Atrium Health©

Evaluation and Management Documentation and Coding for New Clinicians

Feb 2025 | Enterprise Mid-Revenue Cycle

Today's Agenda

- New Clinician Review Process
- Documentation Guidelines for Evaluation and Management Services
  - Office/Outpatient, Hospital Inpatient and Observation Care, Consultations, and Emergency Department Services
- Critical Care Services
- Virtual Health Documentation & Coding
- Medical Record Documentation Standards
- Diagnosis Coding
- Advance Practice Practitioners (APPs)
- Guidelines for Teaching Physicians, Residents and Medical Student
- Code of Conduct Review

Timeline for New Clinician Reviews

Day 1

- Coding & Documentation for New Clinicians (e.g., Physicians and Advanced Practice Practitioners)

Days 2-60

- NPO Instructor will send welcome email to clinicians
- Offer to review recent documentation
- Offer of on-site and/or virtual follow-up
- General Q&A
- Specialty specific topics

Days 90-100

- New Clinician Review
- Post-review meeting
- General Q&A

Days 100+

- A Follow-Up review will be performed within the next 90 days for those New Clinician Reviews that fall below the 90% threshold
- New Clinician Reviews that meet or exceed the 90% threshold, a future clinical documentation review will be completed by Compliance when risks are identified

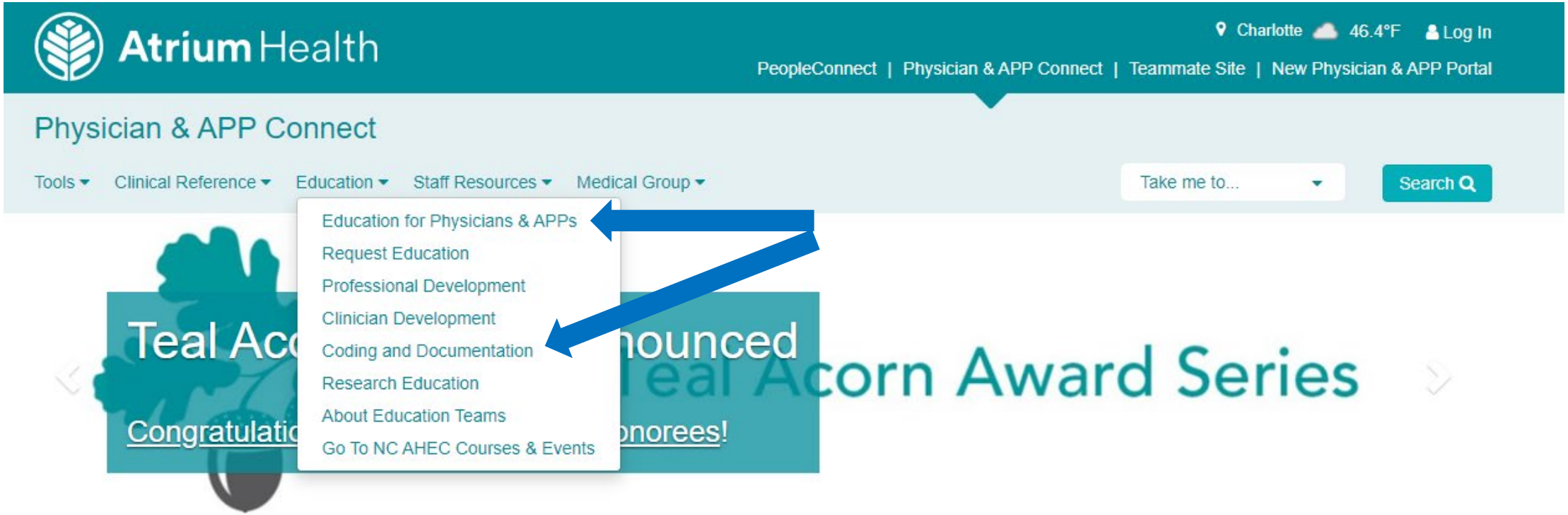
Additional Training Request/Feedback

If you wish to receive additional training, please indicate your interest on the Class Evaluation Form (question #7).

The educational session could include:

- Review and discussion of your recent documentation

Accessing Billing & Documentation Resources via Physician Connect



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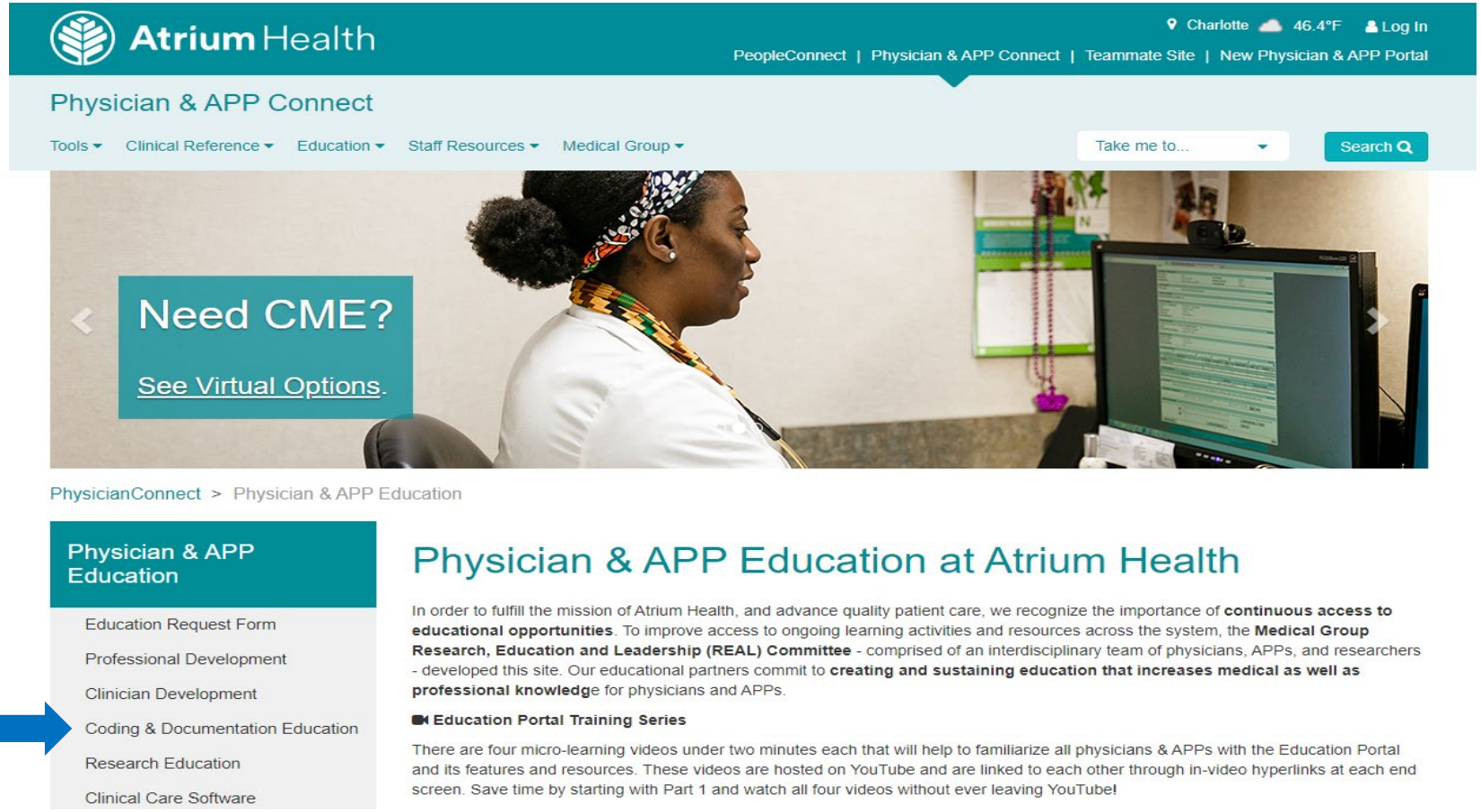
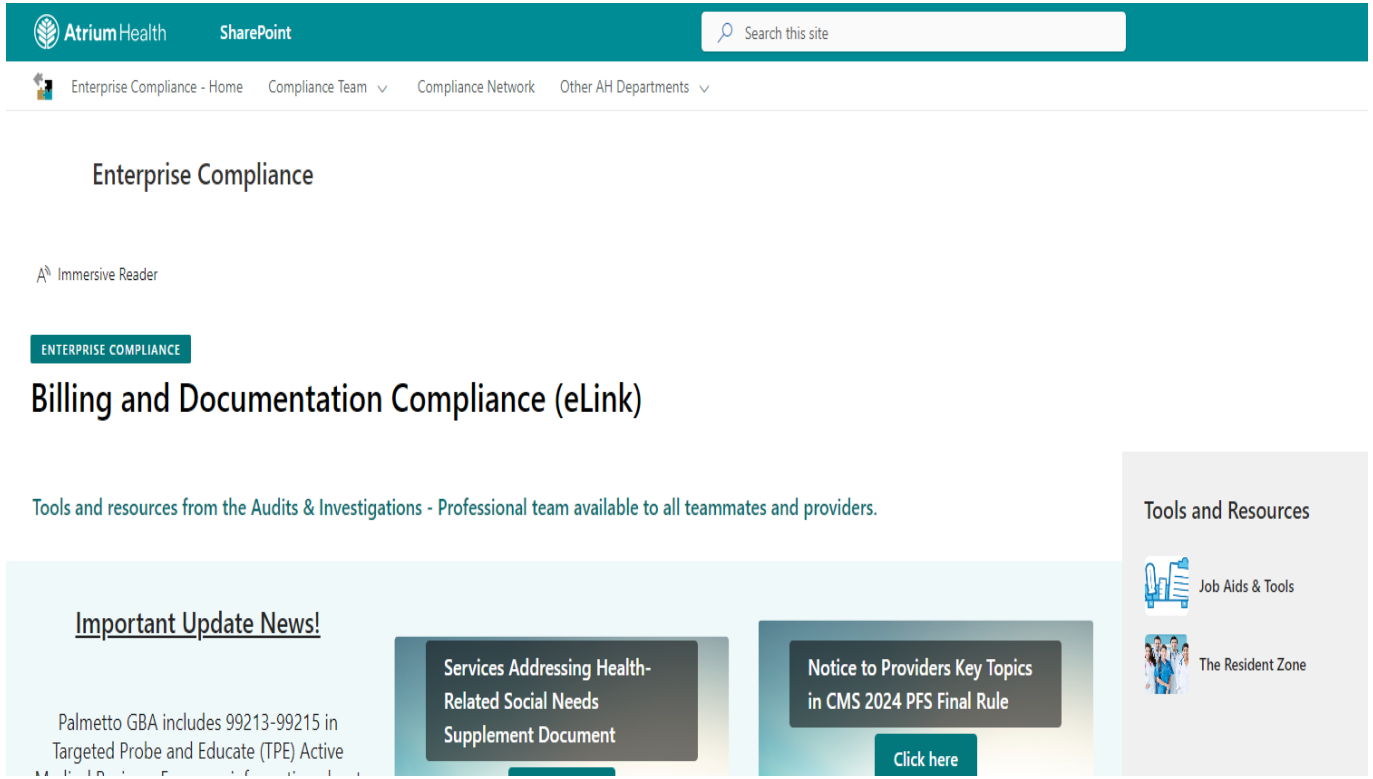


Accessing Billing & Documentation Resources via eLink

eLink is a Compliance SharePoint site that provides access to coding guidance, job aids, learning opportunities, and much more.

[Billing and Documentation Compliance (eLink) (sharepoint.com)]



Atrium Health

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, West Virginia and Alabama.

Documentation Guidelines for Evaluation and Management Services

Evaluation and Management (E/M) Services

Documentation requirements were developed jointly by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS).

These services include:

- Office Visits
- Hospital Visits
- Consultations
- Critical Care Services
- Emergency Room Visits
- Nursing Home Visits

E/M LEVELS OF SERVICE

E/M Services Matrix

EMERGENCY ROOM VISITS: Select E/M code based on Medical Decision Making

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making
99281	May not require the presence of a MD or APC	N/A
99282	Requires a medically appropriate history and/or examination	Straightforward
99283	Requires a medically appropriate history and/or examination	Low
99284	Requires a medically appropriate history and/or examination	Moderate
99285	Requires a medically appropriate history and/or examination	High

NURSING FACILITY CARE – INITIAL

Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99304	Requires a medically appropriate history and/or examination	Straightforward or Low	25
99305	Requires a medically appropriate history and/or examination	Moderate	35
99306	Requires a medically appropriate history and/or examination	High	50

NURSING FACILITY CARE – SUBSEQUENT

Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99307	Requires a medically appropriate history and/or examination	Straightforward	10
99308	Requires a medically appropriate history and/or examination	Low	20
99309	Requires a medically appropriate history and/or examination	Moderate	30
99310	Requires a medically appropriate history and/or examination	High	45

NURSING FACILITY DISCHARGE SERVICES

CPT Code	Discharge	Documentation Requirements	TIME MAY INCLUDE
99315	30 MINUTES **OR LESS**	Requires documentation of time in notes	✓ Final Exam ✓ Discussion of nursing facility stay ✓ Preparation of discharge records, Rx and referral forms ✓ Instructions for continuing care to all relevant caregivers (even if the time spent by the MD is not continuous)
99316	**MORE THAN** 30 MINUTES	Requires documentation of time in notes	

OFFICE VISITS – NEW: Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99202	Requires a medically appropriate history and/or examination	Straightforward	15
99203	Requires a medically appropriate history and/or examination	Low	30
99204	Requires a medically appropriate history and/or examination	Moderate	45
99205	Requires a medically appropriate history and/or examination	High	60

OFFICE VISITS – ESTABLISHED: Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines		Medical Decision Making	Total Time
99211 Non-MD visit (e.g. RN, Pharmacist)	May not require the presence of a MD or APC MD must review note and co-sign	EXAMPLE QUALIFYING VISITS: * BP checks * Glucose checks * + PPD reading Document interval history & vitals – discuss results **Services should be medically necessary and appropriately documented in the medical record.**		N/A
99212	Requires a medically appropriate history and/or examination		Straightforward	10
99213	Requires a medically appropriate history and/or examination		Low	20
99214	Requires a medically appropriate history and/or examination		Moderate	30
99215	Requires a medically appropriate history and/or examination		High	40

OUTPATIENT CONSULTATIONS (Report using I-codes (I1702 – I1705 / I1712 – I1715))

NEW / ESTABLISHED: Select code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99242	Requires a medically appropriate history and/or examination	Straightforward	20
99243	Requires a medically appropriate history and/or examination	Low	30
99244	Requires a medically appropriate history and/or examination	Moderate	40
99245	Requires a medically appropriate history and/or examination	High	55

PROLONGED SERVICES – OUTPATIENT

CPT Code	Time with or w/o direct patient contact on the date of an E/M beyond the required time of the primary service when selected based on Total Time	Total Time
+99417	Report in conjunction with 99205, 99215, 99245, 99345, 99350, 99483	Each 15 min
+G2212 (Medicare)	Do not report on the same DOS as 90833, 90836, 90838, 99358, 99359, 99415, 99416	Each 15 min

E/M LEVELS OF SERVICE

E/M Services Matrix

INITIAL INPATIENT or OBSERVATION CARE
Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99221	Requires a medically appropriate history and/or examination	Straightforward or Low	40
99222	Requires a medically appropriate history and/or examination	Moderate	55
99223	Requires a medically appropriate history and/or examination	High	75

SUBSEQUENT INPATIENT or OBSERVATION CARE
Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99231	Requires a medically appropriate history and/or examination	Straightforward or Low	25
99232	Requires a medically appropriate history and/or examination	Moderate	35
99233	Requires a medically appropriate history and/or examination	High	50

HOSPITAL INPATIENT or OBSERVATION Admitted and Discharged on the SAME Calendar Date
Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99234	Requires a medically appropriate history and/or examination	Straightforward or Low	45
99235	Requires a medically appropriate history and/or examination	Moderate	70
99236	Requires a medically appropriate history and/or examination	High	85

HOSPITAL INPATIENT or OBSERVATION DISCHARGE SERVICES

CPT Code	Discharge	Documentation Requirements	TIME MAY INCLUDE
99238	30 MINUTES OR LESS	Requires documentation of time in notes	✓ Final Exam ✓ Discussion of hospital stay ✓ Preparation of discharge records, Rx and referral forms ✓ Instructions for continuing care to all relevant caregivers (even if the time spent by the MD is not continuous)
99239	MORE THAN 30 MINUTES	Requires documentation of time in notes	

INPATIENT CONSULTATIONS (Report using I-codes (I1722 – I1725))
NEW / ESTABLISHED: Select code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99252	Requires a medically appropriate history and/or examination	Straightforward	35
99253	Requires a medically appropriate history and/or examination	Low	45
99254	Requires a medically appropriate history and/or examination	Moderate	60
99255	Requires a medically appropriate history and/or examination	High	80

CRITICAL CARE SERVICES – TIME BASED

CPT Code	Time Spent	Documentation Requirements
Use appropriate E/M Code	LESS THAN 30 MINUTES	✓ Documentation should reflect the requirements for the CPT code selected
99291	30 - 74 MINUTES	*The clinician's note should indicate:* ✓ The patient's condition is life threatening or they are in imminent danger of organ failure ✓ The details of assessment, treatment plan & any other services provided ✓ The amount of time spent giving care **Not all visits to the ICU qualify as Critical Care**
+99292	EACH ADDITIONAL 30 MINUTES	

INPATIENT NEONATAL & PEDIATRIC CRITICAL CARE SERVICES

CPT Code	DESCRIPTION
99468	**INITIAL** inpatient **neonatal** critical care, per day, for neonate **28 days old or younger**
99469	**SUBSEQUENT** inpatient **neonatal** critical care, per day, for neonate **28 days old or younger**
99471	**INITIAL** inpatient **pediatric** critical care, per day, infant or young child, **29 days – 24 months old**
99472	**SUBSEQUENT** inpatient **pediatric** critical care, per day, infant or young child, **29 days – 24 months old**
99475	**INITIAL** inpatient **pediatric** critical care, per day, infant or young child, **2 – 5 years old**
99476	**SUBSEQUENT** inpatient **pediatric** critical care, per day, infant or young child, **2 – 5 years old**

PROLONGED SERVICES – INPATIENT or OBSERVATION

CPT Code	Time with or w/o direct patient contact on the date of an E/M beyond the required time of the primary service when selected based on Total Time	Total Time
+99418	Report in conjunction with 99223, 99233, 99236, 99255, 99306, 99310 Do not report on the same DOS as 90833, 90836, 90838, 99358, 99359	Each 15 min
+G0316 (Medicare)		Each 15 min

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

Definition of a New Patient

CMS and the AMA CPT® definitions of a new patient align to indicate that:

*A **new** patient is one who has not received any professional (face-to-face) services (E/M, surgical procedures) from the physician/qualified health care professional or another physician/ qualified health care professional of the same specialty and belonging to the same group practice, within the past three years.*

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.

CMS and AMA Updates for E/M Services

- Medical decision making (MDM) **or** Total Time spent in qualifying activities on the date of service is used to drive level of service selection for other E/M services. As a result, code definitions have been revised.
- Observation codes have been deleted. To report these services, inpatient codes are revised to incorporate observation services and are labeled "Hospital Inpatient or Observation Care Services".
- The first level of Consultations have been deleted (99241 and 99251).
- Inpatient and Observation Consultations are combined into one code series (99252-99255), separate from Office or Other Outpatient Consults (99242-99245).
- Time still does not apply to the Emergency Department code set (99281 – 99285) so MDM only is used for code determination.

History and/or Physical Exam

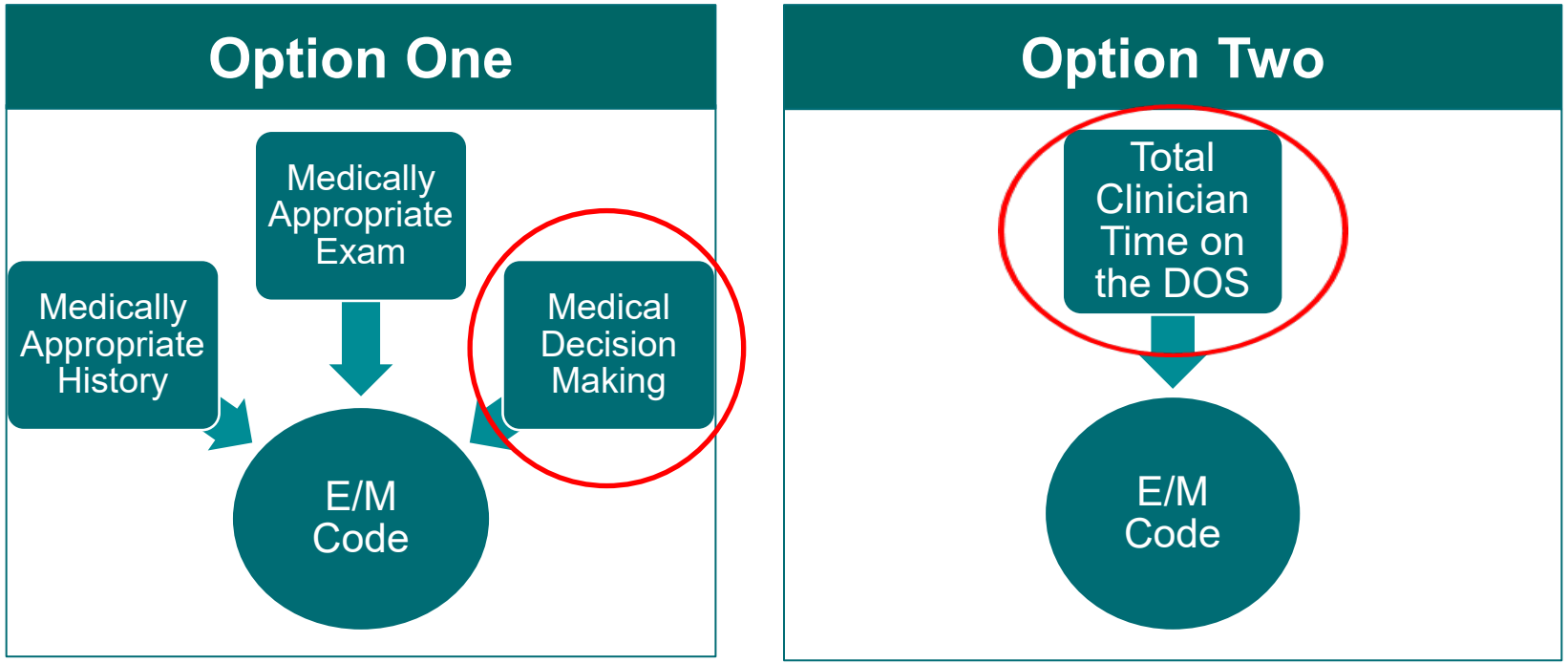
- History (HPI, ROS, PFSH) and/or Physical Exam
  - Are no longer considered key components of evaluation and management services and therefore, no longer utilized in determining the level of service for these visits.
  - Documentation should include a medically appropriate history and/or physical exam.
- The nature and extent of the history and/or physical exam is determined by the clinician.
- The documentation of history and/or physical exam helps to describe the severity of the condition being treated.
- While a certain number of history and/or physical exam elements are not required to support the level of service, the chief complaint should always be documented to establish the reason for the visit.

Presurgical History and Exam

- Documentation requirements for a presurgical history and physical have not changed in association with the Office or Other Outpatient Services (99202-99205 & 99211-99215) documentation changes.
- Clinicians must be certain to continue documenting a complete history and physical examination, as required by medical center bylaws.
  - If the office/outpatient clinic note is used to document a presurgical history and physical, the documentation must contain the required elements.

Evaluation and Management Code Selection

E/M codes are determined by one of two options*



*ED codes can only be determined using MDM (Option One)

Chief Complaint

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

- EVERY service must have a chief complaint
- 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 and should be specific to the condition of the patient
- In the hospital outpatient or inpatient setting:
  - Day 3 of an inpatient hospital stay, i.e., "Continued care of [condition]"

Evaluation and Management Services

Based on Medical Decision Making

Evaluation and Management Service Selection Based on Medical Decision-Making (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 at the encounter:**
   - 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.

Evaluation and Management Service Selection Based on Medical Decision-Making (MDM)

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

E/M Visit Code Criteria

To qualify for a particular level of medical decision making, two of the three MDM elements for that level of medical decision making must be met or exceeded

Elements of Medical Decision Making

Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed + 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
Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** • 2 or more self-limited or minor problems; OR • 1 stable chronic illness; OR • 1 acute, uncomplicated illness or injury OR • 1 stable acute illness OR • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**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)** (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** Examples only: • Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
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) OR **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/ other qualified health care professional (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 • IV fluids with additives • Therapeutic nuclear medicine • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Closed treatment of fracture or dislocation without manipulation • Diagnosis or treatment significantly limited by social determinants of health
High	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**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 (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 elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances

Level of MDM	Number and Complexity of Problems Addressed at the Encounter
Straightforward	Minimal • 1 self-limited or minor problem
Low	Low • 2 or more self-limited or minor problems; OR • 1 stable chronic illness; OR • 1 acute, uncomplicated illness or injury OR • 1 stable acute illness OR • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
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
High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR • 1 acute or chronic illness or injury that poses a threat to life or bodily function

E/M Selection Based on MDM: Number & Complexity of Problems Addressed

The following definitions are related to Number and Complexity of Problems Addressed at the Encounter:

Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. **This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service.** Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

E/M Selection Based on MDM: Number & Complexity of Problems Addressed

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

***Self-limited or minor problem*:** A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status. **[Straightforward/Low]**

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

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. **The treatment required is delivered in a hospital inpatient or observation level setting. [Low]**

E/M Selection Based on MDM: Number & Complexity of Problems Addressed

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition. **[Low]**

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

E/M Selection Based on MDM: Number & Complexity of Problems Addressed

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects. **[Moderate]**

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. **[Moderate]**

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be single system. **[Moderate]**

E/M Selection Based on MDM: Number & Complexity of Problems Addressed

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and **may require escalation in level of care**. **[High]**

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, **that poses a threat to life or bodily function in the near term without treatment.** Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity. **[High]**

Level of MDM	Amount and/or Complexity of Data to be Reviewed + Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.
Straightforward	Minimal or none

Low	**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)
	(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)

Moderate	**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 (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	**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 (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)

E/M Selection Based on MDM: Amount & Complexity of Data to be Reviewed and Analyzed

The following definitions are related to Amount and/or Complexity of Data to be Reviewed and Analyzed:

***Analyzed*:** The process of using the data as part of the MDM. The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment.

- **Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter.**
- **Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed.** In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter.
- **Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.**

E/M Selection Based on MDM: Amount & Complexity of Data to be Reviewed and Analyzed

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. **The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.**

- 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).

Unique: **A unique test is defined by the CPT code set.** When multiple results of the same unique test (e.g., serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. **A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity.** Review of all materials from any unique source counts as one element toward MDM.

E/M Selection Based on MDM: Amount & Complexity of Data to be Reviewed and Analyzed

Combination of Data Elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

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

External physician or other qualified healthcare professional: An external physician or other qualified health care professional is an individual **who is not in the same group practice or is a different specialty** or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational clinician such as from a hospital, nursing facility, or home health care agency.

E/M Selection Based on MDM: Amount & Complexity of Data to be Reviewed and Analyzed

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (e.g., clinical staff or trainees). **Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange**. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (i.e., does not need to be in person), but it **must be initiated and completed within a short time period (e.g., within a day or two)**.

Independent historian(s): An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient **who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis)** or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

E/M Selection Based on MDM: Amount & Complexity of Data to be Reviewed and Analyzed

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

Appropriate source: For the purpose of the **Discussion of Management** data element, an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient **(e.g., lawyer, parole officer, case manager, teacher)**. It does not include discussion with family or informal caregivers.

Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low risk of morbidity from additional diagnostic testing or treatment** Examples only: • Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	**Moderate risk of morbidity from additional diagnostic testing or treatment** Examples only: • Prescription drug management • IV fluids with additives • Therapeutic nuclear medicine • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Closed treatment of fracture or dislocation without manipulation • Diagnosis or treatment significantly limited by social determinants of health
High	**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 or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances

E/M Selection Based on MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

The following definitions are related to Risk of Complications and/or Morbidity or Mortality of Patient Management:

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

For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

E/M Selection Based on MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

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

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.

E/M Selection Based on MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The **monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy.** The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. **Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly.** The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient.

- An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles.
- Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Palmetto GBA, Jurisdiction M (NC, SC, VA, WV): https://www.palmettogba.com/palmetto/jmb.nsf/DID/8EELEJ7715

Palmetto GBA, Jurisdiction J (AL, GA, TN): https://palmettogba.com/palmetto/jjb.nsf/DIDC/8EELEJ7715~Specialties~Drugs%20and%20Biologicals

E/M Selection Based on MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

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

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

E/M Selection Based on MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

Surgery (minor or major, elective, emergency, procedure or patient risk):

- **Surgery–Minor or Major:** The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.
- **Surgery–Elective or Emergency:** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient’s condition. An elective procedure is typically planned (e.g., scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
- **Surgery–Risk Factors, Patient or Procedure:** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

E/M Selection Based on MDM: Risk Associated with Patient's Condition

- All diagnostic/surgical procedures have inherent risk.
- For "HIGH" risk selections on the MDM table, please consider the following outside risk factors:
  - Advanced age/debility
  - Prior surgical difficulties
  - Underlying cardiac disease
  - Underlying lung disease

Please ensure your documentation reflects the severity when selecting high level services

E/M Selection Based on MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

Parenteral Controlled Substances: The level of risk is based on the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty and subspecialty and not simply based on the presence of an order for parenteral controlled substances.

Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed + 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
Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** • 2 or more self-limited or minor problems; OR • 1 stable chronic illness; OR • 1 acute, uncomplicated illness or injury OR • 1 stable acute illness OR • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**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)** (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** Examples only: • Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
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) OR **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/ other qualified health care professional (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 • IV fluids with additives • Therapeutic nuclear medicine • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Closed treatment of fracture or dislocation without manipulation • Diagnosis or treatment significantly limited by social determinants of health
High	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**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 (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 elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances

- Patient with severe exacerbation of chronic illness has been hospitalized for 3 days.
- Clinician reviews and analyzes the results of 2 labs.
- The clinician continues to adjust the patient's meds.
- What is the E/M code?

99232 – Subsequent care, Moderate MDM

Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed + 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
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; OR • 1 stable chronic illness; OR • 1 acute, uncomplicated illness or injury OR • 1 stable acute illness OR • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	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)** (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** Examples only: • Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
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) OR **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/ other qualified health care professional (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 • IV fluids with additives • Therapeutic nuclear medicine • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Closed treatment of fracture or dislocation without manipulation • Diagnosis or treatment significantly limited by social determinants of health
High	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**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 (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 elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances

- New patient presents with an acute uncomplicated illness or injury.
- Clinician collects and documents child's history from an independent historian.
- The clinician prescribes an antibiotic.
- What is the E/M code?

99203 – New patient, Low MDM

E/M Selection Based on MDM: 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

Documentation Tips

Be sure to describe the following in your documentation:

- Gathering history from someone other than the patient, e.g., a family member or friend and why
- Independent interpretation of tests
- Discussion of management of the patient with an external clinician (one outside your practice or specialty)
- Discussion of a test interpretation with an external clinician (one outside your practice or specialty)
- The impact of social determinants of health on the care of the patient
- Decision regarding escalation of hospital-level care
- Route of administration of parenteral controlled substances you order
    - Use descriptive terms to clearly describe the severity of the patient's condition, e.g., "exacerbation of a chronic illness" versus "a severe exacerbation of a chronic illness" or a "life-threatening exacerbation".

Evaluation and Management Services

Based on Total Time

Evaluation and Management Code Selection based on Time

- Time alone may be used to select the level of service.
- The time included is the total time personally spent by the clinician **on the date of the visit.**
- The time includes both face-to-face and non-face-to-face time.
- A face-to-face encounter with the patient is required.
- Total time must be documented in the patient's medical record.
- Only distinct time can be calculated (e.g., in a facility setting, overlapping MD and APP time should only be counted once).
- Time spent by clinical staff on the patient visit is not counted as part of the total time.

Time does not include:

- Travel
- The performance of other services that are reported separately
- Teaching that is general and not limited to discussion of a specific patient's management

Evaluation and Management Code Selection based on Time

- Time spent on services reported separately is not included in the total time (e.g., if an AWV is performed, the time spent on the AWV is not included in total time of the office/outpatient visit).

EPIC SmartPhrase used by Atrium Health – SE Region:

- Charlotte/Navicent/Floyd/Wake SmartPhrase: **.timeattestation**

  "On the day of the visit I spent *** minutes (SmartList inserted here)."

  - This time does not include any time spent performing procedures or assessments that are separately billable.

- The combination of resident and teaching physician's time may not be used to calculate total time. Only the teaching physician's time may be used to support the level of service selected.

Evaluation and Management Code Selection based on Time

Physician/APP time includes the following activities, when performed:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering 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)

Evaluation and Management Code Selection based on Time

Total time associated with each code is a required threshold that must be met or exceeded to report the level of service.

CPT CODE	TIME
99221	40 minutes
99222	55 minutes
99223	75 minutes
99231	25 minutes
99232	35 minutes
99233	50 minutes

Please reference E/M Services Matrix for other E/M categories

Evaluation and Management Code Selection based on Time – Cautionary Example

Clinician sees a total of 25 patients on the date of service in the clinic setting.

- 15 of the patients are billed on time spent:
  - A total of 1080 minutes is documented in the patients' notes.
  - This equates to 18 hours spent on non-face-to-face and face-to-face activities on the day of the visit for the 15 patients.

- The time spent involved with the other 10 patients billed using MDM still needs to be considered during the 24-hour period.

Office & Other Outpatient Visits

Inpatient Visits

Observation Care

Consultations

Emergency Department

Office and Other Outpatient Visits, New 99202-99205

CPT Code	History and Exam	Complexity of MDM	Time
99202	Medically Appropriate	Minimal/Straightforward	15 min **must be met or exceeded**
99203	Medically Appropriate	Low	30 min **must be met or exceeded**
99204	Medically Appropriate	Moderate	45 min **must be met or exceeded**
99205	Medically Appropriate	High	60 min **must be met or exceeded**

Office and Other Outpatient Visits, Established 99211-99215

CPT Code	History and Exam	Complexity of MDM	Time
99211	Evaluation and management of an established patient that may not require the presence of a physician or APP		
99212	Medically Appropriate	Minimal/Straightforward	10 min **must be met or exceeded**
99213	Medically Appropriate	Low	20 min **must be met or exceeded**
99214	Medically Appropriate	Moderate	30 min **must be met or exceeded**
99215	Medically Appropriate	High	40 min **must be met or exceeded**

Initial Hospital Inpatient or Observation Care 99221-99223

CPT Code	History and Exam	Complexity of MDM	Time
99221	Medically Appropriate	Low	40 minutes **must be met or exceeded**
99222	Medically Appropriate	Moderate	55 min **must be met or exceeded**
99223	Medically Appropriate	High	75 min **must be met or exceeded**

Subsequent Hospital Inpatient or Observation Care 99231-99233

CPT Code	History and Exam	Complexity of MDM	Time
99231	Medically Appropriate	Low	25 min **must be met or exceeded**
99232	Medically Appropriate	Moderate	35 min **must be met or exceeded**
99233	Medically Appropriate	High	50 min **must be met or exceeded**

Hospital Inpatient or Observation Discharge Services 99238-99239

CPT Code	Time	Documentation Required
99238	Up to 30 minutes	Per Palmetto GBA guidelines: When documenting discharge services, the amount of time spent performing the service should be documented.
99239	> 30 minutes	

- Includes total duration of time spent by physician/APP for final hospital or observation discharge of a patient.
- Includes (as appropriate) final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms.
- Physicians/APPs of the same specialty and group can combine their time to report 99239.

Time spent with the patient by the physician/APP **DOES NOT** need to be continuous.

Hospital Inpatient or Observation Service (Including Admission and Discharge Services) 99234-99236

Patient is placed in observation or is admitted for **at least 8 hours but less than 24 hours** on the same calendar day. These codes require two or more visits on the same date, one being an initial admission and another being a discharge.

CPT Code	History and Exam	Complexity of MDM	Time
99234	Medically Appropriate	Low	45 min **must be met or exceeded**
99235	Medically Appropriate	Moderate	70 min **must be met or exceeded**
99236	Medically Appropriate	High	85 min **must be met or exceeded**

Per Georgia Medicaid
Observation or Inpatient Hospital Care codes 99234 through 99236 must be used for outpatient observation or hospital admission that begin and end on the same calendar date with a **minimum of twelve (12) hours**.

2 Midnight Rule (Medicare)

Documentation requirements:

- Physician expectation that patient will require medically necessary services for **2 or more midnights**.
- The 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 Services

- The clinician initiating the observation service must place an order for the service.
- Documentation must indicate the medical necessity for the observation status of the patient.
- The series of hospital inpatient or 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 Billing Scenarios

Timing of Care	1 calendar day < 8 hours	1 calendar day 8+ hours	2 calendar days	3 or more calendar days
Report	99221 – 99223 only	99234 – 99236 only	**1st day:** 99221 – 99223 **2nd day:** 99238 – 99239	**1st day:** 99221 – 99223 **2nd + days:** 99231 – 99233 **Last day:** 99238 – 99239

Consultations

A consultation is defined as:

- A written 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

Consultation vs. Transfer of Care

Ask yourself: "**What is the intent of the service being requested** to determine whether this is a 'Consultation' or a 'Transfer of Care' situation?"

- 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:

Consultations

- Effective January 1, 2010, Medicare no longer recognizes the Consultation CPT codes (99242-99255)
- Effective October 1, 2019, UnitedHealthcare no longer recognizes the Consultation CPT codes (99242-99255)
- Effective October 19, 2019, Cigna no longer recognizes the Consultation CPT codes (99242-99255)
- Effective November 1, 2022, BCBS of NC no longer recognizes the Consultation CPT codes (99242-99255)

Office or Other Outpatient Consultations 99242-99245

CPT Code	EPIC I-Codes New/Est	History and Exam	Complexity of MDM	Time
99241	**Code was deleted for 2023**			
99242	**I1702 / I1712**	Medically Appropriate	Minimal/Straightforward	20 min **must be met or exceeded**
99243	**I1703 I1713**	Medically Appropriate	Low	30 min **must be met or exceeded**
99244	**I1704 / I1714**	Medically Appropriate	Moderate	40 min **must be met or exceeded**
99245	**I1705 / I1715**	Medically Appropriate	High	55 min **must be met or exceeded**

Inpatient or Observation Consultations 99252-99255

CPT Code	EPIC I-Codes New/Est	History and Exam	Complexity of MDM	Time
99251	**Code was deleted for 2023**			
99252	**I1722**	Medically Appropriate	Minimal/ Straightforward	35 min **must be met or exceeded**
99253	**I1723**	Medically Appropriate	Low	45 min **must be met or exceeded**
99254	**I1724**	Medically Appropriate	Moderate	60 min **must be met or exceeded**
99255	**I1725**	Medically Appropriate	High	80 min **must be met or exceeded**

Emergency Department Services 99281-99285

CPT Code	History and Exam	Complexity of MDM
99281	**NEW DEFINITION - Evaluation and management of a patient that may not require the presence of a physician or APP**	
99282	Medically Appropriate	Straightforward
99283	Medically Appropriate	Low
99284	Medically Appropriate	Moderate
99285	Medically Appropriate	High

Time is not a descriptive component for ED levels of services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

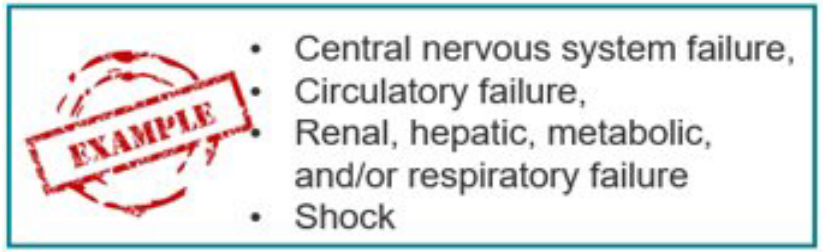
Critical Care Services

Atrium Health

Critical Care

CMS has adopted the **2021 CPT** definition of **critical care**:

*"The direct delivery by a physician(s) or other qualified healthcare professional (QHP) of medical care for a critically ill/injured patient in which there is acute impairment of **one or more vital organ systems,** such that there is a probability of imminent or life-threatening deterioration of the patient's condition. It involves **high complexity decision-making** to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition."*



Critical Care

Critical Care services (99291 & 99292) are time based

99291	+99292
Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

- The clinician's note should indicate the patient's condition as life threatening or in imminent danger of organ failure.
- Noting the patient's condition as **"unstable"** **does not** meet the criteria of a critically ill or injured patient.

Note: The combination of the resident and teaching physician's time may not be used to calculate total time. Only the teaching physician's time may be used to support the code selected.

Not all visits to a patient in ICU qualify as a Critical Care service

Critical Care

Activities that may not meet the 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
- When the patient is ready for transfer to a regular floor or hospice

Critical Care

Use the appropriate E/M code if:

- Patient is admitted to CCU, ICU, SICU when no other beds available
- Patient is 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)
- Patient care no longer meets the critical care criteria as defined by CPT

Critical Care Bundled Services

Critical Care includes the following ***bundled**** services

- interpretation of cardiac output measurements
- chest x-ray
- pulse oximetry
- blood gases
- collection and interpretation of physiologic data
- gastric intubation
- temporary transcutaneous pacing
- ventilator management
- vascular access procedures

These services may not be reported separately for billing

Critical Care Time

Time spent in counseling/discussions with family member 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 Time

Count time spent:

- Ordering/reviewing test results on the unit/floor
- Writing orders and documenting services
- Discussing or coordinating the critical care of the patient on the unit/floor

Do not count time spent:

- Performing separately reportable procedures or services (subtract procedure time from total time)
- In activities outside of the unit or off the floor ***even if related to the patient***

Critical Care 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

*When two or more individuals jointly meet with or discuss the patient, only the time of one individual can be counted.

Critical Care Updates

Same Day E/M

- Clinicians can report medically necessary critical care on the same day as an E/M when the physician documents:
  - The E/M service was provided **prior** to the critical care service at a time when the patient did **not** require critical care.
  - The service is separate and distinct with **no duplicative elements** from the critical care service provided later in the day.

Critical Care Service Crosses Midnight

- CMS has adopted CPT guidance relating to services extending across calendar dates. When this occurs, a continuous service does not reset and create a first hour (initial service). Any disruption in the service does create a **new initial** service. For continuous services that last beyond midnight, report the total units of time provided continuously (99291 and additional units of 99292 when appropriate).
  - CMS states that the clinician can list the date of service billed as either the date the service began or the following day when the service concluded. For consistency, we recommend billing under the date the service was initiated.

Critical Care Updates

Within a Global Surgery Period

- Clinicians can report critical care within a global surgical period when the services are **unrelated to the procedure.**
  - Documentation must clearly indicate the service is *unrelated* and new modifier -FT is required on the claim.

Combining Critical Care time within the Same Group/Specialty

- Physician/APP begins providing a critical care service, but time requirement to report 99291 is not met:
  - Another clinician from the same group practice/specialty continues to deliver critical care to the patient.
  - Time spent by both clinicians can be summed to report 99291.
  - CPT code 99291 would not be reported more than once for the same patient on the same day by the physician/APP.
  - Combined time can be used to meet the critical care add-on code 99292 as well.

Critical Care Updates

Furnished Concurrently by Practitioners in the Same Specialty and Same Group (Follow-up care)

- When multiple practitioners from the same group and same specialty provide critical care to the same patient on the same day, the time spent by both clinicians can be summed to support the time requirement for billing critical care.
    - CPT code 99291 (first 30-74 minutes) would not be reported more than once for the same patient on the same day by these practitioners.
    - Combined time can be used to meet the time requirement for critical care add-on code 99292 (each additional 30 minutes).

Critical Care – Shared Visits

As of January 1, 2022, critical care services may be shared between an APP and MD

- The physician may choose to addend the APP note **OR** each clinician may document separate notes.
- Both the APP and MD provide a medically reasonable and necessary portion of the critical care service and each **independently documents the encounter and his/her individual, distinct time.** The billing clinician must perform and document a *substantive* portion of the E/M service.
  - ***Per CMS, a substantive portion of a critical care visit is defined as more than half the total time spent in critical care qualifying activities as defined by CPT.***
- CMS states the documentation would need to indicate that the services furnished to the patient, including any concurrent care by the clinicians, were medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. **The services provided should be sufficiently documented to allow a medical reviewer to determine the role each practitioner played in the patient's care.**

Critical Care – Shared Visits

- All charges for Critical Care (E/M codes 99291 - 99292) should be submitted by the performing clinician.

- The coding team will evaluate charges for the day and total the time in critical care to select the correct code(s). The billing clinician will be assigned based on who performed the **substantive portion,** and the CMS modifier “FS” will be appended.

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.

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

Virtual Health Documentation and Coding

Technology	Documentation	Code Selection	
		Ambulatory / Office Visits/ OnDemand	Hospital/Facility
Audio Only	• Audio/phone E/M services can be provided to **new and established patients (eff. 01/01/2025).** • **Use EPIC/ENCOMPASS phone visit smart phrase, which includes the following:** ○ Document visit occurred via "telephone – audio only technology" ○ Document patient consent to visit / eConsent ○ Location of the clinician (office/hospital/other) ○ Summarize clinical discussion ○ Document time spent on the call with patient	Select new or established patient phone visit E/M code based on the documented time on the call with the patient or level of MDM documented.	Audio/phone E/M codes are used to report episodes of care initiated by an established patient. There are bundling requirements with other E/M codes that would make these services not applicable in the inpatient setting.
2-Way Audio with Video	• **Use EPIC/ENCOMPASS video visit smart phrase which includes the following:** ○ Visit occurred via "2-way audio/video technology" ○ Location of the Patient ○ Location of the Clinician (office/hospital/other) ○ Document patient consent to visit / eConsent ○ Document teammates assisting with patient • Document key elements performed via video visit as if seeing the patient in person • Document the video start and stop times as prompted in the template **Note:** We are asking for the start and stop times due to some specific payer requirements. The start and stop time is not used for code selection. Please reference EPIC TIP Sheets - Ambulatory and Inpatient for applicable smartphrases	Select the E/M level of office/outpatient code that represents the video service, either based on the level of MDM documented (including medically necessary history and exam); or the total time spent by the billing clinician on the date of service in activities related to the visit. When billing on time, select EPIC or ENCOMPASS time smart phrase and complete with time detail. The time documented should not be a range. **Office consults** – select the consult code from the charge menu for a new or established patient. Append the -GT modifier (MW) or -VVI tracking code (SE) to the selection. **Post Op visits** – select the usual CPT 99024 and append the -GT modifier (MW) or -VVI tracking code (SE).	Select the E/M level of hospital/facility code that represents the video service, either based on the level of MDM documented (including medically necessary history and exam); or the total time spent by the billing clinician on the date of service in activities related to the visit, when the code category allows time-based billing. When billing on time, select EPIC or ENCOMPASS time smart phrase (.timeattestation) and complete with time detail. The time documented should not be a range. **Inpatient or ED consults** – select the usual consult code from the charge menu for a new or established patient. Append the -VVI tracking code to the internal code selection.

Resources for Leaders and Providers: Southeast Region Virtual Health - Home (sharepoint.com)

EPIC Tip Sheets:
Epic Virtual Visit Documentation and Billing Tools (Ambulatory)

Orders - Inpatient Virtual Visit Documentation and Billing Tools.pdf

Medical Record Documentation Standards

Atrium Health

Medical Record Standards

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; and
- Collection of data that may be useful for research and education

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

Medical Record Standards

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

Timeliness of Documentation

- 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

Medicare guidelines:

- Clinicians are encouraged to enter all relevant documents and entries into the medical record **at the time they are rendering the service** in order to maintain an accurate medical record. *Medicare guidelines state that the entry should be in the medical record as soon as practicable after the provision of service.*

Timeliness of Documentation

Effect on Review and Revenue:

- Documentation not completed by the 30th calendar day from the date of the patient encounter:
  - Review - will result in a 100-point deduction for that patient encounter
  - Revenue - is no longer a billable service
- Documentation not started (all possible relevant information brought into the note) within 48 hours of the date of service:
  - Review – will result in best practice education

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.

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

EMR Cautions - Cloning

“**The word 'cloning' refers to documentation that is worded exactly like previous entries**. This may also be referred to as ‘copy/paste’, '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 - 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.
- **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 clinician may be inaccurate.
  - Such features produce information suggesting the clinician performed a more comprehensive service than what was rendered.

Palmetto GBA

Inpatient Medical Record Cloning Example

DOS: 11/19/2022

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: 11/22/2022

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 Cloning Example

DOS: 08/04/2022

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: 11/27/2022

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 08/04/2022: 6.4
Colonoscopy performed in September 2022 was normal.

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

EMR Cautions – Pre-population of Documentation

In this context, pre-population of documentation is the entry of history, exam and/or MDM components into the medical record prior to the arrival of the patient.

- Pre-population is strongly discouraged by Professional Compliance Reimbursements, Auditing and Monitoring. If a clinician chooses to use a prepopulated template, best practice would be to only include accurate, relevant historical elements or the shell of a template to use as a guide for the patient visit.
- When using pre-populated information, 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.
- When total time drives the level of service selected for billing, the total time spent performing qualifying activities on the date of service should not be documented prior to the patient visit.

Pre-populated Template Inconsistencies

Procedure History
Back Surgery
Hysterectomy
Left BKA

Family History
Mother – hypertension
Sister – breast cancer

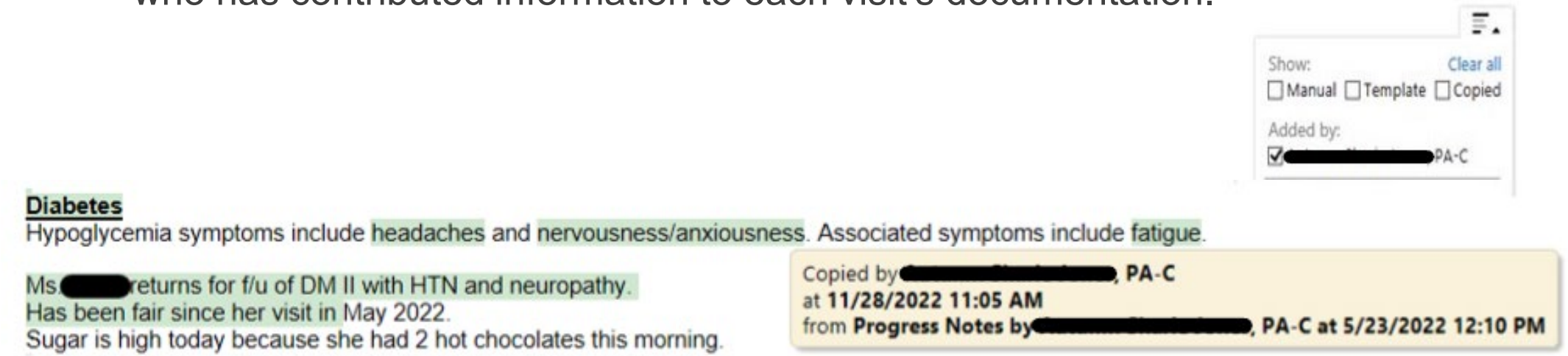
Social History
Alcohol – denies

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

When using a prepopulated note template or macro and exam or other findings are included, inconsistencies such as those identified here can occur.

EMR Cautions - Hover Function

- The EMR has the capability to allow users to hover over the documentation to identify who has contributed information to each visit's documentation.



- Be cautious of ancillary staff documenting any elements of E/M services other than those allowed by CMS.
  - For example: ancillary staff opening templates that include elements of physical exam and/or MDM.

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/APPs 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.

This document was created using the aid of voice recognition Dragon dictation software, please excuse any sound alike substitutions, typographic, or transcription errors. Efforts have been made to correct these dictation errors; however, some may persist, and this does not reflect the standard of medical care. If there are any questions, please do not hesitate to contact me for clarification.

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]

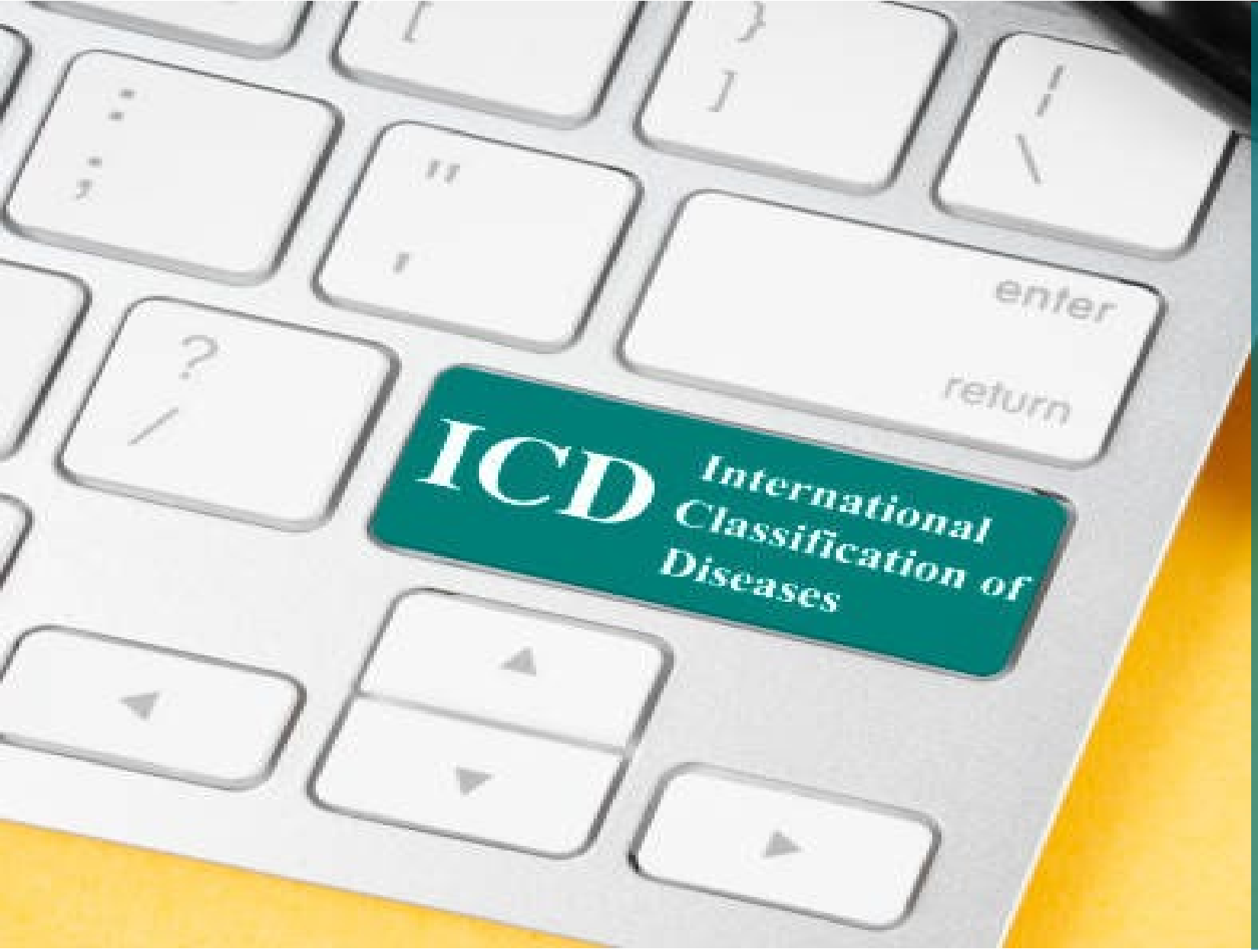
[1] Medicare Carriers Manual, IOM 100-4, Chapter 12, Section 30.6.1.A

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

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

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.
- Incorrect diagnosis coding can have a direct impact on compliance as well as revenue.

It is important to keep the following in mind when documenting and coding a patient 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.

Diagnosis Coding General 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", "differential diagnoses include", 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*"

Diagnosis Coding General 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.)
  - 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

Diagnosis Coding General 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

Diagnosis Coding - Example

- The diagnosis should be documented and selected based on the documentation.
- The first diagnosis in the list should not automatically be selected.

“Patient is diagnosed with an episodic tension headache, not intractable”.

- Headache, unspecified R51.9
- Episodic tension-type headache, intractable G44.211
- Episodic tension-type headache, not intractable G44.219
- Chronic tension-type headache, intractable G44.221
- Chronic tension-type headache, not intractable G44.229

The correct diagnosis code would be G44.219

Advance Practice Practitioners (APPs)

Atrium Health

NP/PA – Billing Guidance

Medicare

- Nurse Practitioners and Physician Assistants (NPs/PAs) are recognized clinicians for Medicare and may bill directly for their services.
- The payment differential from Medicare for NPs/PAs direct billing is 85% of the Medicare Fee Schedule.

Commercial Payers

- Some commercial payers do not currently credential NP/PAs. The NP/PAs should be associated with a supervising physician. Our billing system may automatically default to the physician's name/number, as appropriate.
- Effective February 1, 2022, for Cigna, when the NP/PA provides the service and it is billed under the physician's name and NPI with the SA modifier (Nurse Practitioner rendering service in collaboration with a physician), this will result in a payment reduction.

NP/PA – Billing Guidance

NC Medicaid

- NC Medicaid requires that services provided by NPs/PAs be billed under the NPs/PAs own NPI numbers.
- When the NP/PA provides the service independently, NPs/PAs may bill NC Medicaid directly for the service under his/her own Medicaid provider number (MPN) and will be reimbursed at 85% of the Physician Fee Schedule for E/M services.

Georgia Medicaid

- Each nurse practitioner must enroll and bill for services they provided under their own Medicaid provider number (MPN). Services provided by the physician's assistant shall be billed under their own assigned MPN.
- When the NP/PA provides the service independently, they are reimbursed at 90% of the maximum allowable amount.

Alabama Medicaid

- AL Medicaid CRNPs and PAs are reimbursed at 80% of the allowed amount for all services except lab and injectables, which should pay at 100%.
- Covered services furnished by the PA or CRNP must be billed under the PA's or CRNP's name and NPI as the rendering clinician.

NP/PA – Billing Guidance, Inpatient Setting

- Atrium Health does not allow hospital admitting privileges for Nurse Practitioners or Physician Assistants.
- All admission orders and discharge summaries for inpatient services must be countersigned by the physician.
- Nurse Practitioners and Physician Assistants can independently bill for initial hospital care and hospital discharge services.

Billing for Professional Services

Atrium Health submits claims for payment to insurance payers on behalf of all physicians and APPs when they perform and document professional services.

Services include:

- Evaluation and Management Services (E/M)
- Procedures and Surgery (minor and major)
- Radiology/Pathology Interpretations when appropriate

Complex logic sends the appropriate name (i.e., MD/DO or APP) on the claim based on payer guidelines and other factors.

Physician Services

To ensure billing compliance, when a Physician ***performs and documents the entire service independently*** the physician must:

- Select the service supported by the documentation based on the CPT code requirements
- Enter his/her name in both the *Service Provider* and *Billing Provider* fields

Physicians must not change the Service Provider when co-signing an NP/PA/CNM note

Advanced Practice Practitioner (APP) Services

To ensure billing compliance, when an NP/PA/CNM:

- Performs and documents a service independently, ***OR***
- Performs and documents any portion of an E/M service beyond gathering the Review of Systems and Past/Family/Social Histories such as:
  - History of present illness (HPI)
  - Physical examination
  - Medical decision making (MDM)
  - Counseling/coordination of care

1. **Enter the NP/PA/CNM name in the *Service Provider* field, *and***
2. **Enter the name of the supervising physician in the *Billing Provider* field**

Provider Charge Workflow (PCW)

- PCW allows physicians/NP/PA/CNMs to capture their hospital charges electronically.
- The NP/PA/CNM 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 Advanced Practice Practitioner.

Teaching Physicians, Residents & Medical Students

Teaching Physician Guidelines - Medicare

Medicare will pay for physician services in teaching settings under the physician fee schedule in the following cases:

- The services are personally furnished by a physician who is not a resident. The physician's documentation should include:
  - Patient was seen face to face and examined either with or without the resident
  - Teaching/supervising physician's documentation must be in the first person
  - 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.
- A teaching physician was physically present during the key or critical portion(s) of the service that a resident performs, and the teaching physician participated in the management of the patient.

Teaching Physician Guidelines – Medicare 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 visit codes for which total time is used for the visit level selection

Teaching Physician Guidelines – Medicare

Acceptable attestations 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…."*

Unacceptable **attestations:**

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

Modifier GC

Appended to the CPT code(s) to indicate the teaching physician services rendered follow all the requirements outlined in Section 15016 of the Medicare Carriers Manual.

Teaching Physician Guidelines – Medicare Primary Care Exception

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

Exception to this rule:

Under the primary care exception, in certain teaching hospital primary care centers, teaching physicians can bill certain services that residents provide independently without teaching physicians present, but the teaching physicians must review the care

Certain Primary Care practices are set up as *Primary Care Exception* locations (refer to following slide for approved practice locations).

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

Teaching Physician Guidelines – Medicare Primary Care Exception

The primary care center is considered the patient's primary location for health care services. Residency programs most likely qualifying for this exception include:

- Family Medicine
- Internal Medicine
- Pediatrics
- OB/GYN
- Geriatric Medicine

Note: Atrium Health clinics currently set up to bill Primary Care Exception are:

Greater Charlotte	CMC-Myers Park IM and OB/GYN, Eastland Family, Biddle Point Family, Elizabeth Family, Cabarrus Family, Union Family
Floyd	Family Medicine Residency
Navicent	AH Navicent Primary Care-West Macon
Wake Forest Baptist	Family Medicine – Piedmont Plaza I

Go to Appendix A

Teaching Physician Guidelines – Medicare Surgical Procedures

- Procedures taking five minutes or less to complete and involve relatively little decision making, once the need for the procedure has been determined, the teaching physician must be:
  - Present for the entire procedure in order to bill for the service
- For major procedures including endoscopic operations, 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 Surgical Procedures

- If the teaching physician is involved in overlapping surgeries, he/she must be:
  - Present during the critical or key portions of both procedures. Therefore, the critical or key portions must not take place at the same time.

Acceptable Overlapping Surgical Case Attestation:

*"I was present for the key and critical portions of the procedure ***. In my absence, during the non-critical portions, another surgeon was immediately available to provide assistance."*

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 Anesthesia

- The teaching anesthesiologist must be present during all critical or key portions of the anesthesia procedure and must be immediately available during the entire service.

- If two different teaching anesthesiologists are present with the resident during the key or critical periods of the resident case, the NPI number of the teaching anesthesiologist who started the case will be indicated on the claim to Medicare.

Teaching Physician Guidelines – Medicare Psychiatry

- The general teaching physician policy applies to psychiatric services. However, for certain psychiatric services the requirement for the presence of the teaching physician during the service may be met by concurrent observation of the service by use of a one-way mirror or video equipment. Audio-only equipment does not satisfy the requirement.

- For the time-based services provided such as individual psychotherapy services, the time must include the teaching physician's time only.

- The teaching physician supervising the resident must be a physician. The Medicare Teaching Physician Policy does not apply to psychologists who supervise psychiatry residents in approved GME programs.

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 – Medicaid

NC Medicaid Patients

- The degree of direct supervision remains the responsibility of the teaching physician and is based on the skill level, experience and level of training of the resident, and the complexity and severity of the patient's condition.
- At a minimum, the teaching physician must:
  - Be immediately available by telephone and/or page
  - Review and co-sign the resident's documentation
- Each resident must sign his or her own documentation.

Note: Medicare Managed Care, Virginia Medicaid, West Virginia Medicaid and Tricare follow traditional Medicare teaching physician rules.

Teaching Physician Guidelines – Medicaid

Georgia Medicaid Patients

- Georgia Medicaid follows traditional Medicare guidelines and the teaching physician must be present during the key portion of any exam, surgery or procedure for which payment is sought.
- In E/M services, the teaching physician must be present for the portion of the service that determines the level of services billed.
- The teaching physician must personally document presence and participation in the services in the patient's record.
- Each resident must sign his or her own documentation.

Note: GA Medicaid teaching physician guidelines can be found here: https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Physician%20Services-Q42024%202024091714322 1.pdf

Teaching Physician Guidelines – Managed Care

Managed Care Patients

- Currently, managed care payers have not published specific documentation requirements related to billable services involving a resident or fellow.
- Follow NC Medicaid rules for commercial and managed care payers as listed below:
  - At a minimum, the teaching physician must:
    - Be immediately available by telephone and/or page
    - Review and co-sign the resident's documentation
- 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 – Medicare / Other Payers Medical and APP Students

- 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 MDM.
- The teaching physician must personally perform (or re-perform) the physical exam and MDM activities of the E/M service being billed but may verify any student documentation of them in the medical record, rather than re-documenting this work.
- PA, NP, CNS, CNM, CRNA students as well as medical students are included in this provision, and all may document services in the medical record.
- All medical record documentation should be appropriately signed, titled, dated and approved by the student.

Questions

Additional Information Available in Appendix

Atrium Health

Appendix

Select any link to advance to that topic. Use the  at the end of each segment to return to the appendix.

Additional Topics
A. Primary Care Exception
B. Preventive Medicine Visits
C. Preventive/Split Services
D. Smoking/Tobacco Use Cessation Counseling
E. Commonly Performed Office Procedures
F. Advanced Care Planning
G. Global Surgery
H. Prolonged Services
I. Shared Visits
J. Scribes

APPENDIX A
Primary Care Exception

Primary Care Exception

Teaching physicians providing E/M services with a GME program granted a primary care exception may 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.

The following are covered under the Primary Care Exception:

E/M Services:

- 99202-99203
- 99211-99213

HCPCS Codes:

- G0402, G0438, G0439

Note: The level of service may only be selected based on medical decision-making in the primary care exception setting.

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 - Responsibilities

Residents

- Residents must have completed at least six months of a GME approved residency program.

Teaching Physicians

- Teaching physicians should have primary medical responsibility for the patient(s) being cared for by the residents.
- Teaching physicians should have no other responsibilities (including supervision of other personnel) at the time the service is being provided by the resident.
- Teaching physicians ensure that the care provided was reasonable and necessary.
- Teaching physicians may not supervise more than four residents at any given time.
- Teaching physicians must be immediately available to residents performing patient care.

Primary Care Exception - Documentation

The Primary Care Exception documentation must reflect the following:

- The teaching physician must write a personal note indicating that he/she has reviewed information from the resident's history, exam, assessment and plan and any labs/tests/records etc.
    - Documentation 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.
- The 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 Example

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 modifier GE 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.

Teaching Physician Guidelines

Return to topics

APPENDIX B
Preventive Medicine Visits

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

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APPENDIX C Preventive/Split Services

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 mmedical decision-making (MDM) or the total time spent by the clinician in qualifying activities on the date of service 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 treatment or management, 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 Preventive/Split Services

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, SC and AL 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.
  - AL Medicaid does not cover routine physical exams for adults 21 years of age and older.
- Only services performed *above and beyond* the preventive visit may be used to determine the sick visit level.

Preventive/Split Services and Medicaid

GA 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.
  - Office/Outpatient E/M codes (99202-99205, 99211-99215) can be utilized for the problem-focused visit.
    - ***Use of these E/M codes only applies to recipients 0-20 years of age.***

- If an abnormality is encountered or a pre-existing problem is addressed during the Preventive visit, only services performed *above and beyond* the preventive visit may be used to determine the sick visit level.

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APPENDIX D
Smoking/Tobacco Use Cessation Counseling

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 Practitioner (APP)
- Physician/APP must document intervention methods recommended
- Patient must be alert and competent
- Counseling is covered in both inpatient and outpatient settings
- Medicare co-payment, co-insurance and deductible are waived

Smoking/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

Return to topics

APPENDIX E
Commonly Performed Office Procedures

Commonly Performed Office Procedures and Services

- Cerumen removal*
- EKGs*
- Ultrasounds
- X-rays*
- Laceration (wound) repairs*
- Incision and drainage (I&D)
- Foreign body removal

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

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 a bilateral procedure, report 69210 with modifier -50.

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

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.

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.

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

Global Service

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*

Selecting Wound Repair Codes

- Wound repairs are coded based on anatomical site, 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.

Selecting Wound Repair Codes

- Cauterization or placement of adhesive strips to close a laceration is *not* 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 an intermediate or complex laceration repair is included in the wound repair itself and should not be separately billed.

Selecting Wound Repair Codes

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

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

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

Incision and Drainage (I&D) Codes

- I&D services performed in an office setting are typically found in the *Integumentary Section* of the CPT book.
- Codes include the following:
  - **10060** I&D of abscess, simple or single
  - **10061** I&D of abscess, complicated or multiple
  - **10140** I&D of hematoma, seroma or fluid collection
  - **10160** Puncture aspiration of abscess, hematoma, bulla or cyst
- Typically, no wound closure is needed although a simple drain may be required.
- Includes use of topical anesthesia.

Incision and Removal of a Foreign Body

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

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APPENDIX F
Advanced Care Planning

Advanced 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 Practitioner (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.

Advanced Care Planning: General Requirements

- Order and/or plan of care is necessary and must be documented.
- Time based face-to-face encounter with clinician and patient, surrogate decision-maker and/or caregiver
- Physician and/or Advanced Practice Practitioner 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 non-clinical sources outside the Medicare program.
- No frequency limitations. However, when the Advanced Care Planning is reported multiple times, it is expected to see documented changes in health status or end-of-life wishes.

Advanced 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 and/or 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 physician

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

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

- May be billed separately with Annual Wellness Visit (AWV):
  - 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

Advanced Care Planning: Reporting in the Hospital or Nursing Facility 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

Advanced 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

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APPENDIX G
Global Surgery

Global Surgery

- The global surgical package, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure.

- Medicare payment for the surgical procedure includes the pre-operative, intra-operative and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.

Global Surgery (3 types of global surgical packages)

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

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

10-day Post-operative Period (other minor procedures)

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

90-day Post-operative Period (major procedures)

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

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APPENDIX H
Prolonged Services

Non-Medicare Prolonged Service Code

- The AMA created a prolonged service add-on code in 2021 for use with **99205 and 99215. This has been extended to include 99245 in 2023.**
- Use for **Non-Medicare** patients
- Time spent on performing separately billable service(s) is not counted toward the time for reporting 99205/99215/99245 or the prolonged service code.
- Prolonged total time is time that is 15 minutes beyond the **time threshold** required to report the highest-level primary service.

Code	Definition
+ 99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time

Non-Medicare Prolonged Service Code

New Patient CPT Code	Total Time
99205	60 - 74 minutes
99205 and 99417	75 - 89 minutes
99205 and 99417 x 2	90 - 104 minutes
99205 and 99417 x 3 or more for each additional 15 minutes	105 minutes or more
Established Patient CPT Code	**Total Time**
99215	40 - 54 minutes
99215 and 99417	55 - 69 minutes
99215 and 99417 x 2	70 - 84 minutes
99215 and 99417 x 3 or more for each additional 15 minutes	85 minutes or more
Office or Other Outpatient Consultation CPT Code	**Total Time**
99245	55 minutes
99245 and 99417	70 - 84 minutes
99245 and 99417 x 2	85 - 99 minutes
99245 and 99417 x 3 or more for each additional 15 minutes	100 minutes or more

Non-Medicare Prolonged Service Code

- The AMA has created a new prolonged service add-on code for use with **99223, 99233, and 99255.**
- Use for **Non-Medicare** patients
- Time spent on performing separately billable service(s) is not counted toward the time for reporting 99223/99233/99255 or the prolonged service code.
- Prolonged total time is time that is 15 minutes beyond the time required to report the highest-level primary service.

Code	Definition
+ 99418	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time

Non-Medicare Prolonged Service Code

Initial Hospital Inpatient or Observation CPT Code	Total Time
99223	75 minutes
99223 and 99418	90 - 104 minutes
99223 and 99418 x 2	105 - 119 minutes
99223 and 99418 x 3 or more for each additional 15 minutes	120 minutes or more
Subsequent Hospital Inpatient or Observation CPT Code	**Total Time**
99233	50 minutes
99233 and 99418	65 - 79 minutes
99233 and 99418 x 2	80 - 94 minutes
99233 and 99418 x 3 or more for each additional 15 minutes	95 minutes or more
Inpatient or Observation Consultation CPT Code	**Total Time**
99255	80 minutes
99255 and 99418	95 - 109 minutes
99255 and 99418 x 2	110 - 124 minutes
99255 and 99418 x 3 or more for each additional 15 minutes	125 minutes or more

Medicare Prolonged Service Code for Office and Other Outpatient Services

CMS created HCPCS add-on code **G2212** in 2021 that should be used when reporting prolonged services for **Medicare patients** only. Report this code with **99215 and 99205**.

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

Reporting Prolonged Service Codes

- To simplify the reporting of prolonged service codes, logic has been created in EPIC to prompt a review of patient encounters when a prolonged service code has been ordered by the physician/APP.
- When performed and supported by documentation, the physician/APP will select the appropriate E/M visit code, and then select the prolonged service code **99417/99418** which will trigger an edit in the billing system.
- A coder will review the documentation and select the appropriate prolonged service code based on total time and insurance type.

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APPENDIX I
Shared Visits

Shared Visits

In the **hospital-based clinic and facility settings**, the advanced practice practitioner and physician may perform a *shared* visit, if the following criteria are met:

- CMS defines a shared visit as an E/M visit in the **facility** setting that is performed in part by both an advanced practice practitioner and a physician who are in the same group, in accordance with applicable laws and regulations.
- Concept does not apply in an office setting (POS 11).

One of the clinicians must have face-to-face (in-person) contact with the patient, but it does not have to be the clinician who performs the substantive portion and bills for the visit.

For 2024, CPT revised their guidelines for shared visits; CMS has also aligned their definition of substantive portion with the CPT guidelines.

Shared Visits

Updated Definition

Both the advanced practice practitioner and physician perform a medically necessary portion of the E/M service and each individually documents the encounter. The **billing clinician** must perform and document a substantive portion of the E/M service.

- ***Substantive* is defined by CPT and CMS as more than half of the total time spent by the physician and nonphysician practitioner or a substantive part of the MDM.**
  - *Performance of a substantive part of the MDM requires that the physician or advanced practice practitioner made or approved the management plan for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, the clinician has performed two of the three elements used in the selection of the code level based on MDM.*

Shared Visit Setting

Facility settings include:

- Inpatient setting
- Hospital-based Clinics
- Outpatient Hospital departments
- Skilled Nursing Facility/Nursing Facility (SNF/NF)

Settings not allowed:

- Office setting (POS 11)
- For SNF/NF services that are required to be performed in their entirety by a physician
  - See Conditions of Participation in 42 CFR § 483.30 for further information.

Shared Visits

In the **hospital-based clinic and outpatient hospital settings**, the advanced practice practitioner and physician may perform a *shared* visit, if the following criteria are met:

- Both the advanced practice practitioner and physician must sign their portion of the documentation.
- Best practice would be for the advanced practice practitioner and physician documentation to identify the clinician involved in the shared/split visit.
  - For example, *This is a shared visit with ***.*

Caution: Appending a Teaching Physician Attestation will not support a shared visit with an advanced practice practitioner.

Shared Visits

When time spent is used to select the appropriate level of a service for a shared/split outpatient visit (99202-99205 & 99212-99215), the distinct time personally spent by the advanced practice practitioner and physician assessing and managing the patient on the date of the visit is added together to determine total time.

- Includes face-to-face and non-face-to-face time of each clinician spent in patient activities as defined by AMA/CMS on the day of the visit.
- Only distinct time should be added together for shared/split visits (e.g., when two or more individuals jointly discuss the patient, only the time of one individual should be counted).
- Both the advanced practice practitioner and physician must document individual, distinct time spent for each patient.

Shared Visits

When time is used as the substantive portion, the **billing provider** would be the clinician who spent more than half the total time performing the shared visit.

It is comprised of time **with or without direct patient contact** spent on the following activities (AMA/CMS)**:**

- Preparing to see the patient (i.e., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family
- Ordering medication, test, or procedures
- Referring and communicating with other health care professionals
- Documenting clinical information in the EHR
- Independently interpreting results (not reported separately) and communicating results to patient, family, or caregiver
- Care coordination (not reported separately)

Shared Visits

Time does not include:

- Travel
- The performance of other services that are reported separately
- Teaching that is general and not limited to discussion of a specific patient's management

Shared Visit Modifiers

The APP will enter the charge (level of service) and the correct modifier based on who provided the **substantive portion** of the shared visit.

- If the Physician performed and documented the **substantive portion,** the “F2F” modifier should be appended to the charge.
- If the APP performed and documented the **substantive portion,** the “FS” modifier should be appended to the charge.

Shared Visit Documentation Requirements

	LEVEL OF SERVICE		BILLING PROVIDER	
E/M Category	***Level of Service Selection***	***Documentation Requirements for Level of Service Selection***	***2024 Billing Provider Selection – Substantive Portion***	***Documentation Requirements for Billing Provider Selection - Substantive Portion***
Other Outpatient 99202-99215 (in facility setting only), Inpatient, Observation, Hospital, and SNF	MDM **OR** total time spent	MDM **OR** total time spent on the DOS on qualifying activities	Perform a substantive portion of medical decision making **OR** spend more than half of the total time*	A substantive portion of medical decision making **OR** total time spent on the DOS on qualifying activities**
Emergency Department	MDM (Cannot select E/M level based on time.)	MDM	Perform a substantive portion of medical decision making **OR** spend more than half of the total time*	A substantive portion of medical decision making **OR** total time spent on the DOS on qualifying activities**
Critical Care	Total time spent in Critical Care qualifying activities	Total time spent in and description of Critical Care qualifying activities	Spend more than half of the total time in Critical Care qualifying activities	Total time spent in Critical Care qualifying activities**

*When performing a shared visit with substantive portion based on total time, both providers must document their personal and distinct time.

**List of AMA/CMS defined activities for total time can be located on page 20 the following link: CPT E/M 2023 Code and Guideline Changes

Shared Visits

The following services may *not* be shared:

- IPPE
- Procedures
- Nursing Facility E/M visits that are required to be performed in their entirety by a physician
- Home and Residence Services
- Services performed in an office/clinic setting (POS 11)

Return to topics

APPENDIX J
Scribes

Scribes

Scribe Requirement/Workflow:

- Must be a trained medical scribe.
- The scribe may not act independently (e.g., develop sentence structure, formulate/interject observations/opinions); but should only document the physician's dictation during the service/encounter or at the direction of the physician.

Clinician Requirement/Workflow:

- CMS requires that scribed services be authenticated by the clinician.
- The clinician is ultimately responsible for the contents of the documentation and their signature confirms that they have reviewed the scribe documentation and agree that it is accurate.

Note: Floyd clinicians do not utilize scribes.

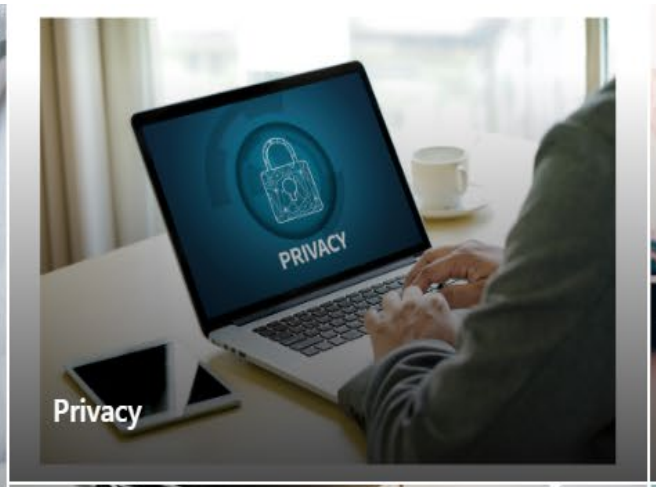
Scribes

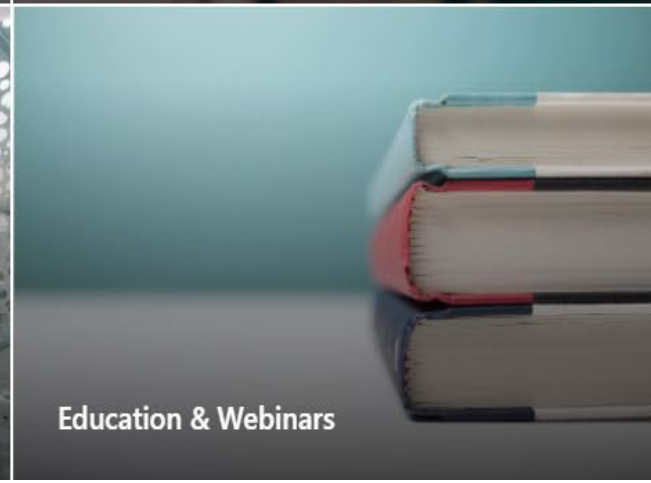
Documentation of a scribed service must include the following elements:

- A personal, dated note from the scribe that:
  - Identifies them as the scribe of the service
    - Example of a compliant scribe statement – “I (scribe's name) am acting as scribe for (provider's name)."
  - Attests that the notes are written/recorded contemporaneously in the presence of the clinician performing the service
  - Identifies the clinician of the service
  - Evidence of review and signature of the billing clinician. This authentication must take place in a timely manner as with any other note since other clinicians may be dependent on the documentation to make informed decisions regarding patient care, treatment and services.
  - Notation by the billing clinician stating: “I have reviewed the above documentation for accuracy and completeness, and I agree with the above.”

Enterprise Compliance

Atrium Health
Now part of ADVOCATEHEALTH





Atrium Health

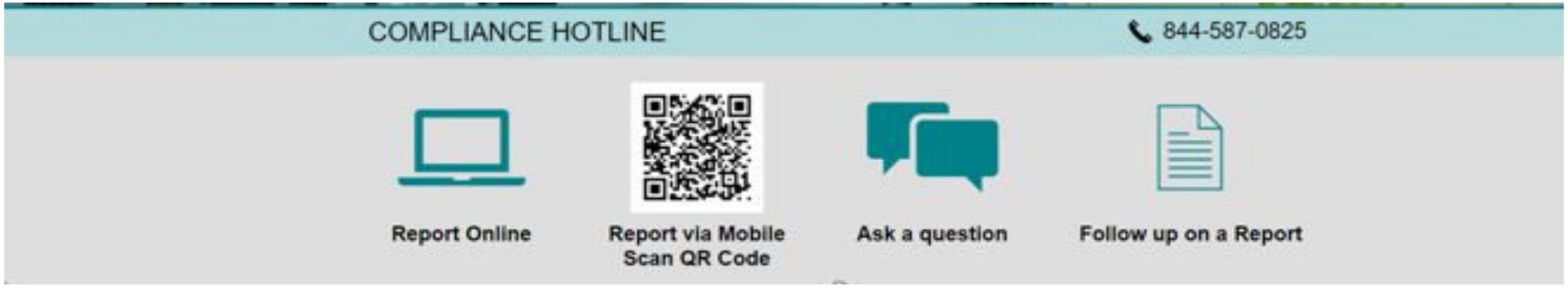
Compliance Hotline

Report a concern and/or issue:

- Confidential & Anonymous Reporting
- 24 hours a day / 7 days a week

Utilize the hyperlink below to access the online Compliance Hotline:

EthicsPoint - Atrium Health



Atrium Health

Code of Conduct/Hotline

[Connect to our Code (atriumhealth.org)]

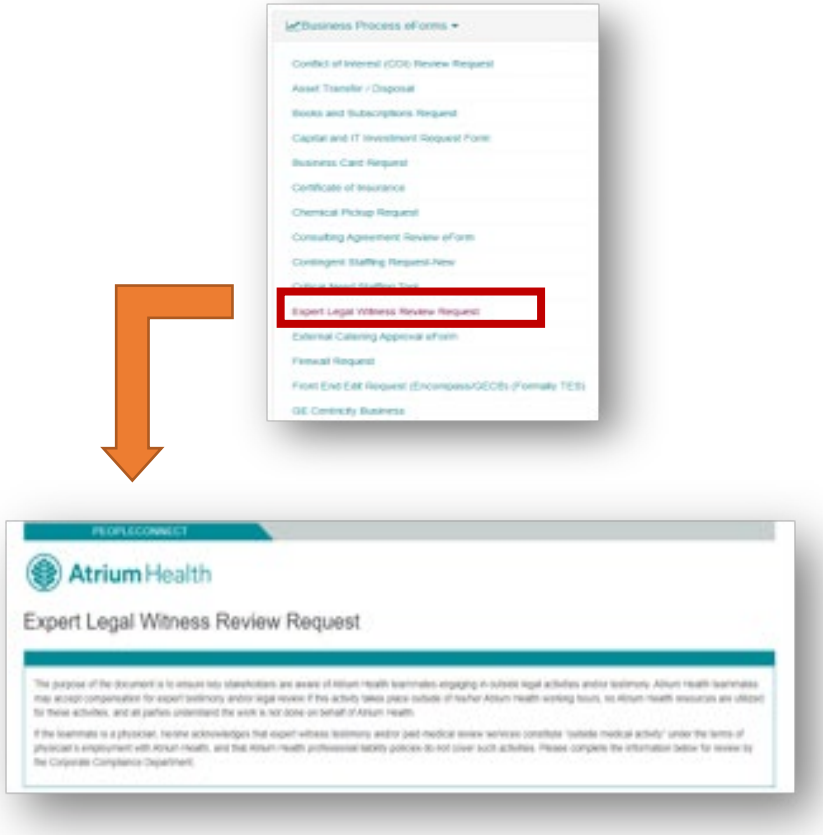
Enterprise Compliance

You Are A Key Piece

Atrium Health

Expert Legal Witness eForm

- Any engagement in outside legal activities and/or testimony must be approved by Risk Management, OGC, and Compliance.
- *Review is critical!*
- Avoid cases where our physicians are involved
  - Avoid cases where AH is a party
  - Avoid overall conflicts of interest
- Complete the Expert Legal Witness eForm on PeopleConnect/eForms
  - Must be signed into PeopleConnect through GoRemote
  - https://peopleconnect.atriumhealth.org/tools/eforms



Atrium Health

Conflict of Interest

- All Individuals must seek prior approval from their leadership and from the Office of Conflicts & Integrity for outside consulting, other employment opportunities, and educational activities funded by Industry.
- Examples of activities that require pre-approval:
  - Consulting for a pharmaceutical company or IT firm
  - Investing in an external urgent care clinic
  - Organizing, attending or speaking at a non-CME educational event funded by a vendor of Atrium Health
  - Owning/operating an outside business that is related to a teammate's Atrium Health employment responsibilities or may seek to do business with Atrium Health
- Examples of activities that DO NOT require pre-approval through eCOI:
  - Participation in CME activities at domestic academic medical centers or for U.S. federally-funded courses
  - Writing, textbook editorship, visiting professorships/lectureships
  - Membership on peer review or grant review panels, service on study sections, participation on DSMBs or OSMBs for domestic federal or state studies, etc.

Conflict of Interest Review Request

- Visit the **Preapproval for Outside Relationships and Activities** page: https://www.wakehealth.edu/about-us/conflict-of-interest/preapproval-for-outside-relationships-and-activities

Print this User Guide for step-by-step instructions before you login.

Click here to login to the Huron eCOI system using your **wakehealth.edu** or **atriumhealth.org** login.

END