and Risk

Example 3:

- ✓ Patient with stable chronic Hypertension and Hyperlipidemia presents for follow-up of chronic conditions. Patient doing well with no complaints.
- ✓ No data ordered
- ✓ HTN is well controlled on Lisinopril 10 mg; HL is well controlled on Rosuvastatin 10mg. Continue current treatment. Return to clinic in 6 months.

2 stable chronic illnesses	S	L	(M)	H
Minimal or no data	(S)	L	M	H
Prescription Medication Management	S	L	(M)	H

For CPT coding, 2 of the 3 MDM elements need to be met or exceeded in order to select the level

MDM = MODERATE

MDM – Problem, Data and Risk

Example 4:

- ✓ Patient presents with worsening cough over the past several days, SOB & wheezing. Hx of COPD and has been hospitalized 3 times in the past year. Has been unresponsive to outpatient nebulizer as O2 sat < 89%.
- ✓ No data ordered
- ✓ Discussed directly admitting him to observation status, but patient refused. Follow up in clinic in 2 days but stressed to go to ED with worsening symptoms.

1 Chronic Illness with severe exacerbation, progression side effect of treatment	S	L	M	H
Minimal or no data	S	L	M	H
Decision regarding hospitalization	S	L	M	H

For CPT coding, 2 of the 3 MDM elements need to be met or exceeded in order to select the level

MDM = HIGH

Inpatient Scenarios

Example 1 – Hospital Admission 99223 – High MDM

✓ Acute MI… clinician reviews chest X-Ray and it shows no cardiomegaly , effusions or infiltrates… K3.1, Troponin 3.4, Hgb 11.

Acute life – threatening illness	S	L	M	(H)
Interpretation of study and order/review 3 tests	S	L	M	(H)
Decision regarding hospitalization	S	L	M	(H)

Example 2 - Hospital Subsequent Visit – 99233 High MDM

✓ New onset of acute respiratory failure, transfer to Intensive Care Unit

Acute life threatening illness	S	L	M	(H)
Minimal or no data	(S)	L	M	H
Escalate hospital care	S	L	M	(H)

For CPT coding, 2 of the 3 MDM elements need to be met or exceeded in order to select the level

MDM = HIGH

Outpatient Evaluation & Management New Patient

Code	MDM	Time
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***straightforward*** medical decision making	15 – 29 minutes of total time is spent on the day of the encounter
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***low*** medical decision making	30 – 44 minutes of total time is spent on the day of the encounter
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***moderate*** medical decision making	45 – 59 minutes of total time is spent on the day of the encounter
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***high*** medical decision making	60- 74 minutes of total time is spent on the day of the encounter

Outpatient Evaluation & Management
Established Patient

Code	MDM	Time
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and ***straightforward*** medical decision making	10 – 19 minutes of total time is spent on the day of the encounter
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and ***low*** medical decision making	20 – 29 minutes of total time is spent on the day of the encounter
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and ***moderate*** medical decision making	30 – 39 minutes of total time is spent on the day of the encounter
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and ***high*** medical decision making	40- 54 minutes of total time is spent on the day of the encounter

2023 Initial Hospital Inpatient or Observation Care New or Established Patient

Code	MDM	Time
99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.	40 Minutes
99222	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***moderate*** level of medical decision making	55 Minutes
99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***high*** level of medical decision making.	75 Minutes

- An initial service may be reported when the patient has not received any professional services from the physician or other QHP or another physician or QHP of the exact same specialty and subspecialty who belongs to the same group practice during the stay.

2023 Subsequent Hospital Inpatient or Observation Care
New or Established Patient

Code	MDM	Time
99231	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***straightforward*** or ***low*** level of medical decision making.	40 Minutes
99232	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***moderate*** level of medical decision making	55 Minutes
99233	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***high*** level of medical decision making.	75 Minutes

- An initial service may be reported when the patient has not received any professional services from the physician or other QHP or another physician or QHP of the exact same specialty and subspecialty who belongs to the same group practice during the stay.

2023 Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services)

Code	MDM	Time
99234	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and ***straightforward or low*** level of medical decision making	45 Minutes
99235	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and ***moderate*** level of medical decision making.	70 Minutes
99236	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and ***high*** level of medical decision making.	85 Minutes
99238	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter	See Required Documentation Below
99239	Hospital inpatient or observation discharge day management; > 30 minutes or less on the date of the encounter	See Required Documentation Below

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.

2023 Emergency Department Visit

Code	MDM
99281	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***straightforward*** medical decision making
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***low*** level of medical decision making
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***moderate*** level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***high*** level of medical decision making

2023 Initial Nursing Facility Care New or Established Patient

Code	MDM	Time
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***straightforward*** or ***low*** level of medical decision making	25 Minutes
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***moderate*** level of medical decision making.	35 Minutes
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***high*** level of medical decision making.	45 Minutes

2023 Subsequent Nursing Facility Care & Nursing Facility Discharge Services

Code	MDM	Time
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***straightforward*** level of medical decision making	10 Minutes
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***low*** level of medical decision making.	15 Minutes
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***moderate*** level of medical decision making.	30 Minutes
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and ***high*** level of medical decision making.	45 Minutes
99315	Nursing facility discharge management; 30 minutes or less total time on the date of the encounter	
99316	More than 30 minutes	

Home or Residence Services – New Patient

Code	MDM	Time
99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***straightforward*** medical decision making.	15 Minutes
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***low*** level of medical decision making	30 Minutes
99343 (Deleted)		
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***moderate*** level of medical decision making.	60 Minutes
99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and ***high*** level of medical decision making	75 Minutes

Home or Residence Services – Established Patient

Code	MDM	Time
99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and ***straightforward*** medical decision making.	20 Minutes
99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and ***low*** level of medical decision making	30 Minutes
99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and ***moderate*** level of medical decision making.	40 Minutes
99350	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and ***high*** level of medical decision making	60 Minutes

* For services longer than 75 minutes, see prolonged service code 99417

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: Procedures

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 guidelines.

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.

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.

The 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: Critical Care

Critical Care

- **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

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.
  - Must use MDM for level selection **not** total time.
  - 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.

Global Surgery

The global surgical package, also called global surgery, includes all the necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for a surgical procedure includes the preoperative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. Global surgery applies in any setting including; Inpatient hospital; Outpatient hospital; Ambulatory Surgical Center (ASC) and Physician's Office.
There are three types of global surgical packages based on the number of post-operative days.

1. 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

2. 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.

3. 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

Prolonged Services

- **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 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 reporting multiple units. For example; 99215 and 99417x2

- **99418**: Prolonged ***inpatient or observation*** evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time.
  - Code 99418 may be used on the highest-level initial and subsequent inpatient and observation codes, and initial and subsequent nursing facility services.
  - It may not be reported with psychotherapy or non-face to face prolonged care codes.
  - It may not be reported with discharge services 99238, 99239, 99315, 99316.
  - It may not be reported with Emergency Department codes.

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

Approved Prolonged Service Attestation in Epic

I provided *** minutes prolonged services. The nature of the prolonged services was due to ***.

E/M and Procedure on the Same Day as a Procedure

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.
- Do not automatically report an E/M code every time you perform a minor procedure in an office or facility.

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."

- *Rationale:* 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 patient comes to the office with complaints of right knee pain. After the physician completes the office visit, an X-ray of the knee is obtained and the physician writes an order for physical therapy. He then determines that the patient would benefit from a cortisone injection to the affected knee.

- *Rationale:* Modifier 25 would be appended as a significant E&M service was prompted by the knee pain for which the cortisone injection was given.

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 comes for evaluation of a new lesion on the arm. The physician examines the lesion, discusses possible diagnoses and treatment options, and decides to biopsy the lesion.

Rationale: All of this care is included in the CPT code for the skin biopsy. It would be inappropriate for the physician to bill an Evaluation and Management in addition to the procedure code.

Example #2

"A 75 year old female, with previous complaints of occasional chest discomfort during exercise is scheduled for a cardiovascular stress test. The physician performs a medically appropriate history and exam related to the stress test.

Rationale: All of this care is included in the CPT code for stress test. It would be inappropriate for the physician to bill an Evaluation and Management in addition to the procedure code as patient came in for a scheduled procedure.

“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 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.
- 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”.
- 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.
- Reviewing the medical record and/or discussing the care with the APP only are *not sufficient to support billing by the attending.*). It is not appropriate to document only “agree with the (APP’s) findings.

- **<u>Please make sure you use this attestation any time you have a shared visit</u>**

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

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: 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.
- For continuous services that extend beyond midnight, the physician or NPP will report the total units of time provided continuously. Any disruption in the service, however, creates a new initial service. We are adopting this rule for critical care being furnished by a single physician or NPP when the critical care crosses midnight.
- *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.

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
104 minutes *(1 hour 15 minutes – 1 hour 44 minutes)*	Code – 99291, 99292
134 minutes *(1 hour 45 minutes – 2 hours 14 minutes)*	Code - 99291 99292 x 2
164 minutes *(2 hours 15 minutes – 2 hours 44 minutes)*	Code - 99291 99292 x 3
194 minutes *(2 hours 45 minutes – 3 hours 14 minutes)*	Code – 99291 99292 x 4

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

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

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.

Social Determinants of Health (SDOH)

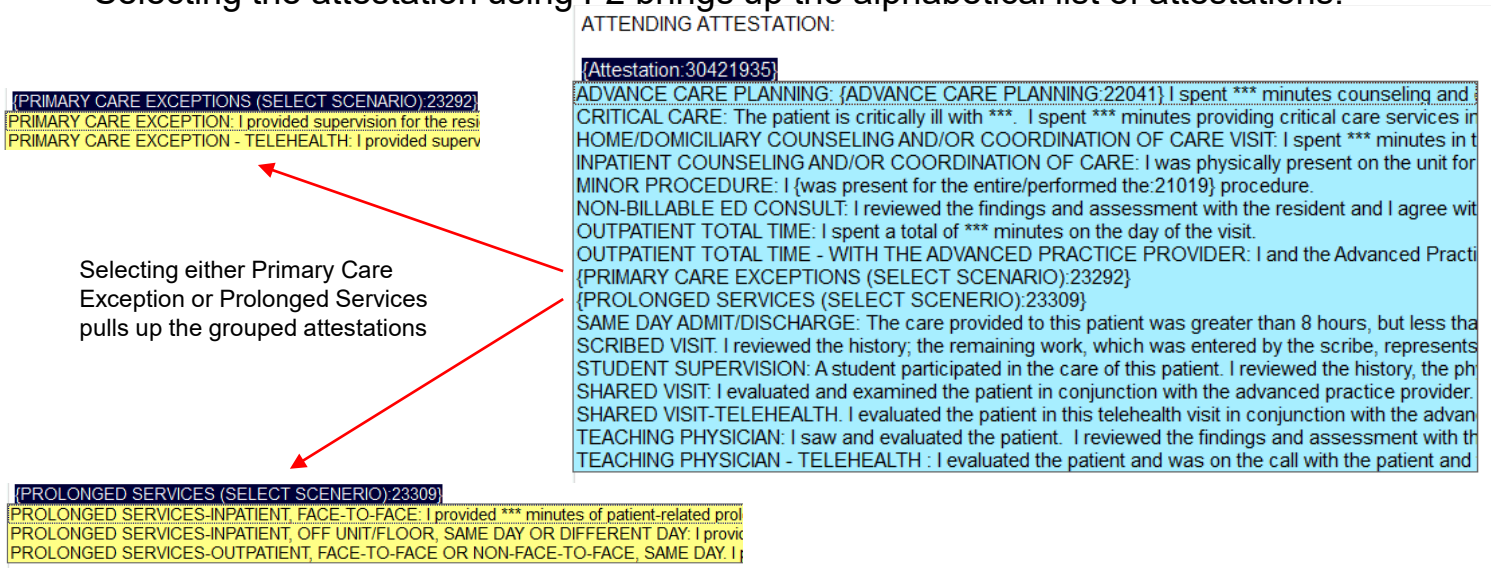
- Hospitals and health systems are working to address not only the clinical factors but the societal factors that influence health to include the social needs of their patients . These societal factors, known as social determinants of health include access to food and transportation, housing, education, etc.
  - ICD-10 Z codes represent subsets of diagnosis codes describing factors influencing health status. Code categories Z55-Z65 identify SDOH.
  - These codes allow physicians, hospitals, health systems and payers to better track patient needs and identify solutions to improve the health of communities. The following are an example:
    - Z59.0 – Homelessness
    - Z59.1 – Inadequate housing
    - Z59.2 – Discord with neighbors, landlord
    - Z59.4 – Lack of adequate food and safe drinking water
  - Please ensure that you are incorporating these in your documentation and add to the list of applicable diagnoses addressed in this encounter.
  - The documentation must show that the patient was monitored/evaluated/assessed/treated. 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, the clinician must sign off in the assessment and plan during the encounter. An example would be; *"Patient states she has been living in a shelter for over a month."*

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

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 30 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

Medicare 1997 Documentation Guidelines for Evaluation and Management Services
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.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/GloballSurgery-ICN907166Printfriendly.pdf

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To open hyperlinks – copy and paste these links into your search engine

Billing Compliance | Boston Medical Center Intranet (bmc.org)

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Questions?