Documentation and Coding for New Physicians/APPs

New Physician/APP Orientation Team

Enterprise Compliance

Revised January 2022

Today's Agenda

- General Information
- Diagnosis Coding
- Coding Guidelines for Office/Outpatient Services
- Coding Guidelines for Inpatient, Consultations, Observation and Emergency Department
- Reporting Advance Practice Providers' Services
- Critical Care Services
- Teaching Physicians, Residents and Medical Students

Today's Agenda

Additional Topics (Appendices)
A. Primary Care Exception
B. Preventive Medicine Visits
C. Preventive/Split Services
D. Smoking/Tobacco Use Cessation Counseling
E. Commonly Performed Office Procedures
F. Advance Care Planning

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

Timeline for New Physicians/APPs

Day 1	• Introduction to the Compliance Program • Coding & Documentation for New Physicians/APPs
Days 15-60	• Review of recent documentation • On-site follow-up • General Q & A • Specialty specific topics • "At the elbow" shadowing
Day 60	• Baseline audit
Days 70-90	• Post-audit meeting • General Q & A

Compliance Baseline Audit

- Compliance Baseline Audits are educational audits performed on all new Physician/APPs joining Atrium Health

- The Compliance Baseline Audit provides an opportunity to:
  - make recommendations to improve documentation
  - tailor additional education beyond the basic Coding/Documentation program presented during New Provider Orientation
  - address provider's coding and documentation questions

Compliance Program Overview

Atrium Health Physician Compliance Program Overview

New Provider
No
Review Comparative Data Report
Outlier?
No
Schedule 2028
Yes
Yes
Yes
Baseline Audit within 60 days
90% threshold met?
No
Conduct Baseline follow up audit based on previous score
90% threshold met?
No
Phase II Review 10 encounters within 90 days of last education
90% threshold met?
No
Yes
Yes
Phase I Review 10 encounters per schedule
Phase IV Repeat Phase III steps as needed until Phase II is accomplished
No
90% threshold met?
Review 10 encounters within 90 days of education
Phase III Partner with Physician/APP leadership; mandatory re-education
Yes

General Information

CMS PFS 2022 Final Rule

The Centers for Medicare and Medicaid Services (CMS) released the Physician Fee Schedule 2022 Final Rule in November 2021.

Key Updates to:

- Behavioral health telehealth services
- Shared visits
- Shared critical care visits
- Shared prolonged services

More information to come shortly…

Definitions

- The **Centers for Medicare & Medicaid Services (CMS)** is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
- **Palmetto GBA**: North Carolina Local Medicare Carrier. Palmetto GBA also covers Georgia, South Carolina, Virginia and West Virginia.

Definitions

- An **Office Setting** (POS 11) is a location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.

- A **Provider-Based Clinic** (Off Campus Outpatient Hospital/POS 19) (On Campus Outpatient Hospital/POS 22) is a portion of an off-campus hospital provider-based department/hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Medical Record Documentation

Medical Record Documentation

- The medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments and outcomes

- The medical record chronologically documents the care of the patient and is an important element contributing to high quality care

Medical Record Documentation

The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his/her health care over time
- Communication and continuity of care among physicians and other health care professionals involved in the patient's care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations
- Collection of data that may be useful for research and education

An appropriately documented medical record can reduce many of the issues associated with claims processing errors and may serve as a legal document to verify the care provided, if necessary.

Medical Record Documentation

The medical record entries must include:

- The chief complaint and/or reason for the encounter, relevant history, physical exam findings, and prior diagnostic test results, as well as a review of any relevant labs, x-rays, and other ancillary services
- Assessment, clinical impression or diagnosis
- Plan for care
- Date and verifiable legible identity, manual or electronic signature of the health care professional that provided the service
- An addendum to the medical record should be dated the day the information is added. Documentation of time the entry was made is encouraged

Medical Record Documentation

- Authorship attributes the origin or creation of a particular unit of information to a specific individual or entity acting at a particular time. When there are multiple authors or contributors to a document, all signatures should be retained so that each individual's contribution is unambiguously identified

- **The author of each medical or clinical record entry must be identified in the health record**

EMR Cautions - Medical Record Cloning

“**The word 'cloning' refers to documentation that is worded exactly like previous entries**. This may also be referred to as 'cut and paste' or 'carried forward.' Cloned documentation may be handwritten, but generally occurs when using a preprinted template or a Promoting Interoperability (PI) Programs electronic record.”

“While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter. Authorship and documentation in an EHR must be authentic.”

Palmetto GBA

EMR Cautions - Medical Record Cloning

- **Cloned documentation does not meet medical necessity requirements for coverage of services**. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.
- **Over-documentation** is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher level services. Some PI Programs technologies auto-populate fields when using templates built into the system. Other systems generate extensive documentation on the basis of a single click of a checkbox, which if not appropriately edited by the provider may be inaccurate. Such features produce information suggesting the practitioner performed more comprehensive services than were actually rendered.
- **Palmetto GBA E/M Weekly Tip: Cloning (Chief Complaint (CC), History of Present Illness (HPI), Review of Systems (ROS) and Examination)**

  Always document the Chief Complaint (CC) and History of Present Illness (HPI) based on the patient's description on that day. **Never copy it from a previous visit**. Only use the Review of Systems (ROS) and examination that is relevant to that day's visit.

https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~JM%20Part%20B~EM%20Help%20Center~Weekly%20Tips~9CAJVP3322?open

Inpatient Medical Record Cloning Example

DOS: 11/19/2020

Interval History:
No acute events overnight. Patient denied any chest pain. No other complaints.

ROS: negative for palpitations and SOB

Objective:
Vital Signs:
Temp: 98.3 °F
Pulse: 74
Resp: 18
BP: 156/89
SpO2: 96 %
CONSTITUTIONAL: well developed, well nourished, no distress
CARDIOVASCULAR: RRR, intact distal pulses
PULMONARY: breath sounds normal and effort normal

A/P:
Unstable angina
Lopressor increased to 50BID, ASA, Losartan

DOS: 11/22/2020

Interval History:
No acute events overnight. Patient denied any chest pain. No other complaints.

ROS: negative for palpitations and SOB

Objective:
Vital Signs:
Temp: 98.1 °F
Pulse: 67
Resp: 17
BP: 158/82
SpO2: 97 %
CONSTITUTIONAL: well developed, well nourished, no distress
CARDIOVASCULAR: RRR, intact distal pulses
PULMONARY: breath sounds normal and effort normal

A/P:
Unstable angina
Lopressor increased to 50BID, ASA, Losartan

Outpatient Medical Record Copy/Paste

DOS: 08/04/2020

HPI: Patient presents for follow-up of well-controlled diabetes and IBS. Denies visual, skin or GI changes. Most recent bloodwork is not available. Patient's last colonoscopy was in 2015.

Physical Exam:
Cardiovascular: RRR
Pulmonary/Chest: CTAB, Effort normal
Abdominal: Soft, non-tender, normal BS
Skin: Skin is warm and dry. No rashes or lesions

Assessment/Plan:
Diabetes, stable – continue Metformin
IBS, stable – continue low fat diet, Imodium as needed

DOS: 11/27/2020

HPI: Patient presents for follow-up of well-controlled diabetes and IBS. Denies visual, skin or GI changes. Most recent bloodwork is not available. Patient's last colonoscopy was in 2015.

Physical Exam:
Cardiovascular: RRR
Pulmonary/Chest: CTAB, Effort normal
Abdominal: Soft, non-tender, normal BS
Skin: Skin is warm and dry. No rashes or lesions

A1C results from 08/04/2020: 6.4
Colonoscopy performed in September 2020 was normal.

Assessment/Plan:
Diabetes, stable – continue Metformin
IBS, stable – continue low fat diet, Imodium as needed

EMR Cautions - Prepopulation

Prepopulation is the entry of history, exam and/or MDM components into the medical record prior to the arrival of the patient.

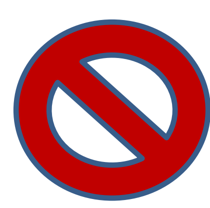
- Prepopulation is strongly discouraged by Physician & Provider Compliance.
- If a provider chooses to prepopulate documentation, only accurate, relevant historical elements or the shell of a template should be documented.
- Review of Systems (ROS), exam findings and/or MDM should not be documented prior to the patient visit.

EMR Cautions - Voice Recognition Technology

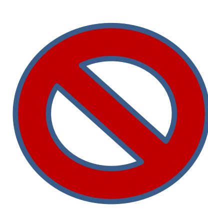
- Exercise caution when using voice recognition technology (e.g., “Dragon”)
- Voice-dictated notes are held to the same standards as those generated by any other means
- Physicians/APPs are responsible for proofreading all elements of their note to ensure accuracy
- The use of phrases (disclaimers) meant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

EMR Cautions - Voice Recognition Technology

Examples of “disclaimers” seen in the EMR



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



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

EMR Cautions - Template Inconsistencies

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

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

Template Use
Failure to update a template that is prepopulated with, for example, negative responses, when the patient has a contradictory positive response to a question as recorded in the HPI (History of Present Illness) section, or failure to remove a negative response when the question was never asked, creates an erroneous record entry and can potentially lead to improper patient care or payment.

EMR CautionsTemplate Inconsistencies

Procedure History
Back surgery
Hysterectomy
Left BKA

Family History
Mother- Hypertension
Sister- Breast Cancer

Social History
Alcohol – Denies

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

When using a prepopulated note template or macro (i.e., charting by exception), the physician/APP must remember to:

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

Medicare Signature Requirements

Atrium Health

Medicare Signature Requirements

- Medicare requires that services *provided or ordered* be authenticated by the author. There are two acceptable methods of authentication:
  - Handwritten signature
  - Electronic signature
- When there are multiple authors or contributors to a document, all signatures should be retained so that each individual contribution is identified

Timeliness of Documentation

Atrium Health Medical Group Medical Records Standards

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

Timeliness of Documentation

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

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

Timeliness of Documentation

Effect on audit and revenue -

- Documentation not completed by the 30th calendar day from the date of the patient encounter:
  - ❑ Audit - will result in a 100-point deduction for that patient encounter
  - ❑ Revenue - is no longer a billable service

Medical Necessity

Medical Necessity

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

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

Medical Necessity

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

Medical Necessity

An important requirement to receive payment for services is to establish medical necessity by documenting the following facts and findings:

- Severity of the signs/symptoms or diagnosis exhibited by the patient
- Probable outcome for the patient, and how that risk equates to the diagnosis being evaluated
- Need for diagnostic studies and/or therapeutic interventions to evaluate the patient's presenting problem or current medical condition
- Accurately reflect the need for and outcome of treatment

Diagnosis Coding

The Importance of Diagnosis Coding

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

General Diagnosis Coding Guidelines

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

- Document and code all diagnoses that directly impact the treatment plan for the presenting problem
  - Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)
  - Chronic condition(s) should be used as secondary diagnoses when not actively being treated but may impact the current treatment plan for the presenting problem

General Diagnosis Coding Guidelines

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

General Diagnosis Coding Guidelines

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

General Diagnosis Coding Guidelines

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

Evaluation and Management Services

Evaluation and Management (E/M) Services

- Includes services such as office visits, hospital visits, consultations, and critical care
- Documentation requirements were developed jointly by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS):
  - *1995 Evaluation and Management Documentation Guidelines*
  - *1997 Evaluation and Management Documentation Guidelines*
  - *2021 Evaluation & Management Guidelines for Office Visits/Other Outpatient Services*

Evaluation and Management (E/M) Services

Guiding Principles

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

Advanced Practice Providers (APPs) Billing

Atrium Health

Billing for APP Services

Enter the APP's name in the "Service Provider" field

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

Billing for APP Services

- If an APP participates in a service, their name must be listed as the service provider
- The billing system determines which name appears on the claim based on the payer

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

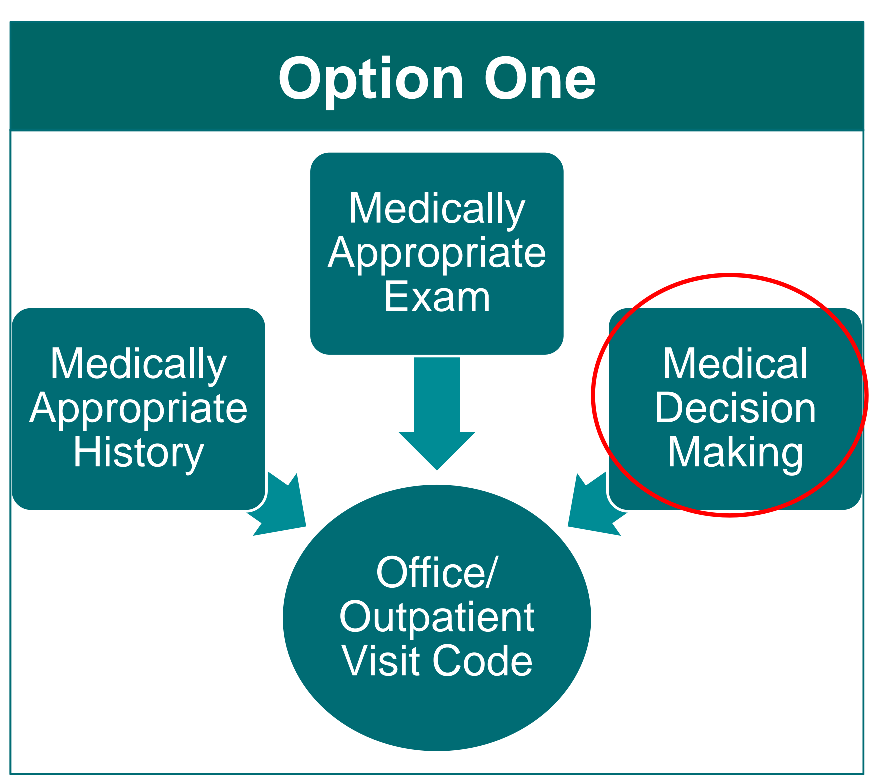
Provider Charge Workflow (PCW)

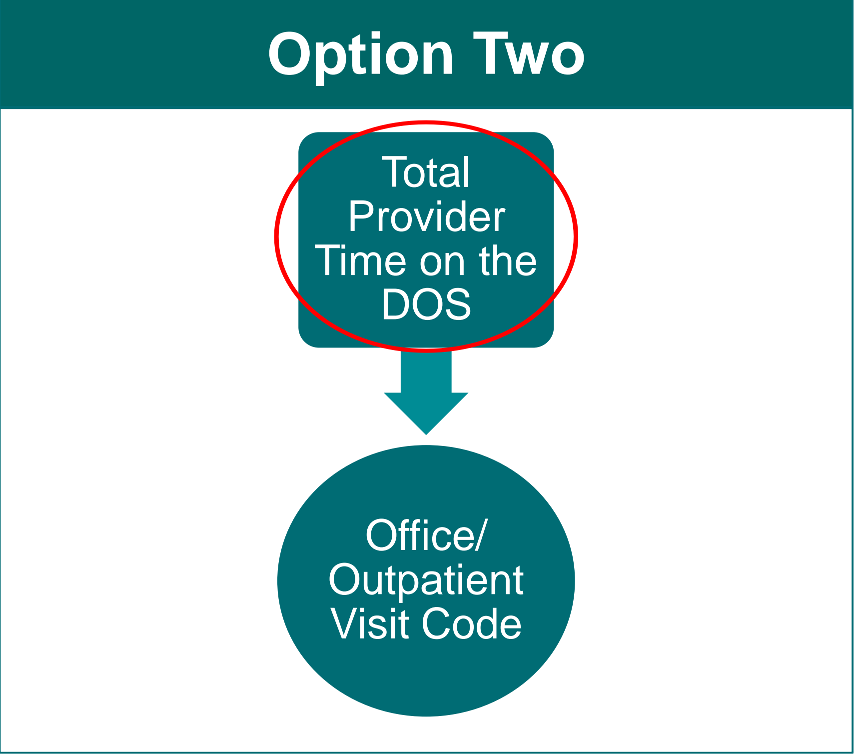
- PCW allows physicians/APPs to capture their hospital charges electronically
- The APP places the order for the charge and indicates the supervising physician on the order
- The physician ***cannot*** place the order and indicate that the service was shared with an APP

Coding Guidelines for Office or Other Outpatient Services

Office or Other Outpatient Services Code Selection

Office/Outpatient Visit Code is Determined Via One of Two Options





Office or Other Outpatient Services Based on Medical Decision-Making

Code Selection Based on MDM

- The medical record must include the documentation of the chief complaint and a medically appropriate history and/or physical examination
- To support a given code level, **2 out of 3 elements of MDM for that code level must be met or exceeded**

1. **Number and complexity of problems addressed**
   - A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or APP reporting the service
   - Referral without evaluation (by history, exam, or diagnostic study) or consideration of treatment does not qualify as being addressed
2. **Amount and/or complexity of data to be reviewed and analyzed**
   - Tests, documents, orders, or independent historian(s) – each unique test (as identified by a CPT code), order, or document is counted to meet a threshold number
   - Independent interpretation of tests
   - Discussion of management or test interpretation with external physician/APP/or appropriate source
3. **Risk of complications and/or morbidity or mortality of patient management**
   - Includes possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family

Code Selection Based on MDM

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ** Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99202 **99212**	**Straightforward**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

- **Self-limited or minor problem**
  - Runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed * Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99203 **99213**	**Low**	**Low** • 2 or more self-limited or minor problems; OR • 1 stable chronic illness; OR • 1 acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1 of the 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* **Category 2: Assessment requiring an independent historian(s)** (*For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high*)	**Low risk of morbidity from additional diagnostic testing or treatment**

- **Stable, chronic illness**
  - Expected duration of at least a year or until the death of the patient
  - "Stable" is defined by the specific treatment goals for an individual patient; a patient that is not at their treatment goal is <u>not</u> stable, even if the condition has not changed
- **Acute, uncomplicated illness or injury**
  - Recent or new short-term problem with low risk of morbidity for which treatment is considered
  - Little/no risk of mortality with treatment, and full recovery without functional impairment is expected
  - Problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course
  - Examples may include cystitis, allergic rhinitis, or a simple sprain

Atrium Health

Code Selection Based on MDM

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*

Category 2: Assessment requiring an independent historian(s)
(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)

- **Independent historian**
  - Individual that provides a history in addition to history provided by patient who is unable to provide a complete or reliable history or because a confirmatory history is judged to be necessary
  - Examples – patient's developmental stage, dementia, psychosis prevent obtaining complete or reliable history
- **External**
  - External records, communications and/or test results are from an external physician, APP, facility, or healthcare organization
- **External physician or other QHP**
  - Individual who is not in the same group practice or is a different specialty or subspecialty
- **Tests**
  - Imaging, lab, psychometric, or physiologic data
  - A clinical lab panel is a single test
  - The differentiation between single or multiple unique tests is defined in accordance with the CPT code set

Atrium Health

Code Selection Based on MDM

- Tests that do not require a separate interpretation (e.g., test that are results only) and are analyzed as part of the MDM may be counted as ordered or reviewed for selecting an MDM level
- The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the MDM level when the service is reported separately by the physician/APP (e.g., EKG, x-ray)

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ** Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99204 99214	**Moderate**	**Moderate** • 1 or 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; **OR** • 1 acute illness with systemic symptoms; **OR** • 1 acute complicated injury	**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 source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/APP (not separately reported); **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/APP/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

Code Selection Based on MDM

- **Chronic illness with exacerbation, progression, or side effects of treatment**
  - 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
  - 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**
  - Illness that causes systemic symptoms and has a high risk of morbidity without treatment
  - For systemic general symptoms (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.”
  - Examples may include pyelonephritis, pneumonitis, or colitis

Code Selection Based on MDM

- **Independent interpretation**
  - Interpretation of a test for which there is a CPT code and an interpretation or report is customary
  - Does not apply when the physician or APP 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
- **Appropriate source**
  - Includes professionals who are not health care professionals, but may be involved in the management of the patient
  - Examples include lawyer, parole officer, case manager, teacher
  - Does not include discussion with family or informal caregivers

Code Selection Based on MDM

- **Social Determinants of Health**
  - Social determinants of health are the environmental conditions where people are born, live, earn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life risks and outcomes
  - There are 5 domains of social determinants of health:
    - Economic Stability
    - Access to and quality of education
    - Access and quality to healthcare
    - Neighborhood and built environment
    - Social/community context
  - Documentation should specify the social determinant(s) that is complicating the medical decision making for the patient’s plan of care

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ** Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99205 99215	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	**Extensive** *(Must meet the requirements of at least 2 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 source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Code Selection Based on MDM

- **Chronic illness with severe exacerbation, progression, or side effects of treatment**
  - Significant risk of morbidity
  - May require hospital level of care
- **Acute or chronic illness or injury that poses a threat to life or bodily function**
  - 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

Code Selection Based on MDM

- **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
  - Monitoring is performed for assessment of these potential adverse effects and not primarily for assessment of therapeutic efficacy
  - Intensive monitoring may be long-term or short-term and must occur at least quarterly
  - Monitoring may be by a lab test, a physiologic test, or imaging
  - Monitoring by history or exam does not qualify
  - The monitoring affects the level of medical decision-making in an encounter in which it is considered in the management of the patient
  - Examples may include monitoring for cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring or electrolytes and renal function in a patient who is undergoing diuresis
  - Examples of monitoring that does <u>not</u> qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect; or annual electrolytes and renal function for a patient on a diuretic since not at least quarterly

Code Selection Based on MDM Example

Chief Complaint

Eyes itching, watery

History of Present Illness

Patient presents with bilateral eye itching, redness, swelling, blurry vision and tearing. Eyes are crusty in the am. Began 3 days ago and is getting worse. Patient is a teacher at a daycare and two children had pink eye last week. Denies any trauma to the eyes. Denies sore throat, congestion or fever. Has seasonal allergies and takes Claritin when needed.

Code Selection Based on MDM Example

Physical Exam

BP 110/76 Temp 97.5 Pulse 72 Wt 120lbs

Eyes: Extraocular movements intact, both eyes are red with yellow discharge. Both lids are swollen and tender to touch

ENT: Tympanic membranes are clear. No pharyngeal erythema

Lymph: No lymphadenopathy

Respiratory: Lungs clear

Cardiovascular: Normal RRR

Integumentary: warm, no rash

Assessment/Plan

Bilateral bacterial conjunctivitis. Order Erythromycin 0.5% ophthalmic ointment, QID each eye for 10 days, 0 refills. Wash hands prior to applying ointment, use clean washcloth when cleansing eye area.

Code Selection Based on MDM Example

1. Number and complexity of problems addressed

   1 Acute, uncomplicated illness or injury - LOW

2. Amount and/or complexity of data to be reviewed/analyzed

   No Data - MINIMAL

3. Risk of complications and/or morbidity or mortality of patient management

   Prescription drug management - Moderate risk of morbidity from additional diagnostic testing or treatment

Elements of Medical Decision-making				
CPT code	**Level of MDM**	**Number and Complexity of Problems Addressed**	**Amount and/or Complexity of Problems addressed at the encounter**	**Risk of Complications and/or morbidity or mortality**
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straight forward**	**Minimal** • 1 self limited or minor problem	**Minimal or none**	**Minimal** risk of morbidity from additional diagnostic testing or treatment
99203 **99213**	**Low**	**Low** • **2** or more self-limited or minor problems; Or • **1** stable chronic illness; Or • **1** acute uncomplicated illness or injury	**Limited** *(must meet the requirements of at least 1 of the 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
99204 **99214**	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression of side effects of treatment Or • **2** or more stable chronic illnesses Or • **1** undiagnosed new problem with uncertain prognosis Or • **1** acute complicated injury	**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 source • Review of the result(s) of each unique test •Ordering of each unique test •Assessment requiring an independent historian(s) Or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional/appropriate source (not separately reported) Or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported)	**Moderate** risk of morbidity from additional diagnostic testing or treatment *Examples only:* • *Prescription drug management* • *Decision regarding minor surgery with identified patient or procedure risk factors* • *Diagnosis or treatment significantly limited by social determinants of health*
99205 **99215**	**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	**Extensive** *(must meet the requirements of at least 2 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 source • Review of the result(s) of each unique test •Ordering of each unique test •Assessment requiring an independent historian(s) Or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional/appropriate source (not separately reported) Or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported)	**High** risk of morbidity from additional diagnostic testing or treatment *Examples only:* • *Drug therapy requiring intensive monitoring for toxicity* • *Decision regarding emergency major surgery* • *Decision regarding hospitalization* • *Decision not to resuscitate or to de-escalate care because of poor prognosis*

Office or Other Outpatient Services Based on Time

Code Selection Based on Time

- **Time alone may be used to select the appropriate E/M code level for office/outpatient visits**
  - Documentation must clearly describe what was done
  - Time documented and reported must be appropriate given the services described in the documentation
  - Tasks typically performed by office staff that are performed by a physician or APP cannot be counted
- **Total face-to-face and non-face-to-face time personally spent by the physician or APP on the day of the encounter can be used to determine the code level**
  - A face-to-face encounter is required
  - Only count unique time (not time required to perform a service that can be separately billed and overlapping MD and APP time should only be counted once)
  - Staff time does not count

Code Selection Based on Time

- **Physician/APP time includes the following activities, when performed:**
  - Preparing to see the patient (eg, 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 medications, tests, or procedures
  - Referring and communicating with other health care professionals (when not separately reported)
  - Documenting clinical information in the electronic or other health record
  - Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)

Code Selection Based on Time

CPT CODE	TIME
99202	15 - 29 minutes
99203	30 - 44 minutes
99204	45 - 59 minutes
99205	60 - 74 minutes
99212	10 - 19 minutes
99213	20 - 29 minutes
99214	30 - 39 minutes
99215	40 - 54 minutes

Document a specific total amount of minutes instead of a range of minutes

Code Selection Based on Time Example – Established Patient

History

Medically appropriate

Exam

Medically appropriate

Assessment/Plan

Cough – possible side effect of Lisinopril. Chest x-ray ordered to evaluate. Discussed possible medication change. Patient prefers to continue Lisinopril.

Muscle aches – differential diagnosis, Vitamin D deficiency vs insomnia. Order Vitamin D lab.

Insomnia – Eliminate all caffeine after 3pm. Gradually reduce all other caffeine to determine impact on insomnia. Can keep one caffeinated drink in the morning.

Tremor – likely due to caffeine intake. Will recheck at next visit in 1 month.

Total of 35 minutes spent gathering history, performing exam, counseling patient on caffeine intake, ordering tests and documenting visit in EMR.

Time supports CPT code 99214

New Prolonged Care Codes

New Prolonged Care Code Per CPT

Non-Medicare

- The AMA created a prolonged care add-on code for use with **99205 or 99215**
- Use for non-Medicare patients

Code	Definition
+ 99417	Prolonged office or other outpatient evaluation and management service(s) beyond the **minimum** required 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 additional 15 minutes

New Prolonged Care Code Per CPT

Non-Medicare

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
Less than 75 minutes	99205
75 - 89 minutes	99205 and 99417
90 - 104 minutes	99205 and 99417 x 2
105 or more	99205 and 99417 x 3 or more for each additional 15 minutes

CPT Code	Time in CPT
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes

New Prolonged Care Code Per CPT

Non-Medicare

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
Less than 55 minutes	99215
55 - 69 minutes	99215 and 99417
70 - 84 minutes	99215 and 99417 x 2
85 or more	99215 and 99417 x 3 or more for each additional 15 minutes

CPT Code	Time in CPT
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

New Prolonged Care Code Per CMS

Medicare

- CMS has created HCPCS add-on code **G2212** that should be used when billing prolonged services for Medicare patients in place of 99417

Code	Definition
+ G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the **maximum** required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact

New Prolonged Care Code Per CMS

Medicare

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
Less than 89 minutes	99205
89 - 103 minutes	99205 and G2212
104 - 118 minutes	99205 and G2212 x 2
119 or more minutes	99205 and G2212 x 3 or more for each additional 15 minutes

CPT Code	Time in CPT
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes

New Prolonged Care Code Per CMS

Medicare

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
Less than 69 minutes	99215
69 - 83 minutes	99215 and G2212
84 - 98 minutes	99215 and G2212 x 2
99 or more minutes	99215 and G2212 x 3 or more for each additional 15 minutes

CPT Code	Time in CPT
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

Definition of a New Patient

- **AMA CPT® definition**:

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

[1] CPT 2022, Professional Edition, AMA, pg.6

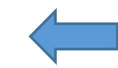
- The CMS definition of a group practice states that physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.
- Provider groups with different Tax Identification Numbers (TIN) can bill independently of one another.

New Patient Office Visit Codes

CPT Code	History	Exam	Complexity of MDM	Average Time
99202	Medically appropriate history and examination		Straightforward	15 - 29 min
99203			Low	30 - 44 min
99204			Moderate	45 - 59 min
99205			High	60 - 74 min

Established Patient Office Visit Codes

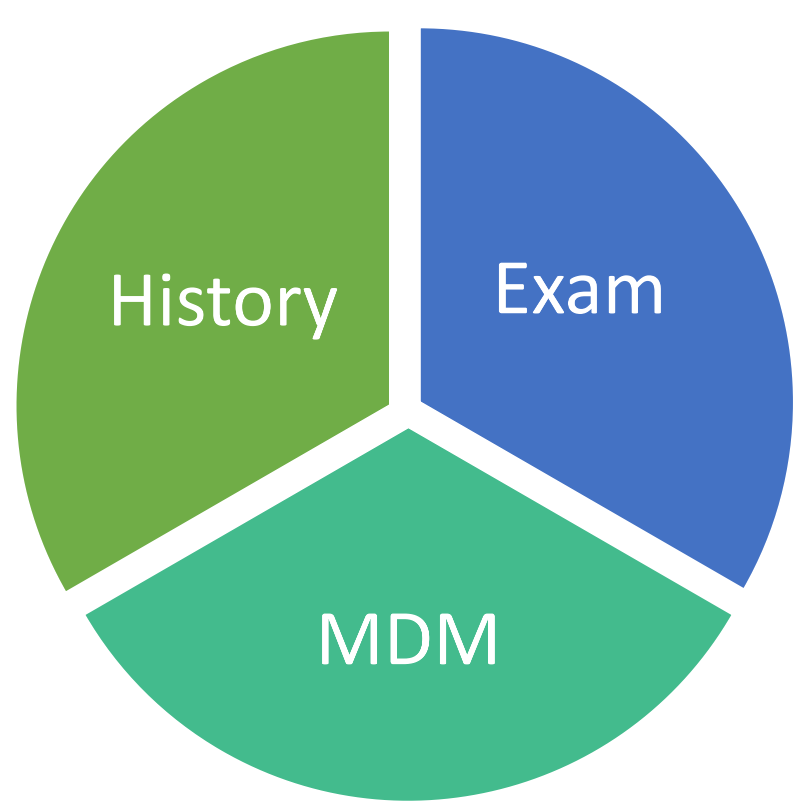
CPT Code	History	Exam	Complexity of MDM	Average Time
99211	NON-MD VISIT (e.g., RN visit). May not require the presence of an MD. MD must review and sign note.			
99212	Medically appropriate history and examination		Straightforward	10 - 19 min
99213			Low	20 - 29 min
99214			Moderate	30 - 39 min
99215			High	40 - 54 min



Coding Guidelines for:
Inpatient Visits
Consultations
Observation
Emergency Department

Supporting the Level of Service

- There are three key elements that make up an evaluation and management service
- Documentation should include details of all three components
- Depending on the code, all three key elements or two of the three key elements will be needed to support a single evaluation and management service code
- Each of the three key elements will be discussed separately



History

History

Consists of four subcomponents:

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

Chief Complaint

A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter

- Establishes the medical necessity for the visit
- Usually stated in the patient's own words
  - Not necessarily an acute condition; follow up of chronic conditions is permitted

History of Present Illness (HPI)

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

History of Present Illness (HPI)

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

Example - History of Present Illness

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

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

Example - History of Present Illness

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

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

History of Present Illness (HPI)

- Only portion of the history that **must** be recorded by the physician/APP
- If a nurse (or other ancillary staff) records the information, the physician/APP must re-state it, adding or amending as appropriate
- High level codes in most categories require documentation of a minimum of four indicators (i.e., extended HPI)

Alternative HPI: Chronic Conditions

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

Review of Systems (ROS)

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

Review of Systems (ROS)

Fourteen systems are available for review:

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

Review of Systems (ROS)

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

Example – Review of Systems (ROS)

Eyes

Constitutional

Patient describes weight loss of 10 lbs in past month. No visual disturbances. Occasional palpitations. Pneumonia six months ago. No GI symptoms. Fractured femur in MVA in 2006. No problems with depression or anxiety.

Psych

Cardiovascular

Gastro

Example – Review of Systems (ROS)

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

This is appropriate documentation of a Complete Review of Systems

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

Example - Review of Systems (ROS)

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

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

Review of Systems (ROS)

Who can record the Review of Systems?

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

Review of Systems (ROS)

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

Past, Family, Social History (PFSH)

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

Past, Family, Social History (PFSH)

Who can record the PFSH?

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

Past, Family, Social History (PFSH)

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

Past, Family, Social History (PFSH)

- If family history is unknown, documentation of the reason will support the family history and credit will be given for that component
- If the history is unobtainable from the patient or other source, the record should state so and describe the patient's condition or other circumstance which precludes obtaining the history. Credit will then be given for a comprehensive history
    - "Patient is a poor historian" is not considered adequate support for a comprehensive history

Example - Past, Family, Social History

New patient presents for evaluation of chest pain.

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

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

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

✓This is appropriate documentation of a Complete PFSH

- All three areas of history are addressed

Example - Past, Family, Social History

Patient presents for evaluation of headaches

Past medical history: Hypertension and gastroesophageal reflux

Family history: Non-contributory

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

Only Past Medical history and Social history are documented properly

- "negative," "noncontributory," "unremarkable," or "unknown" are not considered sufficient

Four History Levels

Problem Focused: 1 HPI

Expanded Problem Focused: 1 HPI and 1 ROS

Detailed: 4 HPI, 2 – 9 ROS, 1 PFSH*

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

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

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

History: Key Points to Remember

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

History:
Coding and Documentation Risk Areas

Coding and documentation risk areas of the history portion of physician/APP's documentation include:

- Missing family history
- Incomplete review of systems
  - i.e., fewer than 10 organ systems addressed for higher level codes

History – Let's Practice

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

Review of Systems

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

Allergies: NKA

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

Family history negative.

Atrium Health

History – Let's Practice

Chief complaint: Back and neck pain

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

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

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

Detailed history

Examination

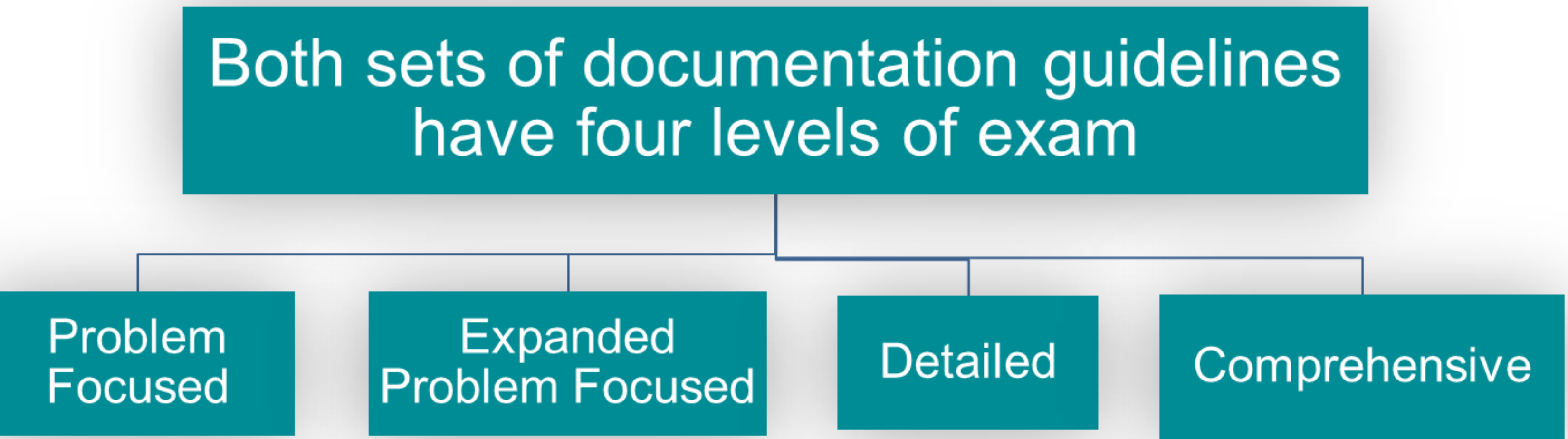
Examination

1995 documentation guidelines:

- Body areas or organ systems

1997 documentation guidelines:

- Bullet points



1995 Exam Guidelines

Body Areas

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

Organ Systems

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

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

Levels of Examination (1995)

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

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

Expanded Problem Focused vs. Detailed 1995 Guidelines

- Both levels require documentation of examination of 2 to 7 organ systems
- Per Palmetto GBA guidelines, a detailed exam requires documentation of 2 to 7 organ systems with at least two findings in at least two organ systems

Examples of What Constitutes a Detailed Exam 1995 Guidelines

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

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

Exam Examples 1995 Guidelines

Expanded Problem Focused	Detailed	Comprehensive
Wt 219 lbs, BP 165/95, pulse 82 Lungs clear Heart regular rate and rhythm ***3 Organ Systems***	Wt 219 lbs, BP 165/95, pulse 82 No JVD, no carotid bruits, Heart regular rate and rhythm Lungs clear, normal effort ***3 Organ Systems <u>with detail</u> in 2, the cardiovascular and respiratory systems***	Wt 219 lbs, BP 165/95, pulse 82 Alert and oriented x 3 HEENT negative Lungs clear Heart regular rate and rhythm Abdomen soft, nontender Skin no rashes or lesions ***8 Organ Systems***

1995 Exam – Let's Practice

Physical Exam

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

EXPANDED PROBLEM-FOCUSED EXAM

6 organ systems documented with no detail

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

1995 Exam – Let's Practice

Physical Exam

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

DETAILED EXAM

7 organ systems documented
with detail in CV and GI systems

1995 Exam – Let's Practice

Physical Exam

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

COMPREHENSIVE EXAM

8 organ systems documented

1997 Exam Guidelines

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

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

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

1997 Exam
Multi-Specialty vs. Specialty

General Multi-System Exam:

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

Specialty Exams:

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

Exam Example
1997 Guidelines

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

No acute distress — Const – 1 bullet

No JVD, no carotid bruits — CV – 2 bullets

Lungs clear — Resp – 1 bullet

Heart regular rate and rhythm — CV – 1 bullet

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

Alert and oriented x 3 — Psych – 1 bullet

9 bullets = Expanded Problem Focused Exam 1997

4 Organ Systems with detail in 2 = Detailed 1995

Complexity of Medical Decision Making (MDM)

Medical Decision Making (MDM)

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

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

MDM Formula

2 out of 3 of ABC = MDM

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

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

A = Number of Diagnoses or Treatment Options

Consider the problems addressed during the encounter

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

A = Number of Diagnoses or Treatment Options

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

Additional Info About How Diagnoses are Counted

New problem “to examiner”

- Physicians/APPs will receive 3 or 4 point credit when evaluating a problem for the first time
  - This does not apply if the problem has been addressed by a physician/APP in the same group

B = Amount and/or Complexity of Data

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

B = Amount and/or Complexity of Data

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

Additional Info About How Data is Counted

Review and summarization of old records:

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

Additional Info About How Data is Counted

Discussion of case with another health care physician/APP:

- Must document what was discussed
- Does not include discussion with nursing staff or supervising physician by an Advanced Practice Provider or a Resident
- Does not include discussion with other physicians/APPs in same practice when “handing off” care of patient at end of shift

Additional Info About How Data is Counted

Independent visualization of image, tracing or specimen

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

"Personal review of image shows …"

C = Risk Associated with Patient's Condition

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

KEY POINT TO REMEMBER!
RISK ≠ Complexity of MDM

C = Risk Associated with Patient's Condition

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

C = Risk Associated with Patient's Condition

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

C = Risk Associated with Patient's Condition

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
- Monitoring is performed for assessment of these potential adverse effects and not primarily for assessment of therapeutic efficacy
- Intensive monitoring may be long-term or short-term and must occur at least quarterly
- Monitoring may be by a lab test, a physiologic test, or imaging
- Monitoring by history or exam does not qualify
- The monitoring affects the level of medical decision-making in an encounter in which it is considered in the management of the patient
- Examples include monitoring for cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring or electrolytes and renal function in a patient who is undergoing diuresis
- Examples of monitoring that does not qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect; or annual electrolytes and renal function for a patient on a diuretic since not at least quarterly

Atrium Health

C = Risk Associated with Patient's Condition

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

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

Atrium Health

Calculate the MDM

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

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

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

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

Calculate the MDM

Final Result of Complexity

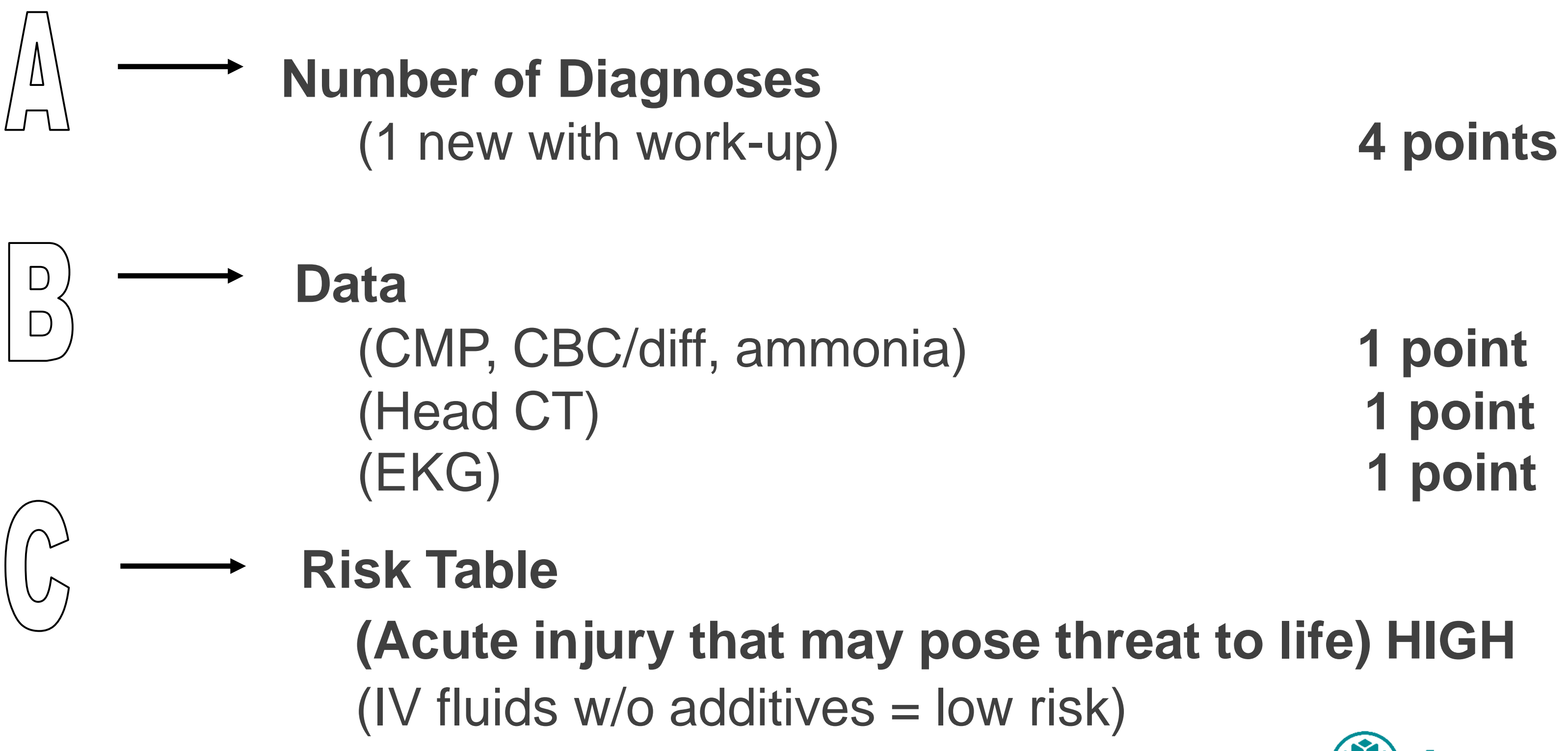
Draw a line down the column with **2 or 3** circles and circle decision making level OR draw a line down the column with the middle circle and circle the decision making level.

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

Atrium Health

Calculate the MDM

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



Atrium Health

Calculate the MDM

Final Result of Complexity

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

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

Medical Decision Making: Coding and Documentation Risk Areas

The most common risk areas of the MDM portion of the documentation includes:

- Not listing all problems addressed during the encounter
- Not clearly describing the severity of the problems addressed during the encounter including whether they are worsening or not improving as expected
- Incomplete documentation of the data reviewed especially discussions with other physicians/APPs and personal review of images, tracings and specimens

Inpatient Services, Consultations, and Observation Services Based on Time

Time Documentation

- Time is considered the controlling factor and can be used to determine the E/M code when ***greater than 50% of the total encounter time*** is spent in ***counseling and/or coordination of care***
    - Outpatient Consultations = Face-to-face time with the patient
    - Inpatient/Observation = Includes bedside and floor/unit time devoted to patient

See your matrix card to determine the total number of minutes associated with various codes

Time Documentation

To code based on time, you **must** document the following:

- Total time spent on the patient encounter
- Statement that over half the visit was spent in counseling/coordination of care
- What was discussed, if counseling, OR what was done for coordination of care

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

Time Documentation

Counseling includes discussion with the patient regarding:

- Diagnosis, prognosis, treatment options, etc.
- Discussion of psychiatric issues
- Instructions for management and/or follow up
- Diagnostic results, impressions, and/or recommended diagnostic studies

Time Documentation

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

Example: Time Documentation

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

The time statement supports Inpatient Consultation CPT code 99254

Consultations

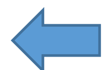
Consult vs. Transfer of Care

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

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

Consult vs. Transfer of Care

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



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

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

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

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

Inpatient Hospital Visit Codes

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

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

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

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

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

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

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

Discharge Day Management Codes 99238-99239

CPT Code	Time	Documentation Required
99238	Up to 30 minutes	Requires documentation of the total time spent in discharge of patient
99239	> 30 minutes	

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

2 Midnight Rule (Medicare)

Documentation requirements:

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

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

Observation Care Codes

Atrium Health

Observation Care Codes

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

Observation Care Codes

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

Atrium Health

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

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

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

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

Observation Care Discharge

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

99217 Observation care discharge

Same Day Observation Care Codes 99234-99236 (3 of 3 Key Elements)

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

Emergency Department Visits

Emergency Department Visits 99281-99285 (3 of 3 Key Elements)

CPT Code	History	Exam	Complexity of MDM
99281	HPI = 1 – 3	1 organ system	Straightforward
99282	HPI = 1 - 3 ROS = 1	2 – 7 organ systems	Low
99283	HPI = 1 - 3 ROS = 1	2 – 7 organ systems	Moderate
99284	HPI = 4+ ROS = 2 PFSH = 1	2 – 7 organ systems with two in detail	Moderate
99285	HPI = 4+ ROS = 10+ PFSH = 2	8+ organ systems	High

Critical Care Services

A coding job aid is available on eLink for your reference

Critical Care

- Direct delivery of medical care to a critically ill or critically injured patient by a physician or APP
    - One or more vital organ systems is impaired such that there is high probability of imminent or life-threatening deterioration of the patient
    - Requires the physician/APP to provide urgent intervention and treatment

- Involves *high* complexity medical decision making

Critical Care Codes

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

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

Documentation Requirements

The following ***must*** be documented:

- Condition of the patient, ***and***
- Details of the assessment, treatment plan, interventions, any services provided, ***and***
- Amount of *distinct time* spent providing critical care

Critical Care

Critical Care Guidelines

Requires the full attention of the physician/APP

- Immediate bedside
- Floor/unit time (e.g., reviewing lab/diagnostic tests, discussing the case with other medical staff)
- Must be immediately available to the patient (on the same floor/unit as the patient)

The Physician/APP is **not allowed** to provide services to other patients during this time

Critical Care

Critical Care Guidelines

Family counseling/discussions can be reported as critical care services when the following are met:

- Patient is no longer able to participate in making decisions
- Discussions are vital in order to determine treatment options

Synopsis **must be documented** in the medical record that supports the medical necessity of the meeting with family or other surrogate decision makers

Critical Care

Critical Care Guidelines

More than one physician/APP can bill for critical care services on the same day

- Services must meet the critical care definition and it cannot be duplicative

- Usually represents a physician/APP from a different specialty that is medically necessary for the patient's care

Critical Care – Teaching Physician

Critical Care Guidelines - Medicare

The teaching physician may refer to the resident's documentation for patient history, physical findings and the medical assessment. However, the teaching physician's documentation must include substantive information including the following:

- The time the **teaching physician** spent providing critical care
- The critical state of the patient during the time the teaching physician saw the patient
- The cause of the patient falling into a critically ill state
- The nature of the treatment and management provided by the teaching physician

Critical Care – Teaching Physician

Critical Care Guidelines - Medicare

- Time spent teaching does not count towards critical care time
- Only time spent by the resident and teaching physician together or by the teaching physician alone can be counted toward critical care time
- Time spent by the resident, ***in the absence of the teaching physician***, cannot be reported by the teaching physician as critical care time

Critical Care

Activities that do not meet Critical Care criteria

- Daily management of a patient on chronic ventilator therapy
- Reviewing or itemizing services provided by someone else
- Comfort measures, waiting for family to remove life support
- Patients which are ready for transfer to the regular floor or hospice

Critical Care

Critical Care Services and Procedures

- When a separately billable procedure is reported, the critical care time statement must indicate that the time is exclusive of any procedure(s) performed
  - e.g., CPT 31500 endotracheal intubation

- Modifier -25 must be appended to the critical care code

Critical Care Documentation

Not all visits to a patient in the ICU qualify as Critical Care services. Use other appropriate E/M codes for the following:

- Admitted to CCU, ICU, SICU when no other beds available
- Admitted to CCU, ICU, SICU for close nursing observation and/or frequent vital signs
- Hospital rules require certain treatments be administered in a CCU, ICU, SICU (e.g., insulin drips)

Teaching Physicians, Residents & Medical Students

Atrium Health

Teaching Physician Guidelines for Medicare & Medicare Managed Care

Medicare

- Medicare will pay for physician services in teaching settings under the physician fee schedule
- Modifier –GC should be appended to the CPT code(s) to indicate that the Teaching Physician services rendered are in compliance with the requirements outlined in Section 15016 of the Medicare Carriers Manual

Teaching Physician Guidelines for Medicare & Medicare Managed Care

Medicare

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

Teaching Physician Guidelines for Medicare & Medicare Managed Care

Suggested documentation includes:

- *“I saw and evaluated the patient. Discussed with Dr. Resident and agree with the findings and plan as written.”*
- *“I saw and evaluated the patient. Discussed with Dr. Resident, I agree with the findings and treatment plan as documented in Dr. Resident’s note except….”*

Teaching Physician Guidelines for Medicare & Medicare Managed Care

Unacceptable documentation for a Medicare patient:

- *“Agree with above.”*
- *“Rounded, reviewed, agree.”*
- *“Discussed with Dr. Resident. Agree.”*
- *“Seen and agree.”*
- *“Patient seen and evaluated.”*

Teaching Physician Guidelines for Medicare & Medicare Managed Care

Medicare

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

Exception to this rule:

Certain Family Practice and Internal Medicine practices are set up as *Primary Care Exception* locations

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

Teaching Physician Guidelines Time-Based Codes

For services provided that are time-based, only the teaching physician's total time may be applied to support the service.

Examples:

- Individual medical psychotherapy
- Critical care services
- Hospital discharge day management
- Prolonged services
- Care plan oversight
- E/M codes (services other than office/outpatient services [99202-99205 & 99211-99215]) in which counseling and/or coordination of care dominates greater than 50% of the total encounter, and time is considered the controlling factor to qualify for a particular level of E/M service.

Teaching Physician Guidelines - Medicare Residents Performing Major Surgeries

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

Teaching Physician Guidelines - Medicare Complex or High-Risk Procedures

- In the case of complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicate that the procedure requires personal supervision of its performance by a physician, the teaching physician must be present for the entire service.

- These procedures include interventional radiologic and cardiologic supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and transesophageal echocardiography.

Teaching Physician Guidelines –Medicare Endoscopy Procedures

The teaching physician must be present during the entire viewing.

- The 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.

Teaching Physician Guidelines – Medicare Interpretation of Diagnostic Testing

- The teaching physician must indicate that he/she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings.

- A countersignature of the teaching physician is not sufficient for a diagnostic interpretation.

Teaching Physician Guidelines - Medicare Residents Performing Minor Procedures

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

Teaching Physician Guidelines

Non-Medicare Patients

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

Teaching Physician Guidelines for Medicare & Other Payors

Medical Students

Medicare will allow the contribution of medical student documentation provided the following criteria are met:

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

Teaching Physician Guidelines for Medicare & Other Payors

Medical Students

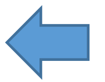
To bill Medicare for services provided by medical students, the teaching physician must:

- See the patient, and
- Personally perform (or re-perform) the physical exam and medical decision making of the E/M service, but may verify any student documentation of them in the medical record, rather than re-documenting this work

Advanced Practice Provider (APP) Students

- Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past medical, family, social history) must be performed in the physical presence of the billing physician/APP

- Students may document services in the medical record however, the billing physician/APP must verify in the medical record all student documentation or findings, including history, physical exam, and/or medical decision making



Additional Training is Available

- If you wish to receive additional training, please indicate your interest on the Class Evaluation Form (question #7). A Compliance Auditor/Educator will coordinate the follow up session.
- The educational session could include:
  - Review and discussion of your recent documentation
  - Specialty-specific services
    - e.g., preventive services, prenatal visits, common procedures

Contacts

CHARLOTTE METRO

Carolee Bryan, CPC, CEMC

Martha Forrest, CPC, CEMC, CDEO

Meleah Oliver, CPC, CEMC, CMA

Jennifer Phillips, RHIT, COC, CPC, CRC, CEMC, CGSC

Cathy Serfass, CPC, CEMC, CDEO

Contacts

BEHAVIORAL HEALTH

Martha Forrest, CPC, CEMC, CDEO

Vanessa Coles, RHIT, CPC, CEMC, CPMA

NAVICENT

Michele Hendrix, CPC, CPMA, CEMC, CDEO, CPCO, CRC-I

NEONATOLOGY

Erica Woolsey, CPC, CEMC, CDEO

COLUMBUS and SCOTLAND REGIONS

Meleah Oliver, CPC, CEMC, CMA

Additional Information Available in Appendices

Atrium Health

Appendices

Appendix	Topic
A	Primary Care Exception
B	Preventive Medicine Visits
C	Preventive/Split Services
D	Smoking/Tobacco Use Cessation Counseling
E	Commonly Performed Office Procedures
F	Advance Care Planning

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

APPENDIX A
Primary Care Exception

Atrium Health

Primary Care Exception

- The Exception Rule permits teaching physicians providing E/M services with a GME program that has been granted a Primary Care Exception, to bill Medicare for lower and mid-level E/M services furnished by residents in the absence of a teaching physician. The Exception Rule does *not* apply to procedures or any services other than the lower and mid-level E/M services listed below:
  - CPT codes 99202 – 99203
  - CPT codes 99211 – 99213
  - HCPCS code G0402 – IPPE (Welcome to Medicare visit)
  - HCPCS codes G0438 & G0439 – AWV (Annual Wellness Visit)
- If a service other than that listed above needs to be furnished, then the general teaching physician policy applies

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

Primary Care Exception – What's Required?

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

Atrium Health

Primary Care Exception – Documentation

- **Teaching physician:**
  - Must review the care provided by the residents during or immediately after each visit which includes a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and the treatment plan
  - Must write a personal note indicating that he/she has reviewed information from the resident’s history, exam, assessment and plan, and any labs/tests/records, etc.
  - Documentation must indicate that the review took place while the patient was in the clinic or immediately after the resident saw the patient

Primary Care Exception – Documentation

- **Teaching physician:**
  - Documentation should clearly indicate the extent of the teaching physician's participation in the review and direction of services furnished to each Medicare patient
  - Only Medical Decision Making (MDM) is used to determine the visit level for office/outpatient EM visits furnished under the Primary Care Exception
  - In order for resident's documentation to be counted toward the documentation requirement for the code selected, the teaching physician must review and link to the resident's note

Primary Care Exception – Documentation

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

APPENDIX B
Preventive Medicine Visits

Atrium Health

Preventive Medicine Visits

Definition of Service

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

Preventive Medicine Visits

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

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

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

APPENDIX C
Preventive/Split Services

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

Atrium Health

Preventive/Split Services

If during the course of a preventive exam, a significant, separately identifiable problem or abnormality is evaluated, a problem-oriented visit may be reported in addition to the preventive exam service.

- The problem or abnormality must be significant enough to warrant additional work beyond the preventive exam
- The documentation must convey that two distinct services were provided – the preventive encounter and a problem-oriented service
  - Problem-oriented E/M code (99202 – 99215) with modifier -25
  - Preventive service code (99381 – 99397)

Preventive/Split Services

- The level of the problem-oriented E/M code is based on Medical Decision Making (MDM) or the Total Time spent by the provider addressing the problem or issue
  - Total Time documentation should not include the time spent performing the preventive exam
- Simply refilling medications for stable chronic conditions or addressing a minor issue that does not require additional work up, does not constitute a separate medically necessary problem-oriented E/M encounter

Example - Preventive/Split Services

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

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

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

Assessment and Plan:

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

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

Diagnosis Codes for Preventive Split Visits

In ICD-10-CM, the diagnosis codes for preventive encounters distinguish between a preventive exam ***with abnormal findings*** and a preventive exam ***without abnormal findings***

ICD-10-CM	Description
Z00.01	Encounter for general adult medical examination with abnormal findings (Use additional code(s) to identify abnormal findings)
Z00.121	Encounter for routine child health examination with abnormal findings (Use additional code(s) to identify abnormal findings)
Z01.411	Encounter for routine gynecological examination with abnormal findings (Use additional code(s) to identify abnormal findings)

Preventive/Split Services and Medicaid

NC and SC Medicaid

- Beneficiaries 20 years of age and younger may receive a preventive exam and a sick visit on the same date of service
  - Preventive split visits are not covered for patients 21 years of age and older
- Only services performed *above and beyond* the preventive visit may be used to determine the sick visit level

APPENDIX D
Smoking/Tobacco Use Cessation Counseling

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

Atrium Health

Smoking/Tobacco Use Cessation Counseling

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

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

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

Smoking/Tobacco Use Cessation Counseling

Medicare coverage criteria:

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

Smoking/Tobacco Use Cessation Counseling

Medicare will cover two smoking cessation attempts per year

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

Medicare Asymptomatic Diagnosis Codes

F17.210 – F17.219 Nicotine dependence, cigarettes

F17.220 – F17.229 Nicotine dependence, chewing tobacco

F17.290 – F17.299 Nicotine dependence, other product

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

Medicare Symptomatic Diagnosis Codes

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

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

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

Smoking/Tobacco Use Cessation Counseling

Commercial insurance benefits may vary by payor and individual plan

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

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

APPENDIX E
Commonly Performed Office Procedures

Atrium Health

Commonly Performed Office Procedures and Services

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

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

Cerumen Removal

CPT CODE	DESCRIPTION
69209	Removal impacted cerumen using irrigation/lavage, unilateral

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

Cerumen Removal

CPT CODE	DESCRIPTION
69210	Removal impacted cerumen requiring instrumentation, unilateral

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

Cerumen Removal

Diagnosis codes for reporting cerumen removal services:

ICD-10-CM diagnosis code options:

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

EKG Documentation Requirements

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

EKG Label

The following label is designed to meet the minimum documentation requirements

- In addition to recording his <u>findings</u>, the interpreting physician/APP should notate any <u>comparison to a prior EKG</u> documenting any changes on the EKG label.

- The interpreting physician/APP should <u>sign and date</u> the EKG label.

❑ Normal (Rate, Rhythm, Axis, Intervals and Wave Changes)
Except as specified ___________________________________
I have personally reviewed the EKG tracing and
❑ Agree with computerized printout
❑ Disagree with computerized printout as noted:

____

Comparison to Prior EKG dated _______ /_______ / _______
❑ Unchanged
❑ Changed as noted:

____

Signature/Date: *Actual size: 1.5" x 3"*

Ultrasound Documentation Requirements

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

Ultrasound Label

The following label is designed to meet the minimum documentation requirements

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

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

____

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

Provider Signature/Date ____________________________

X-Ray Documentation Requirements

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

X-Rays

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

Global Service

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

Wound (Laceration) Repairs

Wound closure utilizing sutures, staples, or tissue adhesives such as Dermabond

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

Atrium Health

Selecting Wound Repair Codes

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

Atrium Health

Selecting Wound Repair Codes

- Cauterization or placement of adhesive strips to close a laceration is <u>*not*</u> billable as a wound repair and would be included in the E/M service
- Use of *Dermabond* adhesive may be reported as a simple repair
- Suture removal following a laceration repair is included in the wound repair itself and should not be separately billed

Selecting Wound Repair Codes

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

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

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

Atrium Health

Incision and Drainage (I&D) Codes

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

  10060 I&D of abscess, simple or single

  10061 I&D of abscess, complicated or multiple

  10140 I&D of hematoma, seroma or fluid collection

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

Incision and Removal of a Foreign Body

- Services performed in the office setting include the following:
  - **10120** Incision and removal of foreign body, subcutaneous tissues; simple
  - **10121** Incision and removal of foreign body, subcutaneous tissues; complicated
- To support billing of these codes, the documentation must indicate that it was necessary to make a simple incision or to extend the edges of the wound in order to remove the foreign body
- If the foreign body can be removed simply by grasping it with forceps and pulling it out, the service is not separately billable and is considered part of the E/M service

APPENDIX F
Advance Care Planning

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

Atrium Health

Advance Care Planning

- A voluntary service to discuss the patient's healthcare wishes if they become unable to make decisions for themselves
- Discussion may include advance directives with or without completion of legal forms such as:
  - Living wills, Instruction directives, Healthcare proxy, Healthcare power of attorney
- May be provided and reported by a:
  - Physician
  - Advanced Practice Provider (e.g., NP, PA)
- Other staff members may assist with certain aspects of the service when using a team-based approach under incident-to guidelines

Advance Care Planning: General Requirements

- Order and/or plan of care is necessary and must be documented
- Time based face-to-face encounter with provider and patient, surrogate decision-maker and/or caregiver
- Physician and/or APP participates and contributes to the provision of this service
- Beneficiaries should be given a clear opportunity to decline if they prefer to receive assistance and/or counseling from other nonclinical sources outside the Medicare program
- No frequency limitations. However, when ACP is reported multiple times, it is expected to see documented changes in health status or end-of-life wishes

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

"Incident to" guidelines applicable

- Evidence of the following in the medical record:
  - Physician initiates request/order for advance care planning
  - Beneficiary's approval
  - Advance Care Planning services furnished under supervisory physician's overall direction and control
  - Physician activity/involvement frequently enough to reflect active participation/management
  - Physician's involvement should be documented in the medical record
  - Physician must be on-site and immediately available (i.e., direct supervision)
  - A signature macro may be used by the supervising provider

"In addition to providing direct supervision, I have actively managed, participated and contributed to the delivery of the advance care planning service."

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

- May be billed separately with Annual Wellness Visit
  - Modifier -33 should be appended to the service
- No copay or deductible applies when performed during an AWV
- May be reported during Transitional Care Management (TCM), Chronic Care Management (CCM), or global surgery period
- May be reported in the same session with other E/M services
  - Except when performed during a “Welcome to Medicare” (IPPE) service

Advance Care Planning: Reporting in the Hospital or NF Setting

- Must be personally performed and reported by the physician or qualified healthcare professional (i.e., NP or PA)
- May be reported in the same session with other E/M services – Except when performed during critical care, neonatal critical care, pediatric critical care, initial and continuing intensive care services

Advance Care Planning

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

Per CPT guidelines, time is satisfied when more than half of the required time is met. Documentation must support at least 16 minutes dedicated to ACP for reporting 99497. At least 46 minutes must be documented to report 99497 and 99498.

Questions?

Atrium Health